

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

PRINTED: 01/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345261</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLEGHANY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>179 COMBS STREET SPARTA, NC 28675</b>	
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F 166 SS=B	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to resolve a resident ' s grievance to make payment of bingo prize monies for 6 months for 1 of 16 residents (#59).</p> <p>The findings included:</p> <p>Resident #59 was admitted with diagnosis of stroke, dementia, and seizure disorder. The annual Minimum Data Set dated 10/08/13 assessed the resident as cognitively intact and able to understand and make self understood.</p> <p>A review of the accounts payable records from May through November 30, 2013 for the bingo prize money receipts revealed payments to the residents were made for the months of May and July 2013. Further review of records revealed that no receipts had been received and no prize money had been paid to 16 residents for the months of April, June, August, September, October, or November 2013.</p> <p>During an interview with Resident #59 on 12/06/13 at 11:08 AM he revealed the facility hadn't paid the bingo prize money for months. He further revealed when he asked the AD about the payment of prize money being behind that the AD</p>	F 166	<p>Resident #59 was paid all bingo prize money due to him on December 16, 2013.</p> <p>All other residents that were due bingo prize money were paid all money due them on December 16, 2013.</p> <p>On December 6, 2013 the Activity Director was in-serviced by the Administrator that any resident due prize money from bingo was to be paid at the time of winning.</p> <p>The Activity Director or Designee will give the Business Office Manager a list of residents that win money prizes in bingo weekly x 1 month then monthly x 2 months. The Business Office Manager will monitor that all prize money from bingo was paid to the residents winning and report findings to the Performance Improvement Committee monthly x 3 months.</p>	12/30/13

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

TITLE

(X6) DATE

Electronically Signed

12/30/2013

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

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F 166	<p>Continued From page 1</p> <p>stated she would pay their prize money at the end of the month for 2 months worth of prizes. He further stated this was what he was told each month by the AD and he just wanted the facility to be fair and pay the prizes due to the residents.</p> <p>During an interview with the Assistant Director of Activities (AAD) on 12/05/13 at 2:33 PM she stated residents were paid 2 months winnings at a time. The AAD revealed the residents were supposed to receive a quarter for each bingo game won and were kept on a tally sheet for each month and 2 months worth of winnings were submitted to the Business Office Manager (BOM) and were paid to the residents. The AAD further stated they were behind some months in paying the bingo winnings to the residents.</p> <p>During an interview on 12/06/13 at 1:44 PM the Activity Director (AD) stated Bingo was provided weekly on Thursdays. The AD revealed that bingo prize winnings were tallied and recorded each month, placed in a receipt book for each resident, and given to the BOM for 2 months totals at a time, and then the money was distributed to the residents. She further revealed that the resident winnings had not been paid for the months of August, September, October, and November 2013. The AD stated that the bingo prize money was allocated through the petty cash and was ultimately deducted from the activity budget. The AD further stated residents had asked her when they were going to get their money and she told them they would receive their money at the end of the December 2013 for the past 2 months. The AD further revealed that she had not told the Administrator about being behind in the payment of bingo prize money and had not asked the Administrator if she could catch up the winning's</p>	F 166			

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F 166	Continued From page 2 to make it current.  During an interview on 12/06/13 at 2:38 PM with the Business Office Manager (BOM) and the Accounts Payable (AP) clerk the BOM explained the AD brought the receipts for residents' bingo prizes to her to be paid. The AP clerk further revealed that no prize money had been paid to 16 residents for the months of April, June, August, September, October, or November 2013. The BOM verified that the AP clerk had not received any receipts for the months of April, June, August, September, October, or November 2013. The BOM stated they relied on the AD to provide the receipts that were due to the residents for bingo winnings and it was the responsibility of the activity department to keep up with what was owed.	F 166			
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, staff and resident interviews the facility failed to maintain dignity during meals when staff stood over residents	F 241	Resident #2 is no longer in facility. Residents #11 and #1 were interviewed by the Social Worker on December 27, 2013	12/30/13	

