STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	07/25/2014

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ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to update a care plan to include the use of hand splints for one of two sampled residents with contractures. (Resident #142) The findings included: Resident #142 was originally admitted to the facility on 2/18/14 with diagnosis of fractures, acute respiratory failure, dysphagia and pressure ulcers.	F 280	For the resident cited: A) the careplan will be reviewed and updated to include the application and removal of the hand splints every shift with passive range of motions with a.m. care and each removal. B) Assigned nurse will removed splints each shift to assess skin for re/open areas. C) Gentle passive range of motion, as tolerated will be done with a.m. care, bathes, and with the application and removal of splints. D) Instructions on use of splints ordered will be placed in the 'Nursing Communications Binder' at the	8/22/14

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

Electronically Signed | 08/18/2014

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F 280	Continued From page 1 The occupational therapy (OT) notes dated 2/19/14 indicated Resident #142 was to have passive range of motion of the upper extremities to reduce the risk of contractures and training/education in splint management. The OT discharge summary dated 2/26/14 included a discharge plan and instructions for aides that were trained in appropriately donning/doffing (putting on/taking off) splints and passive range of motion exercises to the bilateral upper extremities to reduce the risk of contractures. The Minimum Data Set (MDS) dated 5/18/14 indicated Resident #142 was unable to participate in the interview process and did not have intact cognition. The MDS assessed Resident #142 as requiring total assistance for all activities of daily living and as having functional impairment on both sides of his extremities. Review of the initial care plan dated 2/27/14 with updates on 5/14, included a problem of potential for contractures related to cervical fractures. Approaches included the resident was to have gentle range of motion during routine care by the aides. The updated care plan did not address the application of splints. Interview with the MDS nurse and Director of Nursing on 7/25/14 at 9:30 AM revealed the care plan for a resident with contractures would include gentle range of motion during bathing. The MDS nurse continued to explain, application of splints would be included in the care plan when appropriate. An explanation could not be provided as to why the splint application was not included on the care plan for Resident #142. The	F 280	appropriate nursing station for use in educating and re-educating of caregiver staff. For all residents: A) Audit will be completed for all residents with therapeutic devices (splints, boots, braces, etc.) to assure all resident devices are care-planned specific to each resident. B) All careplans will be updated to address needs for skin care and monitoring, and appropriate range of motion (passive or active) based on resident ability to participate. C) Instructions on use of each device ordered for each resident will be placed in the 'Nursing Communications' binder at the appropriate nursing stations for use in educating and re-educating of caregiver staff. System change: A) For all residents with current devices (splints, boots, braces, etc.) Splint/Device Audit will be completed monthly by the Quality Management Coordinator. Audit will include presence and accuracy of order, review of care plan to assure inclusion of device, care and ROM as appropriate, presence of care plan instruction on CNA kiosk, presence of staff instruction materials in 'Nurse Communication' Binder, appropriate placement of device per order, whether a screen should be done and staff education needs. B) For all residents with new orders for therapeutic devices a therapy "Intent to Discharge' form (ITD) will be completed by therapist at time of release from therapy. This form will	

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F 280	Continued From page 2 MDS nurse replied she would add the splints to the care plan at that time.	F 280	include resident specific device needs. C) Care-plan Coordinator will bring all new ITD forms to the morning Interdisciplinary Team meeting. The Care-plan Coordinator, the Director of Nursing/designee, and the unit nurse leader who will review the ITD and resident specific needs and jointly create an appropriate plan of care. D) Review of ITD will be recorded on the meeting minutes. E) Care-plans will be reviewed quarterly, annually, prn and with significant changes to assure they are appropriately updated. Monitoring: A) All orders related to devices and all ITD forms will be given to the Quality Management Coordinator (QMC) each day at the end of the morning interdisciplinary team meeting. Each Monday x 4 weeks the QMC, using the Splint/Device Audit , will review all orders and ITD from the prior week and confirm appropriate updates to the resident care-plans. B) After 4 weeks the QMC will complete a monthly audit and assure compliance and address non-compliance. C) Outcomes of audits will be reported at the quarterly to the Quality Assurance Committee Meeting where recommendations will be reviewed and implemented.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		8/22/14

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to obtain orders upon readmission to the facility for use of (a) condom catheter, (b) hand splints and (c) specialty heel boots for one of twenty nine sampled residents. (Resident #142) The findings included: Resident #142 was admitted to the facility on 2/18/14 with diagnoses including fractures, acute respiratory failure, dysphagia and pressure ulcers. Record review revealed Resident #142 had a readmission to the facility from a hospital stay on 6/25/14. Review of the physician orders upon readmission indicated the following: a. Resident #142 had an indwelling catheter. The order read " Foley Catheter (2of3); Change catheter every month (Physician Order). " Record review revealed the July electronic Medication Administration Record (eMAR) included instructions for Foley catheter care to be provided each shift. Nurses had initialed for each shift indicating Foley catheter care had been provided. Record review of the electronic Treatment Administration Record (eTAR) revealed a nurse ' s entry for 7/7/14 for the treatment to change the Foley catheter. The nurse ' s note indicated the catheter was not changed and the resident currently had a condom catheter.	F 281	For the resident cited: A) Orders for discontinuation of Foley catheter will be obtained. B) Orders for use of condom catheter, care and monitoring of skin will be obtained. C) Appropriate orders for splints and boots and passive range of motion will be obtained and the careplan will be reviewed and updated. For all residents: A) Audit of hospital discharge summaries and admission orders for all current residents admitted and re-admitted in last 90 days will be completed to assure that orders for all therapeutic devices and catheters have been captured, careplanned and initiated. If any omissions are found they will be addressed, orders obtained and proper notifications made. System change: Using a '5 Day Post Admission Checklist' form, all new admissions and readmission discharge summary and orders will be reviewed daily for 5 days following day of admission. The review will specifically address orders for therapeutic devices (splints, boots, braces, etc.) and catheters, accuracy of orders and order-input, completeness of admission care plan or update of prior care-plan for re-admissions, verification of the kardex information for the CNAs. The nursing responsible for the initial admission/discharge process will not be the auditing nurse.	

