STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156	F 156 1. The contact information for the State Agency was posted at each nurses station on August 29.2013 by Social Worker. 2. Residents that reside at the center have the potential to be affected by this alleged deficient practice. 3. Resident Council meeting was held on 9-6-13 by Activity Director and the posting of the contact information for the State Agency was reviewed along with where the information is posted. Education was provided to the Social Service Department by Manager of Clinical Operations on 9-4-13 regarding the regulatory requirements for posting of pertinent State client advocacy groups to include the State Hotline number. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA 9.20.13

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

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	Administrator and or Social Worker will validate posting of State Agency contact information weekly for 30 days and monthly thereafter for 60 days. 4. The Administrator or Director of Nursing will analyze and evaluate the data gathered above looking for patterns and trends. The results of this evaluation will be reported weekly for 30 day and then monthly x 90 days to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9-25-13

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

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post State Agency contact information. The findings included: On 8/26/13 at 11:00 AM, an initial tour of facility was conducted. State contact information was not observed posted in the facility. On 8/27/13 at 10:00 AM., State contact information was not observed posted in the facility. On 8/28/13 at 4:00 PM., State contact information was not observed posted in the facility. On 8/29/13 10 AM., Administrative staff #2 went on tour with this surveyor. No State contact information was posted in the facility. She stated the building was remodeled and the State contact information was waiting to be placed in frames. When asked regarding the remodeling, she stated the remodeling was completed in May 2012. Administrative staff #2 said the State contact information should have been posted. On 8/30/13 at 8:47 AM., the Resident Council President stated that he did not know where the State contact information was located and it had not been discussed at the Resident Council meetings. On 8/30/13 at 9:34 AM., Administrative staff #3 stated the State contact information sign had not been posted for over a year. She indicated they	F 156	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated	9.25.13

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F 156	Continued From page 3 referred concerns to the Ombudsman and did not realize there were two different agencies. On 8/30/13 at 11:55 AM., the activity director stated the State contact information was not addressed in the Resident Council meetings since most concerns were referred to the Ombudsman.	F 156	F253 D 1 The wheelchairs located in room 302B, 303, 318A and 318B as well as the tube feeding pole in room 321 were cleaned by the housekeeping staff on 8-29-13.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain the wheelchairs and tube feeding pole in a clean and sanitary condition in 1 (300 hall) of 5 halls. Findings included: On 8/27/13 at 11:48 AM, the wheelchairs in rooms 302 B, 303, 318 A and 318 B were observed to be dirty with dust and food particles on the seat and the side bars of the wheelchair. The base of the tube feeding pole in room 321 was dirty with dried tube feeding formula. On 8/29/13 at 11:15 AM, floor technician #1 was interviewed. He stated that floor technicians were responsible for cleaning the wheelchairs and the housekeepers were responsible for cleaning the tube feeding pole. He stated that they used to have a wheelchair cleaning schedule for each hall but that was stopped a month ago. He did not	F 253	2 Residents who use assistive devices for mobility or use tube feeding poles have the potential to be impacted by this alleged deficient practice. Assistive devices used for mobility and enteral feeding poles were observed for cleanliness on 8-29-13 by housekeeping supervisor. No other assistive devices or feeding poles were in need of cleaning. 3 Housekeeping staff was educated on the cleaning of resident equipment on 9-11-13 by the Environmental Services Director. A written cleaning schedule was developed by the The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated	9.25.13

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F 253	Continued From page 4 explain why it was stopped. He indicated that nursing staff were supposed to let them know if the wheelchair needed to be cleaned. On 8/29/13 at 11:33 AM, the floor technician had observed the wheelchairs in room 302 B, 303, 318 A and 318 B to be dirty and dusty. The base of the tube feeding pole in room 321 remained the same with dried tube feeding formula. He stated that he would take care of them right away. On 8/29/13 at 12:15 PM, administrative staff #5 was interviewed. She stated that she had a monthly wheelchair cleaning schedule for each hall. When asked when was the last time the wheelchair on 300 hall were cleaned, she stated it was in July, 2013 and showed me an e-mail to the administrative staff #2 to get all wheelchairs out for cleaning. There was no other information provided except for the e-mail. She also stated that the housekeeper should have cleaned the tube feeding pole when she cleaned the room. On 8/29/13 at 12:20 PM, Nurse #3 was interviewed. She stated that the housekeeping department had a schedule to clean the wheelchairs weekly by halls. She added that if a wheelchair needed to be cleaned, the housekeeping department was informed. She stated that she was not aware that the wheelchairs were dirty.	F 253	Housekeeping Supervisor on 9-4-13 for a monthly cleaning schedule. Weekly audits of resident equipment by the housekeeping supervisor or assistant supervisor to identify equipment that may need cleanly more frequently and cleaned as needed. The housekeeping supervisor educated the housekeeping staff on the written schedule on 9-11-13. 4. Housekeeping Supervisor will analyze and evaluate the data gathered from the weekly audit patterns and trends. The results of this evaluation will be reported weekly for 30 day and then monthly x 90 days to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9-25-13
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility failed to address in care plan the sexually inappropriate behavior for 1 (Resident #102) of 1 sampled resident with sexually inappropriate behavior. Findings included: Immediate Jeopardy began on 7/20/13 at 6:00 PM when Resident #102 was observed touching Resident #72 inappropriately. The care plan for behavior did not address the resident's sexually inappropriate behavior. The Immediate Jeopardy was identified on 8/27/13 and was abated on 8/30/13 when the facility provided an acceptable credible allegation. Resident #102 was admitted to the facility on 6/26/13 with multiple diagnoses including Alzheimer's disease, Dementia, Anxiety State and Depression. The admission Minimum Data Set (MDS) assessment dated 7/6/13 indicated that	F 279	F279 J 1. Resident #102 was discharged as of 7-25-13 therefore no further interventions are possible. 2. Social Services Director and Social Workers audited current residents' care plans on 8-29-13 to identify residents with sexually inappropriate behaviors. Audit results identified one resident with verbally inappropriate comments and this resident's care plan was updated to reflect behavior with interventions. 