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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on review of resident trust funds, medical record review and staff interview the facility failed to convey monies within 30 days of expiration for 4 of 4 sampled residents. (Residents #24, #43,#59 and #72) The findings are: On 05/23/14 at 2:40 PM an interview was conducted with the Business Office Manager regarding conveyance of resident trust fund balances after a resident expired. The following concerns were identified through review of four resident records: 1. Review of the medical record revealed Resident #24 expired on 02/18/14. Review of the resident trust account for Resident #24 noted a balance of $126.66 in the account on 02/18/14. The Business Office Manager presented a copy of a check for the remaining balance in the trust account of Resident #24 that was conveyed on 04/04/14. The Business Office Manager stated she had not been trained on conveyance of funds and relied on support by corporate staff. The Business Office Manager stated the last time corporate staff had provided assistance was	F 160	How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Refunds were done for Resident #24 and Resident # 43 on April 4, 2014. Refunds were done and mailed for residents #72 and #59 on May 23, 2014. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ Audit of the remaining patient trust accounts for residents discharged to ensure that there were no outstanding trust fund refunds due to be conveyed. All residents that were identified to need conveyance of personal funds after discharge were completed. June 19, 2014 Measures to be put in place or systemic changes made to ensure practice will not re-occur- Regional Vice President of Operations educated Administrator and Business Office Manager on the business office policy and procedure #636 patient trust funds, the conveyance of funds upon	6/19/14

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

Electronically Signed | 06/19/2014

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F 160	Continued From page 1 04/04/14 which contributed to the delay in conveying the balance for Resident #24 after expiration on 02/18/14. 2. Review of the medical record revealed Resident #43 expired on 02/10/14. Review of the resident trust account for Resident #43 noted a balance of $11.00 in the account on 02/10/14. The Business Office Manager presented a copy of a check for the remaining balance in the trust account of Resident #43 that was conveyed on 04/04/14. The Business Office Manager stated she had not been trained on conveyance of funds and relied on support of corporate staff. The Business Office Manager stated the last time corporate staff had provided assistance was 04/04/14 which contributed to the delay in conveying the balance for Resident #43 after expiration on 02/10/14. 3. Review of the medical record revealed Resident #72 expired on 04/05/14. Review of the resident trust account for Resident #72 noted a balance of $127.05 in the account on 04/05/14. The Business Office Manager presented a copy of a check for the remaining balance in the trust account of Resident #72 that was conveyed on 05/23/14. The Business Office Manager stated she had just recently been trained on conveyance of funds and was aware monies should be conveyed within 30 days of expiration. The Business Office Manager stated because of training and staffing issues the check was conveyed late. 4. Review of the medical record revealed Resident #59 expired on 03/30/14. Review of the resident trust account for Resident #59 noted a balance of $13.05 in the account on 03/30/14.	F 160	the death of a patient and the requirement for the conveyance to occur within 30 days of death. Business office manager will provide Administrator a copy of patient Trust Fund report to review discharge residents balances, identify residents that need refunds and ensure the refunds have been issued. This report will be reviewed weekly for four weeks, biweekly x2 weeks and monthly x1. June 19, 2014 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee QuarterlyX2 thereafter for continued compliance/revisions to the plan if needed. June 19, 14	

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F 160	Continued From page 2 The Business Office Manager presented a copy of a check for the remaining balance in the trust account of Resident #59 that was conveyed on 05/23/14. The Business Office Manager stated she had just recently been trained on conveyance of funds and was aware monies should be conveyed within 30 days of expiration. The Business Office Manager stated corporate staff had come on 04/04/14 to assist with conveyance of funds and did not know why the remaining balance had not been conveyed at that time. The Business Office Manager stated because of training and staffing issues the check was conveyed late.	F 160		
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 observation, record review, guardian interview and staff interviews, the facility failed to dress a resident in personal clothing for 1 of 2 residents (Resident #100). Findings included: Resident #100 was admitted to the facility on 06/03/11 with diagnoses including a history of anoxic brain damage and aphasia. His most recent quarterly Minimum Data Set dated 02/21/14 revealed the resident had no speech, was rarely or never understood, and had highly	F 241	How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident immediately dressed in his own clothing and transferred to Broda Chair. 5/23/14 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice No other residents were found to be wearing a hospital gown rather than their own clothing upon	6/19/14

