1/13/15

PRINTED: 12/30/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156	Preparation and submission of this plan of corrections is in response to the 2567 from the annual survey of December 4, 2014. It does not constitute an Agreement of admission by LibertyWood Nursing Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiencies, the findings, conclusions and actions of the Agency. This plan of correction (and any attached documents) is prepared and submitted solely because of state and federal regulations and also functions as the facility's credible allegations of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
James D Morrison, LNHA

TITLE
Administrator 1-9-15

(X6)
12-31-14

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

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	1. On notification of deficiency the state survey and certification agency state survey was posted on wall in frame on the front hall on December 4th. Medicaid and Medicare information was also posted at the same time. MDS Coordinator was made aware by survey team that name and toll free number was to be placed on form. This information was placed onto the next Medicare cut letter that was mailed on 11-26-2014 and on-going cut letters will also contain the all of the proper information. 2. MDS Coordinator will review upcoming residents whose Medicare will expire and ensure that information is added to notice. 3. When sending notice MDS Coordinator will make copy of notice and bring to morning meeting for discussion. 4. A copy of each notice done during previous month will be brought to QA meeting monthly by the MDS Coordinator for the next X3 months then quarterly to ensure compliance.	12/31/14

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F 156	Continued From page 2	F 156		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to post names, addresses and telephone numbers of the state survey and certification agency, state licensure office and Medicaid fraud control unit. The facility also failed to prominently display in the facility information about how to apply for and use Medicare and Medicaid benefits and the facility failed to insert the name and toll-free number of Quality Improvement Organization on the Notice of Medicare Non-Coverage for one of three residents (resident #108) reviewed for appropriate liability and appeals notice. The findings included:

1. On 12/1 at 11:30 AM and 5:35 PM and on 12/2/14 at 8:30 AM and 5:30 PM, tour of the facility was conducted. There was no posting of state survey and certification agency, state licensure office or Medicaid fraud control unit. There was also no posting of Medicare and Medicaid information.

On 12/4/14 at 8:05 AM, administrative staff members #3 and #4 were interviewed. They went around looking but they could not find it. Administrative staff #3 stated that administrative staff #4 will post them right away.

2. A review of the Notice of Medicare Non-Coverage dated 9/26/14 for resident # 108

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F 156	Continued From page 3 revealed the name and toll-free number of Quality Improvement Organization (QIO) was not inserted on the form. An interview was conducted with Nurse #4 on 12/4/14 at 10:13AM. She stated she was responsible for providing the Notice of Medicare Non-Coverage to the residents or their responsible party. She stated she was not aware the name and toll-free number of QIO was not listed on the Notice of Medicare Non-Coverage signed by the responsible party for resident # 108. An interview was conducted with Administrative Staff # 3 on 12/4/14 at 11:40AM. She stated Nurse #4 was expected to include the name and toll-free number of QIO on the Notice of Medicare Non-Coverage given to the residents or their responsible party.	F 156	1. Immediately terminated employee, began investigation-24 hour and 5 day to Healthcare Personnel Registry. 2. Every resident has potential of defective practice, focusing on residents with behavior problems. Terminating employee removed the potential to other residents. On 12-8-14, the director of nursing did check for a trend of abuse through incident and accident reports and through all allegations that were reported to the state. No trends were noted. 100% education for all staff in all departments for abuse/neglect and termination of employee involved. Social worker notified of all abuse/neglect. Staff Development Coordinator provided 100% staff education-including: housekeeping, dietary, therapies, administrative staff as well as weekend and prn staff, under the direction of the Director of Nursing. (12-8-14). Social Work will be notified of any abuse allegation immediately. If not available, The Director of Nursing will assist as needed. Monitoring occurs on daily department head rounds (including the weekends by the weekend supervisor) beginning 12-8-14. Director of Nursing will bring to QA meetings. The facility Administrator is directly responsible for all abuse allegations. All employees receive abuse education during new employee orientation, prior to direct patient care.	12-8-14
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREEFROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent injury to a demented resident by placing the resident's arm into her mouth causing the resident to bite her arm and lip	F 223		

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F 223	Continued From page 4 for 1 (Resident #75) of 3 sampled residents reviewed for abuse. Findings included: Resident #75 was admitted to the facility on 3/21/13 with multiple diagnoses including alzheimer's disease and anxiety state. The quarterly Minimum Data Set (MDS) assessment dated 11/18/14 indicated that Resident #75 had memory and decision making problems and had exhibited physical behavioral symptoms directed toward others and rejection of care. The care plans dated 11/18/14 (review date) were reviewed. One of care plan problems was "the resident was resistive to care at times related to dementia, she will sometime refuses her medications and meals." The goal was "the resident will cooperate with care through next review date." The approaches included "give clear explanation of all care activities prior to as they occur during each contact, if resident resists with activities of daily living (ADLs), reassure resident, leave and return 5-10 minutes later and try again, praise the resident when behavior was appropriate." Review of the nurse's notes dated 11/2/14 at 4:45 PM revealed "the certified nursing assistant (CNA) giving care to resident reported to writer that when she was giving care to resident, the resident attempted to bite the care giver's arm and she moved her arm away and then gave resident's arm to resident to bite and the resident bit her right arm around wrist area and also bit her left lower lip. A red dry bruise was noted to her right hand." The note indicated that the physician and the resident's responsible party were notified. The note further indicated the site of bite to right arm was cleansed with normal	F 223	3. Upon hire license/certification and reference checks on all nursing employees, abuse/neglect policy is reviewed in orientation Staff Development Coordinator, prior to first day of resident contact and annually. Upon any suspicion of alleged abuse, Social Worker will be notified and document findings in Social Worker notes. Social Worker will be involved in investigation with DON and Administrator. All investigated documentation will be kept in a secured area in the DON office. 4. Staff Development Coordinator will turn in a copy of the abuse education in-service sheets to the DON to ensure compliance. The DON bring completion of abuse policy to stand up meeting for management review. After review, employee will be put on schedule.	12/31/14

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F 223	Continued From page 5	F 223		

saline and antibiotic was applied. The site looked swollen and red.

The 24 hour and 5 day reports were reviewed. The allegation was "resident abuse". The description of the incident was "employee brought resident to the desk and stated that resident was trying to bite her. So she put resident's arm in resident's mouth and resident bit self. Resident bit arm and had bite marks on her right arm as well as swollen cut on her lower lip and posterior right arm was swollen." The allegation was investigated and was substantiated. The alleged employee was terminated.

On 12/3/14 at 2:50 PM, administrative staff #1 was interviewed. She stated that she was called by Nurse # 1 and was informed of the incident that happened to Resident #75 on 11/2/13. When she came to work the next day (11/3/14), she assessed Resident #75. The resident was found to have bite marks on her arm and her lip was swollen and broken. Administrative staff #1 further stated that the alleged nursing assistant (NA#1) was terminated.

On 12/3/14 at 3:05 PM, Nurse #1 was interviewed. He stated that he was the weekend supervisor on 11/2/14 when the incident happened. Nurse #2 (nurse assigned to resident) had informed him of the incident happened to Resident #75. He went to assess the resident and he found the resident's lip was swollen and bleeding and her arm had bite/teeth marks. He added that he was informed of the incident late and NA # 1 had already left. He stated that he had counseled Nurse #2 for not informing him of the incident immediately. NA #1 continued to work after the incident until the end of her shift.

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F 223	Continued From page 6 Nurse #1 immediately called NA#1 to come back but she refused to come for an interview or write a statement. On 12/3/14 at 3:10 PM, NA #1 was not available for interview. On 12/3/14 at 4:15 PM, Nurse #2 was interviewed. She stated that she was assigned to Resident #75 the day of the incident (11/2/14). NA#1 came to the nurse's station with Resident #75 who was sitting on a wheelchair. NA #1 informed her that the resident was trying to bite her when she was doing care and she took the resident's arm and put it in her mouth and she bit herself. She observed the resident to have broken and swollen lip that was bleeding and teeth marks on her arm. She then informed her supervisor (Nurse #1). The incident happened around 4:45 PM. NA #1 left the facility when her shift ended and when she was called to come back she refused.	F 223	1. Physical Therapy assessed res. #46 on 12-5-14 for proper fitting wheelchair, wheelchair then given.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide an assistive device for long distance locomotion about the facility for 1 of 3 residents (Resident	F 246	2. All residents were assessed by the unit managers (nurse) to determine if there any unmet assistive device needs, under the direction of the Director of Nursing. None were found 12.5.14. Residents are being assessed upon admission by MDS for any device need- by the following day. Therapy assessments are performed within 24 hours of admission. 3. Assessment for assistive devices performed by therapy department. On Monday-Friday room rounds are utilized to note any need for assistive devices i.e. walker, grabber etc. Nurse cheat sheet posted-if any assistive device need	

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F 246	Continued From page 7 #46). The findings included: Resident #46 was readmitted 5/29/13 with diagnoses including diabetes, depression, and osteoarthritis. Resident #46 was also on continuous oxygen. The Quarterly Minimum Date Set (MDS) Assessment revealed resident #46 was cognitively intact independent with walking in her room and in corridors, was not steady when walking but could stabilize herself without human assistance and that Resident #46 used a walker. Interview with Resident #46 on 12/1/14 at 3:43 PM revealed that she used to have a wheelchair that she could use to go off the hall. Resident #46 then stated that Administrative Staff #2 " took it away " . Observation of the resident 's room and bathroom at this time revealed that the resident had a walker in the room but did not have a wheelchair. The resident indicated that she was able to walk short distances with her walker but could not manage the oxygen on her own. Resident #46 said that when she wanted to go to the common room off her bedroom she would take off her oxygen and walk with her walker and then ask staff to bring her oxygen after she sat down. She added that she was not able to manage getting off the unit to the dining or to other areas off the unit using her walker. During interview with Administrative Staff #2 on 12/3/14 at 4:29 PM she stated that she did not take away the resident ' s wheelchair. She recalled that at one time the resident was more mobile but then gained weight and with some edema and declining health lost some of her mobility and started asking for a wheelchair. Administrative Staff #2 said she did not want the resident to lose the independence or mobility that she did have so encouraged her to try to walk on her own but eventually Resident #46 was given a	F 246	4. Upon admission assessment-device needed/presence assessed and discussed in management stand up meeting. Monthly QA management added to QA monthly x 3 months, quarterly until compliance met. Director of Nursing will bring to QA meetings.	12/31/14

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F 246	Continued From page 8 wheelchair. Administrative Staff #2 stated that this was while the resident was on 200 hall. She added that Resident #46 had been moved to 100 hall and possible the wheelchair was not sent with her. Administrative Staff #2 said she was unaware the resident did not have a wheelchair at this time and acknowledged it would be unlikely the resident could walk off the unit to the dining room without staff assistance to manage her oxygen and sit down rest breaks along the way. On 12/4/14 at 2 PM interview with the Rehabilitation Director and the Speech Language Pathologist revealed that Resident #46 had not been on their caseload recently and they had not assessed her to see if she needed a wheelchair and the resident had not been referred to them. The Rehabilitation Director did recall that while Resident #46 was on 200 hall the staff had been borrowing a bariatric wheelchair from another resident when Resident #46 wanted to go off the unit. He did not think she ever had her own dedicated wheelchair and said that he thought each of the 2 bariatric wheelchairs the facility had were still on 200 hall. He also said with some weight gain Resident #46 had her mobility may have decreased and if she was needing oxygen all the time now instead of as needed that would also make mobility with a walker difficult.	F 246		1-9-2015
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:	F 253	The Housekeeping Manager was immediately replaced. In-services for a five-step daily resident room cleaning process was begun on 12-16-14 for housekeeping and laundry staff will be completed by 1-9-15 by the housekeeping dept. manager. (Changes in management for housekeeping and new hires has caused a delay in 100%compliance in training.) The housekeeping department manager is auditing the processes used by each housekeeping employee five days a week.	

