STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	2640 DAVIE AVENUE 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide privacy while giving incontinence care to a dependant resident for 1 of 4 residents observed during incontinence care (Resident #48).	F 164	1. NA#1 received further individual training regarding providing privacy while providing incontinence care to dependent residents. 2. All residents receiving incontinence care have the potential to be affected by this alleged deficient practice 3. Nursing staff will be re-educated by the DON or designee on providing privacy while providing incontinence care specifically including closing the door, pulling the curtains and closing the window blinds by 12/5/13. 4. The DON or designee will randomly observe 10 CNAs weekly, while providing incontinence care for 4 weeks and then monthly for 2 months to verify proper privacy procedures are being followed. Opportunities identified as a result of these observations will be corrected by the DON or designee. The results of these observations will be reported during the monthly QAPI "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie K Simon — TITLE: Senior Administrater — (X6) DATE: 11/26/13

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 164	Continued From page 1 The findings included: Resident #48 was admitted to the facility on 05/12/06 with diagnoses that included Alzheimer's dementia, delusional disorder, anxiety, history of fractures and others. The most recent Minimum Data Set (MDS) dated 09/14/13 specified that the resident had severely impaired cognition and required extensive assistance with toilet use and was always incontinent. On 11/04/13 at 3:23 PM Resident #48 was in her bed on the secured unit. At 3:30 PM nurse aide #1 entered Resident #48's room, the door remained halfway open. During this time a male resident stood outside Resident #48's door and was noted to at times look into the room. At 3:40 PM observations were made of Resident #48's room that revealed her door was halfway open and her privacy curtain was not pulled and NA #1 was providing incontinence care. On 11/07/13 at 4:20 PM NA #1 was interviewed and stated that she was trained to provide privacy when rendering care to residents. She explained that this meant she was to close the resident's room door, pull the privacy curtain and close the blinds. The observation that was made on 11/04/13 at 3:40 PM of her providing incontinence care to Resident #48 with the door open and privacy curtain not pulled was shared with the NA. She stated she remembered the incident and should have pulled the privacy curtain and closed the door to offer the resident privacy while she provided incontinence care. She added that it was a busy day and she didn't realize that another resident was outside the room watching. On 11/07/13 at 4:35 PM the Unit Manager was	F 164	meeting by the DON or designee. The QAPI committee will evaluate and make recommendations as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 164	Continued From page 2 interviewed and reported that staff were trained to provide complete privacy when giving care. She stated that this meant closing the doors, pulling the curtains and closing the window blinds. The observation of NA #1 providing incontinence care on 11/04/13 was reviewed with the Unit Manager and she stated that the NA should have closed the door and pulled the privacy curtain to ensure full privacy was maintained.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain dignity by cleaning soiled areas on a mattress and side rail for 1 of 1 residents with incontinence (Resident #55)and failed to maintain dignity during meals when staff stood over residents while they fed residents on 2 of 2 hallways. (Resident #97, #35, and #27). The findings included: 1. Resident # 55 was re-admitted to the facility on 06/18/13 with diagnoses that included cellulitis (a skin infection with redness, swelling, pain and warmth) in both lower legs with chronic itching of the skin, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/17/13 indicated Resident #55 had short term and long term memory problems and was	F 241	1. The mattress of Resident #55 was cleaned and sanitized following identification on 11/6/13. NA#3, NA#8 and Nurse #3 were individually re-educated regarding maintaining dignity while providing assistance with feeding including the requirement to remain at eye level while assisting with feeding and the location of additional chairs if unavailable in the resident's room. 2. All residents receiving incontinence care and requiring assistance with feeding by Nursing staff have the potential to be affected by this alleged deficient practice. The Housekeeping Supervisor, Housekeeping District Manager, and housekeeping staff cleaned the mattresses and side rails for all residents on 11/6/13. '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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 241	Continued From page 3 severely impaired in cognition for daily decision making. The MDS also revealed Resident #55 required extensive assistance for activities of daily living and was always incontinent of bladder and bowel. During an observation on 11/04/13 at 11:45 AM Resident #55 was lying in bed on an air mattress with both lower legs bandaged from her knees to her ankles. There was no bottom sheet on the mattress but there was a large pad underneath the resident's buttocks that was used to turn and position her. Resident #55 had a top sheet partially covering her upper body but had no sheet over her lower legs. A large area of brown substance was observed smeared across the left (L) side of Resident #55's mattress extending from the top edge of the mattress to the bottom edge of the mattress and was approximately 11 inches in width on the side of the mattress. A brown substance was also present on the (L) side rail in a splattered pattern. During an observation on 11/04/13 at 4:40 PM Nurse #2 and Nurse Aide (NA) #6 pulled Resident #55 up in bed. The brown substance was still smeared across the (L) side of Resident #55's mattress and extended from the top of the mattress to the bottom of the mattress and was approximately 11 inches in width on the side of the mattress. A brown substance was still present on the (L) side rail in a splattered pattern. During an observation on 11/05/13 at 9:25 AM Resident #55 was lying in bed with the head of her bed elevated. The brown substance was still observed smeared across the (L) side of Resident #55's mattress and extended from the top of the mattress to the bottom of the mattress	F 241	3. Nursing and Housekeeping staff will be re-educated by the DON or designee on the importance of maintaining dignity by utilizing proper cleaning procedures for soiled mattresses and side rails by 12/5/13. Nursing staff will be re-educated by the DON or designee on the importance of maintaining dignity by feeding residents at eye level by 12/5/13. 4. The Housekeeping Supervisor will randomly observe 5 mattresses per week for 4 weeks and then monthly for 2 months to verify proper cleaning procedures have been followed to ensure maintenance of dignity. The DON or designee will randomly observe 5 members of the Nursing staff while providing feeding assistance weekly for 4 weeks and then monthly for 2 months to verify maintenance of dignity by feeding residents at eye level. Opportunities identified as a result of these observations will be corrected by the Housekeeping Supervisor, DON, or designee. The results of these observations will be reported during the monthly QAPI meeting and '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 and/or executed solely because it is required by the provisions of federal and state law.'	12/5/13