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F 241	Continued From page 3 impaired vision and severely impaired cognition for daily decision making but with no mood or behaviors present. He was coded as requiring total dependence with assist of 2 persons with all activities of daily living (ADL) and had range of motion impairment to both sides of his body in all extremities. His most recent care plan reviewed on 05/13/14 revealed his need for total care with ADL tasks with a goal that the resident "will be well groomed and dressed appropriately daily through next review." On 05/19/14 at 12:12 PM Resident #100 was observed lying in bed and wearing a hospital gown. Similar observations were made on 05/20/14 at 8:20 AM, 05/20/14 at 10:50 AM, 05/20/14 at 4:41 PM, 05/21/14 at 9:30 AM, 05/21/14 at 12:00 PM, 05/21/14 at 5:18 PM, 05/22/14 at 9:32 AM, 05/22/14 at 1:30 PM and 05/23/14 at 9:09 AM. An interview on 05/23/14 at 8:45AM with Nurse Aide (NA) #2 revealed he had provided care to Resident #100 and was knowledgeable of the resident's care needs. He stated the resident was non-verbal and staff had to read his body language to determine his needs. He required total care and staff had to be real patient with him. NA #2 stated ADL care responsibilities were distributed between shifts and the resident received a shower on day shifts. He stated when assigned to the resident he would try to get him up and dress him on his shower day. NA #2 stated the resident was known to sweat much and he would not dress him in heavy clothing, using only a sheet or a gown. He stated the resident wore hospital gowns most of the time but he was known to be dressed in t-shirts and he owned other clothing. NA #2 stated that even	F 241	rounding. 5/23/14 Measures to be put in place or systemic changes made to ensure practice will not re-occur- Current nurses and CNA□s will be in-serviced on making sure resident□s will be dressed in their own clothing everyday unless care planned otherwise. Audit of current totally dependent in-house residents was conducted on this date and care planned for preference of clothing after contacting family and/or Guardian/RP if unable to verbalize choice of clothing. Care plan was revised as needed 6/19/14 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Utilizing the resident census list for each day during the licensed nurses rounds and if a resident is not dressed in their personal clothing the resident will be asked regarding their choice and/or if not will check care plan for choice. This audit will be done 5 x□s a week x□s 2 weeks, weekly x□s 2 weeks, bi-weekly x□s 1 month, and monthly x□s 3 months. The DON or designee will sign the patient list during stand down meeting. All audits will be reviewed and reported to QA&A Committee Quarterly x□s 2 for continued compliance/revisions to the plan if needed.	

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F 241	Continued From page 4 though the resident sweated a lot, there was nothing said to him to have Resident #100 wear hospital gowns as a habit. NA #2 revealed he dressed him as lightly as possible because of his severe sweating and there was no problem with him wearing a t-shirt and changing it out as needed. NA #2 stated the resident's contractures were a little challenging but they did not prevent him from dressing the resident in t-shirts or other clothing. He stated he has seen the resident dressed in jogging pants but never in jeans or shorts. A phone interview on 05/23/14 at 9:18 AM with Resident #100's guardian revealed she had not visited the resident recently due to lack of transportation, but remembered he had plenty of clothing to wear and did not need to remain in a hospital gown. She stated she was not aware of any reason why he could not be dressed in his clothes. An observation on 05/23/14 at 11:45 AM with the Director of Nursing (DON) revealed Resident #100 was in his sling type chair and covered with a sheet. The DON was observed pulling back the sheet to reveal the resident dressed in a gray t-shirt and blue shorts of a lightweight material. On interview, the DON stated that it was not appropriate to leave a resident dressed in a hospital gown, unless it was stated by the resident or family that it was a preference.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242		6/19/14

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F 242	Continued From page 5 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 record review, family interview, staff interview and physician interview, the facility failed to finalize and have available in the medical record documents addressing a resident's and family's wishes for no resuscitative effort for 1 of 1 reviewed records (Resident #132). Findings included: Review of a facility policy titled Physician's Orders, effective date of 09/01/11, revealed upon every resident's admission, readmission or reentry to the facility, a licensed nurse will notify the physician requesting and/or verifying physician orders. This policy noted admission orders should include code status and "if a goldenrod state DDNR [durable do not resuscitate] order does not accompany the patient upon admission the patient will be considered a full code until a signed physician order is secured." Review of the facility policy titled Living Wills/Agents for Health Care Decisions, effective date of 09/01/11, revealed documents of declaration for advance directives that are approved by state law will be placed in the medical record as provided by the patient or legally designated agent/representative. This policy noted that an advance directive is separate from a Do Not Resuscitate (DNR) order, but if the directive actually specified the withholding of cardiopulmonary resuscitation (CPR) then the	F 242	How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Resident coded with documentation in discharge summary that patient had previously been a Do Not Resuscitate. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ An audit of current residents in the facility was completed to ensure that End of Life choices were available on the chart. 6/19/14 Measures to be put in place or systemic changes made to ensure practice will not re-occur- All current licensed nurses were educated on Policy 301 - Living Wills/Agents for Health Care Decisions. An audit will be completed by Director of Nursing, or Designee to ensure completion upon all new admissions. This audit will be completed 5 x□s a week x□s 2 weeks, weekly x□s 2 weeks, bi-weekly x□s 1 month, and monthly x□s 3 months on new admissions. 6/19/14	

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F 242	Continued From page 6 proper securing of a valid DNR order, if a DDNR state form had not accompanied the resident upon admission, was necessary. This policy further noted that upon admission, a licensed nurse must immediately review the advance medical directive documents provided and if the documents declared the withholding of CPR, the licensed nurse must immediately notify the attending physician and secure a valid DNR order. This policy noted that a valid DNR order is an original order initiated by the physician or an original North Carolina DDNR order form. Resident #132 was admitted to the facility on 02/21/14 and died on 03/09/14 with diagnoses including a recent history of bacterial pneumonia, cardiovascular disease and coronary artery disease. Review of the resident's death certificate noted an immediate cause of death as cerebrovascular disease and a significant contributing factor of dementia. Review of Resident #132's admission Minimum Data Set assessment dated 02/28/14 revealed he had severely impaired cognition, a present but fluctuating altered level of consciousness and physical behaviors towards others. No prognosis indicating an expected life expectancy of less than 6 months was noted and the resident was not in hospice care. Review of Resident #132's care plan revealed no problems related to end of life care nor his expressed desires regarding resuscitative efforts. Review of a copy of an Advance Directive for a Natural Death ("Living Will"), executed in 2012 with a hospital medical record label affixed to it with an admission date of 02/17/14, revealed the resident's initials next to statements that life prolonging measures should be withheld or	F 242	How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee Quarterly x□s 2 for continued compliance/revisions to the plan if needed.	