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F 281	Continued From page 4 Observations on 7/23/14 at 10:04 AM revealed Resident #142 had a condom catheter in place. Interview with Nurse #1 on 7/23/14 at 12:35 PM revealed Resident #142 had returned from the hospital with a condom catheter and the staff made the decision to keep the catheter due to a wound on the sacrum. The resident had been in/out of the hospital a couple of times which changed the type of catheter that was being used. Interview with Nurse # 1 revealed the resident had an indwelling catheter when he was sent to the hospital on 5/18/14 and returned with a condom catheter. The staff had failed to obtain orders for the condom catheter and continued with orders indicating a Foley catheter was being used. Orders should have been obtained for the use of a condom catheter. Care and treatment for the condom catheter would include monitoring the skin to ensure no breakdown due to the condom. b. Record review of the Occupational Therapy discharge summary revealed Resident #142 was to receive passive range of motion and hand splints by the aides. The physician orders did not include these orders. Observations on 7/23/14 at 11:08 AM revealed Resident #142 did not have hand splints applied. Interview with NA# on 7/24/14 at 12:20 PM revealed she knew what care residents required by the kardex system in the computer. NA#3 explained the kardex had information about the splints. c. Specialty boots used in treatment of pressure	F 281	Monitoring: A) The Quality Management Coordinator (QMC) will review all admit/re-admit discharge summaries and orders for reference to therapeutic devices and catheters x 4 weeks, then 20% of admissions x 2 months . B) When reference is found, the QMC will verify correct orders have been initated and care-planning of appropriate interventions completed. C) Outcomes of audits will be reported at the quarterly Quality Assurance Committee Meeting where recommendations will be reviewed and implemented.	

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F 281	Continued From page 5 ulcers on heels were not reordered upon readmission. Record review of the electronic Medication Administration Record (eMAR) for July revealed instructions to apply the boots on both feet remove them each shift and do a skin check and then reapply the boots. The eMAR for July had nurses ' initials indicating the boots had been applied, removed for a skin check and reapplied. Observations on 7/23/14 at 11:08 AM revealed the specialty boots were not applied to Resident #142's feet. Interview with Nurse #1 on 7/25/19 at 9:50 AM revealed orders should have been obtained for the use of the condom catheter, splints and specialty boots. Once the order was obtained, the nurse would enter the information in the computer for the aides. Interview with Director of Nursing (DON) on 7/25/14 at 9:10 AM revealed an order should have been obtained for the use of the condom catheter, hand splints and specialty heel boots upon readmission. Any nurse can take the orders and input the information in the computer for the aides to be aware of what to do for the residents. Interview with the DON on 7/25/14 at 3:30 PM revealed the unit managers did the paper work upon admission or readmission to the facility. The paperwork included obtaining physician orders, reviewing the orders and transcription of the orders to the MAR and/or TAR. The kardex for the aides would be updated from the orders also. The orders for Resident #142 had been missed.	F 281		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide specialty boots for Resident #142 for one of three sampled residents with pressure ulcers. The facility failed to maintain a dressing on a pressure ulcer for one of three resident reviewed for pressure ulcers. (Resident #68) The findings included: 1. Resident #142 was originally admitted to the facility on 2/18/14 with diagnosis of fractures, acute respiratory failure, anoxic brain damage, dysphagia and pressure ulcers. Review of the wound assessments on admission 2/18/14 revealed pressure ulcers on the bilateral heels were present. A stage 2 pressure ulcer on the left heel and a stage 3 pressure ulcer on the right heel were present. Record review revealed an order dated 4/12/14 or specialty boots to be applied to the bilateral feet, removed every shift to check the skin and	F 314	Resident cited #142: A) Screen will be done to assure continued appropriateness of boots, their use and placement. B) Clarification orders will be written and careplan updated. C))CNA kardex will be updated to include application of boots and provision of passive range of motion. D) All nursing and CNA staff providing care to this resident will be educated on orders for placement of the boots, the purpose of the boots in protecting the resident safety, and their individual responsibility for caring out this care as ordered. Education will be provided by therapist on passive range of motion for this resident. E) Boots will be applied as ordered. F) All nurses involved in resident's care will be counselled on possible negative outcome to resident when orders are not followed as written and observing presence of boots on resident, as well as actually removing the boots to assess resident skin each shift as ordered. G) Presence of boots will be	8/22/14