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F 253	Continued From page 9 Based on observation and staff interview, the facility failed to keep resident personal care equipment such as bed pans and basins clean and properly stored on 1 of 2 halls (100 hall), failed to maintain an odor free environment and empty urinals and a slipper pan on 1 of 2 halls (100 hall), failed to clean floors in resident rooms and bathrooms and to properly dispose of trash in resident bathrooms on 1 of 2 halls (100 hall), and failed to ensure walls in resident rooms and bathrooms and toilets in resident bathrooms were in good repair on 1 of 2 halls. The findings included: On 12/1/14 the following observations were made: 11:15 AM - Room 107 A had a urinal that was ¼ full of urine at the bedside. 11:20 AM - Room 120 A had a urinal full of urine at the bedside. 3:08 PM - Room 107 C had a urinal on bedside table with approximately 1 cup of dark yellow urine and there was an odor of feces in the room. At the sink in the room (the sinks were in the resident rooms not in the bathrooms attached to the resident rooms) there was a soiled washcloth with brown material on the washcloth. 3:23 PM - Room 120 C - the floors were dirty near the walls and there were scraped and digs on the wall on the right side of the bed. In the bathroom, a wet yellow substance was noted at the base of the commode on the left side and the urinal was lying at the back of the commode on the floor and the bathroom had a urine odor.	F 253	Room 104: The slipper pan was removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The black smudge on the floor was cleaned that day. Room 106 toilet room: The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 107: The urinal that was ¼ full of urine was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. Any soiled washcloths were removed and placed into the dirty laundry. The bed pan and wash basin were removed. Replacement pieces of PCE will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 108/109 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 112/113 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 114/115 shared toilet room: The unlabeled urine catch basin and the slipper	

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F 253	Continued From page 10 3:45 PM - Room 121 B had a dirty washcloth on floor beside commode in bathroom. On 12/2/14 the following observations were made: 11:07 AM - Room 104 A, B and C - the walls appeared dirty in areas, there was baseboard that had separated from the wall, there was a chipped ceiling tile and a black smudge on the floor and the cover was coming off the air conditioning unit. The area around bed 104 B was cluttered to the point where it was not possible to get all the way around the bed. In the bathroom the wall had a rough unfinished area and the heat light/exhaust fan did not work. 11:18 AM -Room 120 C - The bathroom continued to have what appeared to be urine at the base of the commode and a urinal lying on the floor at the back of the commode. 1:10 PM - The toilet in room 119 was loose and moved when pressure was applied and there was an unlabeled uncovered slipper pan on the floor. The bathroom had a urine odor and floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish hazy over the floor. 2:24 PM - The floors in the bathroom of room 107 appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor, and the bathroom had a urine odor. 3:48 PM - Room 116 ' s bathroom had a bathtub with an unlabeled and uncovered bed pan, slipper pan and wash basin in it. On top of the personal	F 253	pan were discarded and replacement pieces of PCE will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall by nursing staff. Room 116 toilet room: The unlabeled pieces of PCE were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The discarded tissues were thrown into the trash. The toilet room floor was cleaned to provide sanitation. Room 118 toilet room: The basin that was on the toilet room floor was removed. Replacement pieces of PCE will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation. Room 119: The slipper pan and urine measuring cup were removed from the toilet room. The toilet room floor was cleaned to provide sanitation. Room 120: The urinal that was full of urine at the bedside was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. The soiled washcloth that was on the vanity has been were removed and placed into the dirty laundry. Room 120 toilet room: The unlabeled urinal was removed. The toilet room floor was cleaned to provide sanitation.	

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F 253	Continued From page 11 care equipment were discarded used tissues, some of them had rusty brown matter on them. The discarded tissues were piled loosely about up about 6 - 12 inches high by approximately 18 inches wide. The toiled has rust colored stains near the base of the tank. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. On 12/2/14 from 5:15 - 6 PM each resident bathroom on 100 hall was observed with the Administrative Staff #3, Administrative Staff #1, Housekeeping Manager, Maintenance Director, and Administrative Staff #8. The following observations were made: Room 123 ' s bathroom had towels on the floor with yellowish stains on them. There was an uncovered and unlabeled basin on the floor and a urine measuring cup on the back of the toilet with yellowish liquid residue in it. The floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. The shared bathroom for room 121 and 122 had 4 holes in the wall up to approximately 2 inches in diameter. There was a plunger on the floor and the floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 120 ' s bathroom had an unlabeled urinal on the floor behind the toilet and the room had a urine smell which the Administrative Staff #3 acknowledged. The floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor.	F 253	Room 121/122 shared toilet room: The observed plunger was removed and taken to the appropriate location in the housekeeping janitor closet. The toilet room floor was cleaned to provide sanitation. Room 123 toilet room: The towels were removed and taken to the laundry room as dirty laundry. The basin and urine measuring cup were both removed. The toilet room floor was cleaned to provide sanitation. Room 123: The floor in the room was cleaned, the corners and edges were specifically cleaned with a HSG-created stripping solution and then scraped to remove all wax/dirt residue. The Maintenance Department repaired all rooms that were in need of repair. Additionally, the Maintenance department installed one hook per licensed bed in the room behind the toilet in the toilet room of each resident so that the labeled, re-useable hygiene supplies (ie: basin, emesis bowl, etc.) could be stored in a bag and hung on the hooks behind the toilet. Room 104: The baseboard was reattached to the wall and the cover was reattached to the A/C unit. The bathroom exhaust fan motor was replaced by the maintenance department. The maintenance department repaired the hole in the toilet room wall and painted the repair with the appropriate color of paint.	

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F 253	Continued From page 12 Room 119 ' s toilet was loose and shook side to side when it was pushed against moderately and there was a wet wash cloth on the back of the toilet. There was a covered, unlabeled slipper pan on the floor and one urine measuring cup on the floor. There was also a urine measuring cup on the back of the toilet. The urine measuring cups had yellowing fluid residue in them and there was a slight smell of urine in the room which the Administrative Staff #3 acknowledged. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 118 ' s bathroom floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. There was a basin on the floor that was not labeled or covered. Room 116 ' s bathroom had a bathtub with an unlabeled and uncovered bed pan, slipper pan and wash basin in it. On top of the personal care equipment were discarded used tissues, some of them had rusty brown matter on them. The discarded tissues were piled loosely about up about 6 - 12 inches high by approximately 18 inches wide. The toiled had rust colored stains near the base of the tank. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for rooms 114 and 115 there was a bed pan on the floor with a slipper pan on top of it and a urine catch basin inside the slipper pan. There were yellowish stains visible on the slipper pan and urine catch basin. Tissue	F 253	Room 106 toilet room: The maintenance department used an outside plumbing vendor and replaced the flange of the toilet, thereby securing it more firmly to the floor. Room 110/111 shared toilet room: The wall that needed the repair patch to be painted by the maintenance department. Room 112/113 shared toilet room: The rubber baseboards were replaced by the maintenance department. Room 119: The maintenance department used an outside plumbing vendor and replaced the flange of the toilet, thereby securing it more firmly to the floor. Room 121/122 shared toilet room: The maintenance department repaired the hole in the toilet room wall and painted the repair with the appropriate color of paint. The nursing department in-serviced staff regarding the following areas: a. Infection control b. Use of bags to store labelled personal care equipment. All personal care equipment (PCE) is labelled by the certified nurses' aides (CNAs). Following the use of labelled PCE, the PCE will be cleaned out and dried then bagged in a clear plastic bag and hung on a hook in the toilet room by the CNAs. The Staff Development Coordinator (SDC) in-serviced all nursing staff as of 12-31-14 and will in-service nursing new staff upon hire.	

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F 253	Continued From page 13 and other debris was inside the urine catch basin. The personal care equipment was not labeled or covered. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for room 112 and 113 the rubber baseboards were coming away from the wall. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shard bathroom for rooms 110 and 111 had a repair patch on the wall that had not been sanded or painted yet. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for rooms 108 and 109 the floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 107 ' s the floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. A bed pan and wash basin were unlabeled but covered and hanging from the safety grab bar. Room 106 ' s bathroom had a bed pan and a slipper pan on the floor that was unlabeled and uncovered and the toilet was slightly unstable. Room 105 ' s bathroom had an odor of urine which Administrative Staff #3 noted as well. The floors appeared clean and had recently been stripped according to Administrative Staff #3.	F 253	Room 104: The resident belongings that were crowding the bed 104B have been placed into different locations, thereby creating room to walk around the bed safely. 2.This deficient practice potentially affected all residents of LibertyWood Nursing Center. The Housekeeping Department made thorough inspections and cleaned the toilets, floors and the walls of all the resident toilet rooms on both units 100 and 200. The resident rooms are on a waxing schedule so that each resident room is stripped and waxed annually. Each resident room can be stripped and waxed additionally if there is a specific need. Housekeeping staff was in-serviced on proper cleaning methods in resident rooms and toilet rooms. A result of using the proper cleaning method will create an odor-free environment. Hooks will be placed in each resident toilet room behind the toilet for the purpose of hanging each resident's labelled personal care equipment which is placed in a bag on the hook. All loose baseboards and areas needing repair were repaired and replaced by the maintenance department as of 12-30-2014. All toilet room exhaust fans were checked for proper functioning. All broken exhaust fans were noted and ordered to be replaced by the maintenance department when the ordered exhaust fans come in. All toilet room exhaust fans will be in working condition as of 2-15-15. All resident toilet rooms were audited by the administrator on 12-7-2014 for any unnecessary housekeeping equipment such as loose plungers and any unnecessary housekeeping equipment located was relocated. All toilets were audited by	

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F 253	Continued From page 14 Room 104 ' s bathroom had a repair patch on the wall that had not yet been sanded or painted. There was a slipper pan on the back of the toilet that was unlabeled and uncovered. The shared bathroom for rooms 101 and 102 had a plunger on the floor. Administrative Staff #1 was interviewed at this time and indicated that she was surprised at the dirty condition of the bathrooms and stated that this was unacceptable and that bathrooms should be clean and in good repair. She also stated that the facility did not provide garbage cans in resident bathrooms but that she thought that policy should be reconsidered. Administrative Staff #1 also said that personal care equipment was supposed to be clean, labeled with the resident ' s name, stored in a plastic bag and off the floor. She acknowledged that tying the bag containing personal care equipment to the safety grab bar was not an acceptable means of storing personal care equipment The Maintenance Director was interviewed at this time and stated that he had been unaware of the maintenance issues in many of the bathrooms as they had not been reported to him. He added that he was in the process of working on some of the maintenance issues. He stated that environmental rounds were done at the facility but that it was the Housekeeping Managers responsibility to monitor the bathrooms. The Housekeeping Manager was interviewed at this time and stated that she was responsible for checking the bathrooms daily but that she had been unaware of their current condition or the trash that had not been disposed of properly.	F 253	administrator and maintenance director for looseness and were repaired or tightened by 12-11-14. All the walls of resident rooms and walls of resident toilet rooms were audited and have been repaired as of 1-8-15. All ceilings were audited by administrator for broken tiles and replaced as necessary. All resident rooms were checked for adequate walking space to move around the bed for resident care. Those residents refusing to have their personal belongings relocated will be care-planned for compliance and re-visited quarterly. Room 101/102 shared bathroom: The observed plunger was removed and taken to the appropriate location. The toilet room floor was cleaned to provide sanitation. Room 104: Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 106 toilet room: The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 107: The urinal that was ¼ full of urine was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. Any soiled washcloths were removed and placed into the dirty laundry. The bed pan and wash basin were removed. Replacement pieces of PCE will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation.	