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withdrawn in the event he became unconscious and would not regain consciousness, as determined with a high degree of medical certainty. This document also revealed his initials next to a statement that life prolonging measures should also be withheld or withdrawn in the event he suffered from advanced dementia or other condition, resulting in the substantial loss of his cognitive ability, as determined by health care providers with a high degree of medical certainty to be irreversible.

Review of a hospital discharge summary dated 02/21/14 revealed Resident #132 was admitted to the hospital on 02/17/14 with diagnoses of acute respiratory failure, likely secondary to pneumonia, and advanced dementia. The summary noted the resident was seen by palliative care/hospice staff and a DNR order was clarified by a family member, who was also the healthcare power of attorney. Under the heading of discharge condition on this summary was documented "DNR/DNI" (do not resuscitate/do not intubate) with a discharge destination to a skilled nursing facility.

Review of an Admission/Nursing Assessment Form dated 02/21/14 and signed by Nurse #4 revealed no documentation of DNR status. Review of an Admission Audit form attached to Resident #132's record revealed his name, date of admission to the facility as 02/21/14 and the name of the physician. Lines for "date of audit" and "audit completed by" were blank. A check was noted next to item 3 ("copy of advance directives on chart"), item 4 ("DDNR sheet on the chart and complete. Order for DNR on Physician Orders"), item 5 ("North Carolina: MOST [Medical Orders for Scope of Treatment] form

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completed and on chart") and item 6 ("copy of Resident Rights on the chart"). Review of Resident #132's medical record revealed no original or copies of a DDNR, MOST form, Resident Rights form or physician orders specifying the resident or family's desires regarding resuscitative efforts.

Review of a progress note dated 02/23/14 revealed Resident #132 was found lying on a fall mat in a fetal position and was sent to the hospital. This note further documented a call was received from a physician at the hospital stating the resident experienced an acute cerebrovascular accident (CVA) on the right side of his brain, nothing else could be done and the resident was sent back to the facility. This note further documented a family member as stating the resident was evaluated the previous month in the hospital by hospice and although he did not meet hospice criteria then, the family member stated he felt the resident now met the criteria. Review of a facility history and physical form completed by the physician and dated 02/25/14 revealed under the heading of code status "Attempt Resuscitation (CPR)." It was further documented a family member expressed concern that hospice may need to get involved based on the resident's appearance the day before, but his was not addressed in the assessment plan. This form further documented the resident was sent to the hospital 2 days prior for a change in mental status, diagnoses with an acute cerebrovascular accident and readmitted to the facility.

Review of a progress note date 03/9/14 revealed that at approximately 1:15 AM the nurse aides (NAs) were performing rounds and found Resident #132 non-responsive. Nurse #5 arrived

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to the room and found the resident not breathing, with no heartbeat and CPR was started as "the MOST form was not signed by MD [medical doctor]." This noted further documented a call was placed to the on-call provider who instructed to continue CPR and release the resident to emergency medical services. This note further documented "EMS worked for forty-five minutes and could not revive him", a family member arrived at 2:30 AM and postmortem care was provided by the nurse aides.

An interview on 05/22/14 at 11:45 AM with the medical records staff member revealed she provided nurses with a blank Admission Audit form to complete upon admission. She stated she pulled all the admission forms the nurses required, which included a MOST form and a yellow DNR sheet from NC Department of Health and Human Services and had printed on it a stop sign. She stated the yellow DNR sheet was completed after the MOST form if a DNR was indicated. The medical records staff member stated that upon admission, nurses were responsible to review the MOST form with family and when wishes were indicated the form was forwarded to the doctor for signature.

A phone interview on 05/22/14 at 1:54 PM was conducted with a family member of Resident #132. The family member revealed he filled out the MOST form when the resident was admitted, turned it in to a staff member who spoke to him about it but whose name he could not remember. The family member stated the facility provided a copy of the MOST form but he could not locate it and he completed one while the resident was admitted to the hospital. The family member stated he recalled indicating a DNR request after

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a nurse spoke with him about the damage that could be done with CPR. He stated he had put on the MOST form to contact him for further directions based on what might be happening.

An interview on 05/22/14 at 5:07PM with the physician revealed nursing staff have been responsible for processing the MOST form which has been used to communicate a resident's wishes regarding resuscitative efforts. He stated the MOST form was considered to be an order; and, if done properly there should also be a physician's order and statement made in a progress note. Upon review of his progress notes and code status, he stated if a resident had been a patient with his practice in the past and at some other facility, the computer charting system auto-populated the form with their previous code status. The physician stated he was unable to view the code status in his computer when charting because it has been only visible when his notes were printed. He stated when a resident is moved to a new facility they must confirm DNR status regardless of what it was at another facility. He stated he could not recall if he had signed a MOST form for Resident #132. The physician stated he expected nursing staff to have a conversation with family when a resident first arrived to the facility, have them document this on the MOST form, and then get the form to him for signature as soon as possible as an unsigned MOST form could not be recognized, which was the case with Resident #132. He stated there was a folder at the nursing stations where nurses placed MOST forms that required his signature and he could not explain why it was not there for his signature during his rounds on 02/125/14.