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F 314	Continued From page 7 reapplied. The Minimum Data Set (MDS) dated 5/18/14 indicated Resident #142 was unable to participate in the interview process and did not have intact cognition. The MDS assessed Resident #142 as requiring total assistance for all activities of daily living. He required total assistance of two staff for bed mobility, hygiene, toileting and dressing. The MDS indicated Resident #142 was incontinent of bowel and had an indwelling urinary catheter. The MDS assessed pressure ulcers as stage 3 and the resident was at high risk for development of pressure ulcers. The care plan updated on 7/10/14 addressed a problem of actual pressure ulcers. The care plan included a left heel with a stage 2 pressure ulcers and a right heel with a stage 3 pressure ulcer. The approaches included staff was to administer treatments as ordered by physician and document, turn and position frequently and use devices to reduce or relieve pressure. The nurses notes dated 7/2/14 indicated the pressure ulcer on the heels were " slowly improving. " The nurses notes dated 7/17/14 indicated the pressure ulcers on the heels were unchanged in the measurements and the wounds were assessed as " unchanged since last assessment. " Review of the electronic Medication Administration Record (eMAR) for July revealed " PRAFO boots " (specialty boots) were to be applied to bilateral feet to float heels. The boots were to be removed each shift to assess skin	F 314	audited by nurse leader/charge nurse each shift x 4 weeks, then by monitoring as described below (see 'Monitoring for Residents with Therapeutic Devices'). H) Instructions for placement of boots will be placed in the 'Nursing Communications' binder at the nursing station to assure easy education of any new staff assigned to this resident. For resident cited #68: A) Dressing will be re-applied by treatment nurse (7/24/14). B) CNAs who failed to report observed skin breakdown will be re-educated on the need for reporting of all changes in condition and the protocol for 'Stop & Watch. C) Presence and competence of dressing will be monitored daily and documented on the treatement administration record (TAR). For all residents having therapeutic devices for prevention of pressure ulcers (splints, boots, braces, etc.): A) All certified and licensed nursing staff will be re-educated on the potential negative outcome to resident safety (and to individual nursing staff for not following orders as written, specifically as related to monitoring of therapeutic devices and completing skin monitoring.) B) All nursing staff will be re-educated on basics of application of therapeutic devices, need for skin monitoring and range of motion as ordered for resident. C) Instructions for application of therapeutic devices will be placed in the 'Nursing Communication' binder at the appropriate nursing station and all nursing staff, licensed and	

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F 314	Continued From page 8 integrity, then reapplied. The order was dated 6/25/14, which was Resident # 142 ' s readmission date from the hospital. Nurses ' initials were documented each shift which indicated the specialty boots had been applied. Initials were present for the dates of the survey. Observations on 7/23/14 at 10:04 AM revealed Resident #142 did not have specialty boots on either foot. Both feet were elevated on pillows with the heels touching the alternating air mattress. Observations of care at 10:36 AM on 7/23/14 NA#4 revealed a bed bath was provided for Resident #142. After the bath was completed, both lower extremities were placed on pillows. The specialty boots were not applied to the feet. Observations of the dressing changes on 7/23/14 at 11:10 AM revealed the right heel had bloody drainage on the old dressing when it was removed. The right heel wound had a yellow center. During the wound care observations Nurse #4 explained the right heel was a stage 3 and the left heel was a stage 2. After completion of the dressing changes, the specialty boots were not applied. Observations on 7/23/14 at 3:58 PM revealed Resident #142 did not have the specialty boots on his feet. Observations on 7/24/14 at 8:43 AM revealed Resident #142 ' s bilateral heels were resting on the alternating pressure mattress. No specialty boots were on his feet. Interview with Nurse #4 on 7/24/14 at 9:20 AM	F 314	unlicensed, will be educated as to the location of this information and use of this information. D) Audit will be completed to verify presences of orders for monitoring of device presence and skin condition. For all residents with dressings for the treatment of pressure ulcers: A) All nursing staff will be re-educated on signs of actual or potential skin breakdown and how to observe for actual or potential skin breakdown, the need to report any dressings that are missing or found in the resident environment, the accountability of each caregiver in the prevention of harm, specifically skin breakdown, to all residents, the requirement for reporting of any noted skin breakdown, bruising, or other change in condition immediately to the charge nurse or nurse leader (whether they believe it has already been reported or not), on the use of the 'Stop & Watch' communication form in communicating change in condition, and on the potential negative consequences to resident a for not reporting. B) Full body skin assessments will be done on all residents assure that if present, any skin breakdown is documented, breakdown is reported to both the MD and the responsible party and appropriate orders initiated. System Change for all residents with dressings: A) Order will be written on TAR to monitor for presence and condition of all dressings each day . All non-competent dressings will be addressed and changed as needed. B) Treatment Nurse will verify presence of all	

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F 314	Continued From page 9 revealed there must have been an order for the AFO boots if it was on the eMAR. She had not seen any type of boots on the resident's bilateral lower extremities. She had worked as a fill in treatment nurse until the past two weeks. The specialty boots were located by Nurse #4 in the resident's closet. She explained she would look for the order and determine if the boots were to be applied. On 7/24/14 an interview was conducted with NA#4 at 9:28 AM. NA#4 explained the boots had not been used for a couple of weeks. When asked who was responsible for applying the specialty boots, NA #4 replied the restorative or therapy staff was to apply the boots. She was not aware of where the boots were located, but thought they were not in his room. Aide #4 explained the nurse should be notified when the boots were not available for application. An interview was conducted with the previous treatment nurse (Nurse #3) on 7/24/14 at 11:15 AM. This nurse explained she had stopped doing treatments about two weeks ago. Resident #142 was wearing the boots when she was the treatment nurse. Nurse #3 further explained she put them on him in the morning. She continued with " Sometimes he had them on, sometimes not " when she did the treatments each morning. Interview with the Director of Nursing on 7/24/14 at 11:45 AM revealed the aides were to provide the specialty boot. THe nrsres should remove the boot and observe the skin and reapply the boot. Interview on 7/24/14 at 2:45 PM with Nurse #3 on 7/23/14 revealed the boots were on when she saw the resident when she "got on" duty that	F 314	dressings each day and document on TAR. System change for all residents with therapeutic devices: Restorative aid will observe and document presence of all therapeutic devices daily and report non-compliance to nurse unit nurse manager. Monitoring for residents with dressings: A) DNS/designee will randomly audit 20% of all dressing each week x 2 months for presence and condition and act on any negative findings immediately. B) DNS/designee will review 20% of all wound related TARs weekly x 2 months and take appropriate action for any negative findings. C) Trends will be reported to Director of Nursing for intervention. D) Results of audits and TAR review will be discussed at the quarterly Quality Assurance meeting to assure compliance, and to review any findings and additional recommendations Monitoring for residents with therapeutic devices: A) Restorative aid will observe and document presence of all therapeutic devices daily. B) Trends will be reported to Director of Nursing for intervention. C) Outcome of monitoring will be reviewed at the quarterly Quality Assurance meeting to assure compliance, and to review any findings and additional recommendations	