3. On 8-28-13, the Director of Nursing provided training to Social Services staff regarding appropriate interventions for residents with behaviors including sexually inappropriate behaviors. Interventions include: Separating residents, offering alternative activities, one on one supervision, psychiatric assessment, medication regime review, ensure other physical needs like hunger and toileting are met. Other interventions will be developed based upon individual needs. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 279	Continued From page 6 Resident #102 had moderately impaired cognition and needed supervision for locomotion on and off unit. The assessment further indicated that Resident #102 had physical and verbal behavioral symptoms directed toward others. The assessment also indicated that the behavior had impact on others and had significantly intruded on the privacy or activity of others. The care plan was reviewed. The care plan on behavior addressed the resident's combativeness and resistance to care but did not address the resident's sexual inappropriate behavior. On 7/1/13 at 5:29 PM, the notes revealed that Resident #102 was sitting on the hallway holding the hand of Resident #123 (cognitively impaired female resident) and was touching her inappropriately. On 7/9/13 at 4:50 PM, the notes revealed that Resident #102 was making inappropriate sexual comments to staff, raised his arms and attempted to hit staff. On 7/11/13 at 4:14 PM, Resident #102 had approached a nurse really closed when she was pulling medications for another resident. When he was asked to move away, he proceeded to raise his arm in an attempt to hit her buttocks. On 7/20/13 at 6:00 PM, the notes revealed that staff member had observed Resident #102 with his hands on the pants and incontinence brief of Resident #72 (cognitively impaired female resident). On 7/23/13 at 3:20 PM, the notes indicated that a nurse aide reported that Resident #102 had	F 279	Residents with sexual, verbal and physical behaviors will be reviewed along with their written care plans by the Inter Disciplinary Team (IDT) weekly for 30 days and monthly thereafter. This review will encompass the effectiveness of the interventions and making appropriate modifications to behavioral care plans. Any newly identified behaviors or changes in behaviors will be reviewed weekly for 30 days and monthly thereafter. 4. The Director of Nursing and or Assistant Director of Nursing will review the monitoring tool from the IDT meeting and will analyze and evaluate the data gathered looking for patterns and trends. The results of this evaluation will be reported weekly for 30 day and then monthly to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 279	Continued From page 7 slapped her on the buttocks. 8/28/13 at 9:50 AM, administrative staff #4 was interviewed. She stated that she was aware of the sexually inappropriate behavior of Resident #102 towards the residents but she was not aware of his behavior towards the staff. She added that she was responsible in developing a care plan for behaviors and acknowledged that she missed to address in the care plan the sexually inappropriate behavior of Resident #102. On 8/28/13 at 1:50 PM, NA #4 was interviewed. She stated that Resident #102 had asked her questions which were sexually inappropriate. On 8/28/13 at 1:55 PM, NA # 3 was interviewed. She stated that Resident #102 was physically and verbally abusive. He had hit her on her buttocks and showed her his private area. On 8/28/13 at 1:58 PM, NA # 5 was interviewed. She stated that she had heard Resident #102 asking other resident to have sex with them. On 8/28/13 at 2:15 PM, NA # 2 was interviewed. She stated that Resident #102 should not be around the residents. He was showing his private area and was asking for sex from her. On 8/30/13 at 10:05 AM, administrative staff # 2 was interviewed. She stated that she was made aware of the sexually inappropriate behaviors of Resident #102. She stated that the social worker was responsible for creating a care plan for behavior. She indicated that the sexually inappropriate behavior should have been addressed in the care plan.	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 279	Continued From page 8 The facility provided the following Credible Allegation of Compliance on 8/30/13 at 12:17 PM. 1. Resident #102 was discharged as of 7-25-13 therefore no further interventions are possible. 2. Social Service Director and Social Workers audited current resident ' s care plans on 8-29-13 to ensure identification of resident ' s with sexually inappropriate behaviors. Audit results identified one resident with verbally inappropriate comments. 3. Social Services Director and or social workers have reviewed care plan interventions for identified residents and updated as appropriate on 8-29-13. Interventions include: Separating residents, offering alternative activities, one on one supervision, psychiatric assessment, medication regime review, ensure other physical needs like hunger and toileting are met. Other interventions will be developed based upon the individual needs. On 8-28-13 the Director of Nursing provided training to social service staff regarding appropriate interventions for resident with behaviors including sexually inappropriate behaviors. Interventions include: Separating residents, offering alternative activities, one on one supervision, emergent medical assessment, medication regime review, ensure other physical needs like hunger and toileting are met. Other interventions will be developed based upon the individual needs. Residents with sexual, verbal and physical behaviors will be reviewed along with their written care plan by the IDT weekly for 30 days and monthly thereafter. This review will encompass the effectiveness of the interventions and making appropriate modifications to behavioral care plans. Any newly identified behaviors or changes	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 279	Continued From page 9 in behaviors will be reviewed weekly for 30 days and monthly thereafter. 4. The Director of Nursing and or Assistant Director of Nursing will review the monitoring tool from the IDT meeting. The monitoring tool is designed to document the care plan interventions and observations of the resident for the effectiveness of interventions. The results of this review will be analyzed and reported to the Quality Assurance committee on a weekly basis for 30 days and monthly thereafter. The credible allegation was verified on 8/30/13 by staff interviews and record review. Resident #102 was discharged to another facility on 7/25/13. Records of 1:1 observation were reviewed. The 1:1 supervision was initiated on 7/20/13 until 7/25/13 when the resident was discharged. Interview with the social worker revealed that an audit of the care plans was completed and one resident was identified with behavior. Review of the identified resident's care plan revealed that it was updated on 8/27/13 to address his behavior. The social worker also indicated that she had received training from the director of nursing regarding developing a care plan for behavior including sexually inappropriate behaviors.	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 J 1. On 8-27-13, Resident #58 was provided immediate first aid and assessed by the Director of Nursing pending transportation to the local Emergency Department (ER) for assessment and evaluation. On 8-27-13 @ 5:25 PM, Resident #58 was transferred to the ER by local EMS by stretcher. Resident #58"s attending physician was notified by the Assistant Director of Nursing (ADNS) on 8-27-13 at 5:25 PM of the incident and he provided directives to her care by providing an physicians order to send to resident to the ER for evaluation. The Responsible Party was notified of the incident on 8-27-13 at 5:30 PM by the ADNS. Resident #58 was returned to the building on 8-27-13 at 11:00 PM after treatment at the local ER.	9.25.13