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F 253	Continued From page 15 She said that she had not checked the rooms yet this week. On 12/2/14 at 6:05 PM Administrative Staff #3 was interviewed and stated that she had been unaware of the poor condition of the resident bathrooms as it was the Housekeeping Manager's responsibility to ensure they were clean and sanitary. She added that their current condition was unacceptable. Administrative Staff #3 indicated that she had concerns about the housekeeping at the facility and had been monitoring it, and had been pushing for the bathroom floors to be stripped and waxed, since she started at the facility two months ago. She stated that the stripping and waxing of the floors started in late November and so far they had completed 4 bathrooms (101/102 (shared), 103 which was not a resident bathroom 104 and 105). She also indicated that she had been focused on many other issues that needed to be addressed at the facility but acknowledged that current the condition of the resident bathrooms, that she just observed, was not homelike and could have implications for infection control. Housekeeping Aide #1 (HA #1) was interviewed on 12/3/14 at 9:10 AM with the Housekeeping Manager present. She stated that she had cleaned the rooms and bathrooms on 100 hall on 12/1/14 and 12/2/14 and that 100 hall was her typical assignment. She also acknowledged that it was housekeeping's responsibility to properly dispose of trash, remove rust stains, clean the floors and that if she noticed any maintenance issues she typically reported them to the Maintenance Director verbally and did not use the written Maintenance Request. She stated that on 12/1/14 and 12/2/14 she did not notice any trash	F 253	Room 108/109 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 112/113 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 114/115 shared toilet room: The unlabeled urine catch basin and the slipper pan were discarded and replacement pieces of PCE will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 116 toilet room: The unlabeled pieces of PCE were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The discarded tissues were thrown into the trash. The toilet room floor was cleaned to provide sanitation. Room 118 toilet room: The basin that was on the toilet room floor was removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation. Room 119: The slipper pan and urine measuring cup were removed from the toilet room. The toilet room floor was cleaned to provide sanitation. Room 120: The urinal that was full of urine at the bedside was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. The soiled washcloth that was on the vanity has been were removed and placed into the dirty laundry. Room 120 toilet room: The unlabeled urinal was removed. The toilet room floor was cleaned to provide sanitation.	

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F 253	Continued From page 16 in room 116, or any other resident bathroom on hall 100, did not notice any holes in the walls, the wobbly toilet in room 119 or any other loose toilets or toilets with rust stains, and did not notice any odors or unemptied urinals. She said that she did clean the floors and acknowledged that they " did not look so fresh " but said she thought that was because they needed to be waxed and stripped. HA #1 stated that she deep cleaned 1 room a day and that on 12/2/14 she deep cleaned the bathroom for rooms 121/122. Administrative Staff #1 was interviewed on 12/3/14 at 10:22 AM and stated that it was Nursing ' s responsibility to empty and properly clean out urinals and bed bans prior to storing them in a plastic bag off the floor and that this would aide in eliminating the urine odors from resident bathrooms. She added that it was Nursing ' s responsibility to label personal care equipment as well. She said that she had been unaware of the condition of the resident bathrooms on 100 hall because it was the Housekeeping Managers responsibility to check the bathrooms and acknowledged they had not looked clean or sanitary. She said that she was unaware staff were not labeling and properly storing personal care equipment but that this had been fixed immediately as it was an infection control issue. HA #2 was interviewed on 12/3/14 at 11:30 AM. She stated that she had just finished cleaning the bathroom for rooms 121 and 122 and she was surprised how dirty it was since it was supposed to have been deep cleaned the day before. The bathroom for rooms 121/122 was observed at this time and the floor no longer had a greyish residue and the tobacco colored stain that had been	F 253	Room 121/122 shared toilet room: The observed plunger was removed and taken to the appropriate location. The toilet room floor was cleaned to provide sanitation. Room 123 toilet room: The towels were removed and taken to the laundry room as dirty laundry. The basin and urine measuring cup were both removed. The toilet room floor was cleaned to provide sanitation. 3. Informal audits are completed daily in the walking rounds done by department heads, while the housekeeping/laundry supervisor completes audits that are specific to housekeeping staff. These audits are completed daily and any training that needs to be done by the housekeeping supervisor is able to be completed then, unless a more formal in-service is necessary. These audits are a part of the daily work routine of the housekeeping supervisor and/or his assistant. Audits are reviewed daily and filed for future reference up to the QA meeting, then the audits are discussed at the QA meeting. 4. The housekeeping supervisor meets with the administrator daily (Mon thru Fri) to discuss any problems that the administrator can resolve. Then, those problems and solutions are brought to the QA meeting by the housekeeping/laundry supervisor along with any system changes in the housekeeping/ laundry department. The administrator will monitor systems for successful compliance. Any systems that need to be amended are reviewed at the QA meeting for three months following the discovery of a discrepancy in a system and amended.	

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F 253	Continued From page 17 around the perimeter of the room and the toilet was gone. The floor and toilet appeared clean and the room smelled clean. HA #2 confirmed that the floor had not been stripped and waxed, just cleaned.	F 253		12/31/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for contracture management for 2 (Residents # 41 & #16) of 3 sampled residents reviewed for limitation in range of motion and for pressure ulcers for 2 (Residents # 16 & #81) of 3 sampled	F 279	1. Care plan developed for #41 #16 #81 Re-educated nurse #4 (MDS Coordinator) on care planning responsibilities for pressure ulcers and contractures; counseling session took place. 2. 100% resident audit conducted to determine those who had contractures. Audit was given to Nurse #4 (MDS Coordinator), all care plans updated. 3. Nurse #4 was re-educated by the Director of Nursing.12.5.14. Ongoing audit of care plan completion is being monitored daily by Director of Nursing. Resident audit was performed by Director of Nursing and Wound Care-completed 12.5.14. Ongoing audit of care plans , for residents with order changes , who have pressure areas and or contractures, is ongoing by Director of Nursing daily. Director of Nursing will take to QA meetings. 4. Copy of order for pressure ulcer/contractures is kept in DON office when care plan initiated-copy to DON-order attached. All care plans for pressure ulcers/contractures will be brought to QA meeting monthly x 3 then quarterly until compliance is ensured.	12/31/14

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F 279	Continued From page 18 residents reviewed with pressure ulcer. Findings included: 1. Resident #41 was admitted to the facility on 3/22/14 with multiple diagnoses including alzheimers disease. The annual MDS assessment dated 11/13/14 indicated that Resident #41 had memory and decision making problems and had limitation in range of motion on one side. The care plan dated 11/13/14 was reviewed. There was no care plan developed for contracture management. Resident #41 was observed on 12/1/14 at 5:05 PM, 12/2/14 at 9:49 AM and 12/3/14 at 9:50 AM, with his left hand contracted. On 12/3/14 at 11:45 AM, Nurse #4 was interviewed. She acknowledged that she did not care planned contracture. On 12/4/14 at 2:30 PM, administrative staff #1 was interviewed. She stated that she expected a care plan for residents with contracture. 2. Resident #16 was admitted to the facility 2/25/14. Cumulative diagnoses included: quadriplegia (paralysis of all extremities), advanced MS (Multiple Sclerosis-a disabling disease of the central nervous system) and contractures of the joints. The Quarterly MDS (Minimum Data Set) dated 11/19/14 indicated that Resident #16 had memory and decision making problems and had limitation in range of motion of both upper and lower extremities. The care plan dated 11/19/14 was reviewed.	F 279		

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F 279	Continued From page 19 There was no care plan developed for contracture management. Resident #16 was observed on 12/1/14 at 4:41PM, 12/2/14 at 10:00AM and 12/3/14 at 2:15PM. Contractures were noted in all extremities. On 12/03/14 at 5:10PM, Nurse #4 was interviewed. She stated she did not realize that contractures should be care planned and she had not been writing care plans for contractures. On 12/4/14 at 2:30PM, administrative staff #1 was interviewed. She stated that she expected a care plan for residents with contractures. 3. Resident #16 was admitted to the facility 2/25/14. Cumulative diagnoses included: quadriplegia (paralysis of all extremities), advanced MS (Multiple Sclerosis-a disabling disease of the central nervous system) and contractures of the joints. The Quarterly MDS (Minimum Data Set) dated 11/19/14 indicated that Resident #16 had memory and decision making problems. Skin conditions were noted as Resident #16 having one stage three (3) pressure ulcer and one stage four (4) pressure ulcer present during the assessment period. A review of the medical record revealed Resident #16 had received treatment to the left outer elbow for the pressure ulcer since 4/7/14. She had received treatment for the stage 3 pressure ulcer at the antecubital space on the left elbow since 11/10/14. The care plan for 11/19/14 was reviewed. There was no care plan developed for pressure ulcers.	F 279		

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LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 279	Continued From page 20 On 12/3/14 at 2:15PM, pressure ulcer care was observed. Resident #16 was noted to have a stage four pressure ulcer on the left outer elbow (area healed) and a stage 3 pressure ulcer (in the left inner elbow at the antecubital (bend of the arm) space. On 12/03/14 at 5:10PM, Nurse 34 stated Resident #16 should have had a pressure ulcer care plan developed when the pressure ulcers were noticed. On 12/4/14 at 8:31AM, administrative staff #1 stated she expected a care plan for pressure ulcers to be developed when the pressure ulcers were noticed. 4. Resident #81 was admitted to the facility 6/2/14. Cumulative diagnoses included: Diabetes, chronic debility and glioblastima multiforms (aggressive brain cancer). A Quarterly MDS dated 10/14/14 indicated Resident #81 had memory and decision making problems. A skin condition was noted as Resident #81 having an unstageable pressure ulcer (pressure ulcer with black tissue) present during the assessment period. Medical record review revealed Resident #81 had been treated for an unstageable pressure ulcer to the right outer ankle since 9/24/14. The care plan last reviewed 10/15/14 was reviewed and revealed no care plan developed for pressure ulcers. On 12/3/14 at 2:15PM, pressure ulcer care to the right outer ankle was observed. Resident #16	F 279		