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F 314	Continued From page 10 morning. She was not aware the boots were not on the resident all day yesterday. Interview on 7/24/14 at 3:30 PM with nurse #5 revealed she worked on the 3-11 shift on 7/22/14. Further interview revealed Resident #142 did not have boots on his feet on 7/22/14. Nurse #5 explained she was aware he was to have boots, which should be removed every shift and the skin checked. When asked why the boots were not applied, she stated she did not know. Interview with Nurse #1 on 7/25/14 at 8:00 AM revealed the boots were not the other day because they (staff) "messed up. Interview with the Director of Nursing and Administrator on 7/25/14 at 11:48 AM revealed the specialty boots for Resident #142 should have been applied by nursing staff. 2. Resident # 68 admitted to the facility on 3/7/11, with diagnoses included chronic kidney disease, urinary retention, history of urinary tract infection, anemia, Alzheimer disease, asthma. Resident ' s recent Minimum Data Set (MDS) dated 4/20/14 indicated severely impaired cognition, physical behavior symptoms toward	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

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F 314	Continued From page 11	F 314		

others less than daily. Resident was totally dependent for all activities of daily living (ADLs) with 2 + physical assistance required, had indwelling catheter, always incontinent for bowel. MDS also indicated mechanically altered diet, and resident at risk of pressure ulcer development. Resident was under the hospice program.

Record review of MD orders revealed: 5/25/14 order for stage II pressure ulcer cleanse + Duoderm dressing to right medial buttock, change every three days.

During the procedure of incontinent care on 7/24/14 at 10:50 AM, resident #68 observed with no dressing to cover her sacral area wound/pressure ulcer: during the observation of incontinent/catheter care provided by two aides, NA#1 (Nursing Assistant) and NA#2, when the resident turned to her side, sacral area wound with no dressing observed. Sacral area wound observed with two not completely healed areas approximately 1x0.5 cm, no drainage or odor noted. There was no dressing in the incontinent product observed at the time of procedure. On the surveyor ' s question who should apply the dressing, both aides answered treatment nurse is responsible to apply the dressing.

During the staff interview with nurse#4, treatment nurse, on 7/24/14 at 11:25 AM, she stated: she remembers that resident #68 has a pressure ulcer, stage II on sacral area. According to MD order, the wound needs to be cleaned and dressing changed every three days, due today. Nurse stated the wound is much better now but not healed completely, and Douderm dressing used more for protection.

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During the staff interview with nurse #3 on 7/24/14 at 11:45 AM, she stated: the resident #68 has pressure ulcer on her sacral/buttocks area, treatment nurse changes the dressing every three days.

During the observation of wound treatment on 7/24/14 at 12:35 PM, provided by nurse #3, treatment nurse with help of NA #3: resident #68 turned to her left side, back area observed with no dressing on the sacral area wound. Nurse #3 was guessing the dressing probably fell off and lost during the previous cleaning/hygiene procedure, because " she applied dressing to that area three days ago " . Nobody reported " no dressing " situation to her. The wound has two small, measured as 1x0.5 cm areas not healed, no drainage, no unpleasant odor noted. Skin prep, saline, 4x4, Duoderm applied. Nurse added it was stage II pressure ulcer of sacral area and " This wound is getting better, almost healed " but we keep dressing for protection.

During the additional staff interview with nurse #3, on 7/24/14 at 2:30 PM, she stated: aides usually report any changes in residents ' condition, included wound dressing condition. Nurse works first shift on 300/400 hall, resident #68 assigned to her, but nobody reported the absence of wound dressing (Duoderm) on the sacral area today or yesterday.

Staff interview with director of nursing (DON), on 7/24/14 3PM revealed: DON expectation from aides to report any changes in residents ' condition to the nurse, included dressings/wound condition. Every time aides found no dressing, immediately notify the floor nurse or treatment nurse. Then, nurse goes to solve the problem.

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F 314	Continued From page 13 Also, facility has a " stop and watch " program: aide can report all negative findings to the nurse with copy to DON.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide medical justification for the continued use of an indwelling catheter for 1 of 3 sampled residents with a catheter(Resident #133). The findings included: Resident #133 was admitted to the facility on 12/5/13.the diagnoses included diabetes, hypertension, hypercholestrolemia, pulmonary embolism, acute respiratory failure and chronic kidney disease. The Minimum Data Set MDS quarterly 5/24/14, indicated that Resident #133 did not have any memory, cognition or decision making problems. There were no identified incontinence issues on the MDS. There was no physician ' s order for the catheter.	F 315	For resident cited: A) A 'Urinary Catheter Order Clarification' form (UCOC) will be completed and provided to physician for review with request for voiding trial. B) Order to be obtained discontinue Foley catheter. B) Voiding trial will be done. For all residents: A) The orders for all other residents with Foley catheter will be reviewed for appropriate use, continuation, discontinuation, using the 'Urinary Catheter Order Clarification' (UOCO) form. B) Each resident's physician will evaluate the resident, diagnosis, potential for voiding trial and orders and write new orders as needed as well as a supporting note in resident	8/22/14