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 adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of manufacturer specifications, the facility failed to safely remove 1 (Resident #58) of 3 sampled residents from the facility van by pushing the resident, in her gerichair, out the rear of the van without ensuring the lift platform was elevated resulting in Resident #58 tipping backward and falling out of the gerichair. The resident sustained a laceration to her scalp requiring 2 staples. The facility also failed to implement interventions to prevent repeated sexual inappropriate behavior towards other cognitively impaired residents for 1 (Resident #102) of 1 sampled resident. Immediate jeopardy began on 7/20/13 when Resident #102 was observed touching a cognitively impaired resident inappropriately. Immediate Jeopardy continued when Resident #58 tipped backward and fell out of the facility transport van on 8/27/13. Immediate jeopardy was identified and brought to the attention of the administrator on 8/28/13 at 2:31 PM. Immediate jeopardy was removed on 8/30/13 for Residents #102 and #58 at 12:17 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy). The findings included:	F 323	Upon return, Resident #58 was assessed by a Registered Nurse (RN) and plan of care updated to include: falls care plan by eliminating facility transportation via Geri chair and care of staples. Driver and Nursing Assistant (NA) were suspended on 8-27-13 pending investigation. Resident transportations have been outsourced as appropriate vendors pending completion of investigation. Resident #102 was discharged as of 7-25-13 therefore no further interventions are possible. 2. All residents transported in the Center's van have the potential to be affected by this deficient practice. Residents that have exhibited verbal, sexual and or physical behaviors have been identified by a review of the MDS and staff interviews by the Inter-Disciplinary Team (IDT) on 8-28-13. The IDT will include representatives from Nursing, Social, Rehabilitation, Activities and Administration. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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

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F 323	Continued From page 11 Manufacturer specifications for the wheelchair lift read in part, "Vehicle (Floor Level) Loading and Unloading: The platform must be fully raised (at floor level) and the inner roll stop (bridge plate) must be properly positioned when loading or unloading passengers in or out of the vehicle. It is the responsibility of the lift attendant to ensure the platform and the inner roll stop are properly positioned at floor level when loading and unloading passengers." 1. Resident #58 was readmitted to the facility on 7/16/13. Diagnoses included status post surgical nailing of a right tibia/fibula fracture, end stage renal disease, hemodialysis and bipolar disorder. The most recent Minimum Data Set, a significant change dated 7/23/13, indicated that Resident #58 had severely impaired vision, was cognitively intact, was non-ambulatory and was totally dependent on staff for locomotion. On 8/27/13 at 5:15 PM an overhead page was heard for a nurse to come immediately to the main entrance of the facility. At this time the facility transport van was observed parked in front of the main entrance to the facility. Resident #58 was observed lying on the lift platform which was resting on the ground at the rear of the van. Her gerichair was tipped backwards and hanging down from the rear doorway of the van. The back of the resident's head was resting on the lift platform's left side plate. Nursing staff arrived and assessed the resident who was intermittently yelling, squirming and complaining of leg pain. The back of the resident's head was bleeding and staff applied a towel, pressure and ice. Following	F 323	3. Staffs that provide transportation services were trained on the safe loading and unloading of residents on 8-27-13 by Maintenance Director and Administrator. Training included: positioning of wheel chair (w/c) in the center of lift, when to lock brakes, lifting and lowering of lift gate, positioning of w/c in van, securing w/c to the floor, placement of seatbelt and validation of lift gate position prior to unloading. Staff provided return demonstration of competency for safe loading and unloading of residents. Competency and training will be validated annually, upon hire and as needed for all staff transporting residents by the Maintenance Director. Manufacturer's (Century 2 Operations Manual and Q-Straint user instructions) recommendations have been incorporated into training material. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 12 the assessment, five staff lifted the resident into a gerichair, keeping her head immobilized. Emergency Medical Service (EMS) arrived at 5:29 PM and transported resident to the Emergency Room (ER). An interview was conducted with NA #6 on 8/27/13 at 5:31 PM. NA #6 indicated she accompanied Resident #58 that afternoon to a physician appointment and they had just returned to the facility. NA #6 stated there were also 2 other residents (Resident #142 in the front passenger seat and Resident #153 in a wheelchair behind Resident #58) and the driver (Driver #1) in the van. NA #6 explained Driver #1 assisted Resident #142 out of the van via the passenger side door while she took Resident #153 out of the van via the wheelchair lift at the rear of the van. NA #6 stated her usual practice was to immediately raise the lift after wheeling a resident off the lift platform so the platform would be level with the floor of the van. However, after moving Resident #153 off the platform she did not raise the lift because she was distracted by Resident #142, who was walking back into the facility behind his wheelchair, and she was keeping an eye on him. NA #6 said the driver re-boarded the van via the side door to assist getting Resident #58 out of the van and pushed the resident out the back door, thinking the lift platform was up. He pushed the chair off the van floor and it tipped back; the resident fell out. During an interview on 8/27/13 at 6:46 PM interview, Driver #1 stated he picked three residents up at three different locations and wanted to get them back to the facility in time for supper. Upon returning to the facility a little after 5:00 PM, Driver #1 said he took Resident #142's	F 323	No staff member will provide transportation services without completing training and demonstration of competency. The Administrator will validate and ensure all training is completed and documented prior to authorizing anyone to operate the Center's vehicle and or transport residents. Maintenance Director and or Administrator will visually validate each trained driver weekly including weekends for 30 days and monthly for 90 days to ensure competencies. On 8-28-13, a sign was posted in the rear of the Center's van providing a visual cue to "Ensure lift gate is in the UPRIGHT position prior to unloading" and placed in the front of the Center's Pre-Trip Vehicle Safety Inspection Checklist Logbook. Maintenance Director will audit and validate placement of signs on a weekly basis for 30 days and monthly thereafter. Salisbury Center will no longer offer transportation in Geri Chairs effective 8-27-13. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 13 wheelchair from the van and was going to push the resident back into the building but the resident said he wanted to push his wheelchair and walk. The driver indicated he returned to the van to get Resident #58. He explained that the residents always face the front of the van, so when taking them off the van he would be in front of the resident and push them backwards. Driver #1 indicated he realized the lift platform was not up when the rear wheels of the resident ' s gerichair went over the edge. He stated he tried to stop the resident from falling but could not. The driver acknowledged that he was hurrying so the residents would not be late for supper and he just assumed the lift platform was up. Driver #1 indicated there was no specific procedure to follow when two staff members were unloading residents. He said he was trained by the Maintenance Director on how to transport residents when the facility got the van, about one and one-half years ago. No additional training has been provided. Nurse's notes dated 8/27/13 at 11:04 PM revealed Resident #58 had returned to the facility. ER records of 8/27/13 indicated a 1.5 centimeter superficial laceration to the scalp, closed with 2 staples. X-rays of the right femur, right foot, right tibia and fibula and pelvis revealed no new fracture. Computerized axial tomography (CT) of the head revealed no acute intracranial abnormality and CT of the cervical spine revealed no fracture. On 8/28/13 at 9:40 AM, Resident #58 was observed in her room awaiting transport to dialysis. The Nurse Practitioner (NP) was also visiting. The resident refused her right hip to be visualized, but did allow the NP to loosen the	F 323	Staff to include Licensed Nurses, Nursing Assistants, therapist, dietary, housekeeping, maintenance, social and business services were provided training by the Director of Nursing and Assistant Director of Nursing, Nursing Practice Coordinator and Nursing Supervisors on 8-28-13 and 8-29-13, Training included the reporting of resident to resident incidents (including sexually inappropriate behaviors) by the completion of an incident report, care plan interventions and updating and how to manage residents' behaviors. Behavior interventions include: to separate residents and ensure safety, redirection by : talking, offering snacks, checking for physical needs and offering alternative activities, provide one on one supervision, attempt to identify the root cause of the behavior, medication reviews, lab reviews and psychological/psychiatric interventions. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 14 immobilizer on her right leg so the leg could be visualized, revealing a healed incision from knee to upper shin. The resident complained of leg pain with any movement but did not indicate an increase in pain after the fall on 8/27/13. Two staples were intact to the crown of her head, slightly to the left. During an interview on 8/28/13 at 1:26 PM, the Maintenance Director indicated he trained Driver #1 when the facility first got the van, about 2 years ago. The Maintenance Director stated he also trained the 3 activities staff members and one of the maintenance technicians on driving the van at the same time he trained Driver #1. The training did not include procedures for loading/unloading residents if more than one staff was assisting with the transport. The Maintenance Director added that after the training, Driver #1 was responsible for training any additional staff who were expected to drive the van. During a follow up interview on 8/29/13 at 5:26 PM, NA #6 said she had no training on van transport procedures, but had learned to operate the lift by watching Driver #1 and would therefore operate the lift to facilitate loading and unloading residents. 2. Resident #102 was admitted to the facility on 6/26/13 with multiple diagnoses including Alzheimer's disease, Dementia, Anxiety State and Depression. The admission Minimum Data Set (MDS) assessment dated 7/6/13 indicated that Resident #102 had moderately impaired cognition and needed supervision for locomotion on and off unit. The assessment further indicated that Resident #102 had physical and verbal behavioral symptoms directed toward others. The	F 323	Incident/Accident report will be reviewed by the IDT Monday thru Friday to identify any sexually inappropriate incidents and ensure effective interventions are implemented. These reviews (M-F) will occur for 60 days and weekly thereafter. Any resident to resident altercations will be reported by the licensed nurse, after implementation of an intervention, to the Director of Nursing after each occurrence. The Director of Nursing will review the implemented intervention and adjust as needed to ensure resident safety. Assistant Directors of Nursing will provide back up to the Director of Nursing for after hours, holidays and vacations. The DON and Social Services Director will visually monitor residents for the effectiveness of interventions on a weekly basis for 30 days and then monthly and adjust as needed to ensure safety of residents. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 15 assessment also indicated that the behavior had impact on others and had significantly intruded on the privacy or activity of others. The care plan was reviewed. The care plan on behavior addressed the resident's combativeness and resistance to care but did not address the resident's sexual inappropriate behavior. The physician's orders for July, 2013 revealed that Resident #102 was on xanax (anti anxiety drug) for anxiety state and Desyrel (antidepressant drug) for depression. The nurse's notes, doctor's progress notes and incident reports were reviewed. The notes dated 6/27/13 at 12:13 AM, 4:20 AM and 5:51 AM revealed that Resident #102 was agitated and combative during care. He was physically abusive towards staff by hitting and scratching the staff during care. The notes further indicated that he was able to wheel self around. On 6/27/13, there was a doctor's order for ACT (a behavioral treatment for psychological disorder) consult for agitation and behavior issues. " Review of the records revealed that there was no ACT consult provided to Resident #102. On 8/28/13 at 5:45 PM, administrative staff # 4 was interviewed. She stated that Resident #102 was not seen by the psychiatrist from ACT. She added that the psychiatrist was scheduled to come to the facility once a month. Resident #102 had signed the consent for psychiatric consult but it would take a while to process the papers for approval before he could see the psychiatrist. She further stated that when the psychiatrist	F 323	4. The Administrator and or Director of Nursing will review Safe Unloading Audit tool, incident/accident reports and the results of the visual monitoring on a daily basis Monday thru Friday for 30 days, weekly for 90 days and monthly thereafter. The results of these reviews will be reported to Quality Assurance committee on a weekly basis for 30 days and monthly thereafter. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.5.13

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F 323	Continued From page 16 came to the facility, Resident #102 was already discharged. . On 7/1/13 at 5:29 PM, the notes revealed that Resident #102 was sitting on the hallway holding the hand of Resident #123 (cognitively impaired female resident) and was touching her inappropriately. The notes further indicated that Resident #123 was removed from the area and Resident #102 was redirected. The incident report dated 7/1/13 at 5:29 PM revealed that Nurse #2 had seen Resident #102 with his hand on a female resident ' s peri area outside her pants. Nurse #2 removed the female resident away from him immediately. On 8/28/13 at 10:45 AM, Nurse #2 was interviewed. She stated that she was working on the hall that day when she saw Resident #102 sitting in his wheelchair touching Resident #123 on her crotch while she was standing. She immediately removed Resident #123 away from him. She added that Resident #102 was then moved to another hall away from Resident #123. On 7/2/13 at 11:49 AM, the notes indicated that Resident #102 was moved to room 504 from room 321. There were no other interventions implemented aside from moving him to another hall. On 7/9/13 at 3:49 PM, the doctor ' s progress notes indicated that Resident #102 " mostly mumbles and is difficult to understand. Interview is limited due to advanced dementia. " On 7/9/13 at 4:50 PM, the notes revealed that Resident #102 was making inappropriate sexual