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F 241	<p>Continued From page 3</p> <p>while they fed them and failed to engage them in conversation during 2 of 2 meal observations. (Resident #11, #1, and #2).</p> <p>The findings included:</p> <p>1. Resident #11 was re-admitted to the facility on 09/04/10 with diagnoses which included depression, anxiety and difficulty swallowing. The most recent annual Minimum Data Set (MDS) dated 10/01/13 revealed Resident #11 had no short term or long term memory problems and had no impairment in cognition for daily decision making. The MDS further indicated Resident #11 was totally dependent on staff with eating and had range of motion impairment in upper and lower extremities on both sides.</p> <p>During continuous observations on 12/02/13 starting at 11:40 AM Nurse Aide (NA) #2 who was tall in height carried a meal tray into Resident #11's room and placed it on an overbed table on the right side of the bed. There was no chair in the room for NA #2 to sit on. Resident #11 was lying on his left side turned toward the over bed table with the head of the bed slightly elevated. NA #2 towered over Resident #11 and looked down at him as she fed him lunch. While NA #2 fed Resident #11 she talked with NA #3 who stood beside his roommate Resident #1's bed while she fed him lunch. At 11:55 AM NA #2 carried Resident #11's meal tray out to a metal cart in the hallway.</p> <p>During an interview on 12/05/13 at 1:40 PM with NA #2 she stated she knew she was supposed to sit down when she fed residents and they were not supposed to hover over them. She confirmed she stood while she fed Resident #11 his lunch</p>	F 241	<p>about staff standing to assist them with eating.</p> <p>The Social Worker interviewed other residents that require assistance with eating on December 27, 2013.</p> <p>Nurse Aide # 2 and #3 were in-serviced on December 9, 2013 by the Administrator about standing to feed residents, engaging the resident in conversation and avoiding conversation with staff while feeding residents.</p> <p>On December 18 &amp; 19, 2013 staff was in-serviced by the Administrator, Director of Nursing and Assistant Director of Nursing on sitting to feed residents, engaging the residents in conversation and avoiding conversation with other staff while feeding.</p> <p>The Director of Nursing or Designee will monitor 3 random meals a week x 1 month, then weekly x 2 months to ensure that staff is sitting to feed and engaging residents in conversation and avoiding conversation between staff. Findings will be submitted to the Performance Improvement Committee by the Director of Nursing monthly x 3 months with follow up as needed.</p>		

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F 241	<p>Continued From page 4</p> <p>on 12/02/13 and sometimes she just didn't take the time to sit down when she fed residents. She stated some resident rooms had chairs for them to sit in but if there was not a chair in the room there were chairs available that they were supposed to take to the room when they fed residents but she didn't think to go get one.</p> <p>During an interview on 12/06/13 at 11:55 AM Resident #11 confirmed he could not feed himself and needed staff to feed him at every meal. He stated he preferred for staff to sit next to him because when the staff stood and fed him he felt they were in a hurry for him to eat and he felt rushed. He further stated he enjoyed when staff talked and visited with him during meal times.</p> <p>During an interview on 12/06/13 at 3:55 PM the Director of Nursing (DON) stated it was her expectation for staff to sit next to residents at eye level when they fed them. She further stated if there was not a chair in the room for them to sit on they should go get one. She explained she expected for them to communicate only with the resident and not with co-workers while they fed residents.</p> <p>2. Resident #1 was re-admitted to the facility on 01/08/08 with diagnoses which included dementia, depression, difficulty swallowing and paralysis due to a stroke. The most recent quarterly Minimum Data Set (MDS) indicated Resident #1 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #1 was totally dependent with eating and required 1 staff assistance during meals.</p>	F 241			

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F 241	<p>Continued From page 5</p> <p>During continuous observations on 12/02/13 starting at 11:45 AM Nurse Aide (NA) #3 who was medium height carried a meal tray into Resident #1's room and placed it on an overbed table on the left side of the bed. There was no chair in the room for NA #3 to sit on. Resident #1 was lying on his back with the head of the bed slightly elevated and NA #3 towered over Resident #1 and looked down at him while she fed him lunch. While NA #3 fed Resident #1 his lunch she talked with NA #2 while she fed his roommate Resident #11 his lunch. At 12:00 PM NA #2 took Resident #1's meal tray out of the room to a metal cart in the hallway.</p> <p>During a phone interview on 12/06/13 at 12:23 PM with NA #3 she stated sometimes she stood next to residents and sometimes she sat down when she fed residents. She stated she thought it was okay to either sit or stand when she fed residents and verified she stood next to Resident #1 when she fed him lunch on 12/02/13. She stated there was no chair in the room for her to sit on but there were chairs available for them to take to the resident's room but didn't think about getting one.</p> <p>During an interview on 12/06/13 at 3:55 PM the Director of Nursing (DON) stated it was her expectation for staff to sit next to residents at eye level when they fed them. She further stated if there was not a chair in the room for them to sit on they should go get one. She explained she expected for them to communicate only with the resident and not with co-workers when they fed residents.</p> <p>3. Resident #2 was admitted to the facility on 05/12/11 with diagnoses which included anemia</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>(low iron in blood), and esophageal reflux (stomach contents leak backwards from the stomach into the esophagus). The most recent quarterly Minimum Data Set (MDS) dated 09/24/13 indicated Resident #2 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #2 was totally dependent on staff with eating and had range of motion impairment in upper and lower extremities on both sides.</p> <p>During continuous observation on 12/03/13 starting at 11:47 AM Nurse Aide (NA) #2 who was a tall in height carried a meal tray into Resident #2's room and placed it on an overbed table on the right side of the bed. There was no chair in the room for NA #2 to sit on. Resident #2 was lying on his back with the head of the bed slightly elevated and NA #2 towered over Resident #1 and looked down at him while she fed him lunch. NA #2 asked Resident #2 if he wanted something to drink but otherwise did not talk with the resident. At 12:05 PM NA #2 carried Resident #2's meal tray to a large metal cart in the hallway.</p> <p>During an interview on 12/05/13 at 1:40 PM with NA #2 she stated she was supposed to sit down when she fed residents and was not supposed to hover over them. She confirmed she stood while she fed Resident #2 his lunch on 12/03/13 and sometimes she just didn't take the time to sit down when she fed residents. She stated some resident rooms had chairs for them to sit in but if there was not a chair in the room there were chairs available that they were supposed to take to the room when they fed residents but she didn't think to go get one.</p>	F 241			