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F 242	Continued From page 11 An interview on 05/23/14 at 7:54 AM with Nurse #5 revealed if there was no DNR information in a resident's record it needed to get corrected and the forms filled out. The nurse said there was little she could do on the night shift other than flagging a record if there was no MOST or DNR record. She stated the MOST forms were placed in a folder to await the physician's signature and if a resident was cognitively intact they could sign the form. Nurse #5 stated when Resident #132 was found unresponsive she pulled his chart and could not find a MOST form. She stated the physician note documented him as a full code, this was the only information she could find, she spoke to the on-call provider and when she shared this information she was told to begin CPR. She stated the MOST form documents medical interventions and specific details in situations when there was an unresponsive resident. She revealed the MOST form would be pulled from the chart for reference to specific treatment options the resident had preferred. She stated Resident #132 did not have a MOST form in his record. She stated the Unit Manager and Director of Nursing (DON) were notified of his expiration and was sure they asked about the resident's code status, that it was a full code and she did not know anything different. Nurse #5 stated she thought the MOST form was one of the most important forms in the record. She stated whoever admitted a resident reviewed their discharge summary. She stated she did not think she had ever seen a physician write an order in addition to the MOST form for DNR status. She stated she was under the impression the DNR status was transcribed onto the medication administration record (MAR) as she had seen the status on that document for other residents, but she was not sure who did the transcription.	F 242		

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An interview on 05/23/14 at 8:25 AM with Nurse #4 revealed most newly admitted residents arrived from the hospital with a DNR status and if not they were considered a full code. She stated the MOST form was filled out with family present or if the resident was alert and oriented they would fill it out, have the resident or family sign the form, get the physician to sign and then get it in the chart. She stated if the physician was not present for their signature then they either flagged the chart, pass it onto the next shift and at one point folders were created for different documents requiring signatures like new orders. She stated her personal preference was to leave the forms on the chart and leave them flagged so staff had something to refer to in case of emergencies for resident wishes. Nurse #4 stated she called on-call providers to say the MOST form was not signed and the form noted their wishes, but it was not a valid form without a physician's signature. She stated most of the time in this situation the on-call provider would go with the documented wishes, regardless of a lack of a physician signature and respect the family's wishes or resident's wishes. She stated she was not sure of the time it took from when the MOST form was completed to when the physician signed the form, but stated if the resident had been admitted for a few weeks it would be reasonable to think the MOST form could be signed and placed in the chart. She stated not all admission forms were completed at the same time, with important forms ones like fall risk and skin assessments getting done first and anything not completed getting passed onto the next shift. Nurse #4 stated nurses had 24 hours to admit a patient, but not all the paperwork would be done in 24 hours as the physician might not be here or

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it would occur over a weekend. She stated the MOST form should be done when they were admitted and if family were with them, but that always did not always happen, so she flagged the form, placed it in the chart and communicated this to the next shift. She stated Resident #132 was never her patient and never assigned to her, but she did recall his name. She stated that although she could be wrong, she had no recollection of helping another nurse in his admission process.

An interview on 05/23/14 at 9:17 AM with the family member of Resident #132 stated he could not find a copy of the MOST form from the facility, but was sure he filled one out and that it was identical to one he filled out at the hospital 1 or 2 days prior to the resident ' s admission to the facility. Review of a MOST form provided by him was noted with an effective date of 02/18/14, a hospital medical record label affixed to it with an admission date of 02/17/14 and the resident's name. Section A of this MOST form had checked a block for DNR/no CPR and Section B checked for limited additional medical interventions with an added comment to contact the family member for further direction if hospitalization was needed. Section C was checked for indicated use or limitation of antibiotics and intravenous fluids for a defined trial period, with an added comment to contact the family member for direction and as needed. The MOST form was signed by a physician assistant and by the family member with his relationship to the resident noted and his status as "HCA" (health care agent).

An interview on 05/23/14 at 10:09 AM with the DON revealed nurses were responsible for processing the MOST form or DNR form after

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discussing them with families. She stated the physician would generally go over a resident's code status and nurses would meet with families or residents who were able to make their own decisions and could communicate their wishes. She stated the physicians had communication books on both sides of facility and DNR forms were put in a folder labeled as such to separate them from orders. She stated physicians were expected to sign the MOST form and write an order and once signed, the form was filed in the record. She stated that when a resident was found unresponsive she expected nurses to look for the MOST form and the goldenrod form to determine a resident's wishes. She stated facility policy was if these documents were missing, then staff had to assume a full code. She stated how much time it took to get these forms in to chart depended on family and the facility tried to contact them, sometime having to mail them and send the form back to the facility. She stated she would hope this process was done as quickly as possible. She stated it was possible to have a DNR noted on the goldenrod form and/or an MD order without the MOST form, but she was not sure if it was possible to have an MD order without a MOST form. She stated the goldenrod form was most important at the bare minimum which could be quickly signed by the physician, where the MOST form was more time consuming. She stated a family member of Resident #132 visited the facility while the resident was still in the hospital, staying in a hotel. She stated when the resident was admitted, the family member wanted to talk to the physician whom she thought met with the family member the following day. She stated she was called on a Friday or a Saturday and was told Resident #132 coded. She stated she spoke to the on-call