comments to staff, raised his arms and attempted	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 17 to hit staff. He was educated on the inappropriate nature of his behavior. On 7/11/13 at 4:14 PM, Resident #102 had approached a nurse really closed when she was pulling medications for another resident. When he was asked to move away, he proceeded to raise his arm in an attempt to hit the buttocks of the nurse. Resident #102 was educated on the inappropriate behavior, hitting and sexual approaches to the staff. Resident #102 continued to exhibit sexually inappropriate behavior and there were no other interventions implemented aside from redirection and education. On 7/20/13 at 6:00 PM, the notes revealed that NA #6 had observed the resident with his hands on the pants and incontinence brief of Resident #72 (cognitively impaired female resident). Resident #102 was immediately stopped and was separated from Resident # 72. Resident #102 had denied any sexually abusive behavior and was shaking his fist at staff upon removal. One on one supervision was initiated immediately. The Director of Nursing (DON) and the doctor were notified. The doctor had ordered to send Resident #102 to the emergency room (ER) for evaluation due to sexually aggressive behavior/abuse. The written statement from NA #6 dated 7/20/13 revealed that she had witnessed the hand of Resident #102 inside the pants of Resident # 72. He was moving his arm up and down while Resident #72 was sitting with a frown. On 7/20/13 at 9:35 PM, Resident #102 had	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 18 returned from the emergency room. He was moved to room 102 from room 504 and was placed on one on one supervision. On 7/22/13 at 10:10 AM, the care plan evaluation notes revealed that Resident #102 was observed with his hand in the pants/brief of Resident #72 on 7/20/13 at 6:00 PM. Resident #102 was removed immediately from the environment and was placed on 1:1 supervision. He was sent to the hospital and he returned without interventions. He was referred to ACT, his room was changed and the social worker was actively seeking for alternate placement. On 7/23/13 at 3:20 PM, the notes indicated that a nurse aide reported that Resident #102 had slapped her on the buttocks. On 7/25/13 at 9:30 AM, the notes revealed that Resident #102 was discharged to an assisted living facility. On 8/28/13 at 9:50 AM, administrative staff #4 was interviewed. She stated that Resident #102 had been requesting to be moved to another facility closer to home since admission but she could not find one. She revealed that she was aware of the sexual inappropriate behavior of Resident #102 towards Resident # 123 on 7/1/13. She added that she had moved Resident #102 to another hall to be away from Resident #123. She also stated that she was not aware of his inappropriate sexual behavior towards the staff. She indicated that after the incident on 7/20/13, she started looking for placement and she found one closer to his home. She further stated that Resident #102 was not seen by ACT prior to discharge.	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 19 On 8/28/13 at 1:50 PM, NA # 4 was interviewed. She stated that Resident #102 had asked her questions which were sexually inappropriate. She further stated that nurses and administrative staff were aware of his behavior. On 8/28/13 at 1:55 PM, NA # 3 was interviewed. She stated that Resident #102 was physically and verbally abusive. He had hit her on her buttocks and showed her his private area. She indicated that nurses were aware of his behavior. On 8/28/13 at 1:58 PM, NA # 5 was interviewed. She stated that she had heard Resident #102 asking other resident to have sex with them. She added that the nurses were aware of his behavior. On 8/28/13 at 2:15 PM, NA # 2 was interviewed. She stated that Resident #102 should not be around the residents. He was showing his private area and was asking for sex from her. She added that his behavior had been reported to the nurses. On 8/30/13 at 10:05 AM, administrative staff # 2 was interviewed. She stated that she was made aware of the sexually inappropriate behaviors of Resident #102. She stated that his behavior had been discussed in the care plan meeting and as far as she could remember they had made room changes. She added that after the 2nd incident dated 7/20/13, the resident was placed on 1:1 supervision, was sent to the hospital and the social worker started to look for placement. She added that there was no training provided to the staff regarding behavior management.	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 20 The facility provided the following Credible Allegation of Compliance on 8/30/13 at 12:17 PM. 1. On 8-27-13, Resident # 58 was provided immediate first aid and assessed by the Director of Nursing pending transportation to the local Emergency Department for assessment and evaluation. On 8-27-13 @ 5:25PM, Resident #58 was transferred by local EMS per stretcher. Resident #58's attending physician was notified by the Assistant Director of Nursing (ADNS) on 8-27-13 at 5:25 PM of the incident and provided directives to her care by providing an order to send the resident to the Emergency Room for evaluation. Responsible Party was notified of incident on 8-27-13 at 5:30 PM by ADNS. Resident # 58 was returned to the building on 8-27-13 at 11:00 PM after treatment at the local Emergency Department. Upon return Resident # 58 was assessed by a Registered Nurse (RN) and plan of care updated to include: falls care plan by eliminating facility transportation via Geri chair and care of staples. Driver and Nursing Assistant were suspended on 8-27-13 pending investigation. Resident transportations have been outsourced to appropriate vendors pending completion of the investigation. Resident #102 was discharged as of 7-25-13 therefore no further interventions are possible. 2. All Residents transported in the Center's van have the potential to be affected by this deficient practice. Residents that have exhibited verbal, sexual and or physical behaviors have been identified by a review of the MDS and staff interviews by the Inter-Disciplinary Team (IDT) on 8-28-13. IDT Team will include representative from Nursing, Social, Rehabilitation, Activities and	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 21 Administration. 3. Staff (Maintenance Director, Maintenance Technician, Receptionist and 3 Activities Staff) that provide transportation services were trained on the safe loading and unloading of residents on 8-27-13 by Maintenance Director and Administrator. Training included: positioning of wheel chair (w/c) in center of lift, when to lock breaks, lifting and lowering of lift gate, positioning of w/c in van, securing the w/c to the floor, placement of seatbelt and validation of lift gate position prior to unloading. Staff provided return demonstration of competency for safe loading and unloading of residents. Competency and training will be validated annually, upon hire and as needed for all staff transporting residents by Maintenance Director. Manufacturer's (Century 2 operations manual and Q-traint user instructions) recommendations have been incorporated into training material. No staff member will provide transportation services without completing training and demonstration of competency. The Administrator will validate and ensure all training is completed and documented prior to authorizing to operate the center's vehicle and transport residents. Maintenance Director and or Administrator will visually validate each trained driver weekly including weekends for 30 day and monthly for 90 days to ensure competencies. On 8-28-2013, a sign was posted in the rear of the center's van providing a visual cue to " Ensure lift gate is in the UPRIGHT position prior to unloading " and placed in the front of the Center's Pre-trip Vehicle