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F 241	Continued From page 7 During an interview on 12/06/13 at 3:55 PM the Director of Nursing (DON) stated it was her expectation for staff to sit next to residents at eye level when they fed them. She further stated if there was not a chair in the room for them to sit on they should go get one. She explained she expected for them to communicate with the resident while they fed them.	F 241			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to honor resident choices when staff woke residents at 5:30 AM for finger stick blood sugar checks. (Resident #6, #36 and #10) and failed to honor choice of time to go to bed in 2 of 3 residents (Resident #44 and #63).  The findings included:  1. Resident #6 was re-admitted to the facility on 02/25/13 with diagnoses which included anxiety and type 2 diabetes. The most recent quarterly Minimum Data Set (MDS) dated 09/16/13 indicated Resident #6 had short term and long term memory problems and was moderately	F 242	Residents #6, #36 and #10 were interviewed by the Director of Nursing on December 27, 2013 for what time they would like to have their finger stick blood sugar done prior to their breakfast meal and changes were made with physician approval.  An audit was completed on December 27, 2013 by the Director of Nursing and Designee of current residents with orders for finger stick blood sugars prior to the breakfast meal for their choice of when to have the procedure done prior to breakfast. The physician for each resident	12/30/13	



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F 242	<p>Continued From page 8</p> <p>impaired in cognition for daily decision making.</p> <p>During an observation of a medication pass on the 300 hall on 12/06/13 at 5:30 AM Nurse #6 who was a 7:00 PM to 7:00 AM nurse gathered supplies for a finger stick blood sugar test from a medication cart parked in the hallway outside the door of Resident #6's room. At 5:37 AM Nurse #6 knocked on Resident #6's door and opened the door and entered the room. There were no lights on in the room and Nurse #6 turned on a bathroom light and called Resident #6's name and stated it was time for his finger stick blood sugar. Resident #6 was lying in bed and opened his eyes and reached to find the cord to turn the light on over his bed. Nurse #6 checked Resident #6's finger stick blood sugar and washed her hands and turned off the lights and closed the door of the room and walked back to the medication cart in the hallway. At 5:45 am all of the hallway lights for the 300 hall were turned on.</p> <p>During an interview on 12/06/13 at 5:53 AM with Nurse #6 she verified morning medications and finger stick blood sugars were usually ordered to be given between 6:00 AM and 6:30 AM but she started medication pass at 5:30 AM because she never knew what might happen before the end of her shift. She explained she started medication pass early so she would be ready for report with the day shift nurse before her shift ended before 7:00 AM. Nurse #6 stated most of the morning medications she gave on the 300 hall were finger stick blood sugar checks or insulin. She stated she estimated she woke approximately one-half of the residents who had morning medications or finger stick blood sugars. She further stated she had not thought about asking residents choices regarding their morning blood sugar checks.</p>	F 242	<p>was notified and orders were received to change the time for the finger stick blood sugar. New admitted residents will be interviewed for their preference of when to get the finger stick blood sugar prior to the breakfast meal.</p> <p>Nurses were in-serviced by the Administrator on December 18 &amp; 19, 2013 on providing residents choices about being woken for Fingerstick Blood Sugars prior to breakfast.</p> <p>The Social Worker will do random interviews with residents receiving Finger stick Bloodsugars prior to breakfast 3 x weekly for 1 month then 1 x weekly for 2 months to assure residents receiving finger sticks at time of choice.</p> <p>Findings will be reported to the Director of Nursing and submitted to the Performance Improvement Committee by the Director of Nursing monthly x 3 months with follow up as needed.</p> <p>Residents #44 and #63 were interviewed by the Social Worker on December 27, 2013 for what time they prefer to go to bed at night.</p> <p>All other residents being affected by this practice were interviewed for time preference in going to bed. All new admissions will be interviewed for preferences in bed times.</p> <p>Staff was in-serviced by the Administrator</p>		