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F 241	Continued From page 4 and was approximately 11 inches in width on the side of the mattress. A brown substance was still present on the (L) side rail in a splattered pattern. During an observation of personal care on 11/06/13 at 8:48 AM NA #7 assisted Resident #55 to turn on her (L) side and the resident grabbed the side of the mattress with her right (R) hand and touched the brown substance that was smeared across the side of the mattress. Resident #55 then moved her (R) hand and took hold of the (L) bed rail and touched the brown splattered area on the rail. During an interview on 11/06/13 at 9:05 AM with NA #7 she acknowledged there was a large brown substance on the (L) side of Resident #55's mattress. She stated she had not noticed it before and did not know what the substance was but then took a towel and wet it with water and wiped the side of the mattress. NA #7 verified the substance was brown in color and held it to her nose and stated it smelled like a bowel movement. She then wiped the (L) side rail with the wet towel and verified it was brown in color and it also smelled like bowel movement. NA #7 stated she had not noticed the brown substance on the side of the mattress or side rail before now but the mattress and side rail should have been cleaned. During an interview on 11/06/13 at 9:10 AM Nurse #1 stated nursing staff were expected to wipe mattresses with soap and water if they were soiled. She stated no one had told her about the substance on the side rail or mattress but it should have been cleaned. During an interview on 11/06/13 at 10:06 AM the	F 241	evaluations/recommendations will be made as indicated. '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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 241	Continued From page 5 interim Director of Nursing stated it was her expectation when nursing staff saw spillage or soiling on a resident's mattress or side rail they should clean it off with soap and water. She stated they should then tell housekeeping that it needed to be cleaned so that housekeeping staff could thoroughly clean the mattress and side rail with a sanitizer. 2. Resident #97 was admitted to the facility on 12/22/13 with diagnoses which included Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 09/28/13 indicated Resident #97 had short term and long term memory problems, was severely impaired in cognition for daily decision making and was totally dependent on staff for eating with 1 staff member for assistance. During an observation of the lunch meal service on 11/04/13 at 12:16 PM Resident #97 was seated in a recliner chair next to her bed and Nurse Aide (NA) #3 entered the resident's room and placed a meal tray on an overbed table. There was no chair in the room for NA #3 to sit on so NA #3 stood up and towered over Resident #97 while she fed the resident with a spoon. Resident #97 ate slowly while NA #3 stood looking out into the hallway and fed her. At 12:25 PM NA #3 removed the meal tray from the Resident #97's room and took it to a tray cart in the hallway. During an interview on 11/07/13 at 3:18 PM with NA #3 she stated sometimes there was not a chair in the room to sit on when she fed a resident so she had to stand to feed them. She confirmed she stood next to Resident #97 while she fed her but could not remember why she did	F 241		

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F 241	Continued From page 6 not go get a chair so she could have sat next to the resident. During an interview on 11/07/13 at 4:47 PM the Unit Manager stated nursing staff should be seated next to residents when they fed them so they could maintain eye contact with the resident. She further stated it was not acceptable for staff to stand over a resident while they were being fed. During an interview on 11/07/13 at 5:39 PM the interim Director of Nursing stated it was her expectation that nursing staff should sit next to residents while they fed them. She stated if there was not a chair in the resident's room to sit in, there were chairs available and they should go get one to sit on while they fed a resident. 3. Resident #35 was admitted to the facility on 08/01/13 with diagnoses that included heart disease, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/24/13 indicated Resident #35 was cognitively intact for daily decision making but was totally dependent on staff for eating with 1 staff member for assistance. A section titled B on the MDS indicated Resident #35 was severely impaired with vision. During an observations of the lunch meal service on 11/04/13 at 12:20 PM Resident # 35 was lying in bed with the head of her bed elevated approximately 30 degrees. Nurse Aide #8 entered Resident #35's room with a lunch tray and placed it on an overbed table. She then opened containers of food and stood up over the resident on the left side of the bed and fed her. There was no chair available in the room for NA	F 241		

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F 241	Continued From page 7 #8 to sit on. At 12:33 PM NA #8 carried the meal tray out of Resident #35's room and placed it on a meal cart in the hallway. During an interview on 11/04/13 at 1:15 PM with Resident #35 she stated she did not know if staff sat in a chair or stood beside her when they fed her but she preferred for them to sit next to her because she did not think it was polite to stand over someone. During an interview on 11/07/13 at 2:52 PM with NA #8 she verified she stood next to Resident #35 while she fed her. She stated there was not a chair in the room for her to sit in but she should have gotten one to sit next to the resident. During an interview on 11/07/13 at 4:47 PM the Unit Manager stated nursing staff should be seated next to residents when they fed them so they could maintain eye contact with the resident. She further stated staff should sit in a chair next to the resident and stated it was not acceptable for staff to stand over a resident while they were being fed. During an interview on 11/07/13 at 5:39 PM the interim Director of Nursing stated it was her expectation that nursing staff should sit next to residents while they fed them. She stated if there was not a chair in the resident's room to sit in, there were chairs available and they should go get one to sit on while they fed a resident. 4. Resident #27 was admitted to the facility on 08/01/12 with diagnoses that included heart disease, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/24/13 indicated Resident #27 was cognitively	F 241		

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F 241	Continued From page 8	F 241		

intact for daily decision making but was totally dependent on staff for eating with 1 staff member for assistance. A section titled B on the MDS indicated Resident #27 was highly impaired with vision.

During an observation during lunch meal service on 11/04/13 at 12:34 PM Resident #27 was sitting in a semi reclined position in a geri chair next to her bed and Nurse #3 stood and towered over Resident #27 on the left side of her chair and fed her. At 12:42 PM Nurse #3 was still standing up over Resident #27 while she fed her and there was no chair available in the room for her to sit on. At 12:44 PM Nurse #3 exited Resident #27's room and placed the tray on a tray cart in the hallway.

During an interview on 11/04/13 at 1:25 PM Resident #27 stated she needed to be fed at meals because she could not see to feed herself. She stated she could only see shadows and expected staff would sit next to her to feed her because it made her feel uncomfortable when someone stood over her.

During an interview on 11/07/13 at 4:09 PM with Nurse #3 she stated there was no chair in Resident #27's room for her to sit on while she fed her. She further stated most of the time there was not a chair in the resident's room for her to sit on so she stood up while she fed residents.

During an interview on 11/07/13 at 4:47 PM the Unit Manager stated nursing staff should be seated next to residents when they fed them so they could maintain eye contact with the resident. She further stated staff should sit in a chair next to the resident and stated it was not acceptable

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F 241	Continued From page 9 for staff to stand over a resident while they were being fed. During an interview on 11/07/13 at 5:39 PM the interim Director of Nursing stated it was her expectation that nursing staff should sit next to residents while they fed them. She stated if there was not a chair in the resident's room to sit in, there were chairs available and they should go get one to sit on while they fed a resident.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to accommodate the resident needs by providing a call bell light within reach of the resident for 1 of 3 residents who required assistance with activities of daily living (ADL). (Resident #78). The findings included: Resident #78 was admitted to the facility on 05/17/13 with diagnoses which included high blood pressure, anxiety, dementia, and malnutrition. A review of the quarterly Minimum Data Set (MDS) dated 07/17/13 coded Resident	F 246	1. Call bell for Resident #78 was placed within her reach on 11/6/13. 2. All residents have the potential to be affected by this alleged deficient practice. The DON and designees completed an audit of all residents ensuring call lights were within the residents reach on 11/6/13. 3. Nursing staff will be re-educated by the DON or designee on accommodating the resident needs by proper placement of a call bell light within the reach of the resident by 12/5/13. '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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 246	Continued From page 10 #78 as severely impaired cognitive skills. Resident #78 required extensive to total assistance with staff for her activities of daily living skills (ADLs). The current care plan for ADLs, last updated 08/26/13, included the goal for Resident #78 to have all her ADL needs anticipated and met with staff assistance and intervention. The current care plan for falls last updated on 08/26/13, included the goal to be free of fall related injuries. Interventions included for staff to observe for potential patterns and possible causes, place frequently used items within reach, and place call bell light within reach. A review of the physician progress notes dated 10/07/13 indicated resident #78 went through a 3 week period of decline, medication changes were made and resident returned to baseline, the notes further indicated resident #78 had returned to normal behaviors, was pleasantly confused and answered brief simple questions. Resident #78 was observed on 11/05/13 at 10:16 AM up in her wheelchair on the right side of her bed with the call bell light wrapped around the left side rail of the bed and dangling onto the floor away from the resident's reach. Resident #78 was observed on 11/05/13 at 12:22 PM up in her wheelchair on the right side of her bed with her lunch tray on the tray table in front of her. The call bell light was wrapped around the left side rail of the bed and dangling onto the floor away from the resident's reach. Resident #78 was observed on 11/05/13 at 4:49 PM lying in her bed on her left side with her eyes	F 246	4. The DON or designee will randomly observe 10 residents weekly, for call bell light placement for 4 weeks and then monthly for 2 months to verify accommodation of residents needs by proper placement of the call bell within the reach of the resident. Opportunities identified as a result of these observations will be corrected by the DON or designee. The results of these observations will be reported in the monthly QAPI meeting and evaluations/recommendations will be made as indicated. '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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 246	Continued From page 11	F 246		

open. The call bell light was wrapped around the left side rail of the bed and dangling onto the floor away from the resident's reach.