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F 279	Continued From page 21 was noted to have an unstageable pressure ulcer to the right outer ankle. On 12/4/14 at 8:03AM, Nurse #4 stated she did not know Resident #81 did not have a care plan for pressure ulcers and should have had a care plan for pressure ulcers. On 12/4/14 at 8:31AM, administrative staff #1 stated she expected a care plan for pressure ulcers to be developed when the pressure ulcers were noticed.	F 279		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to monitor fluid intake for one of one sampled residents on dialysis with fluid restriction (Resident #54) and failed to prevent infestation of maggots on resident #39. The findings included: 1. Resident #54 was admitted to the facility 8/5/14. Cumulative diagnoses included: diabetes and ESRD (end stage renal disease). Resident #54 was on renal dialysis.	F 309	1. Accurate monitoring of fluid intake began 12/8/14 for resident #54. Intake record was placed in MAR-MD order written that specifically dictates how much fluid intake per day-specific amount. 2. Audit performed by Director of Nursing on 12.5.14. As of now, no residents have potential to be affected by deficient practice. 3. Staff education provided by Staff Development Coordinator under the direction of the Director of Nursing on 12-5-14, in coordination with the Dietary Manager, to all nursing staff including weekends, and prn staff. Fluid amount information will be documented on the intake record form –placed in MAR for nurse to keep current. Fluid restriction protocol will be reviewed during new-hire orientation.	

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F 309	Continued From page 22 A Quarterly MDS (Minimum Data Set) dated 10/31/14 indicated Resident #54 was cognitively intact. The resident was assessed as receiving dialysis as part of her medical treatment during the assessment period. A care plan dated 8/13/14 and last reviewed on 11/19/14 stated Resident #54 was on a therapeutic diet with 1200 cc. (cubic centimeters) fluid restriction. Interventions included, in part, monitor intake and record every meal. Physician orders for December 2014 revealed an order for 1200 cc. (cubic centimeter) fluid restriction. Medication Administration Records for October, November and December 2014 were reviewed and revealed an entry that stated 1200 cc. fluid restriction. There was no documentation of the amount of fluid consumed by the resident recorded on any of the three MARs '. A review of the nursing notes from October 1, 2014 through 12/3/2014 was conducted. There was no documentation of the amount of fluid consumed by Resident #54. On 12/4/14 at 10:30AM, an interview was conducted with Resident #54. She stated she was aware of her fluid restriction and tried to keep her fluid intake low. On 12/04/2014 at 1:38PM, Nurse #7 stated Resident #54 was not on a fluid restriction. On 12/4/14 at 1:56PM, Nurse #3 stated, if a resident was on a fluid restriction, there would be a physician ' s order written and the fluid	F 309	4. Daily, unit manager will review each fluid restriction sheet and address in morning meeting x 7 days, weekly x 4 weeks, and then quarterly. Reviewed in QA monthly x 3, then quarterly until compliance occurs. Director of Nursing will bring to QA meetings.	12/31/14

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F 309	Continued From page 23 restriction would be on the MAR so the nursing staff could document the amount of fluid intake. She stated she was unaware that Resident #54 was on a fluid restriction. On 12/4/14 at 2:36PM, administrative staff #2 stated, if a resident was on a fluid restriction, the amount of fluid intake would be documented on an intake and output sheet. She reviewed Resident #54 ' s medical record and noted that the last intake and output record was in August 2014. Administrative staff #2 stated Resident #54 should have had an intake and output sheet and nursing staff should have recorded the intake on that sheet. On 12/4/14 at 2:48PM, administrative staff #1 stated she expected nursing staff to follow the facility policy and nursing staff should have documented the intake on the intake and output sheet. 2. Resident #39 was admitted to the facility 1/30/13. Cumulative diagnoses included: Diabetes Mellitus, severe bilateral lower extremity lymphydema (swelling of both lower legs), anxiety, depression, recurrent cellulitis (bacterial infection involving the skin) and Milroy ' s disease (a rare condition in which there is lymphedema and cellulitis. Proper hygiene is important in controlling the cellulitis.). A Quarterly Minimum Data Set (MDS) dated 10/10/14 indicated Resident #39 was cognitively intact. She was totally dependent for personal hygiene and bathing. A care plan dated 7/2/14 and last reviewed on 10/10/14 stated Resident #39 had an ADL	F 309	1. Daily showers began-orders obtained to add periwash and vinegar to bath water for any cleansing/bathing in room for res. #39. Staff made aware that shower can be given on 1st or 2nd shift daily. 2. Every resident is at risk for this deficient hygiene practice. Audit performed by the Director of Nursing on 12-5-14 to determine if any other resident has the potential for this deficient practice (i.e.- refused showers, demand bed bath, open/draining skin areas etc.) There were not any residents noted at present with potential for this deficient practice.	

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F 309	Continued From page 24 (activity of daily living) self care performance deficit related to shortness of breath and morbid obesity. Resident #39 refused a bath in bed/ showers at times. Interventions included: Resident is bedfast all or most of the time due to her preference. If a bath/ shower was refused, explain the importance of hygiene especially with the skin ailment on legs. Offer to return. Encourage her to set a time for care and return at that time. An addition to the care plan dated 10/17/14 indicated may use vinegar and water mix to spray on legs during bath/ shower. On 12/2/14 at 4:20PM, an interview was conducted with Resident #39. She stated that an incident happened in October when nursing staff were giving her incontinent care. Resident #39 stated she noticed a change in the nursing assistants ' faces during the incontinent care and became really upset when they would not tell her what they had seem. Resident #39 stated she told them she had a right to know and one of the nursing assistants pointed to a white object on her sheet. She stated the object was moving and she knew it was a maggot. Resident #39 stated she was only able to wash her face and hands. She said she had received showers every day after the nursing staff had observed the maggots and now received showers on Monday, Wednesday and Friday. Resident #39 stated nursing staff would sometimes not give her a shower on the day shift and day shift would tell her that the evening shift would administer the shower. Evening shift would not give her a shower and, therefore, she would not receive her bath or shower. Resident #39 stated she had never refused care, bathing or a shower. A review of shower schedule was conducted and	F 309	Any personal care refusal will be reported to assigned nurse-nurse will speak with resident explaining need for personal hygiene, offer schedule change, different time of day, different method. Outcome is documented in nursing note. DON to address with social worker, psychologist, MD/NP if needed. Staff education provided to all nursing staff by Staff Development Coordinator under the direction of the Director of Nursing 12.5.14. Reminders placed in all ADL books 12.5.14. Shower audits are performed weekly by unit managers (nurses) on each unit. This process is on going. 4. QA monthly x 3, then quarterly until compliance occurs. In-service will be reviewed in stand up meeting. Director of Nursing will take to QA meeting.	12/31/14

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F 309	Continued From page 25	F 309		

revealed Resident #58 should receive her shower on first shift (day shift) every Monday, Wednesday and Friday. There was a note dated 12/1/14 on the front of the shower schedule that stated Resident #39 was to have her shower on first shift daily for the week of 12/1/14.

On 12/3/14 at 6:31AM, NA (nursing assistant) #3 stated he was assisting staff with incontinent care on the day that the nursing staff observed the maggots on Resident #39. He said he did observe one to two maggots on resident #39 's lower leg at that time.

On 12/3/14 at 9:20AM, Resident #39 was observed during her shower. Resident #39 had a large amount of blisters and nodules covering her body from her groin area to her ankles. No open areas were noted and no evidence of maggots was observed.

On 12/3/14 at 10:40AM, administrative staff #1 stated she thought it was the first Sunday in October when she stopped by the facility and was told that Resident #39 had two " bugs " on her. She stated they cleaned her room and bed that day and gave her a shower. Administrative staff #1 stated they began daily showers at that time. She stated Resident #39 had been anxious about a shower because she had fallen from a Hoyer (mechanical lift) in another facility and consequently fractured a hip so she had a fear of falling. She said Resident #39 refused showers and baths and, if she refused her bath or shower, it would be documented on the NA (nursing assistant) flow sheets. Administrative staff #1 stated she thought Resident #39 got the maggots as a combination of her skin condition (Milroy 's). Her legs would weep fluid and she also had food

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F 309	Continued From page 26 in the room which caused flies. Administrative staff stated she expected the nursing assistants to document on the flow sheet if Resident #39 refused baths/ showers and also expected licensed nursing staff to document the refusals in the nursing notes. NA flow sheets and nursing notes from September 1, 2014 through December 3, 2014 were reviewed with administrative staff #1 and no refusal had been documented during that time period. On 12/3/14 at 2:59PM, NA#4 stated she had provided care for Resident #39 on day shift for the past five months. She stated her assignment changed and she was not providing care for Resident #39 for about a month and resumed provision of care after Resident #39 was observed to have maggots. NA#4 indicated Resident #39 had never refused showers during the time that she had provided care for her.	F 309		
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 record review, observation and staff interview, the facility failed to apply the carrot	F 318	1. Upon discovering carrots not in place for Resident #41, carrots applied with passive ROM to both hands. Additional staff added to restorative team 12.5.14. 2. Audit was conducted performed by Director of Nursing on 12-5-14, residents had carrots in place as ordered. No additional carrots were needed.	