Safety Inspection Checklist Log Book. Maintenance Director will audit and validate placement of signs on a weekly basis for 30 days and monthly thereafter. Salisbury Center will no longer offer	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 22 transportation in Geri chairs effective 8-27-13. Staff to include Licensed Nurses, Nursing Assistants, therapist, dietary, housekeeping, maintenance, social and business services was provided training by the Director of Nursing and or Assistant Director of Nurses, Nurse Practice Coordinator and Nursing Supervisor on 8-28-13 and 8-29-13. Training included the reporting of resident to resident incidents (including sexually inappropriate behavior) by the completion of an incident report, care plan interventions and updating and how to manage residents' behaviors. Behavioral interventions included: to separate residents and ensure safety, redirection by: talking, offering snacks, checking for physical need and offering alternative activity, provide one on one supervision, attempt to identify the root cause of the behavior, medication reviews, lab review and psychological/psychiatric interventions. As of 8-29-13, 140 of 176 staff have completed training. Staff will not be allowed to work without first completing the training. Incident/Accident report will be reviewed by the IDT daily Monday thru Friday to identify any sexually inappropriate incidents and ensure effective interventions are implemented. The daily reviews (M-F) will occur for 60 days and weekly thereafter. Any resident to resident altercation will be reported by the licensed nurse, after implementation of an intervention, to the Director of Nursing after each occurrence. The Director of Nursing will review the implemented intervention and adjust as needed to ensure resident safety. Assistant Directors of Nursing will provide back up to the Director of Nursing for after hours, holiday and vacations. The Director of Nursing and Social Services Director will visually monitor residents for the effectiveness of interventions on a weekly basis 30 days and then	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 323	Continued From page 23 monthly and adjust as needed to ensure the safety of residents. 4. The Administrator and or Director of Nursing will review Safe Unloading audit tool, incident/accidents reports and the result of the visual monitoring on a daily basis Monday thru Friday for 30 days, weekly for 90 days and monthly thereafter. The results of this reviewed and reported to Quality Assurance committee on a weekly basis for 30 days and monthly thereafter. The credible allegation was validated on 8/30/13 at 1:30 PM when staff interviews revealed training on behavior management and reporting behaviors. Staff members were able to verbalize what behaviors to report and to whom and when they would report behaviors. Van drivers indicated, during interviews, awareness of safety measures during resident transport, including visualizing the position of the lift platform prior to unloading residents. Brightly colored signs were observed posted above the rear door of the van and the interior of the van directly opposite the passenger door which read, "Ensure lift gate is in the UPRIGHT position prior to unloading."	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F332 D 1. Upon notification Resident #122 was provided an opportunity to rinse her mouth and a pulse rate was obtained by the Director of Nursing on 8-29-13. Nurse #2 was provided training by the Director of Nursing on Medication Administration on 8-29-13 to include the obtaining of pulse rates as directed by a physician's order, shaking inhalers prior to administration and the rinsing of a resident's mouth after administration of inhalers with return demonstration of competency.	9.5.13
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332	2. Residents residing in center who receive medication have the potential to be impacted by the alleged deficient practice.	

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F 332	Continued From page 24 by: Based on record review, observation, facility policy review, manufacturer ' s specifications and staff interview, the facility failed to ensure that the medication error rate was 5% or less as evidenced by two (2) errors of thirty-one (31) opportunities resulting in a 6.45% error rate. The findings included: 1. Resident #122 was admitted to the facility on 8/2/13. Cumulative diagnoses included COPD (chronic obstructive pulmonary disease) and Hypertension. Physician's orders dated 8/2/13 stated Symbicort (inhalation medication used for COPD) 160/4.5 mg. one puff daily. Manufacturer's instructions for Symbicort stated, in part, to shake the inhaler well for 5 seconds before using. Rinse mouth after each use. On 8/29/13 at 8:14 AM., Nurse #2 was observed during medication pass. Nurse #2 handed Resident #122 the inhaler. Resident #122 self administered the inhaler. Nurse #2 did not shake the inhaler prior to giving Resident #122 the inhaler nor did she instruct the resident to shake the inhaler. Nurse #2 did not instruct Resident #122 to rinse her mouth after administration. On 8/29/13 at 8:32 AM., Nurse #2 stated she should have shaken the inhaler prior to giving it to Resident #122 and should have instructed Resident #122 to rinse her mouth after administration of the medication. On 8/29/13 at 4:00 PM., Nurse #1 stated nursing staff should follow the manufacturer's instructions	F 332	3. Reeducation on medication administration including monitoring vital signs as required by the medication and the administration of inhalers was provided by the Nurse from Omnicare Pharmacy on 9-12-13. Further reeducation was provided on September 23,24 2013 by Director of Nursing or Assistant Director of Nursing on medication administration. Licensed nurses have had a medication administration pass observed by the nurse from Omnicare Pharmacy, Nurse Practice Educator or Assistant Director of Nurses on September 4, 8, 12, 21,22,23,24 2013 After the initial medication administration observation the Director of Nursing, Nurse Practice Educator and Assistant Director of Nursing will conduct 3 medication pass observation weekly for a month and then 3 observations monthly thereafter. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 332	Continued From page 25 for the administration of Symbicort. 2. Resident #122 was admitted to the facility on 8/2/13. Cumulative diagnoses included COPD (chronic obstructive pulmonary disease) and Hypertension. Physician orders dated 8/2/13 stated Metoprolol Tartrate (a medication for hypertension) 50 mg. (milligrams) po. (by mouth) daily. Hold for SBP (systolic blood pressure) < (less than) 100 or heart rate < 65. On 8/29/13 at 8:17 AM., Nurse #2 was observed during the medication pass. Nurse #2 administered the Metoprolol Tartrate after she had obtained a blood pressure of 142/68. She did not obtain Resident #122's pulse rate. On 8/29/13 at 11:00 AM., Nurse #2 stated she should have taken the pulse prior to administration of the medication. On 8/29/13 at 4:00 PM., Nurse #1 stated the nursing staff should follow physician's orders to obtain the pulse prior to medication administration.	F 332	4. Director of Nursing will analyze and evaluate the data gathered above looking for patterns and trends. The results of this evaluation will be reported monthly for 90 day and then quarterly to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F356 C 1. The daily staffing sheet was complete and posted 8-30-13 by Scheduling Manager in the Common Administrative Hallway.	9.25.13
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		