Resident #78 was observed on 11/06/13 at 8:56 AM lying in her bed on her left side with her eyes open. The call bell light was wrapped around the left side rail of the bed and dangling onto the floor away from the resident's reach. Observed the NAs come into the room and provided AM care to Resident #78. Resident #78 was then transferred into her wheelchair on the right side of the bed and the call bell was unwrapped from the left side rail and placed onto the bed within the resident's reach.
During an interview on 11/06/13 at 9:14 AM Nurse Aide (NA) #4 who is familiar with the care of Resident #78 stated that Resident was able to answer yes & no to simple questions and that Resident #78 doesn't always use the call light but she was able to use her call bell light, and had used it and was able to communicate what she needed. NA #4 further stated that she had forgotten to put the call bell within her reach all day yesterday (11/05/13).

During an interview on 11/06/13 at 3:35 PM NA #5 who is familiar with the care of Resident #78 stated that Resident was able to answer yes & no to simple questions and that she was able to use her call bell light and communicate what she needed if you ask her. NA #5 asked Resident #78 to show me the call bell and the resident then picked up the call light and pushed the button.

During an interview on 11/06/13 at 4:00 PM Nurse #3 who is familiar with the care of Resident #78 stated Resident #78 was able to use her call bell light and had used it and rung for assistance.

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F 246	Continued From page 12 During an interview on 11/07/13 at 1:52 PM the interim Director of Nursing (DON) stated that Resident #78 needed extensive assistance for all her ADLs and transfers. The interim DON revealed that she completes in-services on a weekly basis regarding the accommodation of resident needs and the placement and use of call bell lights. The interim DON confirmed that the placement of call bell lights should be at the residents' sides at all times. The interim DON further confirmed that the call bell for Resident #78 was not placed within her reach.	F 246		
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 observations and staff interviews the facility failed to clean a soiled area on a resident's mattress and side rail for 1 of 2 residents sampled with incontinence. (Resident #55). The findings included: Resident # 55 was re-admitted to the facility on 06/18/13 with diagnoses that included cellulitis (a skin infection with redness, swelling, pain and warmth) in both lower legs with chronic itching of the skin, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/17/13 indicated Resident #55 had short term and long term memory problems and was	F 253	1. The mattress of Resident #55 was cleaned and sanitized following identification on 11/6/13. 2. All residents receiving incontinence care have the potential to be affected by this alleged deficient practice. The Housekeeping Supervisor, Housekeeping District Manager, and staff cleaned the mattresses and side rails for all residents on 11/6/13. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 253	Continued From page 13 severely impaired in cognition for daily decision making. The MDS also revealed Resident #55 required extensive assistance for activities of daily living and was always incontinent of bladder and bowel. During an observation on 11/04/13 at 11:45 AM Resident #55 was lying in bed on an air mattress with both lower legs bandaged from her knees to her ankles. There was no bottom sheet on the mattress but there was a large pad underneath the resident's buttocks that was used to turn and position her. Resident #55 had a top sheet partially covering her upper body but had no sheet over her lower legs. A large area of brown substance was observed smeared across the left (L) side of Resident #55's mattress extending from the top edge of the mattress to the bottom edge of the mattress and was approximately 11 inches in width on the side of the mattress. A brown substance was also present on the (L) side rail in a splattered pattern. During an observation on 11/04/13 at 4:40 PM Nurse #2 and Nurse Aide (NA) #6 pulled Resident #55 up in bed. The brown substance was still smeared across the (L) side of Resident #55's mattress and extended from the top of the mattress to the bottom of the mattress and was approximately 11 inches in width on the side of the mattress. A brown substance was still present on the (L) side rail in a splattered pattern. During an observation on 11/05/13 at 9:25 AM Resident #55 was lying in bed with the head of her bed elevated. The brown substance was still observed smeared across the (L) side of Resident #55's mattress and extended from the top of the mattress to the bottom of the mattress	F 253	3. Housekeeping staff will be re-educated by the Housekeeping Supervisor on the proper cleaning procedures for soiled mattresses and side rails for residents with incontinence by 12/5/13. The DON or designee will re-educate Nursing staff on intermittent cleaning or obtaining Housekeeping Services as needed upon identification of soiled mattresses and side rails by 12/5/13. 4. The Housekeeping Supervisor will randomly select 5 mattresses per week for 4 weeks and then monthly for 2 months to verify proper cleaning procedures have been followed. Opportunities identified as a result of these observations will be corrected by the Housekeeping Supervisor. The results of these observations will be reported during the monthly QAPI meeting and evaluations/recommendations will be made as indicated "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 253	Continued From page 14	F 253		

and was approximately 11 inches in width on the side of the mattress. A brown substance was still present on the (L) side rail in a splattered pattern.

During an observation of personal care on 11/06/13 at 8:48 AM NA #7 assisted Resident #55 to turn on her (L) side and the resident grabbed the side of the mattress with her right (R) hand and touched the brown substance that was smeared across the side of the mattress. Resident #55 then moved her (R) hand and took hold of the (L) bed rail and touched the brown splattered area on the rail.

During an interview on 11/06/13 at 9:05 AM with NA #7 she acknowledged there was a large brown substance on the (L) side of Resident #55's mattress. She stated she had not noticed it before and did not know what the substance was but then took a towel and wet it with water and wiped the side of the mattress. NA #7 verified the substance was brown in color and held it to her nose and stated it smelled like a bowel movement. She then wiped the (L) side rail with the wet towel and verified it was brown in color and it also smelled like bowel movement. NA #7 stated she had not noticed the brown substance on the side of the mattress or side rail before now but the mattress and side rail should have been cleaned.

During an interview on 11/06/13 at 9:10 AM Nurse #1 stated nursing staff were expected to wipe mattresses with soap and water if they were soiled. She stated no one had told her about the substance on the side rail or mattress but it should have been cleaned.