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F 318	Continued From page 27 splint and to provide the passive range of motion as ordered and care planned for 2 (Residents # 6 & # 41) of 3 sampled residents with contractures. Findings included: 1. Resident #6 was admitted to the facility on 4/11/14 with multiple diagnoses including cerebro vascular accident (CVA) and bilateral hand contractures. The quarterly Minimum Data Set (MDS) assessment dated 9/17/14 indicated that Resident #6 had severe cognitive impairment and had no limitation in range of motion on upper and lower extremities. The care plan dated 9/23/14 was reviewed. One of the care plan problems was " the resident has an activity of daily living (ADL) self care performance deficit related to alzheimers. " The goal was the resident will have all needs anticipated and met through the next review date. " The approaches included carrots to bilateral hands to help prevent further contractures. Resident #6 was observed on 12/1/14 at 4:01 PM, 12/2/14 at 10:33 AM and 12/3/14 at 8:20 AM with both hands contracted and with no carrots on. On 12/3/14 at 8:35 AM, Nurse #3 was interviewed. She stated that Resident #6 should have carrots in her hands at all times. She went to the resident's room and observed Resident #6 with no carrots in her hands. On 12/3/14 at 8:36 AM, NA # 2 was interviewed.	F 318	3. All residents are assessed upon admission for need of devices and/or proper fitting. Mon-Fri room rounds to note if device in place. Restorative nursing assistants apply splints and remove daily. Staff Education provided to all nursing employees regarding importance of range of motion being provided 12/8/14. Visual observation will occur by nurses on unit daily and MDS to ensure devices are in place, as ordered .Room audits will be completed daily-including weekends. Director of Nursing will monitor these audits daily and will be reviewed in daily meeting. 4. QA monthly x 3 then quarterly until compliance occurs. Director of Nursing will monitor these audits daily and will be reviewed in daily meeting. This will be an ongoing process. Director of Nursing will take to QA meetings.	12/31/14

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F 318	Continued From page 28 She stated that she was assigned to Resident #6 and would apply the carrots on the resident's hands after she had gotten the resident out of bed. On 12/4/14 at 2:30 PM, administrative staff #1 was interviewed. She was aware that Resident #6 had contractures to both hands. She stated that she expected the NAs assigned to the resident to ensure the carrots were on at all times. 2. Resident #41 was admitted to the facility on 3/22/14 with multiple diagnoses including alzheimers disease. The annual MDS assessment dated 11/13/14 indicated that Resident #41 had memory and decision making problems and had limitation in range of motion on one side. The care plan dated 11/13/14 was reviewed. There was no care plan developed for contractures management. The occupational therapy (OT) notes were reviewed. The notes indicated that Resident #41 was under the OT case load for orthotic management to reduce skin breakdown and left hand contracture. On 2/6/14, Resident #41 was discontinued from OT services and was referred to the restorative nursing for passive range of motion (PROM) and carrot splint application to prevent further contracture. The physician's orders were reviewed. On 10/1/14, there was a doctor's order for " restorative nursing PROM to left upper extremity,	F 318		

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F 318	Continued From page 29 carrot splint on at all times except bathing and hygiene to prevent further contracture 5 x per week x (times) 12 weeks." Resident #41 was observed on 12/1/14 at 5:05 PM, 12/2/14 at 9:49 AM and 12/3/14 at 9:50 AM, with his left hand contracted and with carrot on. On 12/3/14 at 10:15 AM, occupational therapist #1 was interviewed. She remembered working with Resident #41 for contracture management of his left hand. After the discharge, she had recommended for the resident to have PROM and carrot application to prevent further contracture of the left hand. She added that Resident #41 had never refused PROM or the application of the carrot. On 12/3/14 at 11:45 AM, Nurse #4 was interviewed. She stated that she was assigned to the restorative program. She stated that she was aware that restorative care was not provided on 12/1 and 12/2/14 because the restorative aide was doing the monthly weights. She added that on 12/3/14, restorative care was also not provided because the restorative aide was off. On 12/4/14 at 2:30 PM, administrative staff #1 was interviewed. She stated that she was aware that restorative care ordered or care planned for residents was not provided when the restorative aide was doing the monthly weights or when she was out for some reason. On 12/4/14 at 3:02 PM, restorative aide #1 was interviewed. She stated that on 12/1 and 12/2/14, she was doing the monthly weights so she did not provide the PROM and the carrot splint to Resident #41. She added that on 12/3/14 she	F 318		

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F 318	Continued From page 30 was off and nobody was assigned to apply splints or to provide PROM when she was not available.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a medication (Depakote, a mood stabilizer drug) was administered as ordered and failed to monitor the valproic acid level after the dose of Depakote was	F 329	1. Resident #30- Valporic Acid level was drawn on 12.5.14. Level reported was 42.3. 2. Both MD and NP received results on 12.5.14- order to repeat level in 2 weeks. Director of Nursing had a conference with MD and NP regarding the importance of writing orders in chart –not dictating the orders only. 100% chart audit , completed by unit managers, showed no missed orders on 12.5.14. All orders are now being reviewed by 3rd shift nurse and initialed in corner that order has been carried out. 3. 3rd shift unit nurse will review all written MD/NP orders to ensure all orders noted have been carried out with initial in lower right corner. Those signed orders come to the office of the Director of Nursing and all orders are reviewed in morning meeting ongoing, beginning 12-5-14. 4. Director of Nursing will take to QA meeting. QA monthly x 3 then quarterly until compliance occurs.	12/31/14

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F 329	Continued From page 31	F 329		

increased for 1 (Resident # 30) of 5 sampled residents reviewed for unnecessary drugs.

Findings included:

Resident #30 was admitted to the facility on 9/6/14 with multiple diagnoses including anxiety and depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 10/9/14 indicated that Resident #30 was cognitively intact and had received an antidepressant and antianxiety medications. The assessment further indicated that Resident #30 had not exhibited any behavioral symptoms but had rejection of care.

The care plan dated 10/9/14 was reviewed. The use of the psychotropic medications was care planned and the approaches included to administer medication as ordered and to monitor/document/report as needed adverse reaction to drugs.

The physician ' s orders (9/6/14) on admission were reviewed. Resident #30 had an order for Depakote 250 milligrams (mgs) twice a day for behaviors.

Review of the current physician ' s order (December, 2014) revealed that Resident #30 was receiving Depakote 500 mgs twice a day.

The telephone orders were reviewed and there was no order for Depakote 500 mgs twice a day found.

The Medication Administration Records (MARs) from September through December, 2014 were reviewed. The MARs indicated that from September 15, 2014, Depakote 500 mgs had

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F 329	Continued From page 32 been administered to Resident #30. The nurse ' s notes were reviewed. There were no notes as to why the Depakote was increased from 250 to 500 mgs. On 12/4/14 at 10:25 AM, Nurse #3 was interviewed. Nurse #3 stated that she could not find an order for the increase of Depakote from 250 mgs to 500 mgs. She further stated that Nurse #5 was the one who transcribed the Depakote 500 mgs to the MAR. On 12/4/14 at 11:30 AM, tried to contact Nurse #5 but was not available. On 12/4/14 at 2:55 PM, administrative staff #1 was interviewed. She stated that the nurse or the nurse practitioner should have written the order for the Depakote 500 mgs. Administrative staff #1 further stated that after the increase of the Depakote from 250 mgs to 500 mgs, the valproic acid level should have been checked.	F 329	1 Pneumonia Vaccine was ordered on 12.4.14, by the Director of Nursing. Vaccine into facility on 12.5.14. Residents #39, 29 and 49 were given the vaccine on 12-8-14.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	2. Everyone has potential to be affected. 100% chart audit: Resident name, date shot given. Weekend nursing supervisor performed 100% chart audit on all residents. 12.8.14 and vaccines began to be administered. All completed by 12/20/14. All residents who had requested pneumococcal were given. All residents' immunization reviewed-for those determined not to received pneumonia vaccine, consent form reviewed-those who were eligible for pneumonia vaccine were given.	

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F 334	Continued From page 33 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 334	3. Staff Development Coordinator-upon admission will speak with resident, discuss need for vaccine and given vaccination information and administer. Residents who refuse will be re-approached/re-educated quarterly. Director of Nursing continues to monitoring this. Admission log created and is being kept by Director of Nursing to ensure all vaccines are given in timely manner. This process will be ongoing. 4. QA # of people monthly who have received/declined x 3 months then quarterly until compliance occurs. Director of Nursing will take to QA meeting.	12/31/14

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F 334	Continued From page 34 the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to administer the pneumo coccal vaccine to 3 (Residents # 39, #28 & 49) of 5 sampled residents who consented to receive the vaccine. Findings included: The facility ' s policy and procedure on Pneumococcal vaccine dated December 2007 was reviewed. The policy read in part " all residents will be offered the pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infection (pneumonia). " The policy further stated " prior to or upon admission, residents will be assessed for eligibility to receive the pneumovax and when indicated will be offered the vaccination within 30 days of admission to the facility unless medically contraindicated or the resident had already been vaccinated. " 1. Resident #39 was admitted to the facility on 1/30/13 with multiple diagnoses including	F 334		

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F 334	Continued From page 35 Diabetes Mellitus. The current physician ' s orders (December, 2014) was reviewed. The orders for Resident #39 included " may have pneumonia vaccine every 5 years unless allergic with consent. " Review of the immunization record for Resident #39 revealed that she had not had pneumococcal vaccine in the past. On 9/5/14, there was a consent form signed by the responsible party allowing Resident #39 to receive the pneumococcal vaccine. As of 12/4/14, Resident #39 had not received the pneumococcal vaccine. On 12/4/14 at 11:25 AM, administrative staff #1 was interviewed. She stated that she was waiting for guidance from the pharmacy on how to give the pneumococcal vaccine. On 12/4/14 at 12:42 PM, the pharmacist was interviewed. The pharmacist stated that he remembered talking with administrative staff #1 but he forgot to get back with her. 2. Resident # 28 was admitted to the facility on 10/11/13 with multiple diagnoses including cerebro vascular accident (CVA). The current physician ' s orders (December, 2014) was reviewed. The orders for Resident #28 included " may have pneumonia vaccine every 5 years unless allergic with consent. " Review of the immunization record for Resident	F 334		

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F 334	Continued From page 36 #28 revealed that she had not had pneumococcal vaccine in the past. On 9/5/14, there was a consent form signed by Resident #28 to receive the pneumococcal vaccine. As of 12/4/14, Resident #28 had not received the pneumococcal vaccine. On 12/4/14 at 11:25 AM, administrative staff #1 was interviewed. She stated that she was waiting for guidance from the pharmacy on how to give the pneumococcal vaccine. On 12/4/14 at 12:42 PM, the pharmacist was interviewed. The pharmacist stated that he remembered talking with administrative staff #1 but he forgot to get back with her. 3. Resident # 49 was admitted to the facility on 5/27/14 with multiple diagnoses including diabetes mellitus. The current physician ' s orders (December, 2014) was reviewed. The orders for Resident #49 included " may have pneumonia vaccine every 5 years unless allergic with consent. " Review of the immunization record for Resident #49 revealed that she had not had pneumococcal vaccine in the past. On 9/5/14, there was a consent form signed by Resident #49 to receive the pneumococcal vaccine.	F 334		

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F 334	Continued From page 37 As of 12/4/14, Resident #49 had not received the pneumococcal vaccine. On 12/4/14 at 11:25 AM, administrative staff #1 was interviewed. She stated that she was waiting for guidance from the pharmacy on how to give the pneumococcal vaccine. On 12/4/14 at 12:42 PM, the pharmacist was interviewed. The pharmacist stated that he remembered talking with administrative staff #1 but he forgot to get back with her.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356	1. Daily nursing schedule hours/staffing are posted on hall bulletin board beginning 12/3/14. 2. Every resident can be affected by this deficient practice-by posting daily-problem is eliminated. 3. Documentation of posting will be documented on daily room rounds of Staff Development Coordinator. Human Resources and Director of Nursing are responsible for daily posting of nursing hours. Adjustments are being made daily by the DON, Staff Development Coordinator, weekend supervisor, and unit Nurses. 4. QA monthly x 3 then quarterly until compliance occurs. Director of Nursing will take to QA.	12/31/14