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F 356	Continued From page 26 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to post daily staffing information that was accurate and in a location that was accessible to residents and visitors on five consecutive days of the survey. The findings included: On 8/26/13 at 3:00PM., staff posting information was noted to be on a bulletin board behind the nursing station. Staff posting for day shift and the resident census was blank. On 8/27.13 at 9:00AM., staff posting information was noted on the bulletin board behind the	F 356	2. Residents residing the center have potential to be affected by the alleged deficient practice. 3. The Manager of Clinical Operations provided re –education to the Director of Nursing, the Assistant Directors of Nursing and scheduling Manager on 9-4-13. The education included the requirement to post in public view, completing with the number of nursing staff on duty each shift and correct census for each shift. The Director of Nursing, Assistant Director of Nursing or Scheduling Manager will conduct an audit on Monday thru Friday to ensure posting was completed on a daily basis and is accurate. The Manager on Duty will complete audit on weekends to ensure that the staffing sheet is posted and complete. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9-13

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F 356	Continued From page 27 nursing station on A hall and day shift was blank. On 8/27/13 at 5:00PM., staff posting information was observed with day shift and evening shift information blank. On 8/28/13 at 9:00AM., staff posting information was observed with day shift information blank. On 8/30/13 at 8:45AM., staff posting information was observed. The number of staff working the day shift was completed. The census was blank and the actual hours worked was blank. On 8/30/13 at 8:45 AM., Nurse #1 stated the staffing information was usually completed by himself, another assistant director of nursing or the scheduling manager. He stated the information was completed at the beginning of the shift with the number of nursing staff and the census information; the actual hours were completed at the end of the shift. Nurse #1 said the staffing information was always posted at station A nursing station on the bulletin board inside the nursing station. On 8/30/13 at 8:47 AM., the Resident Council President stated that he did not know where the staff posting information was located. On 8/30/13 at 8:55AM., the scheduling manager stated the assistant director of nursing completed the form information for first shift and the supervisors for second and third shifts filled out the information for their respective shifts. She stated there were blank forms at the nursing station and the night supervisor put up the posting on the bulletin board. She stated she picked up the forms when she came in the	F 356	4. The Director of Nursing will analyze and evaluate the data gathered above looking for patterns and trends. The results of this evaluation will be reported monthly for 90 day and then quarterly to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9-25-13

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

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F 356	Continued From page 28 morning for the previous day, attached the assignment sheets to them and filed the forms. On 8/30/13 at 9:15 AM., the daily nurse staffing forms for 8/26/13 through 8/30/13 were reviewed with Administrative staff #2. On 8/26/13, the day and evening shift census information, number of staff and actual hours worked were blank. The night shift had a census of 158 that included assisted living residents. On 8/27/13, the day and evening shift census information, number of staff and actual hours worked were blank. On 8/28/13, the census information for day and evening shift was noted as 157 which included assisted living residents. On 8/29/13, the day and evening shift census information was 159 which included assisted living residents. On 8/30/13 at 9:15AM., Administrative staff #2 stated the nursing supervisor filled out their shift information at the beginning of the shift and changes were made as needed. She indicated the staffing form had always been posted at the nursing station On 8/30/13 at 9:15AM., Administrative staff #1 stated the staff posting should be in a prominent place and all of the staffing information and census information should be completed prior to each shift and adjusted as needed. Also, the census information should be separated with skilled nursing residents and assisted living residents listed separately on the form.	F 356	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F371 E 1. The potatoes were removed from the tray line by the Dietary Manager and brought to temperature the correct of 140 degrees on 8-29-13. The meal plates with low temperature potatoes were removed and food items discarded by Dietary Manager on 8-29-13.The wet dome lids were removed from services by Dietary Manager on 8-29-13. 2. Residents who dine at the center have the potential to be affected by this alleged deficient practice. An audit was completed by the Dietary Manager to identify residents who may have received potatoes at a low temperature and who may have been served meal tray with a wet dome lid. No resident received potatoes at a temperature below 140 degrees or meal plate served with a wet dome lid.	9.25.13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 29 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the hot food temperature above 140 degrees and failed to ensure that dome lids were not stacked wet. Findings included: 1. On 8/29/13 at 12:00 PM, operation of the tray line in the dining room was observed. The temperature of the food was checked by the dietary aide prior to serving. The temperatures of the hot foods were above 140 degrees except for the mashed potato which was 130 degrees. After checking the temperatures, the dietary aide was observed to start the tray line and served the mashed potato to the residents. This was brought to the attention of the administrative staff #6 who immediately removed the mashed potato from the line. At 12:30 PM, the dietary aide was interviewed. She stated that the temperature of hot food should be maintained at 140 degrees and above but she did not provide an explanation why she served the mashed potato with 130 degrees temperature. 2. On 8/29/13 at 11:50 AM, dietary staff members were observed bringing food and kitchenware to the dining rooms ready for serving. There were	F 371	3. Reeducation for Dietary Staff will be provided by the Dietary Manager on 9-10-13 to include but not limited to: proper temperature for food service and how to remediate, proper drying techniques for dishes including dome lids. Dietary Manager or Assistant Manager will conduct audits of food temperatures and wet stacked dishes for 5 meals a week for 60 days and then at least weekly and randomly thereafter. 4. The Dietary Manager or Administrator will analysis and evaluate the data gathered above looking for patterns and trends. The results of this evaluation will be reported monthly for 90 days to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee will review and make recommendations or modification as needed to assure continued compliance. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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F 371	Continued From page 30 61 dome lids observed stacked on top of each other wet in 2 dining rooms. When brought to the attention of the administrative staff # 6, he immediately removed the wet dome lids from the tray line on the 2 dining rooms. On 8/30/13 at 9:30 AM, administrative staff #6 was interviewed. He stated that the dish machine was changed 6 months ago to a low temperature machine which made the dishes to dry slowly. He further stated that they had racks to dry the dishes but there was not enough time to dry them prior to meal time. He indicated that they had enough dry dishes to use but the dietary aide yesterday (8/29/13) had pulled the dome lids from the racks and stacked them together and obviously they were still wet. He stated that he had already retrained the dietary aide on the wet dome lids and the proper food temperature.	F 371	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 497 B 1. No resident was identified in this tag. 2. Resident residing the center have a potential to be effected by the alleged deficient practice. 3. The Director of Nursing and Nurse Practice Educator were reeducated on the requirement that nursing assistants working the center are to obtain 12 hours of education a year, anniversary to anniversary date. Nursing assistants will receive the required 12 hours of education prior to their anniversary date or be removed from the schedule to work. Education including Falls and Prevention of Falls, Stress Management, HIV and AIDs, Restraints, Blood borne Pathogens, Infection Control, Restorative Programs by Manager of Clinical Operations on Sept 11,12 ,13, & 14. 2013.	9.25.13