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F 242	<p>Continued From page 9</p> <p>During an interview on 12/06/13 at 6:24 AM with Nurse #7 she explained she usually gave medications on the 100 and 200 halls and usually started her medication pass by 5:45 AM. She stated some residents were awake at that time but she estimated she had to wake up over one-half of the residents when she gave their medications.</p> <p>During an interview on 12/06/13 at 6:54 AM with Nurse #5 she stated she started her medication pass at 5:30 AM and she had to wake residents up to do their finger stick blood sugar checks. She explained she knocked on the resident's door, went into the room and turned on the light so she could see. She stated she told the resident she was there to do their finger stick blood sugar and they held their arm out and she stuck their finger. She stated the residents were used to the routine and she had not asked them about choices related to morning finger stick blood sugar checks.</p> <p>During an interview on 12/06/13 at 3:41 PM the Director of Nursing stated it was her expectation for resident's choices to be honored and it was important for residents to get their hours of sleep. She stated finger stick blood sugars should be done after 6:00 AM and the hallway lights should be turned on later than 5:45 AM.</p> <p>2. Resident #36 was re-admitted on 12/11/10 with diagnoses which included dementia and diabetes. The most recent annual Minimum Data Set dated 04/16/13 indicated Resident #36 had short term and long term memory problems and was severely impaired in cognition for daily decision making.</p>	F 242	<p>on December 18 &amp; 19, 2013 about honoring resident's preference in their choice of time to go to bed each night.</p> <p>Random interviews will be done by the Social Worker or Designee on honoring resident's choice on what time to go to bed at night 3 x weekly for 1 month and then weekly x 2 months. Resolutions of the interviews will be taken to the Performance Improvement Committee by the Social Worker monthly. Results will be on-going with follow up as needed.</p>		

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F 242	<p>Continued From page 10</p> <p>During an observation on the 300 hall on 12/06/13 at 5:30 AM Nurse #6 who was a 7:00 PM to 7:00 AM nurse gathered supplies for a finger stick blood sugar test from a medication parked in the hallway outside the door of Resident #36's room. At 5:44 AM Nurse #6 knocked on Resident #36's door which was partially opened and entered the room. The light in the room was dim and Nurse #6 turned on a bathroom light. Resident #36 was sitting in a wheelchair next to her bed with her eyes closed. Nurse #6 stated to Resident #36 it was time for her blood sugar check and Resident #36 held out her hand for Nurse #6 to stick her finger. Nurse #6 completed the blood sugar check and washed her hands and turned the bathroom light off and left the room. At 5:45 am all of the hallway lights for the 300 hall were turned on.</p> <p>During an interview on 12/06/13 at 5:53 AM with Nurse #6 she verified morning medications and finger stick blood sugars were usually ordered to be given between 6:00 AM and 6:30 AM but she started medication pass at 5:30 AM because she never knew what might happen before the end of her shift. She explained she started medication pass early so she would be ready for report with the day shift nurse before 7:00 AM. Nurse #6 stated most of the morning medications she gave on the 300 hall were finger stick blood sugar checks or insulin. She stated she estimated she woke approximately one-half of the residents who had morning medications or finger stick blood sugars. She further stated she had not asked residents about choices related to morning blood sugar checks.</p> <p>During an interview on 12/06/13 at 6:24 AM with</p>	F 242			

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F 242	<p>Continued From page 11</p> <p>Nurse #7 she explained she usually gave medications on the 100 and 200 halls and usually started her medication pass by 5:45 AM. She stated some residents were awake at that time but she estimated she had to wake up over one-half of the residents when she gave their medications.</p> <p>During an interview on 12/06/13 at 6:54 AM with Nurse #5 she stated she started her medication pass at 5:30 AM and she had to wake residents up to give them medication or do their finger stick blood sugar checks. She explained she knocked on the resident's door, went into the room and turned on the light so she could see. She stated she told the resident she was there to do their finger stick blood sugar and they held their arm out and she stuck their finger. She stated the residents were used to the routine and she had not asked them about their choices related to morning finger stick blood sugar checks.</p> <p>During an interview on 12/06/13 at 3:41 PM the Director of Nursing stated it was her expectation for resident's choices to be honored and it was important for residents to get their hours of sleep. She stated finger stick blood sugars should be done after 6:00 AM and the hallway lights should be turned on later than 5:45 AM.</p> <p>3. Resident #10 was re-admitted to the facility on 09/20/13 with diagnoses which included diabetes. The most recent 5 day Minimum Data Set (MDS) dated 11/27/13 indicated Resident #10 had no short term or long term memory problems and had no impairment in cognition for daily decision making.</p> <p>A review of admission physician orders dated</p>	F 242			

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F 242	<p>Continued From page 12</p> <p>08/23/13 indicated bedside glucose checks (finger stick blood sugar checks) daily at 7:00 AM; 11:00 AM; 4:00 PM and 10:00 PM.</p> <p>During an observation on 12/06/13 at 6:02 AM Nurse #6 completed her medication pass and rolled her medication cart back toward the nurse's station. Resident #10 was sitting in the doorway of his room in an electric wheelchair and was fully dressed.</p> <p>During an interview on 12/06/13 at 6:03 AM Resident #10 stated he had his finger stick blood sugar done that morning around 5:30 AM. He further confirmed it was the same routine every day and he usually got his finger stick blood sugars around 5:30 AM. Resident #10 stated staff had not asked him his choice about getting his finger stick blood sugars done in the morning.</p> <p>During an interview on 12/06/13 at 5:53 AM with Nurse #6 she verified morning medications and finger stick blood sugars were usually ordered to be given between 6:00 AM and 6:30 AM but she started medication pass at 5:30 AM because she never knew what might happen before the end of her shift. She explained she started medication pass early so she would be ready for report with the day shift nurse before 7:00 AM. She stated she had not thought about asking resident's their choices about their morning finger stick blood sugar checks.</p> <p>During an interview on 12/06/13 at 6:24 am with Nurse #7 she explained she usually gave medications on the 100 and 200 halls and usually started her medication pass by 5:45 AM. She stated some residents were awake at that time but she estimated she had to wake up over</p>	F 242			