During an interview on 11/06/13 at 9:13 AM the

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F 253	Continued From page 15 Environmental Services Director explained housekeeping staff cleaned resident mattresses during deep cleaning of resident rooms once a month or as needed. She further explained housekeeping staff cleaned air mattresses because nursing staff did not have access to chemicals to clean and sanitize them. During an interview on 11/06/13 at 9:22 AM Housekeeper #1 stated she was the housekeeper assigned to the hall where Resident #55 lived and stated she had not done any cleaning of Resident #55's mattress recently. She further stated no one had mentioned to her that the mattress needed to be cleaned. During an interview on 11/06/13 at 10:06 AM the interim Director of Nursing stated it was her expectation when nursing staff saw spillage or soiling on a resident's mattress or side rail they should clean it off with soap and water. She stated they should then tell housekeeping that it needed to be cleaned so that housekeeping staff could thoroughly clean the mattress and side rail with a sanitizer.	F 253		
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	1. Care plans for Resident #48 were updated to reflect a realistic care plan goal for bruising. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 279	Continued From page 16 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a realistic care plan goal for 1 of 1 resident prone to bruising (Resident #48) and failed to develop individualized care plans for 2 of 7 residents that required assistance with activities of daily living (Resident #82 and Resident #117). The findings included: 1. Resident #48 was admitted to the facility on 05/12/06 with diagnoses that included Alzheimer's dementia, delusional disorder, anemia, anxiety, history of fractures and others. Resident #48's medical record was reviewed and revealed the resident had a history of frequent bruising. Nurse's entries included: - 03/12/13 right hand and 2 fingers bruised - 04/15/13 bruise to right wrist - 05/20/13 bilateral bruising to hands, wrist and forearms - 07/26/13 bruise to left forearm - 08/07/13 bilateral bruising of hands - 08/14/13 bruising on right shoulder and left	F 279	Care plans for Residents #82 and #117 were updated to reflect individualized approaches with activities of daily living. 2. All residents have the potential to be affected by this alleged deficient practice. RCMD, MDS Coordinator, Unit Coordinator, and DON will complete an audit of current resident care plans related to skin care and activities of daily living to include more individualized approaches and goals. This audit will be completed by 12/5/13. 3. The DON, RCMD and MDS Coordinator will be re-educated by Regional Clinical Director on writing realistic care plan goals and individualized care plan approaches. 4. The DON or designee will randomly review 5 resident care plans weekly for 4 weeks then monthly for 2 months to verify individualized care plan approaches and goals. Opportunities identified as a result of the audit will be corrected by the RCMD or MDS "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 279	Continued From page 17 wrist Resident #48's care plan updated on 09/03/13 for non-pressure ulcer skin impairment specified the "resident will be free of further skin impairment." The most recent Minimum Data Set (MDS) dated 09/14/13 specified that the resident had severely impaired cognition and required extensive assistance with activities of daily living. Further review of the medical record after the care plan was updated revealed additional nurse's entries documenting skin impairment that included: - 09/16/13 bruise to right hand - 10/6/13 skin tear to left forearm and left finger On 11/07/13 at 9:10 AM MDS Coordinator #1 was interviewed and stated that care plans were developed based on areas of concern. She explained that she and the Interdisciplinary Team (IDT) collaborated to ensure the care plan was appropriate and individualized. She also stated that care plan goals were developed to be realistic. She stated that she had not developed Resident #48's care plan goal for non-pressure ulcer skin impairment. On 11/07/13 at 9:20 AM MDS Coordinator #2 was interviewed and reported that she had developed and reviewed Resident #48's care plan. She was asked about Resident #48's non-pressure ulcer skin impairment care plan goal and confirmed that the goal was not realistic. She explained that Resident #48 was very prone to developing bruises and bruised very easily. She stated it was an oversight and that the goal should have been re-evaluated at the last care plan update to	F 279	Coordinator. Audit results will be reported on during the monthly QAPI meeting and evaluations/recommendations will be made by the QAPI committee as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 279	Continued From page 18 reflect a more realistic goal. She added that she considered care plan goals to be appropriate when there was a positive outcome. She confirmed that in the case of Resident #48 despite the care plan goal the resident was continuing to develop bruises. 2. Resident #82 was admitted to the facility with diagnoses which included dementia. Resident #82's most recent Quarterly Minimum Data Set (MDS) dated 08/24/13 revealed she had severe cognitive impairment. The MDS further assessed the resident as needing limited assistance of one person for personal hygiene. Resident #82's care plan for activities of daily living (ADL) revealed she needed limited assistance of one staff member for completion of ADL needs. The goal for ADLs, Resident #82 would have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function possible to include wash own face and hands daily, brush own teeth daily, and brush hair independently daily. Resident #82 gave no mention to the fact she had dentures or particular care of the dentures including removal of the dentures at night for soaking, cleaning the dentures, etc. An interview was conducted with the MDS Coordinator #1 who was responsible for care plans. She stated they use pre-developed care plans. She stated the care plans were not	F 279		