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F 242	Continued From page 15 provider who stated the physician's progress noted note indicated the resident was a full code, but the hospital discharge summary noted him to be a DNR. She stated transcription of a resident's code status was tied to the provider writing an order and any language used on MAR should be DNR or full code. She stated a full code did not need an order but a DNR did need an order and only a DNR was put on the MAR.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to keep clean and in good repair fixtures, walls, floors, ceilings, resident care equipment and furniture for 1 of 2 common shower rooms, 10 of 63 resident rooms and an exterior door in the main kitchen. Findings included: During a facility tour on 05/23/14 from 4:20 PM to 5:00 PM with the Maintenance Supervisor (MS) and Housekeeping Supervisor (HS), the following environmental concerns were observed: a. In the 200 Hall Shower Room in a shower enclosure, a light fixture was not flush to the ceiling, hanging from three sides approximately one inch from the ceiling. Next to this light fixture was another that was inoperable. Directly under	F 253	How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ At the time of notification by surveyor of areas of concern, Maintenance Director and Housekeeping Director corrected the issues that could be addressed immediately were corrected. a) 200 Hall shower light fixture mounted flush to the ceiling on 5/26/14. b) Oscillating fan in room 220B taken by housekeeping and cleaned during the rounds on 5/23/14. Area of staining at the base of the commode was scraped and new caulking put in place post rounds with surveyor on 5/23/14. Drywall was repaired on 6/19/14. Wall scheduled to be painted 6/19/14.	6/19/14

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F 253	Continued From page 16 these light fixtures was observed a plastic bariatric sized bedside commode, from which protruded from the underside of the seat to the front of the chair a metal track used to hold a bedpan. This metal track was held in place on one end and the broken protruding end had a jagged and sharp edge b. In Room 220B was noted on the resident's tray table adjacent to his bed an approximately 1 foot diameter oscillating fan in operation and angled towards the resident. Upon turning the fan off, the fan blades were observed covered in a dusty black substance and the metal grill over the blades were covered in a grey dusty substance. In this room's bathroom was observed brown staining at the base of the commode, scraped and gashed drywall approximately one foot wide from the floor and an approximately 2 inch diameter punched area in another section of drywall. In the bathroom was observed 2 different colors of paint on drywall in the vicinity of the commode c. In Room 232 was observed brown staining around the base of the commode and dirty baseboard in the corner of the bathroom next to the commode. The bathroom mirror was observed as not level with the upper right corner of the mirror touching the adjacent wall. The Maintenance Director was observed freely sliding the mirror from side to side and upon his removal and inspection of the mirror determined it was hanging on the left mirror hanger and not on the right mirror hanger. Multiple pencil sized holes were observed in vicinity of the toilet paper holder and on the wall adjacent to the doorframe to the hallway. An area of patched drywall to the right of the window was observed as not primed or	F 253	c) Room 232 staining around base of commode scraped and replaced with fresh caulk on 5/23/14. Baseboard in the corner was cleaned by housekeeping on 5/23/14. Mirror was secured to the wall utilizing the right hanger on 5/23/14. Pencil sized holes were patched and painted on 6/19/14. Drawer pull was replaced and corrected on ___6/19/14_.Drawer pull on bed B bedside table secured on 5/26/14. Dusty material on the ceiling was cleaned by housekeeping on 5/23/14_____ d) Room 205 water stained drywall along the baseboard and PTAC unit was repaired on _6/19/14_____. e) Room 220A □ Wheel chair arm replaced with new cushion on _5/26/14_____. f) Room 222 drywall was primed and painted on __6/19/14_____. g) Room 224B Drywall was repaired on ___6/19/14_____ Housekeeping cleaned the brown substance off the wall on _____5/23/14_____. h) Room 227 Drywall in the bathroom was patched and primed and painted __6/19/14_____. i) Room 229 Drywall was patched and primed and painted on ___6/19/14__ Stained caulking removed and replaced with fresh caulking on 5/23/14. Door facings are scheduled to be painted on ____6/19/14_____. j) Room 230A Drawer pull replaced on bedside table on ___6/19/14_____. k) Room 231 Peeling paint removed on	

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F 253	Continued From page 17 painted and 2 different colors of paint on the wall next to the bathroom door and to the left of the doorframe to the hallway in a patch-like pattern. A missing drawer pull was observed on a bedside table next to Bed A and the drawer pull to that of Bed B was hanging loose on one end of the pull. Grey dusty material was observed clinging to the textured ceiling in the vicinity of the privacy curtain track and in a direct line from the package terminal air conditioner (PTAC) unit d. In Room 205 was observed water-stained drywall along the baseboard and PTAC unit. e. In Room 220A was observed a resident seated in a wheelchair with the right arm of the chair missing its vinyl cover f. In Room 222 was observed a section of drywall to the right of the PTAC unit that was marred, patched and not primed or painted g. In Room 224B was observed over the bed headboard a section of shredded drywall in an approximately 6 inch by 8 inch area. On this same wall between A and B beds was observed a brown substance with dried drips running down the wall h. In Room 227's bathroom was observed an approximately 4 inch diameter punched area in the drywall. In the room was observed 2 different colors of paint in large patches i. In Room 229 was observed an approximately 4 inch diameter hole punched into the bathroom drywall at baseboard level. Brown staining was observed around the base of the	F 253	___6/19/14_____. Area primed and be painted on _____6/19/14_____. l) Door in kitchen leading to the outside had a door sweep added to the inside and outside of the door to provide proper seal when door is shut. This was accomplished on_____5/27/14_____. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice A Center quarterly inspection was done by the Regional Coordinator of physical plant management and environment was done with the Maintenance and Housekeeping/Laundry Director on ___5/28/14_____. All areas identified were addressed. May 28, 2014. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Administrator educated Maintenance Director and Housekeeping/Laundry Director on the following policies: Maintenance policy and procedure #207-monthly patient rooms inspection and Housekeeping policy and procedure # 301-resdient rooms. The Maintenance Director will complete the routine room work orders in building engines as scheduled. The Housekeeping/Laundry Director will utilize the housekeeping repair checklist to ensure maintenance room orders or resident room repairs are put into work orders on building engines to be completed by housekeeping and/or maintenance. June 19, 2014.	