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F 242	<p>Continued From page 13</p> <p>one-half of the residents when she gave their medications.</p> <p>During an interview on 12/06/13 at 6:54 AM with Nurse #5 she stated she started her medication pass at 5:30 AM and she had to wake residents up to give them medication or do their finger stick blood sugar checks. She explained she knocked on the resident's door, went into the room and turned on the light so she could see. She stated she told the resident she was there to do their finger stick blood sugar and they held their arm out and she stuck their finger. She stated the residents were used to the routine and she had not asked them about choices related to morning finger stick blood sugar checks.</p> <p>During an interview on 12/06/13 at 3:41 PM the Director of Nursing stated it was her expectation for resident's choices to be honored and it was important for residents to get their hours of sleep. She stated finger stick blood sugars should be done after 6:00 AM and the hallway lights should be turned on later than 5:45 AM.</p> <p>2. Resident #44 was admitted to the facility on 05/25/12 with diagnosis including congestive heart failure, atrial fibrillation, and chronic pain syndrome. The most recent Minimum Data Set dated 10/08/13 revealed the resident was cognitively intact and had the ability to understand others and make self understood.</p> <p>An interview with Resident #44 on 12/03/13 at 10:32 AM revealed resident was told each night to go to bed starting at about 8:00 PM. Resident #44 stated he has always stayed up late each night watching television and working on his</p>	F 242			

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F 242	<p>Continued From page 14</p> <p>hobbies and does not like going to bed early. Resident #44 stated he told staff he did not want to go to bed early but every night they argued with him until he got into bed. Resident #44 stated he believed he did not have any choices related to bedtime and he got very upset with the way the staff treated him each night as they told him to go to bed. Resident #44 stated he felt like a child each night when told by staff to go to bed.</p> <p>Interview with Nurse #8 on 12/05/13 at 2:43 PM revealed Resident #44 did not like to be told what to do and frequently became angry when told to go to bed at night. Nurse #8 stated Resident #44 preferred to stay up late but staff tried each night to get him to go to bed early in the evening.</p> <p>Interview with Nurse Aide (NA) #1 on 12/05/13 at 4:17 PM revealed nurse aides tried to get Resident #44 to go to bed early each evening and leave the room when Resident #44 becomes angry. NA #1 stated Resident #44 prefers to stay up late each night and doesn't like to be asked to go to bed early each evening.</p> <p>Interview with Nurse #5 on 12/06/13 at 5:40 AM revealed that Resident #44 is difficult to persuade to go to bed each evening. Nurse #5 stated Resident #44 prefers to stay up late at night and clean out his drawers and closets. Nurse #5 stated staff has a routine for putting the residents on the 400 hall to bed, beginning with the end of the hall where Resident #44 lives. Nurse #5 stated she has not asked residents about their bedtime preferences.</p> <p>Interview with Admissions Director (AD) 12/06/13 at 9:37 AM revealed neither residents nor resident families are assessed specifically for</p>	F 242			

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F 242	<p>Continued From page 15</p> <p>their preferences regarding time to go to bed. AD stated if residents or their families complain about bedtime, the concern is brought to their team meeting and added to their care plan as a preference.</p> <p>Review of Resident #44's care plan revealed no preference regarding time to go to bed.</p> <p>3. Resident #63 was admitted to the facility on 01/12/13 with diagnosis including cerebrovascular disease, depressive disorder, and diabetes type II. The most recent Minimum Data Set dated 10/04/13 revealed the resident was significantly cognitively impaired and had the ability to understand others and make self understood.</p> <p>An interview with family member of Resident #63 on 12/02/13 at 2:54 PM revealed he was with resident in nursing home every day and observed staff come in between 7:30 and 8:00 PM and tell Resident #63 it was time to go to bed. Family member of Resident #63 stated although this schedule was not Resident #63's choice of bedtime, nor was it according to Resident #63's previous routine, Resident #63 does not like to argue with staff or ask for help. Resident #63's family member stated Resident #63 would prefer to go to bed much later each evening but had assumed residents were put to bed according to needs of the facility staff and residents did not have a choice. The family member of Resident #63 stated they had never been asked by any facility staff about Resident #63's preference of bedtime.</p> <p>Interview with Nurse #8 on 12/05/13 at 2:43 PM revealed Resident #63 was one of the residents that was put to bed earliest in the evening. Nurse</p>	F 242			