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F 279	Continued From page 19 individualized for each resident for ADLs. She stated if a resident's routine was different, specifics should be on the care plan and on the Nursing Assistant Care Sheet. 3. Resident #117 was admitted to the facility with diagnoses which included dementia and depression. Resident #117's most recent Quarterly Minimum Data Set (MDS) dated 10/07/13 revealed she had moderate cognitive impairment and needed extensive assistance with personal hygiene. Review of Resident #117's care plan for activities of daily living revealed she required staff assistance and intervention for completion of ADL needs. Further, the care plan revealed she needed extensive assistance of 1-2 people. The goal for Resident #117, she would have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function possible to include washing her own face and hands daily, bushing her own teeth daily and bushing her hair independently daily. Interventions did not address nail care needed for this resident or identify specifics which could cause this resident to have dirty fingernails. An interview was conducted with the MDS Coordinator #1 who was responsible for care plans. She stated they use pre-developed care plans. She stated the care plans are not individualized for each resident for ADLs. She stated if a resident's routine is different, specifics should be on the care plan and on the Nursing Assistant Care Sheet.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 20 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to follow the care plan and provide services for 2 of 7 residents whose care plans were reviewed. (Residents #82 and #117) The findings included: 1. Resident #82 was admitted to the facility with diagnoses which included dementia. Resident #82's most recent Quarterly Minimum Data Set (MDS) dated 08/24/13 indicated she had severe cognitive impairment. Further review of the MDS revealed she needed assistance with personal hygiene and was dependent for bathing assistance. Review of Resident #82's care plan dated 11/20/12 and updated 08/23/13 for activities of daily living (ADL) revealed she needed limited assistance of one person for assistance with ADL needs. The goal, Resident #82 would have ADL needs identified and met with staff assistance and intervention. Resident #82 was observed on 11/05/13, 11/06/13, and 11/07/13 to have food debris and white film on her dentures. An interview was conducted on 11/07/13 at 9:36 AM with Nursing Assistant (NA) #2 who had been	F 282	1. Denture care was provided to Resident #82 on 11/7/13. Nail care was provided to Resident #117 on 11/7/13. 2. All residents requiring assistance with activities of daily living have the potential to be affected by this alleged deficient practice. RCMD,MDS Coordinator, Unit Coordinator, and DON will complete an audit of current resident care plans to update care plan goals and individualized approaches. This audit will be completed by 12/5/13. 3. The DON or designee will re-educate nursing staff regarding following interventions as care planned for activities of daily living by 12/5/13. 4. The DON or designee will randomly review 5 residents per week for completion of care planned interventions related to activities of daily living, weekly for 4 weeks then monthly for 2 months. Opportunities identified as a result of the audit will be corrected by the RCMD or MDS Coordinator. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 282	Continued From page 21 assigned to care for Resident #82. NA #2 stated she had not cleaned Resident #82's dentures recently. An interview was conducted on 11/07/13 at 3:15 PM with the interim Director of Nursing (DON). The interim DON stated the resident's denture care should have been provided after each meal and before bed. 2. Resident # 117 was admitted to the facility with diagnoses which included diabetes, dementia, and depression. Resident #117's most recent Quarterly Minimum Data Set dated 10/09/13 revealed she had moderate cognitive impairment and needed extensive assistance with personal hygiene. Resident #117's care plan dated 06/14/13 and updated 09/13/13 revealed she needed extensive assistance of 1-2 staff members for completion a activities of daily living (ADL) needs. The goal was for Resident #117 to have all ADL needs identified and met with staff assistance and intervention. Observations were made on 11/04/13, 11/06/13, and 11/07/13 of Resident #117's having dark brown matter under the first three fingers of her left hand. An interview was conducted on 11/07/13 at 9:20 AM with Nursing Assistant (NA) #2. NA #2 stated she should have cleaned under Resident #117's fingernails as part of her daily care. An interview was conducted on 11/07/13 at 3:12 PM with the interim Director of Nursing (DON). The interim DON stated it was her expectation for	F 282	Audit results will be reported on during the monthly QAPI meeting and evaluations/recommendations will be made by the QAPI committee as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 282	Continued From page 22 staff to keep residents' nails neat, clean, and trimmed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews and record reviews the facility staff failed to administer pain medications according to physician's orders for pain control for 1 of 3 sampled residents. (Resident's #124). The facility failed to assess and treat a new area of skin breakdown for 1 of 1 resident reviewed for non-pressure wounds (Resident #111). The findings included: 1. Resident #124 was admitted to the facility on 06/07/13 with diagnoses which included kidney disease, dementia, generalized weakness, debility and strokes. A review of the admission Minimum Data Set (MDS) dated 06/14/13 coded Resident #78 as severely impaired cognitive skills. Resident #78 required extensive assistance with staff for his activities of daily living skills (ADL) s which included bed mobility, transfers, bathing, and toileting. The current care plan for pressure ulcers last	F 309	1. A medication variance report was completed for Resident #124 and the physician was notified. The physician was notified of the new area of skin breakdown for Resident #111 and treatment administered as ordered. 2. All residents with skin breakdown and residents receiving pain medication have the potential to be affected by this alleged deficient practice. The DON or designee will complete an audit of current medication administration records including ordered pain medications to verify administration as ordered by 12/5/13. Additionally, the DON or designee will complete an audit of all residents with skin breakdown to verify accurate assessment and documentation of skin breakdown by 12/5/13. 3. The DON or designee will re-educate all Licensed Nurses and Certified Medication Aides regarding following physicians orders for pain medication administration by 12/5/13. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 309	Continued From page 23 updated 10/22/13, included evaluation and treatment for Resident #124 Stage 4 pressure ulcers to left shin and left heel by the wound care physician. Interventions included treatment as indicated by the wound care physician orders, turn and reposition while in bed for comfort and pressure reduction. A review of the wound care physician evaluation progress notes dated 10/29/13 indicated Resident #124 had a stage 4 (the description of a wound that involved full thickness of skin tissue loss with exposed bone, tendon, or muscle which often includes undermining and or tunneling into the wound under the skin tissue) pressure ulcer to the left heel which measured length by width by depth (LxWxD) 2.5 centimeters (cm) by 3.9 cm by 0.7cm with undermining of 4.6 cm in length over the past 97 days of duration. The physician further noted the left heel wound surface area had decreased, the depth and undermining had increased and the wound was not improved. The notes further indicated a second stage 4 pressure ulcer to the left posterior lateral shin which measured LxWxD 2.2 cm by 1.9 cm by 0.6 cm over the past 52 days duration. The physician further noted the left shin had decreased depth and the wound was improved. A review of the physician orders dated 10/04/13 included an order to administer: ' Norco (hydrocodon - acetaminophen) 5/325 mg (milligram) tablet; Take 1 tablet by mouth 30 minutes daily before wound care for pain control ' . A review of the Practitioner Progress notes report revealed on the plan of treatment Resident #124 was prescribed Norco 5/325 mg 1 tablet by mouth	F 309	The DON or designee will re-educate all Licensed Nurses regarding assessment, documentation and treatment of skin breakdown by 12/5/13. 4. The DON or designee will randomly review 5 residents with wounds and receiving pain medications, weekly for 4 weeks and then monthly for 2 months to verify that pain medications have been administered according to physician's orders. The DON or designee will randomly review 5 residents with wounds, weekly for 4 weeks then monthly for 2 months, to verify accurate assessment, documentation and treatment of the wound. Opportunities identified as a result of these observations will be corrected by the DON or designee. The results of these observations will be reported in the monthly QAPI meeting and evaluations/recommendations will be made as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 309	Continued From page 24 daily 30 minutes prior to wound care for pain control. A review of Medication Administration Records (MAR) dated for October and November 2013, indicated the pain medication was scheduled for every day 30 minutes prior to wound care for pain control. A review of the monthly October and November 2013 treatment record revealed wound care was scheduled and completed by nurses daily on the 7 AM to 3 PM shift to wounds on the left heel and left shin. Further review of the narcotics medication sign out sheet for October and November 2013 revealed that the Norco medication tablets were pulled from the medication cart, were signed out by the medication aide initialed and administered to the Resident #124 on the following dates prior to wound care: 10/08/13 10/15/13 10/22/13 10/29/13 11/02/13 11/03/13 11/05/13 11/06/13. A review of Resident #124's Treatment Administration Record revealed the order for the dressing change had been signed as having been done daily. Observation of wound care on 11/05/13 at 8:37 AM was provided by the wound care physician and the ADON provided the dressing changes and was assisted by Nurse # 4. The physician measured, assessed and treated the pressure	F 309		

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F 309	Continued From page 25 ulcers to the left heel and the left shin, and completed a full body skin assessment on Resident #124. The physician talked to Resident #124 while he provided wound care. The nurses provided assistance to the physician and positioned the resident during the care that was provided. The physician instructed the two nurses on treatments and the dressings needed for Resident #124 and left the room. Nurse #3 completed the dressing changes assisted by nurse #4. During the observation of the dressing change and cleansing of the left shin wound with saline water Resident #124 jerked his leg and spoke out and said "ouch that's my bad leg." Nurse # 3 stated "I'm sorry, I'll be real gentle." The wound care was completed observing infection control and without further comments from the Resident. During an interview on 11/06/13 at 4:00 PM Nurse #3 stated she provided wound care treatments and that she instructed the Medication Aide (MA) s who administered daily medications as ordered by the physician prior to providing the wound care. Nurse #3 further stated that she expected Resident #124 had received his daily Norco pain medication prior to wound care as the physician ordered and that it was the responsibility of the nurse providing wound care treatments to notify the MA 30 minutes prior to treatments to give the pain medication. Nurse #3 revealed that she normally told the MA when to give the pain medication for Resident #124 before wound treatment within a time range for effective pain control. Nurse #3 confirmed that Resident #124 had not received his daily pain medication as ordered prior to wound treatments as indicated by the medication had not been signed out daily. She further explained that if the medication had	F 309		

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been given daily as prescribed by the physician then the narcotic sign out sheet would reflect daily entries or the medication pill count would be wrong.