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F 356	Continued From page 38 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the nurse staffing information on a daily basis and to maintain the daily nurse staffing data for a minimum of 18 months. Findings included: On 12/1 at 11:30 AM and 5:35 PM and on 12/2/14 at 8:30 AM and 5:30 PM, tour of the facility was conducted. There was no nurse staffing information posted. On 12/4/14 at 8:05 AM, administrative staff members #3 and #4 were interviewed. They went around looking but they could not find it. Administrative staff #3 stated that administrative staff #5 was responsible for posting the nurse staffing information. On 12/4/14 at 8:08 AM, administrative staff #4 was interviewed. She acknowledged that the nurse staffing information was not posted on 12/1 and 12/2/14. She also stated that she was not keeping the daily nurse staffing data, she was throwing them away.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 39 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 record reviews, staff interviews and observations, the facility failed to contain exposed hair with a hair net for three of three kitchen staff (administrative staff #7, dietary staff #1 and dietary staff #2). The facility failed to label and date an opened bag of mozzarella cheese located in the reach in refrigerator and 2 heads of lettuce in an opened bag located in the walk in refrigerator observed in two of three kitchen refrigerators. The facility failed to monitor freezer temperatures in two of two resident nourishment refrigerators (Wing 1 and Wing 2) and failed to monitor refrigerator temperatures in one of two resident nourishment refrigerators (Wing 1). The findings included: #1. A review of the facility policy regarding personal appearance of the kitchen staff was conducted. The policy stated hair must be " kept restrained with a hair net or cap covering all hair. " An observation of facility staff working in the kitchen was made on 12/1/14 at 10: 50 AM.	F 371	1.All items not dated and labeled were disposed of. Beard-guards and hair nets were immediately put in place and ALL dietary staff were in-serviced on the proper way to conceal hair by the dietary district manager on 12-8-14. 2. All dietary staff members were in-serviced on dating and labeling and the proper way to store food by the district dietary manager on 12-8-14. All staff will be in-serviced on a weekly basis every month and with all new hires to ensure repetitive training on proper way to conceal hair. All staff with facial hair must always wear a beard guard to assure no facial hair falls into food. All hair including pony tails and bangs will be covered at all times while in the kitchen with proper hair restraints. A mirror was placed in the managers office on 12-8-14 so staff can easily check to assure all hair is covered. All staff not in compliance will receive a documented counseling. 3. Cooks will be required to complete the dating and labeling check list for the walk in cooler/freezer and reaching cooler after each shift. The dietary aides will be required to complete the dating and labeling check list of the nourishment room each shift. Each task must be initialed after each shift to assure ALL items are properly dated and labeled and discarded after 7 days. The manager will follow up to ensure the items are dated and labeled and sign on a daily basis.	

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F 371	Continued From page 40 Administrative Staff #7 was observed working in the kitchen without wearing a hair net. Dietary Staff #1 was observed to have a beard. Dietary Staff #1 was observed working in the kitchen without wearing a beard guard. Dietary Staff#2 was observed working in the kitchen with her ponytail not contained with a hair net. An interview was conducted with Administrative Staff #7 on 12/3/14 at 11:50 AM. She stated the staff was expected to cover all hair with hair nets before entering the kitchen. She also stated the staff was expected to cover beards with beard guards before entering the kitchen. She stated she had put on a hair net on 12/1/14 and it must have fallen off. An interview was conducted with Administrative Staff #3 on 12/4/14 at 11:40 AM. She stated the kitchen staff was expected to cover their hair with hair nets while working in the kitchen. #2. An observation was made on 12/3/14 at 8:45 AM of an opened bag of mozzarella cheese in the reach in refrigerator. The bag was not labeled with the date the bag was opened. An interview was conducted with the Administrative Staff #7 on 12/3/14 at 8:45 AM. She stated the undated bag of mozzarella cheese would be discarded. An observation was made on 12/3/14 at 8:53 AM of two heads of lettuce in an opened bag in the walk in refrigerator. The bag was not labeled with the date the bag was opened. An interview was conducted with the Administrative Staff #7 on 12/3/14 at 8:53 AM.	F 371	4. QA monthly x 3 then quarterly until compliance occurs. Administrator or DON will monitor for compliance. 1.Third shift nurses in-serviced about responsibility of maintaining refrigerator temp daily by the district dietary manager on 12-8-14. Temps were checked and were correct on both halls. Dietary district manager in-serviced the dietary staff on 12-8-14, and the dietary service manager is in-servicing staff weekly for 4weeks, then monthly for 12 months. 2. All residents have the potential to be affected by this practice. 11-7 shift nurse on each hall will be responsible for checking refrigerator and freezer temp nightly and adjust temp if required. 3. Refrigerator logs will be checked by unit managers daily and report results to stand up meeting daily until compliance occurs. Dietary district manager in-serviced the dietary staff on 12-8-14, and the dietary service manager is in-servicing staff weekly for 4weeks, then monthly for 12 months. 4. Temp logs will be brought to QA monthly by the dietary service manager from the previous month to ensure compliance is correct for 3 months then quarterly for 12 months. The administrator will ensure compliance through monitoring and weekly communication regarding any deficient practices.	12/31/14 12/31/14

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F 371	Continued From page 41 She stated the undated bag containing 2 heads of lettuce would be discarded. An interview was conducted with Administrative Staff #7 on 12/3/14 at 11:50 AM. She stated the kitchen staff was expected to label all opened containers of food with the date on which it was opened. #3. A notice stating " Nursing document fridge and freezer temps-notify maintenance if temps are not with within range " was observed on the door of the nourishment refrigerator on Wing 1 on 12/4/14 at 8:45 AM and on the door of the nourishment refrigerator on Wing 2 on 12/4/14 at 9:00 AM. An observation of Wing 2 resident nourishment freezer was made on 12/4/14 at 11:05 AM. Two containers of ice cream were observed in the freezer. An interview was conducted with Nurse #6 on 12/4/14 at 11:12 AM. She stated the residents routinely store ice cream in the nourishment freezer on Wing 1. An interview was conducted with Administrative Staff # 8 on 12/4/14 at 11:16 AM. He stated the temperature of the nourishment freezers on Wing 1 and Wing 2 were not monitored until December 2014. He stated the nursing staff was not expected to monitor the temperatures in the nourishment freezers until December 2014. #4. A notice which stated " Nursing document fridge and freezer temps-notify maintenance if temps are not with within range " was observed on the door of the nourishment refrigerator on Wing 1 on 12/4/14 at 8:45 AM.	F 371		

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F 371	Continued From page 42 An interview was conducted with Administrative Staff #1 on 12/4/14 at 1:20 PM. She stated the facility was unable to locate documentation of the monitoring of the temperatures of the nourishment refrigerator on Wing 1 for the month of November 2014.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, 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	F 431	1. All expired medications were removed and destroyed from the med carts, med-rooms and med refrigerator. 2. Everyone has potential to be affected by deficient practice. 3. Pharmacy will perform quarterly cart, med-room and refrigerator audits. Nursing administration will perform weekly audits x 4 weeks of carts/med-room/refrigerator. Unit nurses perform daily checks. Responsibility of floor nurse to be sure all expired meds are removed from cart. Audit tool created. 4. QA monthly x 3 then quarterly until compliance met. Director of Nursing will take to QA.	12/31/14

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F 431	Continued From page 43 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 and staff interviews, the facility failed to discard expired medications, failed to date opened Advair (steroid/ bronchodilator medication), Prostat (liquid protein supplement) and Procel powder (protein supplement) in four of four carts and Aplisol (tuberculin vaccine used for skin test in the diagnosis of tuberculosis) in one of one medication refrigerators (Unit 2). The findings included: 1. On 12/4/14 at 11:00AM, an observation of the medication cart on unit 2 (cart 2) was conducted. The following was observed: one opened/undated bottle of Prostat sugar free and one opened/undated can of Procel powder. Manufacturer's specifications for Prostat and Procel were reviewed. The directions on the bottle of Prostat stated "Discard three months after opening" . The instructions for the Procel powder stated "stable up to six months after opening" . On 12/4/14 at 11:00AM, Nurse #7 stated she was unaware that the Prostat and Procel should be dated when opened. On 12/4/14 at 11:30AM, Administrative staff #1 stated the nursing staff should follow the facility policy regarding dating/ discarding items and all	F 431		

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F 431	Continued From page 44 the items should have been dated when opened. 2. On 12/4/14 at 11:00AM, an observation of the medication cart on unit 2 (cart 2) was conducted. There was observed ½ bottle of calcium carbonate chewable antacid tablets 500 mg. (milligrams) in the medication cart. The expiration date was 10/14. On 12/4/14 at 11:00 AM, Nurse #7 stated the medication should have been discarded. On 12/4/14 at 11:30AM, Administrative staff stated she expected nursing staff to discard expired medication by the expiration date. 3. On 12/4/14 at 11:14AM, an observation of the medication refrigerator on unit 2 was conducted and revealed one opened/ undated vial of Aplisol. The manufacturer's product information was reviewed and indicated opened vials should be discarded after thirty (30) days. On 12/4/14 at 11:30AM, Administrative staff#1 stated the nursing staff should follow the facility policy regarding dating/ discarding items. All opened items should be dated when opened. 4. On 12/4/14 at 11:20AM, an observation of the medication cart on unit 2 (cart 1) was observed. The following items were noted: one Advair discus opened and undated (one dosage left in discus), one opened can of Procel powder dated 10/8/13 and one opened/ undated bottle of Prostat. Manufacturer's specifications for Prostat and Procel were reviewed. The directions on the	F 431		

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F 431	Continued From page 45 bottle of Prostat stated "Discard three months after opening" . The instructions for the Procel powder stated "stable up to six months after opening" . Manufacturer's insert for Advair Diskus read, in part, "Safely discard ADVAIR DISKUS 1 month after you remove it from the foil pouch, or after the dose indicator reads "0", whichever comes first. Take ADVAIR DISKUS out of the box and foil pouch. Write the "Pouch opened" and "Use by" dates on the label on top of the Diskus. The "use by" date is 1 month from date of opening the pouch." On 12/4/14 at 11:20AM, Nurse #8 stated she knew the Prostat and procel powder should have been dated as they had been instructed to date everything when it was opened and she knew the Advair should have been dated. On 12/4/14 at 11:30AM, Administrative staff #1 stated the nursing staff should follow the facility policy regarding dating/ discarding items. All opened items should be dated when opened. All medications expired should have been discarded. 5. On 12/4/14 at 11 AM observation of 100 Hall Cart 2 was conducted. An opened Advail discus with 2 doses of Advair used was observed. Interview with Nurse #9 at this time revealed that be was aware the Advair was to be dated when it was opened and stated that the opened Advair discus should have had a date on it but did not. Nurse #8 was uncertain how long the Advair could be used after it was opened before it needed to be discarded. 6. On 12/4/14 at 11:15 AM observation of 100	F 431		

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F 431	Continued From page 46 hall Cart 1 was conducted. On opened and undated bottle of Prostat was observed. At this time Nurse #10 stated the Prostat should have been dated when opened. She said she thought that it was recently put in 100 hall Cart #1 when a resident was moved from 200 hall to 100 hall and she had not yet noticed that it had been undated when opened. Nurse #10 stated she would discard the Prostat and open and date a new bottle. She was aware Prostat needed to be discare 90 days after opening.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview the facility failed to, sanitize bathrooms, dispose of trash in resident rooms, repair toilets and sheetrock damage on one of two halls (100 hall). The findings included: On 12/1/14 the following observations were made: 3:08 PM - At the sink in the room (the sinks were in the resident rooms not in the bathrooms attached to the resident rooms) there was a soiled washcloth with brown material on the washcloth. 3:23 PM - Room 120 C - the floors were dirty near the walls and there were scraped and digs	F 465	1. The Housekeeping Manager was immediately replaced. Room 101/102 shared bathroom: The observed plunger was removed and taken to the appropriate location. A result of using the proper cleaning method will provide sanitation. Room 104: The slipper pan was removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The black smudge on the floor was cleaned that day. Room 106 toilet room: The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall.	