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F 253	Continued From page 18 commode and the doorframe leading into the bathroom was noted to be scraped up on both sides j. In Room 230A a drawer pull was observed missing from a bedside table k. In Room 231 was observed peeling paint to the right of the PTAC unit l. Observation of the door leading from the main kitchen to outside behind the facility revealed a missing door sweep along the entire width of the door, resulting in an approximately ¼ inch gap between the bottom of the door and the threshold and permitting visible daylight from the outside An interview on 05/23/14 at 4:20 PM and during the facility tour with the Maintainance staff (MS) and Housekeeping staff (HS) revealed staff could enter a work order request in a computerized system and if they caught the MS he could enter it but would still remind them of the process. The MS stated the computerized system could prioritize work requests but he tried to keep his working list of tasks to 10 orders or less. He stated his current room refurbishment process included 10 rooms and none of the room concerns on the facility tour were a part of the refurbishment plans. The MS stated he needed to know about physical damage such as holes in walls or water damage, staff were expected to place a work order for those things and he was not aware of the room concerns noted on the facility tour. The HS stated for staining of floors his staff would first strip and re-wax the floor then if that did not remove the staining then his floor technician would cut the caulk around the	F 253	Housekeeping staff were in-serviced on work-order system and placing work orders in that system for the maintenance director repair list. June 19, 2014. Housekeeping Director and /or Maintenance Director or designee will make weekly rounds x4 weeks, bi-weekly rounds x1 month. Areas needing repair during these rounds will be placed in the building engines Work Order system and print out of schedule given to Administrator. Maintenance and Housekeeping Director will ensure areas identified are corrected. June 19, 2014 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The building engines work orders for room repairs and equipment repair will be reviewed and reported to QA&A Committee QuarterlyX2 for continued compliance/revisions to the plan if needed. June 19, 2014.	

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F 253	Continued From page 19 commode and Maintenance would re-caulk. The HS stated Maintenance and Housekeeping worked together, he performed rounds, had a work order system and housekeepers had been in the facility for a long time and were aware to let him know of issues. He stated for lights not properly working that all staff could report these things but the floor technician and housekeeping staff were real good to jump on things. The MS stated resident care equipment issues were the responsibility of Maintenance but he need nursing staff to make him aware when something needed attention. The HS stated personal resident fans could be cleaned by housekeeping staff if they could be taken apart. The MS and HS stated the facility had no formal auditing or checking of rooms and they relied on staff to report things. An interview on 05/23/14 at 5:00 PM with the Dietary Manager and MS, upon inspection of the door from the kitchen to the outside behind the facility, revealed that the gap between the bottom of the door and the threshold was wide enough to permit the entry of insects and required attention. An interview on 05/23/14 at 5:45 PM with the Administrator revealed her expectation that facility environmental issues beyond normal wear and tear should be reported by staff.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/1/14

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This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview the facility failed to administer pain medication as ordered by the physician for 1 of 3 sampled residents reviewed for administration of pain medication. (Resident #45)

The findings included:

Resident #45 was readmitted to the facility 03/13/14 with diagnoses which included chronic pain, anxiety and depression. The latest Minimum Data Set (MDS) assessment dated 03/20/14 assessed Resident #45 with no cognitive impairment. The 03/20/14 MDS also included an assessment of pain which noted a response of "yes, almost constantly" to the question of the presence of pain; noting pain made it hard to sleep at night and limited daily activities. In response to the intensity of pain on a scale of 0-10, Resident #45 responded her pain level was a "7".

The current care plan for Resident #45 included the problem area, Pain-arthritis, neuropathy, multiple sclerosis. One of the approaches to this problem area was to administer medications and monitor effects.

Review of physician orders after readmission on 03/13/14 noted the following medications ordered for Resident #45 for management of pain: Fentanyl, Neurontin, Lyrica and Norco. The Norco 10/325 was ordered to be administered four times a day to Resident #45 with

How corrective action will be accomplished for each resident found to have been affected by the deficient practice Medication Error reports were completed for both missed doses of medication. 5/22/14

How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice 100% Audit of current residents on pain medication for proper administration. 7/01/14

Measures to be put in place or systemic changes made to ensure practice will not re-occur- All current licensed nursing staff will receive education on proper medication administration and medication error reporting. 10% Audit by DON or designee of patients on pain medications completed weekly x s 2, bi-weekly x s 2 and monthly x s 3. 6/19/14

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed by DON or designee. Audits will be reviewed and reported to QA&A Committee Quarterly x s 2 for continued compliance/revisions to the plan if needed.

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F 309	Continued From page 21 administration times on the Medication Administration Record (MAR) noted at 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM. Review of the April 2014 and May 2014 MARs in conjunction with the narcotic control medication utilization sheet noted the scheduled Norco 10/325 was not administered to Resident #45 as ordered on 04/12/14 at 10:00 PM and 05/04/14 at 2:00 PM. On 05/22/14 at 3:00 PM Resident #45 stated she had pain on a daily basis which was managed when the scheduled pain medication was given in a timely manner and as ordered. Resident #45 stated there had been times when she had not received the pain medication as ordered and, when that happened, it made her feel uncomfortable. Resident #45 could not recall specific times or dates the pain medication had not been administered as ordered. On 05/22/14 at 4:00 PM the Director of Nursing (DON) verified the Norco had not been administered to Resident #45 on 04/12/14 and 05/04/14 as ordered. The DON contacted nursing staff that was responsible for administering the Norco to Resident #45 on 04/12/14 and 05/04/14 and no explanation was given for the omission. The DON stated she expected staff to administer medication as ordered by the physician.	F 309		
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	F 314		7/1/14