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F 315	Continued From page 14 Review of the catheter assessment dated 12/12/13, revealed the indwelling catheter was inserted at hospital during the course of care for urinary retention. The catheter care included checking the tubing and securing the catheter to thigh every shift and change bag weekly and tubing monthly. Review of Resident #133 physician ' s note dated 12/20/13, revealed that Resident #133 was admitted to facility with indwelling catheter for urinary retention while in the hospital. The section under assessment revealed there was never a real issue with incontinence and the indwelling catheter would be removed at some point. Review of the urinary incontinence and indwelling catheter Care Area Assessment dated 5/24/14, did not code any incontinence issues or disease conditions/factors. Review of the care plan dated 6/14/14, identified the problem as potential for injury related to indwelling catheter. The goal included no injury secondary to catheter manipulation. The approaches included secure catheter to thigh to prevent pulling on tubing and keep collection bag below bladder level, monitor record intake/output of urine, observe/document urine appearance, report any negative fluid balances trends to physician. Review of the monthly physician ' s progress notes dated 1/14/14 through 7/8/14, there was no discussion of the indwelling catheter, any voiding trials or referrals to an urologist regarding the removal or continuation of the indwelling catheter. Resident#133 ' s intake/output had not been	F 315	medical record. System Changes: A) The 'Urinary Catheter Order Clarification' (UOCO) form will be completed for all residents with currently existing catheters, for admitted or re-admitted residents with an order for a catheter and all newly ordered catheters. B) The UOCO will also be completed with all quarterly, annual and significant change assessments. C) Residents with catheters will be care planned for completion and review of UOCO with all assessments. Monitoring: A) Quality Management Coordinator (QMC) will audit for the completion and accuracy of the 'Urinary Catheter Order Clarification' (UOCO) for all new orders for catheters and existing catheters x 3 months to assure that order is appropriate for resident and that voiding trials are considered. B) QMC will audit x 3 months charts of all residents with existing catheters who are scheduled for quarterly, annual or significant change for completion of UOCO. Any negative outcome will be reported to Director of Nursing. C) Results of audits will be discussed at the quarterly Quality Assurance meeting to assure compliance, and to review any findings and additional recommendations	

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F 315	Continued From page 15 discussed or reviewed. During an observation and interview on 7/24/14 at 8:30AM, Resident #133 was seated in his room with catheter in place. He indicated that he had the indwelling catheter for a long time, but could not remember the actual reason why it was in place. He added that it was put in while he was in the hospital and no-one ever asked or tried to take it out. He further stated that no-one even asked me to go to the bathroom on my own. During an interview on 7/24/14 at 9:00AM, Nurse #1 indicated that Resident #133 was admitted with the indwelling catheter and the orders were carried over from the last hospital note dated 12/20/13. She indicated the expectation was to inform the physician of the recommendation from the hospital discharge summary or notes. In addition, she confirmed that after reviewed the chart and the physician ' s progress notes date 12/20/13, the physician indicated intention of indwelling catheter removal. She acknowledged that even though Resident #133 had been seen by the physician 1/14/14 through 7/8/14, there was no further discussion regarding the continuation/removal of the indwelling catheter. She acknowledged that a voiding trial and/or referral to urologist had not been done for Resident #133. During an interview on 7/24/14 at 9:40 AM, NA#1 indicated the expectation was to change the indwelling catheter bag daily and ensure the leg bag was secured. NA#1 indicated that she was uncertain whether Resident #133 could use the bathroom with assistance since he had the indwelling catheter; she just did the normal	F 315		

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indwelling catheter care. She was unaware if Resident #133 had been on a voiding trial/toileting program.

During an interview on 7/24/14 at 10:13AM, the director of nursing indicated that the expectation would be for nursing to inform the physician of any recommendations that were obtained from the discharge summary for review to ensure that treatment was provided in accordance with a resident ' s needs. The director of nursing reviewed the physician ' s progress notes dated 12/20/13 and 1/14/14 through 7/8/14, and acknowledged that Resident #133 indwelling catheter should have been reassessed /discussed with the physician to determine whether there was a need to continue the use of the catheter. In addition, a voiding trial should have been attempted at this point since Resident #133 had not been identified with any incontinence issues at the last MDS review.

During an interview on 7/24/14 at 11:18AM, Nurse #2 indicated that Resident #133 should have indwelling catheter was the justification of the indwelling catheter was missed and should have been addressed during the assessment period. Nurse#2 added that an assessment voiding trial and/or referral to urologist should have been identified and addressed for the continuation.

During an interview on 7/25/14 at 8:35AM, the physician indicated the expectation would be a resident with an indwelling catheter have the proper diagnoses based on a disease/condition that should be assessed to determine the medical justification for the use/continuation. The

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F 315	Continued From page 17 assessment would include a voiding trial and/or referral to urologist if necessary. In addition, he would review the hospital notes/discharge summary and review of the urinary output as part of his evaluation. The physician acknowledged that a post void catheter should have been done. In addition, the monthly physician notes should reflect some discussion and/or treatment plan to address the indwelling catheter.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide passive range of motion and hand splints for one of two sampled residents with contractures. (Resident #142) The findings included: Resident #142 was originally admitted to the facility on 2/18/14 with diagnosis of fractures, acute respiratory failure, dysphagia and pressure ulcers. The occupational therapy (OT) notes dated 2/19/14 indicated Resident #142 was to have	F 318	For resident cited: A) Education will be provided by therapist on passive range of motion for this resident. B) All nursing and CNA staff providing care to this resident will be educated on the proper cleaning of the residents hands during a.m. care and as needed, the purpose and application of the splints, and staff members individual responsibility for caring out this care as ordered. C) CNA kardex will be updated to include application of the splints and provision of passive range of motion. D) Range of motion will be done as ordered. E) Unit nurse will observe and document	8/22/14