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F 242	Continued From page 16 #8 stated she had not asked Resident #63 or family of the resident about preferences for bedtime.  Interview with Nurse Aide (NA) #1 on 12/05/13 at 4:17 PM revealed nurse aides begin putting residents on 400 hall to bed as early as 3:30 PM in the afternoon, starting with the residents who are less cognitively aware. NA #1 stated once in bed, many ate dinner in bed and went to sleep soon after. NA #1 stated Resident #63 is one of the residents he has seen put to bed late in the afternoon or very early evening. NA #1 stated he has never asked Resident #63 or the family of Resident #63 about bedtime preferences.  Interview with Nurse #5 on 12/06/13 at 5:40 AM revealed staff has a routine for putting the residents on the 400 hall to bed, beginning with the end of the hall Nurse #5 stated she has not asked residents about their bedtime preferences. Nurse #5 stated if residents complain about bedtime, staff tries to accommodate them but she has not heard of Resident #63 complaining.  Interview with Admissions Director (AD) 12/06/13 at 9:37 AM revealed neither residents nor resident families are assessed specifically for their preferences regarding time to go to bed. AD stated if residents or their families complain about bedtime, the concern is brought to their team meeting and added to their care plan as a preference.  Review of Resident #63's care plan revealed no preference regarding time to go to bed.	F 242			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		12/30/13	

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F 364	<p>Continued From page 17</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to ensure food was palatable and seasoned to resident preference for 3 of 3 residents (Resident #44, 40, and 34).</p> <p>1. Resident #44 was admitted to the facility on 05/25/12 with diagnosis including congestive heart failure, atrial fibrillation, and chronic pain syndrome. The most recent Minimum Data Set dated 10/08/13 revealed the resident was cognitively intact and had the ability to understand others and make self understood.</p> <p>Observation was made during lunch on 12/03/13 of multiple residents returning food trays and requesting alternate meals.</p> <p>An interview with Resident #44 on 12/03/13 at 10:32 AM revealed resident did not like the food served at the facility. The resident stated the food was tasteless, hard, dry, and often unidentifiable. Resident #44 stated he had spoken to various nurse aides, nurses and to the dietary manager about his dislike of the food. Resident #44 stated the alternates offered were the same every day and were also tasteless. Resident #44 stated the food was the worst he'd ever seen.</p>	F 364	<p>Residents #44, #40 and #34 were interviewed by the Food Service Director on December 27, 2013 concerning food palatably and seasoning to resident preference.</p> <p>Residents having the potential to be affected by this practice were identified by conducting random interviews of residents on December 27, 2013 by the Food Service Director for palability and seasoning.</p> <p>The Food Service Director in-serviced the Dietary Staff on December 13, 2013 about preparing meals by the recipe and not over cooking or under cooking the meals.</p> <p>The Food Service Director will complete random interviews of residents affected 3 x weekly for one month and then weekly for 2 months. New residents admitted to facility will be interviewed for food preferences with follow up for palatability on-going. Findings will be taken by the Food Service Director to the Performance Improvement Committee monthly x 3 months and on-going with follow up as</p>		

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F 364	Continued From page 18  Interview with Nurse Aide (NA) #1 on 12/05;13 at 4:17 PM revealed Resident #44 frequently complained of food taste and quality. NA #1 stated Resident #44 was offered the alternatives of hamburger, hotdog, soup, or sandwiches when he didn ' t like the main meal but Resident #44 frequently complained about the alternates as well. NA #1 stated he reports to dietary each time he requests an alternate for Resident #44 that he did not like the food.  Interview with Nurse #5 on 12/06/13 at 5:40 AM revealed she was aware that Resident #44 had frequently complained to nurse aides and nurses about the taste and appearance of the food. Nurse #5 stated NAs had reported Resident #44's complaints to dietary staff on numerous occasions. Nurse #5 stated Resident #44 was one of several residents on the 400 hall who made frequent complaints about the food.  Interview with NA #4 on 12/06/13 at 6:06 AM revealed Resident #44 is one of several residents who complain daily about the nursing home food. NA #4 stated she has frequently reported Resident #44's complaints to the dietary staff. NA #4 stated she is occasionally not able to identify the food on residents' trays when they ask her what it is.  An interview with the Dietary Manager (DM) on 12/05/13 at 12:00 PM revealed she received quarterly three week menus from corporate the facility has to follow. The DM stated she had the option to choose one of two meals to prepare from the menu and she had been monitoring to see which meal the residents like best. She further stated if they altered the seasonings the	F 364	needed.		