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F 465	Continued From page 47 on the wall on the right side of the bed. In the bathroom, a wet yellow substance was noted at the base of the commode on the left side and the urinal was lying at the back of the commode on the floor and the bathroom had a urine odor. 3:45 PM - Room 121 B had a dirty washcloth on floor beside commode in bathroom. On 12/2/14 the following observations were made: 11:07 AM - Room 104 A, B and C - the walls appeared dirty in areas, there was baseboard that had separated from the wall, there was a chipped ceiling tile and a black smudge on the floor and the cover was coming off the air conditioning unit. In the bathroom the wall had a rough unfinished area and the heat light/exhaust fan did not work. 11:18 AM -Room 120 C - The bathroom continued to have what appeared to be urine at the base of the commode and a urinal lying on the floor at the back of the commode. 1:10 PM - The toilet in room 119 was loose and moved when pressure was applied and there was an unlabeled uncovered slipper pan on the floor. The bathroom had a urine odor and floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish hazy over the floor. Resident # 121 was in room 119 at the time of this observation. Interview with Resident #121 at this time revealed that she used the toilet in the bathroom of this room and when she sat on it the toilet would wobble from side to side. She also stated that there was urine in the slipper pan that had not been emptied in several days.	F 465	Room 107: The urinal that was ¼ full of urine was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. Any soiled washcloths were removed and placed into the dirty laundry. The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 108/109 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 112/113 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 114/115 shared toilet room: The unlabeled urine catch basin and the slipper pan were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 116 toilet room: The unlabeled pieces of personal care equipment were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The discarded tissues were thrown into the trash. The toilet room floor was cleaned to provide sanitation.	

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F 465	Continued From page 48 2:24 PM - The floors in the bathroom of room 107 appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor, and the bathroom had a urine odor. 3:48 PM - Room 116 ' s bathroom had a bathtub with an unlabeled and uncovered bed pan, slipper pan and wash basin in it. On top of the personal care equipment were discarded used tissues, some of them had rusty brown matter on them. The discarded tissues were piled loosely about up about 6 - 12 inches high by approximately 18 inches wide. The toiled has rust colored stains near the base of the tank. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Resident #46 was in room 116 at the time of this observation. During interview with Resident #46 at this time she stated that the Housekeeping Aid did not clean her bathroom. Resident #46 said the Aid would only look inside the bathroom and then leave without cleaning it. She added that the tissues had been in the tub for at least 6 days as her previous roommate had put them there and was discharged about 6 days ago. On 12/2/14 from 5:15 - 6 PM each resident bathroom on 100 hall was observed with the Administrative Staff #3, Administrative Staff #1, Housekeeping Manager, Maintenance Director, and Administrative Staff #8. The following observations were made: Room 123 ' s bathroom had towels on the floor with yellowish stains on them. The floors appeared dirty with a tobacco brown color around	F 465	Room 118 toilet room: The basin that was on the toilet room floor was removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation. Room 119: The slipper pan and urine measuring cup were removed from the toilet room. The toilet room floor was cleaned to provide sanitation. Room 120: The urinal that was full of urine at the bedside was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. The soiled washcloth that was on the vanity has been were removed and placed into the dirty laundry. Room 120 toilet room: The unlabeled urinal was removed. The toilet room floor was cleaned to provide sanitation. Room 121/122 shared toilet room: The observed plunger was removed and taken to the appropriate location in the housekeeping janitor closet. The toilet room floor was cleaned to provide sanitation. Room 123 toilet room: The towels were removed and taken to the laundry room as dirty laundry. The basin and urine measuring cup were both removed. The toilet room floor was cleaned to provide sanitation.	

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F 465	Continued From page 49 the perimeter of the room and toilet and a greyish haze over the floor. The shared bathroom for room 121 and 122 had 4 holes in the wall up to approximately 2 inches in diameter. There was a plunger on the floor and the floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 120 ' s bathroom had an unlabeled urinal on the floor behind the toilet and the room had a urine odor which the Administrative Staff #3 acknowledged. The floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 119 ' s toilet was loose and shook side to side when it was pushed against moderately and there was a wet wash cloth on the back of the toilet. There was a slight odor of urine in the room which Administrative Staff #3 acknowledged. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 118 ' s bathroom floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 116 ' s bathroom had a bathtub with an unlabeled and uncovered bed pan, slipper pan and wash basin in it. On top of the personal care equipment were discarded used tissues, some of them had rusty brown matter on them. The discarded tissues were piled loosely about up about 6 - 12 inches high by approximately 18 inches wide. The toiled had rust colored stains near the base of the tank. The floor appeared	F 465	Room 123: The floor in the room was cleaned, the corners and edges were specifically cleaned with a HSG-created stripping solution and then scraped to remove all wax/dirt residue. The Maintenance Department repaired all rooms that were in need of repair. Additionally, the Maintenance department installed one hook per licensed bed in the room behind the toilet in the toilet room of each resident so that the labeled, re-useable hygiene supplies (ie: basin, emesis bowl, etc.) could be stored in a bag and hung on the hooks behind the toilet. All hooks were installed on 12-26-14. Room 104: The baseboard was reattached to the wall and the cover was reattached to the A/C unit. The bathroom exhaust fan motor was replaced by the maintenance department. The maintenance department repaired the hole in the toilet room wall and painted the repair with the appropriate color of paint. Room 106 toilet room: The maintenance department used an outside plumbing vendor and replaced the flange of the toilet, thereby securing it more firmly to the floor. Room 110/111 shared toilet room: The wall that needed the repair patch to be painted by the maintenance department. Room 112/113 shared toilet room: The rubber baseboards were replaced by the maintenance department.	

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F 465	Continued From page 50 dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for rooms 114 and 115 there was a bed pan on the floor with a slipper pan on top of it and a urine catch basin inside the slipper pan. There were yellowish stains visible on the slipper pan and urine catch basin. Tissue and other debris was inside the urine catch basin. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for room 112 and 113 the rubber baseboards were coming away from the wall. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shard bathroom for rooms 110 and 111 had a repair patch on the wall that had not been sanded or painted yet. The floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. In the shared bathroom for rooms 108 and 109 the floor appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 107 ' s the floors appeared dirty with a tobacco brown color around the perimeter of the room and toilet and a greyish haze over the floor. Room 106 ' s bathroom had a bed pan and a slipper pan on the floor that was unlabeled and uncovered and the toilet was slightly unstable.	F 465	Room 119: The maintenance department used an outside plumbing vendor and replaced the flange of the toilet, thereby securing it more firmly to the floor. Room 121/122 shared toilet room: The maintenance department repaired the hole in the toilet room wall and painted the repair with the appropriate color of paint. The nursing department in-serviced staff regarding the following areas: a. Infection control b. Use of bags to store labelled personal hygiene items. The Staff Development Coordinator (SDC) in-serviced all nursing staff including PRN and weekend staff) as of 12-05-14 and will in-service nursing new staff upon hire. Room 104: The resident belongings that were crowding the bed 104B have been placed into different locations, thereby creating room to walk around the bed safely. 2. This deficient practice potentially affected all residents of LibertyWood Nursing Center. The Housekeeping Department made thorough inspections and cleaned the toilets, floors and the walls of all the resident toilet rooms on both units 100 and 200. The resident rooms are on a waxing schedule so that each resident room is stripped and waxed annually. Each resident room can be stripped and waxed additionally if there is a specific need.	

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F 465	Continued From page 51 Room 105 ' s bathroom had an odor of urine which Administrative Staff #3 noted as well. The floors appeared clean and had recently been stripped according to Administrative Staff #3. Room 104 ' s bathroom had a repair patch on the wall that had not yet been sanded or painted. The shared bathroom for rooms 101 and 102 had a plunger on the floor. Administrative Staff #1 was interviewed at this time and indicated that she was surprised at the dirty condition of the bathrooms and stated that this was unacceptable and that bathrooms should be clean and in good repair. She also stated that the facility did not provide garbage cans in resident bathrooms but that she thought that policy should be reconsidered. The Director of Nursing also said that personal care equipment was supposed to be clean, labeled with the resident ' s name, stored in a plastic bag and off the floor. She acknowledged that tying the bag containing personal care equipment to the safety grab bar was not an acceptable means of storing personal care equipment The Maintenance Director was interviewed at this time and stated that he had been unaware of the maintenance issues in many of the bathrooms as they had not been reported to him. He added that he was in the process of working on some of the maintenance issues. He stated that environmental rounds were done at the facility but that it was the Housekeeping Managers responsibility to monitor the bathrooms. The Housekeeping Manager was interviewed at	F 465	All housekeeping staff was in-serviced by the housekeeping supervisor on 12-16-14 on proper cleaning methods in resident rooms and toilet rooms. A result of using the proper cleaning method will create an odor-free environment. Hooks will be placed in each resident toilet room behind the toilet for the purpose of hanging each resident's labelled personal care equipment which is placed in a bag on the hook. All loose baseboards and areas needing repair were repaired and replaced by the maintenance department. The repairs that were noted in the primary audit were completed on 12-30-2014. All toilet room exhaust fans were checked for proper functioning. All broken exhaust fans were noted and ordered to be replaced by the maintenance department when the ordered exhaust fans come in. All resident toilet rooms were audited for any unnecessary housekeeping equipment such as loose plungers and any unnecessary housekeeping equipment located was relocated. All toilets were audited for looseness and were repaired or tightened, if necessary. All the walls of resident rooms and walls of resident toilet rooms were audited and have been repaired or are in the process of repair.	