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F 314	Continued From page 22 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 observation, record review, and staff interviews, the facility failed to measure and evaluate a pressure ulcer weekly for 1 of 3 sampled residents for pressure ulcers. (Resident #96) Findings included: A record review revealed Resident #96 was admitted to the facility on 12/17/11 with diagnoses of heart failure and Alzheimer's Disease. A record review of an annual Minimum Data Set (MDS) dated 11/06/13 revealed Resident # 96 had severe cognitive impairment and was rarely or never understood. The MDS specified the resident was at risk for pressure ulcers. A record review of the Ulcer and Wound Record and nurse's notes revealed Resident #96 did not receive weekly wound measurements and evaluation of right heel unstageable pressure ulcer for the weeks of 03/27/14, 04/03/14, 04/10/14, 04/17/14, 04/24/17, 05/08/14 and 05/15/14. There was no care plan concerning a right heel wound. Interview with Nurse #3 on 05/19/14 at 1:39 PM revealed Resident #96 had an unstageable	F 314	How corrective action will be accomplished for each resident found to have been affected by the deficient practice Wound evaluated by Administrator, Director of Nursing and Nurse Consultant when nurse told us surveyor asked her about the heel wound. Upon inspection found skin of right heel pink with like new tissue with no open area, nor was the area mushy, documentation that wound was healed dated 5/19/14. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice - Audit of 100% of current residents skin assessments and wound records were done and completed if needed to ensure current assessment and wound measurements are present. 7/01/14 Measures to be put in place or systemic changes made to ensure practice will not re-occur- All current licensed nursing staff educated on Policy 2301 requiring Skin Assessment weekly and wound measurements every 7 days. Facility also	

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F 314	Continued From page 23 pressure ulcer on her right heel that was acquired in the facility on 03/10/14. Nurse #3 shared that each nurse was responsible for their own resident's treatments. An observation of a wound treatment to resident #96's right heel pressure ulcer was conducted on 05/21/14 at 2:19 PM. Nurse #2 performed wound care to right heel which had an open area with a red center, no drainage, and was about the size of a 50 cent piece. The right heel was observed with peeling skin around the circumference of the wound. Nurse #2 shared the right heel wound was not resolved. Nurse #2 did not measure the wound during treatment. An interview with Nurse #2 on 05/22/14 at 10:45 AM revealed skin assessments were completed for residents upon admission to the facility and weekly. An Ulcer and Wound Record was generated when a skin condition was found on a resident during the weekly skin assessment. Nurse #2 stated the nursing staff was expected to complete the Ulcer and Wound record and skin assessments weekly. Nurse #2 shared weekly skin measurements were turned in to the Director of Nursing (DON). Nurse #2 verified the Ulcer and Wound Record for Resident #96 did not have documentation of the right heel wound after 03/20/14. From that date, the right heel wound was not documented as measured and evaluated until 05/01/14 and not again until 05/19/14. An interview was conducted with the DON on 05/22/14 at 3:45 PM. The DON stated her expectations were for nursing staff to perform weekly wound assessments.	F 314	implemented new software program which triggers assessments as they are due. 10% of patient population will be audited for up-to-date Skin Assessments by Unit Manager/or designee weekly x□s 4weeks , bi-weekly x□s 2 and monthly x□s 1month and turned in to Director of Nursing. 7/01/14 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee Quarterly x□s 2 for continued compliance/revisions to the plan if needed.	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		6/19/14

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F 431 SS=D	Continued From page 24 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 431	How corrective action will be	

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F 431	Continued From page 25 interviews, the facility failed to discard an opened Novolog insulin medication vial that was expired for 3 days and was available for use in 1 of 5 medication carts. Findings included: A review of facility protocol regarding the use of Novolog insulin indicated after opening may be used for up to 28 days. Resident #17 was admitted to the facility on 11/05/13 with diagnosis of diabetes mellitus. Record review of a quarterly Minimum Data Set (MDS) dated 02/27/14 revealed resident #17 was severely cognitively impaired. Record review of physician orders dated 04/24/14 revealed an order for Resident #17 to receive Novolog 7 units after breakfast, lunch, supper and hold if she eats less than 50% of meals. On 05/22/14 at 1:45 PM, an open Novolog 100 unit/milliliter (mL) vial with expiration date 04/21/14 was observed in the West North medication cart. A review of the May 2014 Medication Administration Record (MAR) was conducted. Nurse's initials indicated Resident #17 received outdated Novolog insulin for 3 days after the 28 days expiration date of 04/21/14. Interview with Nurse #1 on 05/22/14 at 1:50 PM revealed that vials of insulin are marked with the date they are opened and Novolog was dated 04/21/14. Nurse #1 revealed she thought she had checked the insulin vials in the morning and must	F 431	accomplished for each resident found to have been affected by the deficient practice Vial of Novolog discarded at the time of discovery. Physician was notified that insulin had expired. Med error report was completed. 5/22/14 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice 100% Audit of the remaining Medication Carts to ensure that no other insulin was expired past recommended time frame. 6/19/14 Measures to be put in place or systemic changes made to ensure practice will not re-occur- All current licensed nurses were educated on insulin storage and expiration policies. 100% of medication carts will be audited for expiring soon insulin 3 x s a week by Manager weekly x4, bi-weekly x2 and monthly x1 and turned in to Director of Nursing. 6/19/14 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee Quarterly x s 2 r for continued compliance/revisions to the plan if needed.	