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F 364	<p>Continued From page 19</p> <p>recipe is changed so each cook prepared it the same way. The DM reported she received many complaints about the food and she met with each resident when they had a complaint. She further stated she had talked to corporate about the resident complaints and dislike of certain menus.</p> <p>A follow up interview with Resident #44 on 12/06/13 at 9:14 AM revealed the DM has met with him on several occasions over the past few months and has told him they would change the way the food was prepared or the recipes. Resident #44 said there had been no changes in the quality or taste of the food since the DM met with him.</p> <p>During an interview with the Administrator on 12/06/13 at 10:18 AM she reported she had received numerous complaints about the food but there were a lot of alternates such as hot dogs, hamburgers, soups and sandwiches for the residents to choose from. The Administrator stated corporate sends the menus and recipes for dietary staff follow. She further stated that staff would bring residents food from nearby restaurants' if requested by a resident. The Administrator stated she had known of frequent complaints by residents of food taste and flavor.</p> <p>Review of grievance log for prior 3 months revealed 4 grievances filed by residents involving the taste and flavor of the facility food. Response recorded for each grievance was that dietary manager had been notified of the complaints and would follow her procedures to make improvements.</p> <p>Review of minutes of Resident Council meetings for prior six months revealed complaints were</p>	F 364			

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F 364	<p>Continued From page 20</p> <p>made about food at almost every meeting. The minutes included responses that the activity director would pass the complaints on to the dietary manager.</p> <p>2. Resident #40 was admitted to the facility on 01/17/13 with diagnosis including chronic airway obstruction, diabetes type II, diverticulitis of colon, and venous insufficiency. The most recent Minimum Data Set dated 11/05/13 revealed the resident was cognitively intact and had the ability to understand others and make self understood.</p> <p>An interview with Resident #40 on 12/02/13 at 2:53 PM revealed resident did not like the flavor or texture of the food served at the facility. Resident #40 stated she ate hot dogs for lunch and dinner almost every day because she did not like the regular meals served. The resident stated the food tasted bad, wasn't flavorful, sometimes tasted odd, and was frequently unidentifiable. Resident #40 stated she returned items from her tray at least twice each day because she considered it to be inedible. Resident #44 stated she had told many nurse aides, nurses, the dietary manager, and the administrator about her complaints of the food and nothing had changed. Resident #40 stated the alternates offered were the same every day and the only one she liked were hot dogs, which is why she ate hot dogs every day. Resident #40 stated she was concerned about her nutritional health because she had eaten so many hot dogs and so little anything else in the past year.</p> <p>Observation was made during lunch on 12/03/13 of multiple residents returning food trays and requesting alternate meals.</p>	F 364			

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F 364	<p>Continued From page 21</p> <p>Interview with Nurse Aide (NA) #1 on 12/05/13 at 4:17 PM revealed Resident #40 frequently complained of food taste and quality. NA #1 stated Resident #40 was offered the alternatives of hamburger, hotdog, soup, or sandwiches when she didn't like the main meal but Resident #40 said she didn't like the alternates except for the hot dogs. NA #1 stated he reports to dietary each time he requests an alternate for Resident #40 that she did not like the food.</p> <p>Interview with Nurse #5 on 12/06/13 at 5:40 AM revealed she was aware that Resident #40 had frequently complained to nurse aides and nurses about the taste and appearance of the food. Nurse #5 stated NAs had reported Resident #40's complaints to dietary staff on numerous occasions. Nurse #5 stated Resident #40 was one of several residents on the 400 hall who made frequent complaints about the food.</p> <p>Interview with NA#4 on 12/06/13 at 6:06 AM revealed Resident #40 is one of several residents who complain daily about the nursing home food. NA #4 stated that when delivering a tray into Resident #40's room, Resident #40 asks staff to stop and wait while she lifts the plate cover off to see what the food is, because usually there is some portion of the food Resident #40 asks the staff to return to dietary. NA #4 stated she has frequently reported Resident #40's complaints to the dietary staff. NA #4 stated she is occasionally not able to identify the food on residents' trays when they ask her what it is, especially when she has not had a chance to read the day's menu from the board by the kitchen.</p> <p>An interview with the Dietary Manager (DM) on 12/05/13 at 12:00 PM revealed she received</p>	F 364			

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PRINTED: 01/09/2014  
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OMB NO. 0938-0391

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F 364	<p>Continued From page 22</p> <p>quarterly three week menus from corporate the facility had to follow. The DM stated she had the option to choose one of two meals to prepare from the menu and she had been monitoring to see which meal the residents like best. She further stated if they altered the seasonings the recipe was changed so each cook prepared it the same way. The DM reported she received many complaints about the food and she met with each resident when they had a complaint. She further stated she has talked to corporate about the resident complaints and dislike of certain menus.</p> <p>A follow up interview with Resident #40 on 12/06/13 at 9:10 AM revealed the DM has met with her on several occasions over the past year and has told her they would change the way the food was prepared or the recipes. Resident #44 said there have been no changes in the quality or taste of the food since the DM met with her.</p> <p>During an interview with the Administrator on 12/06/13 at 10:18 AM she reported she received numerous complaints about the food but there are a lot of alternates such as hot dogs, hamburgers, soups and sandwiches for the residents to choose from. The Administrator stated corporate sends the menus and recipes for dietary staff follow. She further stated that staff would bring residents food from nearby restaurants if requested by a resident. The Administrator stated she had known of frequent complaints by residents of food taste and flavor.</p> <p>Review of grievance log for prior 3 months revealed 4 grievances filed by residents involving the taste and flavor of the facility food. Response recorded for each grievance was that dietary manager had been notified of the complaints and</p>	F 364			