During an interview on 11/07/13 at 7:52 AM the wound care physician stated he expected that Resident #124 was medicated for pain prior to wound care treatments daily.

During an interview on 11/07/13 at 10:08 AM MA #1 stated that Resident #124 was to receive Norco pain medication daily 30 minutes prior to wound care. MA #1 revealed that the nurses who provided the wound care normally notified her when to give the medication within a time range prior to the treatment of the wounds for effective pain control. MA #1 stated that Resident #124 had not received his daily Norco pain medication prior to the wound treatments as was ordered by the physician and that she had not given the pain medication every day.

During an interview on 11/07/13 at 1:52 PM the interim Director of Nursing (DON) verified that Resident #124 had physician orders to receive Norco pain medication daily 30 minutes prior to wound care treatments for pain control. The interim DON further verified that the MAR record indicated that Resident #124 had not received the pain medication daily. The interim DON stated that monthly physician orders were checked for accuracy at the beginning of the month by two nurses. The interim DON stated that her expectation was that Resident #124 received his pain medication daily as ordered by the physician. The interim DON further stated that the orders for the pain medication administration for Resident #124 were not followed and Resident #124 had

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F 309	Continued From page 27 not received his daily pain medication prior to the wound care treatments. 2. Resident #111 was admitted to the facility 10/24/13 with diagnoses which included congestive heart failure and diabetes. Resident #111's most recent Admission Minimum Data Set dated 11/31/13 revealed she was cognitively intact and needed extensive assistance with bed mobility, transfer and activities of daily living. A Non- Pressure Skin Condition Record dated 10/24/13 indicated Resident #111 had a 1 x 1 centimeter (cm) wound on her right buttock. This wound was labeled an abrasion. Physician orders dated 10/24/13 revealed an order to clean abrasion to right buttock with normal saline, pat dry, apply dressing, change every three days and as needed until healed. The care plan for Resident #111 dated 10/24/13 for potential for skin impairment revealed an intervention to clean abrasion to right buttock with normal saline, pat day and apply dressing, change dressing every three days and as needed. Review of Resident #111's Treatment Administration Record revealed the order for the dressing change had been signed as having been done daily and most days more frequently.	F 309		

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F 309	Continued From page 28 On 11/05/13 at 9:57 AM an observation was made of incontinence care for Resident #111. During this observation it was noted Resident #111 did not have a dressing on her buttocks. She had thick dry stool on her buttocks. When the staff cleaned the stool from Resident #111's bottom it was noted there were two areas of skin breakdown and her bottom was very red. There were two areas of skin breakdown noted which were approximately dime size. On 11/06/13 at 8:36 AM an interview was conducted with Resident #111. She stated she had been up since 6:30 AM and has been sitting up in her wheelchair. She stated her bottom was hurting. She stated she used her call bell last night but they cut it off. She stated it was at least 30 minutes before the staff returned to provide incontinence care. An interview was conducted on 11/06/13 at 10:24 AM with Nurse #1. Nurse #1 stated the wound nurse only sees the residents the wound doctor is following. She stated she observes the wound and measures it weekly. An interview was conducted on 11/06/13 at 10:56 AM with the Assistant Director of Nursing (ADON) who is also the Wound Nurse (WN). The ADON/WN stated she had not seen Resident #111's wound. She went on to explain she only sees wounds if the floor nurse tells her a wound has worsened. She explained only sees complicated wounds. On 11/06/13 at 11:45 AM an interview was conducted with Nurse #1. Nurse #1 stated she did put the dressing back on Resident #111's wound (#1) yesterday. She stated she did not	F 309		

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assess or measure the wound at that time. She further stated she did not notice there was a new area of breakdown (wound #2) on Resident #111's right buttock. Nurse #1 gave no explanation as to why there was not a dressing on Resident #111's wound.

Review of the Non Pressure Skin Condition Record dated 11/06/13 revealed wound #2 first observed 11/06/13, right buttock wound area measured 1.2 x 0.6 cm.

On 11/06/13 at 12:20 PM an interview was conducted with Resident #111 who was still up sitting in her wheelchair. Again she stated her bottom was hurting and she was wet but she did not want to get back into bed as her lunch was coming and she wanted to sit up to eat it. Resident #111 stated the nursing assistants did not come to check on her to see if she needed to be changed. She stated she had to ring the call bell to let them know she needed to be changed.

On 11/06/13 at 2:19 PM an interview was conducted with Nurse #1. Nurse #1 stated she had just changed the dressing on Resident #111's buttocks and she did see the new area of skin breakdown. She stated she was going to notify the ADON/WN.

On 11/06/13 at 2:40 PM an observation of Resident #111's with the ADON/WN. The new dressing was in place and not removed as not to further damage the skin. The area around the dressing was red. The ADON/WN stated they needed to put a barrier cream on the resident ' s bottom. At this time Resident #111 told the ADON/WN about staff coming in and turning off her call light and not proving care, and not

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returning for 30 minutes to an hour. The ADON/WN stated that was unacceptable and told Nurse #1 to monitor the call lights being answered.

ON 11/06/13 at 3:18 PM an interview was conducted with the interim Director of Nursing (DON). She stated it was her expectation was the new area of skin breakdown should have been reported to the wound nurse, measured and the physician notified. She further stated the nursing assistants should have reported Resident #111's wound dressing had come off.

On 11/06/13 at 4:00 PM an interview was conducted with Nurse #2 who worked on 2nd shift. She stated she did the original assessment when Resident #111 was admitted to the facility. She stated she assessed Resident #111's wound as being an abrasion because it was blanchable. She further stated she had changed Resident #111's wound dressing the night of 11/05/13 and she did not notice the new area of skin breakdown on her right buttock.

On 11/07/13 at 7:35 AM an observation of Resident #111's buttock wound was observed with the Wound Doctor (WD). He stated the wounds on Resident #111's buttocks were friction wounds. He stated the dressing should be continued but that a barrier cream should be used as well as an air mattress. He stated his preference would be to see all wounds in the facility.

On 11/07/13 at 8:57 AM during an interview with Nurse #1 she stated had she seen the new area of skin breakdown on Resident #111's buttock she would have measured the area and told the