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F 431	Continued From page 26 have gotten her dates mixed up and missed the expiration date. Nurse #1 revealed she administered expired Novolog insulin to Resident #17 at 10:00 AM on 05/22/14. An interview with the Director of Nursing (DON) was conducted on 05/22/14 at 3:45 PM. She revealed her expectations were for nurses to check insulin vials for expiration dates prior to administering insulin. The DON verified the insulin used for Resident #17 was expired. She shared that Novolog insulin could be used for 28 days after being opened.	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to monitor temperatures to ensure the safe storage of laboratory specimens for 1 of 1 refrigerators. Findings included: An observation on 05/19/14 at 9:23 AM revealed in the soiled utility room on the 200 hallway a college dormitory-sized refrigerator. Inside the refrigerator were observed numerous blood specimens in lavender top tubes, labeled and placed inside zipper-type closing plastic bags which were lying on the bottom of the refrigerator. The freezer box was observed with an	F 456	How corrective action will be accomplished for each resident found to have been affected by the deficient practice Maintenance looked at refrigerator and found it to be in good working condition. Refrigerator was defrosted and temperature log placed on refrigerator by DON. 5/20/14 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice Temperature log will be checked by the 3rd shift West Wing nurse or designee daily and annotated on	6/19/14

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F 456	Continued From page 27 approximately 1 inch thick coating of ice and the door to the freezer compartment was frozen shut and could not be opened. A kitchen-type thermometer laying on the bottom of the refrigerator read 28 degrees Fahrenheit and there were no temperature logs on or in the vicinity of the refrigerator. Affixed to the door of the refrigerator was a sign with a temperature range for the storage of medications, but no medications were observed in the refrigerator. An observation on 05/19/14 at 12:07 PM revealed affixed to the door of the refrigerator a note from the laboratory service documenting the laboratory courier had been in the facility on 05/19/14 at 9:30 AM with their initials. No laboratory specimens were observed inside the refrigerator and the thermometer was noted with a temperature of 28 degrees Fahrenheit. No temperature logs were observed on or in the vicinity of the refrigerator. An observation on 05/20/14 at 8:20 AM revealed no laboratory specimens in the refrigerator and the thermometer was noted with a temperature of 28 degrees Fahrenheit. No temperature logs were observed on or in the vicinity of the refrigerator. An interview on 05/21/14 at 8:15 AM with Nurse #6 revealed a laboratory phlebotomist came to the facility on Tuesdays, Wednesdays and Thursdays and facility nurses would draw blood specimens as needed on other days. He stated on days that nurses collected routine specimens, they would put them in bags, sealed them up, the tubes labeled with names and the time of collection, batched with other specimens and a laboratory courier would come and pick them up	F 456	the temperature log and placed on the lab refrigerator in the soiled utility. 6/19/14 Measures to be put in place or systemic changes made to ensure practice will not re-occur- All current licensed nurses were educated on the need to do temperature checks of the Lab Refrigerator in the soiled utility room daily and the need for documentation on the temperature log provided to ensure temperature is within normal range. If found to be out of normal range the maintenance director will be notified of need for corrective maintenance. Director of Nursing/Designee will monitor the refrigerator weekly x4, bi-weekly x2 and monthly x1 and turned in to Director of Nursing. 6/19/14 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee Quarterly x□s 2 for continued compliance/revisions to the plan if needed.	

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in one trip. Nurse #6 stated nurses coordinated the collection of specimens which were stored in a refrigerator.

An observation and interview on 05/21/14 at 8:30 AM with Nurse #6 revealed a college dormitory-sized refrigerator in the soiled utility room on the 200 hallway with Nurse #6 stating that it was where laboratory specimens were held until picked up by the laboratory courier. No laboratory specimens were observed inside the refrigerator and Nurse #6 stated he did not know who did temperature checks. Nurse #6 was observed checking the thermometer and the temperature was noted as 34 degrees Fahrenheit.

An interview on 05/21/14 at 9:00 AM with the Director of Nursing (DON) revealed the laboratory service courier came to the facility twice a day around 10:00 AM and 3:00 PM, or the facility would call them to let them know if there were specimens. She stated she did not want laboratory specimens sitting around any longer than necessary and they did not let them sit in the refrigerator all night long. She stated refrigerator temperatures were expected to be checked by the night shift and temperature logs would be located on the refrigerator in a plastic sleeve.

An observation and interview on 05/21/14 at 9:10 AM with the DON revealed a college dormitory-sized refrigerator in the soiled utility room on the 200 hallway with the DON noting the temperature on the thermometer as between 32 and 34 degrees Fahrenheit. No laboratory specimens were observed inside the refrigerator and affixed to the right side of the refrigerator was a paper pocket labeled "fridge temp log" and

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above it taped a note "please check temp on fridge in soiled utility paper on side thanks." The DON stated she did not know where temperature logs for this refrigerator would have be kept or if they had been kept. The DON stated her expectation that all refrigerators, including this one for holding biological specimens, should have been checked daily for temperatures. She stated she would not want a specimen to freeze and be tossed out, requiring a resident to be stuck again for another specimen.

An interview on 05/22/14 at 11:10 AM with the laboratory service manager and the account executive revealed if the refrigerator thermometer was accurate and was reading below freezing, it was possible for the red blood cells in the specimen tube to burst, rendering the specimen not suitable for testing. They stated it was a professional laboratory standard to routinely check temperatures of refrigerators for the storage of biological specimens and the facility was responsible for this monitoring.