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F 318	Continued From page 18 passive range of motion of the upper extremities to reduce the risk of contractures and training/education in splint management. The OT discharge summary dated 2/26/14 included a discharge plan and instructions for aides that were trained in appropriately donning/doffing (putting on/taking off) splints and passive range of motion exercises to the bilateral upper extremities to reduce the risk of contractures. The Minimum Data Set (MDS) dated 5/18/14 indicated Resident #142 was unable to participate in the interview process and did not have intact cognition. The MDS assessed Resident #142 as requiring total assistance for all activities of daily living and as having functional impairment on both sides of his extremities. Review of the initial care plan dated 2/27/14 with updates on 5/14, included a problem of potential for contractures related to cervical fractures. Approaches included the resident was to have gentle range of motion during routine care by the aides. The updated care plan did not address the application of splints. Observations on 7/23/14 at 10:08 AM revealed splints were not applied to Resident #142 ' s hands. Observations during the bath on 7/23/14 at 11:00 AM revealed passive range of motion was not provided during the bath. The aide washed the back and palm of the hand. The fingers were not separated to clean between the fingers or range of motion provided. Observations were made of two hand splints located on the top of a hutch	F 318	observation of ROM daily x 4 weeks. For all residents: B) Audit will be completed for all residents with therapeutic devices (splints, boots, braces, etc.) to assure all resident devices are care planned specific to each resident and include needs for skin monitoring, and appropriate range of motion (passive or active) based on resident ability to participate. C) CNA kiosk will be updated on the 'Routine Care Task' firing to include "Confirm that care was provided in accordance with the resident Plan of Care to include Range of Motion (passive or active) as care-planned for resident". The electronic signature of the aide on the kiosk is his/her confirmation that he/she has provided the required range of motion. D) List of all residents with devices will be place in 'Nurses Communication Binder' at each nursing station. E) All nursing staff will be re-educated on basics of application of therapeutic devices, need for skin monitoring and range of motion as ordered for resident. System change: A) CNA kiosk will be updated on the 'Routine Care Task' firing to include "Confirm that care was provided in accordance with the resident Plan of Care to include Range of Motion (passive or active) as care-planned for resident". The electronic signature of the aide on the kiosk is his/her confirmation that he/she has provided the required range of motion. B) Hands-on, return demonstration, range of motion, device	

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F 318	Continued From page 19 beside the bed. The hand splints were not applied after the bath. On 7/24/14 an interview with NA #3 was conducted at 9:28 AM. NA revealed she does range of motion to his hands and thought she had provided range of motion. She further explained the resident was supposed to wear a splint on one of his hands. During the interview, NA#3 explained the resident did not have a splint on yesterday and it had been missing for about a week. This NA was asked if the splint(s) were in the room, and she stated " no. " Interview with the Director of Nursing (DON) on 7/24/14 at 11:45 AM revealed the aides on the floor were to provide the splints for Resident #142. Observations on 7/24/14 at 12:15 PM revealed Resident #142 did not have splints on either hand. Interview with NA#3 and the DON on 7/24/14 at 12:20 PM revealed the splints were located in the room. The aide explained she would apply the splints. The aide explained she knew what care residents required by the kardex system in the computer. NA#3 explained the kardex had information about the splints and she was aware they were to be applied. No answer was provided as to why the splints had not been applied. Interview with Nurse #1 on 7/25/14 at 8:00 AM revealed the splints were not on the other day because they (staff) "messed up." But the staff had noted the resident would spike a temperature of 101 degrees when splints were applied. The resident had an order to remain in the facility for	F 318	application, skin care and monitoring in-service will be added to annual skills checklist. Monitoring: A) Unit nurse leader will observe and document observation of ROM and presence of splints daily x 4 weeks for cited resident. B) For all other resident with therapeutic devices, ongoing weekly observations will be conducted unit nurse leader to observe for range of motion and presence of ordered device are ordered. Corrective action will be taken as needed. Any negative outcome will be reported to Director of Nursing. C) Results of audits will be discussed at the quarterly Quality Assurance meeting to assure compliance, and to review any findings and additional recommendations	

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F 318	Continued From page 20 elevated temperatures. She explained they would monitor him today and see if his condition changed when splints were applied.	F 318		
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, staff interviews, and record review, the facility failed to maintain sanitary conditions in the kitchen by not 1) ensuring that foods were labeled and dated in 1 of 1 walk in refrigerator, 2) separate dented cans from ready to use food items, 3) Clean and remove the food debris and grease from the steamer box and hot plate warmer and 2 refrigerators 4) failed to air dry 22 wet serving pans in 1 of 1 dry storage racks, and 5) failed to calibrate the thermometer to ensure food was cooked to the proper temperature or clean the thermometer probe between uses which was used to check food temperatures on the hot holding tray line before the food was plated for service on 1 of 1 observations. The findings included:	F 371	For all residents - Thermometers: The Facility will maintain Proper food temps according to state and local health department guidelines using properly calibrated and sanitized thermometers. (All sited thermometers were calibrated immediately.) System changes: A) All staff will be in-serviced on proper calibration and sanitation of thermometers as well as the difference between clean versus sanitizeD) B) Cook Supervisors will conduct and document daily thermometer calibrations. C) Cook Supervisor will properly sanitize their thermometer between each food item that is being probed for temperature.	8/13/14