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F 309	Continued From page 31 ADON/WN.	F 309		
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 observation, record review and staff interviews the facility failed to provide denture care and nail care for 2 of 7 residents who were observed for activities of daily living. (Residents #82 and #117) The findings included: 1. Resident #82 was admitted to the facility with diagnoses which included dementia. Resident #82's most recent Quarterly Minimum Data Set (MDS) dated 08/24/13 indicated she had severe cognitive impairment. Further review of the MDS revealed she needed assistance with personal hygiene and was dependent for bathing assistance. The MDS indicated Resident #82 refused care daily. Review of Resident #82's care plan dated 11/20/12 and updated 08/23/13 for activities of daily living (ADL) revealed she needed limited assistance of one person for assistance with ADL needs. The goal, Resident #82 would have ADL needs identified and met with staff assistance and intervention while maintaining highest level of	F 312	1. Denture care was provided to Resident #82 on 11/ 7/13. Nail care was provided to Resident #117 on 11/7/13. 2. All residents have requiring assistance with activities of daily living have the potential to be affected by this alleged deficient practice. The DON or designee will complete an audit of all residents who require assistance with activities of daily living to verify cleanliness of denture care and nail care by 12/5/13. 3. The DON or designee will re-educate nursing staff on providing assistance with activities of daily living to include dental and nail care by 12/5/13. 4. The DON or designee will randomly review 5 residents who require dental and nail care, weekly for 4 weeks then monthly for 2 months, to verify residents are receiving required assistance. Opportunities identified as a result of the audit will be corrected by the DON or designee. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 312	Continued From page 32 independent function possible to include: wash own face and hands daily, brush own teeth daily and brush hair independently daily. Resident #82 had no teeth of her own and the interventions made no mention of denture care for this resident. An observation was made on 11/05/13 at 11:20 AM of Resident #82 in her room her top and bottom dentures were noted to be covered with a white film and food debris. Resident #82 had not had lunch yet. An observation was made on 11/06/13 at 9:30 AM of Resident #82 again in her room her dentures where noted to be covered with a white coating and food debris. On 11/07/13 at 9:36 AM an interview was conducted with Nursing Assistant (NA) #2. NA #2 stated she took care to Resident #82. She stated she had performed morning care for Resident #82 which included "washing her up", changing her clothes, and taking her to the restroom. She stated she would provide mouth care when the resident would allow it. She stated she did not document the resident's refusals and that she had not cleaned the resident's dentures recently. On 11/07/13 at 9:45 AM an observation was made of NA #2 asking Resident #82 if she could clean her dentures. Resident #82 allowed NA #2 to remove the dentures from her mouth to be cleaned. On 11/07/13 at 9:56 AM an interview was conducted with Nurse #1. Nurse #1 stated Resident #82 had refused care before but it had never been reported to her that she refused to	F 312	Audit results will be reports on during the monthly QAPI meeting and evaluations/recommendations will be made by the QAPI committee as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 312	Continued From page 33 have her dentures cleaned. On 11/01/13 at 3:15 PM an interview was conducted with the interim Director of Nursing (DON). The interim DON stated denture care should be provided after each meal and before bed. 2. Resident # 117 was admitted to the facility with diagnoses which included diabetes, dementia, and depression. Resident #117's most recent Quarterly Minimum Data Set dated 10/09/13 revealed she had moderate cognitive impairment and needed extensive assistance with personal hygiene. Resident #117's care plan dated 06/14/13 and updated 09/13/13 revealed she needed extensive assistance of 1-2 staff members for completion a activities of daily living (ADL) needs. The goal was for Resident #117 to have all ADL needs identified and met with staff assistance and intervention while maintaining the highest level of independent function possible to include: washing her own face and hands daily, brushing her own teeth daily and brushing her hair independently daily. Interventions included gathering and providing needed supplies and allowing the individual adequate time to complete the tasks. There were no interventions specific to nail care. On 11/04/13 an observation was made at 2:53 PM of Resident #117 in her geri-chair in her room. Resident #117 had brown matter under the first three fingers of her left hand. An observation was made on 11/06/13 at 8:43 AM of Resident #117 lying in her bed. She continues to have brown matter under the	F 312		

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F 312	Continued From page 34 fingernails of her left hand. An observation was made on 11/06/13 at 12:15 PM of Resident #117 up in her geri-chair in her room. Resident #117 continued to have dark brown matter under her the fingernails of her left hand. On 11/07/13 at 9:20 AM an observation was made of Resident #117 in her room. She continued to have brown matter under the fingernails of her left hand. This observation was made with Nursing Assistant #3. An interview was conducted on 11/07/13 at 9:20 AM with Nursing Assistant (NA) #3. NA #3 stated she provided care for Resident #117 which included brushing her teeth, combing her hair, dressing, and incontinent care. NA #3 stated the brown matter under Resident #117's fingernails is from where she scratches herself. She stated she should have noticed her nails were dirty and cleaned them as this would be part of her AM care. On 11/07/13 at 9:28 AM an interview was conducted with the Unit Manager (UM). The UM stated she helped to monitor the care nursing assistants give on the halls. She stated part of morning care is making rounds with the off going shift making sure residents are presentable before meals. She stated this would include hands and faces being clean. She went on to say staff should have looked at Resident #117's hands to make sure her nails were clean. The nurses should also check this when they do weekly skin assessment as well. On 11/07/13 at 3:12 PM an interview was	F 312		

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F 312	Continued From page 35 conducted with the interim Director of Nursing (DON). The interim DON stated she had addressed the issue of nail care with the NA staff. She stated it was her expectation for staff to keep residents' nails neat, clean, and trimmed.	F 312		
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement interventions after falls occurred for 1 of 3 residents reviewed for falls (Resident #87). The findings included: Resident #87 was admitted to the facility on 05/30/13 with diagnoses that included dementia and unsteady gait among others. The most recent Minimum Data Set (MDS) dated 07/22/13 specified the resident had severely impaired cognition and had impaired vision with no corrective lenses. The resident was ambulatory but not steady and was only able to steady herself with staff assistance when moving from seated to standing position, walking, turning and surface to surface transfer. The MDS also specified that the resident had not fallen since her admission to the	F 323	1. Resident # 87 has been reviewed by the interdisciplinary team for appropriate interventions related to falls. 2. All residents have the potential to be affected by this alleged deficient practice. The DON or designee will audit residents who have had falls for the past thirty days to verify appropriate interventions are in place by 12/5/13. 3. The Rehab Program Manager will re-educate rehab staff regarding timely completion of therapy screens. The Administrator will re-educate the interdisciplinary team on verification of implementation of fall interventions by 12/5/13. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 323	Continued From page 36 facility. Resident #87's fall care plan updated 07/22/13 specified the resident was at risk for falls and identified approaches to keep the resident free from a fall related injury. The Care Area Assessment (CAA) dated 08/05/13 for falls specified the resident ambulated independently and had an unsteady gait and unsteady balance. The CAA also specified that Resident #87 had poor safety awareness and attempted to toilet self at times. Review of Resident #87's medical record revealed a document titled "Change in Condition" dated 08/18/13 that specified the resident was found on the floor in another resident's room. The nurse's entry specified that there was no injury. The document titled "Post Fall Review" dated 08/19/13 specified the intervention for the fall was to refer the resident to physical therapy. Further review of the medical record revealed there was no documented evidence of a physical therapy referral, screen or evaluation. A second "Change in Condition" form dated 09/27/13 specified the resident fell when ambulating. The nurse's entry specified that there was no injury. The document titled "Post Fall Review" form 09/30/13 specified the intervention for the fall was to refer the resident to physical therapy. On 11/05/13 at 8:30 AM Resident #87 was observed during the breakfast meal. She ate in the dining room on the secured unit and ambulated ad lib. Her gait was unsteady and staff were noted to offer her assistance.	F 323	4. The Rehab Program Manager or designee will randomly review 5 resident falls weekly for 4 weeks and then monthly for 2 months to verify appropriate implementation of fall interventions. Opportunities identified as a result of the audit will be corrected by the Rehab Program Manager or designee. Audit results will be reports on during the monthly QAPI meeting and evaluations/recommendations will be made by the QAPI committee as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 323	Continued From page 37 On 11/07/13 at 12:30 PM the interim Director of Nursing (DON) was interviewed and explained the facility's fall review process. She stated that physical therapy screened every resident who fell and that this process was automatic. She added it was the nurse's responsibility to implement an immediate intervention but that sometimes the Unit Manager could implement fall interventions as well. The interim DON reported that all falls were reviewed by the Fall team (consisting of the DON, Unit Manager, Rehab Director and others) the following business day to ensure that interventions were in place at the time of fall and that new interventions were implemented. On 11/07/13 at 12:45 PM the Unit Manager was interviewed and reported that her primary responsibility after a resident fell was to ensure all required paperwork was completed. She stated that she was a part of the "fall team" and assisted with developing new interventions to prevent further occurrences. She explained that all residents who fell were referred to physical therapy. She reported that there was no formal process for making the referral to physical therapy and that the "fall team" did not follow up with physical therapy to ensure the referral occurred. She added that the Rehab Director was in the "fall team" meetings and communicated with the physical therapist residents who fell. She added that the Rehab Director would also communicate with the "fall team" interventions that physical therapy might have determined necessary. . During the interview with the Unit Manager, Resident #87's falls were reviewed. The Unit Manager stated that after the fall on 08/18/13 the	F 323		