F 497 SS=B	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 497	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that 3 of 3 nurse aides (Nurse Aides # 1, #2 & #3) acquired 12 hours of in-services annually. The findings included: On 8/30/13 at 10:45 am, a record review was conducted of three nurse aide ' s personnel files. 1. Nurse Aide #1 was hired on 5/14/02. In 2013, she had 1.25 hours of coursework recorded in her file. In 2012, it was noted that she attended two in-services, however the time allotted for the courses was not specified. A record review revealed that the Administrator was hired last week. He shared in an interview on 8/26/13, at 11:13 am that as a new employee, he was still learning the organizations ' policies and procedures. On 8/30/13 at 2:35 pm, Administrative Staff #1 was interviewed. She stated that the human resources department could not find sufficient documentation for 2012 in-services and many of the courses on file did not specify the length of time of the program. In-services were calculated per calendar year. She shared that many of their required in-services were done independently online, instead of in a classroom setting and she couldn ' t verify that staff were logging in to sign up for courses. The Administrative Staff #1 further stated that the Staff Development Coordinator had been in place since November, 2012 but was on vacation and	F 497	Regulated and Regular Waste Management, Dementia Training-Communication, Successful Strategies for Difficult Behaviors, Resident Wandering, Tuberculosis, Caring for Residents with COPD, Age Related Changes, Cultural Competency, Handling and Disposal of Hazardous Drugs, Caring for Residents with Sickle Cell Disease by the Administrator on September 19, 20 2013. Education hours will be logged on the Individual In service record by the Nurse Practice Educator after each education session. The Nurse Practice Educator has developed an education calendar for the completion of this year and yearly thereafter to ensure that education hours are provided to nursing assistants. The Director of Nursing will monitor the Individual In-service log monthly to ensure that the nursing assistants are receiving the required 12 hours of education prior to their anniversary date. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated	9.23.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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F 497	Continued From page 32 was unavailable for interview. 2. Nurse Aide #2 was hired on 8/20/92. In 2013, she had 2.5 hours of coursework recorded in her file. In 2012, she attended three in-services. One of the classes had a recorded length of 7.5 hours, the length of program for the other classes could not be determined. A record review revealed that the Administrator was hired last week. He shared in an interview on 8/26/13, at 11:13 am that as a new employee, he was still learning the organizations ' policies and procedures. On 8/30/13 at 2:35 pm, Administrative Staff #1 was interviewed. She stated that the human resources department could not find sufficient documentation for 2012 in-services and many of the courses on file did not specify the length of time of the program. In-services were calculated per calendar year. She shared that many of their required in-services were done independently online, instead of in a classroom setting and she couldn ' t verify that staff were logging in to sign up for courses. The Administrative Staff #1 further stated that the Staff Development Coordinator had been in place since November, 2012 but was on vacation and was unavailable for interview. 3. Nurse Aide #3 was hired on 4/18/05. In 2013, she had 4 hours of coursework recorded in her file. In 2012, she attended two in-services. One of the classes had a recorded length of 7.5 hours, the length of program for the other class could	F 497	4. The Director of Nursing will present the results of the monitoring of the Individual in-service log to the Quality Assurance Committee monthly for 90 days. The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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F 497	Continued From page 33 not be determined. A record review revealed that the Administrator was hired last week. He shared in an interview on 8/26/13, at 11:13 am that as a new employee, he was still learning the organizations ' policies and procedures. On 8/30/13 at 2:35 pm, Administrative Staff #1 was interviewed. She stated that the human resources department could not find sufficient documentation for 2012 in-services and many of the courses on file did not specify the length of time of the program. In-services were calculated per calendar year. She shared that many of their required in-services were done independently online, instead of in a classroom setting and she couldn ' t verify that staff were logging in to sign up for courses. The Administrative Staff #1 further stated that the Staff Development Coordinator had been in place since November, 2012 but was on vacation and was unavailable for interview.	F 497	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9.25.13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III (211) protected construction and is equipped with a complete automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	A. Contact Electrical contractor on 10/01/2013 to measure and get quote on materials needed to install emergency lighting at the ends of 500 and 600 halls. B. Maintenance Director completed an Audit on 10/01/2013 of the Center's exit discharge illumination. There were no other negative findings.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 9/17/2013 following exit discharge illumination was observed as noncompliant as the specific findings include there were no exit discharge lighting on the path of egress to the public way from the 500 hallway to the 600 hallway. CFR#: 42 CFR 483.70 (a)	K 045	C. Identified emergency lighting will be installed by 10/31/2013 by contractor. Maintenance Director will inspect project at completion to ensure compliance with Life Safety Code Standards. Maintenance Director and/or Maintenance Technician will complete an audit weekly for 30 days and monthly thereafter ensuring illumination of the means of egress, including exit discharge are operating as designed. Any negative findings will be addressed. D. Maintenance Director will collect and analyze the data collected looking for patterns and trends. The result of the analysis will be reported monthly for 90 days and quarterly thereafter to the Quality Assurance and Process Improvement (QAPI) committee. The QAPI committee will review and make recommendations or modifications as needed to assure continued compliance	10.31.13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 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 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.