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F 371	Continued From page 21 1). During an observation on 7/21/14 at 9:45AM, the walk-in refrigerator had 2 bags of yellow cheese unlabeled, 2 bags of white product in zip lock bag, 2 bags of leaf like spices unlabeled/undated. During an interview on 7/21/14 at 9:45AM, the dietary manager (DM) identified parmasien cheese and thyme/parsley each of the items and indicated that any of the dietary staff that opens a product should label and dated the item before it was returned to the refrigerator. During an interview on 7/23/14 at 11:35AM, dietary aide #1(DA) indicated that all staff in the kitchen that opened and food products were responsible for labeling and dating the product when open/used. 2. During an observation on 7/21/14 at 9:45AM, the following items were found 3 dented cans of ketchup, 4 cans of pasta sauce, 4 cans of vanilla pudding and 2 cans of tomato soup. During an interview on 7/21/14 at 9:45AM, the DM indicated he was responsible for checking dented cans before they were placed on the shelves. The DM added that the label should be removed from the cans and returned to the vendor and the cans discarded. 3. During an observation on 7/21/14 at 9:45AM and 7/23/14 at 11:10AM, the steamer box, hot plate warmer and 2 stand alone refrigerators was dirty and had a large volume of grease and food/liquid build up on the inside and outsides of the units.	F 371	Monitoring: A) The FSD or designee will monitor compliance and accuracy of the calibration logs daily. B) The FSD or designee will monitor compliance for proper procedures when sanitizing between food items at each meal daily for 4 weeks, twice a week for 2 weeks, and then randomly on going. C) The Area Manager will preform unannounced food safety audits once a weekly for 4 weeks, and twice a month for a month. For all residents - Clean and Remove Food debris: The Facility will maintain Proper sanitation of all equipment according to state and local health department guidelines. (All sited equipment was cleaned and sanitized Immediately.) System changes: A) All staff will be in-serviced on proper cleaning and sanitizing of equipment. B) The plate warmer, steamer box, and reach in refrigerators will be added to the job flows and regular cleaning assignments Monitoring: A) The FSD or designee will check cleaning assignments after each shift daily for compliance and take corrective action as needed. B) The FSD or designee will monitor compliance and accuracy of the sanitation walk- through and closing check lists daily for 4 weeks, twice a week for 2 weeks, and then randomly on going. C) The Area Manager will preform unannounced food safety	

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F 371	Continued From page 22 During an interview on 7/23/14 at 11:10AM, the DM indicated that the hot plate cart, steamer was only cleaned once a month on the outside and bottom surfaces. He indicated that it had not been cleaned in a month and the dietary aide was responsible for cleaning the hot plate steamer outside surfaces and the refrigerator daily. During an interview on 7/23/14 at 11:35AM, dietary aide #1(DA) indicated she was responsible for cleaning the hot plate carts and refrigerators daily after the shift. She confirmed after review of the hot plate cart and refrigerators that they had not been cleaned and there was large volumes of dried foods/liquids remaining in each of the identified areas. 4. During an observation on 7/23/14 at 11:10AM, there were 22 wet silver serving pans stacked on top one another on the dry storage shelf. During an interview on 7/23/14 at 11:10AM, the DM indicated that the pans should not be stacked wet and they should be separated to air dry. During an interview on 7/23/14 at 11:38AM, DA#2, indicated that the pans should not be stacked on top of one another at anytime time. She indicated that the pans should be stacked in a staggered format so that they air dried. During the observation of the drying racks, the pans were stacked on top of one another. DA#2 confirmed they were not stacked properly and were not air dried. 5. During an observation on 7/23/14 at 11:30AM, the foods prepared on the hot tray line, revealed the cook did not calibrate the digital thermometer prior to taking temperatures of the food. He did	F 371	audits once a weekly for 4 weeks, and twice a month for a month. For all residents - Separate Dented Cans: The facility will remove all dented cans separate from ready to use food products. (All dented cans were removed immediately from the can rack and discarded) System changes: A) All staff will been in-serviced on the proper procedure for receiving and discarding dented cans. B) The stock person will check with the FSD or shift supervisor after receiving and stocking cans to ensure that they were received and stocked properly. C) Any dented cans will be discarded and the labels from the cans will be given to the FSD. D) The closing supervisor will check the can rack on the nights of delivery to ensure that nothing was missed by the previous shift. Monitoring: A) The FSD or designee will do daily random spot checks 3 x daily of the store room for compliance and take corrective action as needed. B) The FSD or designee will monitor compliance and accuracy of the sanitation walk- through and closing check lists daily for 4 weeks, twice a week for 2 weeks, and then randomly on going. C) The Area Manager will preform unannounced food safety audits once a weekly for 4 weeks, and twice a month for a month.	

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	345535	A. BUILDING _____ B. WING _____	07/25/2014

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F 371	Continued From page 23 not stop to calibrate the thermometer when stopped by the surveyor. The cook did not use proper cleaning sanitizer for the thermometer probes in between taking temperatures of hot and cold foods. The sanitizer wipes were located in a box on top of the cook table. The cook started the process by cleaning the thermometer probe with a hand towel. When he was stopped he began to use the sanitizer wipes for portions of the meal temperatures, but did not clean the thermometer probe when changed from hot foods to cold foods (fruit cocktail and ice cream). During an interview on 7/23/14 11:40AM, the first cook acknowledged that he should have calibrated the thermometer prior to checking the temperatures and use the sanitizer wipes instead of a hand towel to clean the thermometer probes. He added that the thermometer probes should be clean between meats, vegetables and cold foods/beverages. The DM confirmed the expectation of the cook to calibrate and clean the thermometer proper prior to the start of the meal preparation and service. During an interview on 7/23/14 at 2:45PM, the administrator indicated the expectation would be the DM was responsible for ensuring that the kitchen remained sanitary at all times and operated in accordance with the safe serve process.	F 371	For all residents - Ensuring that foods were labeled and dated: The Facility will maintain sanitary conditions in the kitchen by ensuring all food items are properly labeled and dated in all food storage areas. (All effected food that were not labeled and dated in the walk-in cooler were discarded immediately.) System changes: A) All staff will be in serviced on the proper procedures for label and dating. B) Cook Supervisors will conduct and document daily opening sanitation walk-throughs and a closing checklist to ensure that items are properly labeled and dated. These items are specified on the checklists. Monitoring: A) The FSD or designee will do daily random spot checks 3 x daily for compliance and take corrective action as needed. B) The FSD or designee will monitor compliance and accuracy of the sanitation walk- through and closing check lists daily for 4 weeks, twice a week for 2 weeks, and then randomly on going. C) The Area Manager will preform unannounced food safety audits once a weekly for 4 weeks, and twice a month for a month. For all residents - Air Dry Serving Pans: The Facility will maintain all small-wares, pots, pans, and utensils in according to state and local health department	