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F 323	Continued From page 38	F 323		

"fall team" recommended a physical therapy screen. The Unit Manager reviewed Resident #87's medical record and revealed there was no documented evidence that the physical therapy screen had occurred. She also stated that she had not followed-up with the therapy department regarding the screen/referral. Resident #87's fall on 09/27/13 was reviewed with the Unit Manager and she reported that the "fall team" recommended another physical therapy referral. The Unit Manager stated that this intervention was not different from the 08/18/13 fall intervention and was unaware if the referral occurred. She reviewed the resident's care plan and stated that no new interventions were listed on the care plan following the 2 falls.

On 11/07/13 at 1:00 PM the physical therapist was interviewed and reported that she reviewed the 24 hour reports Monday through Friday to look for residents who fell. She added that she automatically conducted a physical therapy screen on each resident who fell and documented the screen on therapy progress notes that were kept in the medical record. She explained that this was her primary way of screening residents after falls. She added that if a fall was not documented on the 24 hour reports then it was possible she would miss the physical therapy screen. The physical therapist reviewed her records as well as Resident #87's medical record and revealed that there was no evidence that a physical therapy screen occurred after the fall on 08/18/13. She noted that a physician's order was written on 09/30/13 by the nurse practitioner for therapy to evaluate the resident following the fall on 09/27/13. The physical therapist shared the evaluation that she conducted on 10/01/13 that indicated physical therapy services were not

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F 323	Continued From page 39 indicated for Resident #87. On 11/07/13 at 1:45 PM a second interview with conducted with the interim DON and she reported that she would have expected physical therapy to screen the resident after her fall on 08/18/13 and 09/27/13. She confirmed that following the 2 falls no interventions were implemented to prevent the resident from falling again.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. A medication variance report was completed for Resident #67 and physician order was corrected. 2. All residents receiving eye drops have the potential to be affected by this alleged deficient practice. The DON or designee will audit all residents receiving eye drops for past thirty days to verify accurate order transcription. 3. The DON or designee will re-educate licensed nurses regarding physician order transcription by 12/5/13. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 329	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews and record reviews the facility staff failed to administer medications according to physician's orders for 1 of 3 sampled residents reviewed for unnecessary medications. (Resident's #67). The findings included: Resident #67 was admitted to the facility on 04/05/10 with diagnoses which included chronic kidney disease, glaucoma (a disease of the eyes characterized by increased pressure that causes the optic nerve to waste and may result in blindness), cataracts, and dementia. A review of an Eye, Ear, Nose & Throat (ENT) Associates documentation revealed the Ophthalmologist physician orders dated 03/12/13 included an order to administer: "Alphagan (medicated eye drops for glaucoma) 0.1 % (percent) 1 drop twice daily to the right eye, Lumigan (medicated eye drops for glaucoma) 0.01% 1 drop every night to the right eye and discontinue the Timolol (medicated eye drops for glaucoma) eye drops." A review of Medication Administration Records (MAR) for Resident #67 dated for the month of March 2013, indicated the Timolol eye drops was discontinued on 03/12/13, and both the Alphagan and the Lumigan eye drops were written to be given in both eyes and were not changed to the right eye only as per physician orders and were administered into both eyes. A review of each monthly MAR from April through November 2013 revealed the eye drops of Alphagan and Lumigan remained written to be given in both eyes and were not changed to the right eye only as per physician orders and were initialed as administered Alphagan twice daily in both eyes	F 329	4. The DON or designee will randomly review 5 residents receiving eye drops, weekly for 4 weeks and then monthly for 2 months, to verify accurate order transcription. Opportunities identified as a result of the audit will be corrected by the DON or designee. Audit results will be reported on during the monthly QAPI meeting and evaluations/recommendations will be made by the QAPI committee as indicated. "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 and/or executed solely because it is required by the provisions of federal and state law."	12/5/13

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F 329	Continued From page 41 and Lumigan every night in both eyes. During an interview on 11/06/13 at 4:00 PM Nurse #3 stated that the Medication Aide (MA) s administered daily medications as ordered by the physician. She stated that she expected Resident #67 received his daily eye drops for glaucoma as the physician ordered. Nurse #3 confirmed the physician orders were changed from administered to both eyes to the eye drops were to be administered in the right eye only. She further stated that according to the MARs that the eye drops were administered to both eyes and not the right eye according to the physician's order change. During an interview on 11/06/13 at 5:11 PM the Assistant Director of Nursing (ADON) verified that Resident #67 had physician orders for Alphagan eye drops 1 drop twice daily to the right eye and Lumigan eye drops 1 drop every night to the right eye. The ADON revealed the monthly physician orders were checked for accuracy at the beginning of each month by two nurses. The ADON stated that her expectation was that Resident #67 received his daily medications as ordered by the physician. The ADON further stated that according to the physician orders for the eye drops medications Resident #67 should have been given the drops in the right eye only. The ADON further verified that the records indicated that Resident #67 received both eye drops in both eyes. During an interview on 11/07/13 at 10:08 AM the MA #1 stated that Resident #67 received the Alphagan and the Lumigan eye drops in both eyes according to the MARs. MA #1 further stated that she administered the Alphagan drops	F 329		

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F 329	Continued From page 42 during the day shift to both of the Resident #67 ' s eyes. During an interview on 11/07/13 at 1:52 PM the interim Director of Nursing (DON) verified that Resident #67 had physician orders for Alphagan eye drops 1 drop twice daily to the right eye and Lumigan eye drops 1 drop every night to the right eye. The interim DON revealed the monthly physician orders were checked for accuracy at the beginning of each month by two nurses. The interim DON stated that her expectation was that Resident #67 received his daily medications as ordered by the physician. The interim DON further stated that according to the physician orders for the eye drops medications Resident #67 should have been given the drops in the right eye only. The interim DON further verified that the records indicated that Resident #67 received both eye drops in both eyes. During a telephone interview on 11/07/13 at 3:33 PM the assistant with the doctor at ENT Associates she stated she consulted with the eye doctor regarding his eye drops orders for glaucoma. She verified the physician orders for the eye drops were to be administered in the right eye only and confirmed the physician stated he wanted the eye drops given as ordered in the right eye only for both the Alphagan and the Lumigan.	F 329		