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F 364	<p>Continued From page 23</p> <p>would follow her procedures to make improvements.</p> <p>Review of minutes of Resident Council meetings for prior six months revealed complaints were made about food at almost every meeting. The minutes included responses that the activity director would pass the complaints on to the dietary manager.</p> <p>3. Resident #34 was admitted to the facility on 01/31/13 with diagnoses of coronary artery disease, heart failure, dysphagia, chronic airway obstruction. The Minimum Data Set dated 06/26/13 revealed the resident was cognitively intact and had the ability to understand others and make self understood. Resident #34 was on a regular diet with no restrictions.</p> <p>An observation was made of Resident #34 on 12/06/13 at 1:45 PM revealed Resident #34 had not eaten her lunch, her tray was on her bedside table untouched. Resident #34 requested NA #5 bring her 2 boxes of cereal and take her tray away.</p> <p>An interview with NA #5 revealed Resident #34 eats cereal for lunch a lot because she doesn't like the food. NA #5 stated she let the kitchen know when a resident doesn't eat their meal.</p> <p>During an interview with Resident #34 on 12/05/13 at 8:34 AM stated the food is terrible. She specified the food had no seasoning and when it did it was too salty and tasted bad. Resident #34 further stated the same meals were served over and over and the alternates were always the same. Resident #34 stated she had</p>	F 364			



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F 364	<p>Continued From page 24</p> <p>spoken to the nurse aides, nurses and the social worker many times about the food quality.</p> <p>Interview with Nurse Aide (NA) #1 on 12/05/13 at 4:17 PM revealed Resident #34 frequently complained of food taste and quality. NA #1 stated Resident #34 was offered the alternatives of hamburger, hotdog, soup, or sandwiches when she didn't like the main meal but Resident #34 frequently complained about the alternates as well. NA #1 stated he reports to dietary each time he requested an alternate for a Resident.</p> <p>An interview with the Dietary Manager (DM) on 12/05/13 at 12:00 PM revealed she receives quarterly three week menus from corporate the facility has to follow. The DM stated she had the option to choose one of two meals to prepare from the menu and she has been monitoring to see which meal the residents liked best. She further stated if they alter the seasonings the recipe is changed so each cook prepared it the same way. The DM reported she received many complaints about the food and she met with each resident when they had a complaint. She further stated she talked to corporate about the resident complaints and dislike of certain menus. The DM stated when a resident complained about the food she would talk to them individually and placed their dislikes on their tray card and highlighted the dislikes daily.</p> <p>During an interview with the Administrator on 12/06/13 at 10:18 AM she reported she received numerous complaints about the food but there were a lot of alternates such as hot dogs, hamburgers, soups and sandwiches for the resident to choose from. The Administrator stated corporate sends the menus and recipes for</p>	F 364			

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F 364	Continued From page 25 dietary staff follow. She further stated that staff would bring residents food from nearby restaurants ' if requested by a resident.	F 364			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date thawed nutritional supplement shakes intended for resident consumption.  The findings are:  During the initial tour of the kitchen on 12/02/13 at 11:41 AM one cardboard box of 43 thawed chocolate frozen shakes were observed on the shelf in the walk in cooler. The individual cartons of frozen shakes did not indicate when they expired and/or when they had been transferred from the freezer to the walk in cooler.  According to the manufacturer's recommendations they indicated that once the shakes were thawed, they were good for 14 days.	F 371	The 43 cartons of thawed chocolate frozen shakes were removed and discarded.  Frozen shakes were manually dated with the date when taken from the freezer to the cooler to thaw.  Dietary Staff was in-serviced by the Food & Nutrition Manager December 13, 2013 on proper dating of frozen shakes when coming from the freezer to the cooler and when the box is opened to individually date each shake with the expiration date.  The Food Service Director will complete random audits of the dating of the frozen/thawed shakes 3 x weekly for 1 month then weekly for 2 months. The	12/30/13	

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F 371	<p>Continued From page 26</p> <p>An interview with the dietary manager (DM) on 12/02/13 at 11:41 AM revealed the frozen shakes were usually taken from the freezer to the walk in cooler to thaw before they were distributed to the residents. The DM reported she was not aware the frozen shakes didn't have an expiration date and she did not know how long the shakes had been thawed in the walk in cooler. The DM further stated she did not know how long the shakes could be stored in the cooler after thawing and was not aware of a facility policy for storage of frozen shakes. The DM stated they normally used a box of thawed shakes in a week or week and a half.</p> <p>During a phone interview with the dietician on 11/05/13 at 4:30 PM she stated frozen shakes could be stored in the cooler for 7 days after thawed and should then be discarded.</p> <p>On 12/06/13 at 10:18 AM the Administrator stated the facility had a label gun that was to be used to label each individual frozen shake carton with the expiration date. The Administrator stated when she spoke to the DM she was informed the label gun was broken and was not able to be repaired and no expiration dates had been marked on the frozen shakes for the past couple of weeks.</p>	F 371	Administrator will take the results of the audit to the Performance Improvement Committee monthly for review.		