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F 371	Continued From page 24	F 371	guidelines by properly air drying. System changes: A) All staff will be in-serviced on proper procedure for air drying pots and pans. B) All small-wares, pots, pans and utensils will stay on drying rack until completely dry and will be shingled to ensure proper air flow for them to dry. C) All utensils will be placed right side down to ensure no water can be trapped and that they are properly dried Monitoring: A) The FSD or designee will do daily random spot checks 3 x daily for compliance and take corrective action as needed. B) The FSD or designee will monitor compliance and accuracy of the sanitation walk- through and closing check lists daily for 4 weeks, twice a week for 2 weeks, and then randomly on going. C) The Area Manager will preform unannounced food safety audits once a weekly for 4 weeks, and twice a month for a month.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		8/22/14

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F 428	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, consultant pharmacist interview and record review the consultant pharmacist failed to identify and report to the Director of Nursing and attending physician irregularities in the medication regimen for 2 of 5 sampled residents reviewed for unnecessary medications, Residents #29 and #104. Findings included: 1. Resident #29 was admitted to the facility on 03/12/14 with cumulative diagnoses of hypertension, diabetes mellitus and muscle weakness. Review of the physician ' s orders for July 2014 revealed an order for Ambien 5 mg (milligram) tablet: Give one tablet by mouth at bedtime, written on 03/12/14. Lexi-Comp ' s Geriatric Dosage Handbook, 17th edition stated that Ambien is a sedative/hypnotic medication. Under Warnings and Precautions: Should be used only after evaluation of potential causes of sleep disturbance. Failure of sleep disturbances to resolve after 7-10 days may indicate psychiatric or medical illness. In an interview with the consultant pharmacist on 07/24/14 at 10 AM, he stated he was aware the resident was on a hypnotic but he had not written a review to the physician to see if the order should be moved to an as needed basis. The resident continued to receive Ambien each night for 4 months. 2. Resident #104 was admitted to the facility on 01/31/12 with cumulative diagnoses of dementia,	F 428	For Resident cited #29: The Ambien order will be discontinued. The resident will be started on an order for prn temazepam 7.5mg(on 7/29/14). Pharmacist will continue to monitor the temazepam for usage and recommend GDR as needed. Fore resident cited #104: A risk benefit analysis will be requested of the physician for this resident with the option of tapering and discontinuing one of the antidepressant orders. For all residents: A) A report of all residents on sedative/hypnotic drugs has been obtained. If indicated, a gradual dose reduction will be requested of the resident□s provider. B) 3. A report of all residents on antidepressant drugs will be obtained. A risk benefit analysis will be requested, using the 'Note to Attending Physician /Prescriber' format, of the physician with the option of tapering and discontinuing one of the antidepressant orders. System Change: A) For sedative/hypnotic drugs: The consultant pharmacist will: 1) add each sedative/hypnotic order to the RxPertise software and record a next evaluation date for gradual dose reduction; 2) note in the progress notes each new order for sedative/hypnotic medications including the date of origin; 3) send a note to the provider asking for	

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F 428	Continued From page 26 chronic kidney disease stage III and rheumatoid arthritis. Review of the physician ' s order sheet for July revealed an order for Lexapro 10 mg tablet: administer one tablet by mouth daily written on 02/17/13 and an order for Remeron 15 mg: give one tablet daily, written on 03/05/14. Lexi-Comps Geriatric Dosage Handbook, 17 edition, stated that Lexapro is classified as a selective serotonin reuptake inhibitor used for depression. Under warnings and precautions: use caution with renal impairment and concomitant CNS (central nervous system) depressants. Remeron is also defined as an antidepressant. Under Warnings/Precautions: Use with caution in patients with renal impairment and the elderly. In an interview with the consultant pharmacist on 07/24/14 at 10:15 AM, he stated he had not asked the attending physician for a risk/benefit statement for duplicate therapy. The resident had received duplicate therapy for 4 months without a review	F 428	gradual dose reduction on sedative/hypnotic drugs on the next monthly medication regimen review immediately after the drug is originally ordered and quarterly thereafter. B) For all antidepressants, including those used for indications other than depression the consultant pharmacist will write a note to the provider asking for a risk/benefit analysis whenever duplicate antidepressant therapy exists. The provider□s response will be documented on the pharmacist signature log or progress notes. For each antidepressant order on any resident the consultant pharmacist will review the patient medication profile to assure that there is not duplication of therapy. Monitoring: A) For sedative/hypnotic drugs each month for three months the consultant pharmacist will obtain a report from the dispensing pharmacy and compared against the list from RXPertise to assure that no GDR has been missed. Any omissions will be acted upon. B) Outcomes of this audit will be reported at the quarterly to the Quality Assurance Committee Meeting where recommendations will be reviewed and implemented. B) For antidepressant medications, each month as new antidepressant medication orders are received, consultant pharmacist will audit the resident medication profile for duplicate therapy. C) Outcomes of these audits will be recorded and reported quarterly to the Quality Assurance Committee Meeting where	

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F 428	Continued From page 27	F 428	recommendations will be reviewed and implemented.	