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F 465	Continued From page 52 this time and stated that she was responsible for checking the bathrooms daily but that she had been unaware of their current condition or the trash that had not been disposed of properly. She said that she had not checked the rooms yet this week. On 12/2/14 at 6:05 PM Administrative Staff #3 was interviewed and stated that she had been unaware of the poor condition of the resident bathrooms as it was the Housekeeping Manager's responsibility to ensure they were clean and sanitary. She added that their current condition was unacceptable. Administrative Staff #3 indicated that she had concerns about the housekeeping at the facility and had been monitoring it, and had been pushing for the bathroom floors to be stripped and waxed, since she started at the facility two months ago. She stated that the stripping and waxing of the floors started in late November and so far they had completed 4 bathrooms (101/102 (shared), 103 which was not a resident bathroom 104 and 105). She also indicated that she had been focused on many other issues that needed to be addressed at the facility but acknowledged that current the condition of the resident bathrooms, that she just observed was not homelike and could have implications for infection control. Housekeeping Aide #1 (HA #1) was interviewed on 12/3/14 at 9:10 AM with the Housekeeping Manager present. She stated that she had cleaned the rooms and bathrooms on 100 hall on 12/1/14 and 12/2/14 and that 100 hall was her typical assignment. She also acknowledged that it was housekeeping's responsibility to properly dispose of trash, remove rust stains, clean the	F 465	All ceilings were audited for broken tiles and replaced as necessary, All resident rooms were checked for adequate walking space to move around the bed for resident care. Those residents refusing to have their personal belongings relocated will be care-planned for compliance and re-visited quarterly. Room 101/102 shared bathroom: The observed plunger was removed and taken to the appropriate location. Room 104: Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation. Room 106 toilet room: The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 107: The urinal that was ¼ full of urine was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. Any soiled washcloths were removed and placed into the dirty laundry. The bed pan and wash basin were removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation.	

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F 465	Continued From page 53 floors and that if she noticed any maintenance issues she typically reported them to the Maintenance Director verbally and did not use the written Maintenance Request. She stated that on 12/1/14 and 12/2/14 she did not notice any trash in room 116, or any other resident bathroom on hall 100, did not notice any holes in the walls, the wobbly toilet in room 119 or any other loose toilets or toilets with rust stains, and did not notice any odors or unemptied urinals. She said that she did clean the floors and acknowledged that they " did not look so fresh " but said she thought that was because they needed to be waxed and stripped. HA #1 stated that she deep cleaned 1 room a day and that on 12/2/14 she deep cleaned the bathroom for rooms 121/122. When asked how long she left the cleaning solution used by the facility on a surface before wiping it off she stated that she wiped if off immediately. At this time the Housekeeping Manager stated that the solution used at the facility was to remain on a surface for 1 minute before being wiped off in order to sanitize the surface. The House Keeping Manager stated she was unaware that HA #1 did not know this and was not doing it. The label of the cleaning product was reviewed at this time and indicated the product was to stay wet on a surface for 1 minute. Administrative Staff #1 was interviewed on 12/3/14 at 10:22 AM and stated that it was Nursing ' s responsibility to empty and properly clean out urinals and bed bans prior to storing them in a plastic bag off the floor and that this would aide in eliminating the urine odors from resident bathrooms. She said that she had been unaware of the condition of the resident bathrooms on 100 hall because it was the Housekeeping Managers responsibility to check	F 465	Room 108/109 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 112/113 shared toilet room: The toilet room floor was cleaned to provide sanitation. Room 114/115 shared toilet room: The unlabeled urine catch basin and the slipper pan were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. Room 116 toilet room: The unlabeled pieces of personal care equipment were discarded and replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The discarded tissues were thrown into the trash. The toilet room floor was cleaned to provide sanitation. Room 118 toilet room: The basin that was on the toilet room floor was removed. Replacement pieces of personal care equipment will be labelled with the resident's name and hung in a bag on a hook at the back toilet wall. The toilet room floor was cleaned to provide sanitation. Room 119: The slipper pan and urine measuring cup were removed from the toilet room. The toilet room floor was cleaned to provide sanitation.	

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F 465	Continued From page 54 the bathrooms and acknowledged they had not looked clean or sanitary. When asked she stated that while she did not know for sure she believed that walls with sheetrock repairs that had not been painted over yet could not be effectively sanitized. HA #2 was interviewed on 12/3/14 at 11:30 AM. She stated that she had just finished cleaning the bathroom for rooms 121 and 122 and she was surprised how dirty it was since it was supposed to have been deep cleaned the day before. The bathroom for rooms 121/122 was observed at this time and the floor no longer had a greyish residue and the tobacco colored stain that had been around the perimeter of the room and the toilet was gone. The floor and toilet appeared clean and the room smelled clean. HA #2 confirmed that the floor had not been stripped and waxed, just cleaned. On 12/4/14 at 9 AM the Housekeeping Contract Agency District Manager was interviewed. She stated indicated that the cleanliness of the bathrooms did not meet expectations but that she had not previously identified this, although she had looked in some of the bathrooms on 12/1/14. She said that there was a half time Housekeeping Aid position at the facility that she had been unable to fill permanently and that it was currently open but the Housekeeping Manager was supposed to do complete the tasks that were not getting done due to unavailability of staff . The District Manager said that the floors would be in better condition if they were stripped and waxed but that this had just been started recently and required that she bring in extra staff to complete the task. She acknowledged that the current staffing schedule did not accommodate stripping	F 465	Room 120: The urinal that was full of urine at the bedside was emptied and cleaned. It was then labelled with the resident's name and placed into a bag. It was then hung on a hook in the toilet room. The soiled washcloth that was on the vanity has been were removed and placed into the dirty laundry. Room 120 toilet room: The unlabeled urinal was removed. The toilet room floor was cleaned to provide sanitation. Room 121/122 shared toilet room: The observed plunger was removed and taken to the appropriate location. The toilet room floor was cleaned to provide sanitation. Room 123 toilet room: The towels were removed and taken to the laundry room as dirty laundry. The basin and urine measuring cup were both removed. The toilet room floor was cleaned to provide sanitation. Room 123: The floor in the room was cleaned, the corners and edges were specifically cleaned with a HSG-created stripping solution and then scraped to remove all wax/dirt residue. The room floor was cleaned to provide sanitation.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 55 and waxing the entire facility once yearly. She was unaware that Housekeeping Aide #1 did not know that the cleaning solution they used must stay wet on a surface before being wiped off in order to sanitize the surface being cleaned. She stated that the House Keeping Manager was responsible for ensuring staff were aware of this and were doing it. On 12/4/14 at 10:30 AM the Maintenance Director was interviewed. He acknoledged that there were walls, baseboards toilets and other items in resident rooms that required repair and indicated that he and another maintenance staff member were busily in the midst of these repairs. He stated that a number of the items had not yet been brought to his attention but also said that they had gotten behine when they had to do alot of work on the sprinkler system.	F 465	The use of walking rounds by department heads is used to monitor the corrective actions (noted above) taken by various departments and those department heads will report any negative findings to the administrator daily in the morning stand-up meeting. Any corrective action deemed necessary will be brought to the attention of the administrator who will have the appropriate department head resolve the noted issue. 3. A maintenance log is available for facility employees to inform the maintenance department of any necessary corrective action. The logs are available on both units 100 & 200 so the maintenance department can correct any issues found. The maintenance logs will be brought daily to the morning stand-up meeting. 4.The Quality Assurance (QA) committee will monitor the effectiveness of the walking rounds and the consistency of the infection control program that has been put into place. The administrator or the director of nurses will review the round sheets for any discrepancies and take the appropriate actions to correct the noted discrepancies. These discrepancies and corrective actions will be monitored monthly for three months, then quarterly until compliance is attained.	12/31/14
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require			

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F 520	Continued From page 56 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's Quality Assessment and Assurance Committee failed to ensure that action plans developed for the 1/10/14 and 9/13/12 recertification surveys were implemented, monitored and revised as needed to ensure compliance was achieved and sustained. The facility had a pattern of repeat deficiency in development of care plans (F279) and treatment and services for range of motion (F318) on 12/4/14, 1/10/14 and 9/13/12 surveys. The facility had also repeat deficiencies on proper labeling of drugs and biological (F431), housekeeping and maintenance services (F253), accommodation of needs (F246) and kitchen sanitation (F371) on 12/4/14 and 1/10/14 recertification surveys. Findings included: This tag is cross referred to: 1. F279 - Development of care plans: Based on record review and staff interview, the facility failed to develop a care plan for contracture management for 2 (Residents # 41 & 16) of 3 sampled residents with contractures and failed to develop a care plan for pressure ulcers for 2 (Residents # 16 &81) of 3 sampled residents with	F 520	1.The Quality Assurance (QA) meeting was held on December 9, 2014 and did meet the criteria that a QA meeting be held quarterly. 2.This alleged practice could affect all residents at Liberty Wood Nursing Center. 3.The QA meeting is now scheduled to be held monthly, with an open invitation to both the medical director and the pharmacy consultant, who are required to attend quarterly. Department heads bring various issues to the QA meeting with the solutions that have resolved the issue. Attendance is taken at each QA meeting and the meeting minutes are also recorded at pertaining to each meeting. 4. The administrator is responsible for monitoring the issues that the department heads have brought to the administrator and the dissemination of information to the parties involved in the meeting for the success of the QA meeting. All areas that have been identified as deficient will be reviewed for compliance at the initial meeting and then for two meetings thereafter. The administrator will monitor those systems for compliance. If compliance is found by the third meeting, the issue will be considered resolved.	12/31/14

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F 520	Continued From page 57 pressure ulcer. During the recertification surveys 1/10/14 and 9/13/12, the facility was cited F279 for failing to develop a care plan. 2. F318 - Treatment and services for range of motion: Based on record review, observation and staff interview, the facility failed to apply the carrot splint as ordered/care planned for 2 (Residents# 6 & 41) of 3 sampled residents with contracture. During the recertification surveys 1/10/14 and 9/13/12, the facility was cited F318 for failing to provide contracture management to residents with contracture. 3. F431 - Proper labeling of drugs and biological: Based on observation and staff interviews, the facility failed to discard expired medications, failed to date opened Advair (steroid/ bronchodilator medication), Prostat (liquid protein supplement) and Procel powder (protein supplement) in four of four carts and Aplisol (tuberculin vaccine used for skin test in the diagnosis of tuberculosis) in one of one medication refrigerators (Unit 2). During the recertification survey 1/10/14, the facility was cited F431 for failing to store medications at proper temperature. 4. F253 - Housekeeping and maintenance services: Based on observation and staff interview the facility failed to keep resident	F 520		

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F 520	Continued From page 58 personal care equipment such as bed pans and basins clean and properly stored on 1 of 2 halls (100 hall), failed to maintain an odor free environment and empty urinals and a slipper pan on 1 of 2 halls (100 hall), failed to clean floors in resident rooms and bathrooms and to properly dispose of trash in resident bathrooms on 1 of 2 halls (100 hall), and failed to ensure walls in resident rooms and bathrooms and toilets in resident bathrooms were in good repair on 1 of 2 halls. During the recertification survey 1/10/14, the facility was cited F253 for failing to ensure residents ' room/bathrooms were clean and in good repair. 5. F246 - Accommodation of needs: Based on record review, observation and staff interview, the facility failed to provide assistive device for long locomotion for 1 (Resident #46) of 3 sampled residents. During the recertification survey 1/10/14, the facility was cited F246 for failing to provide resident ' s accommodation of needs. 6. F371 - Kitchen sanitation: Based on record reviews, staff interviews and observations, the facility failed to contain exposed hair with a hair net for three of three kitchen staff (administrative staff #7, dietary staff #1 and dietary staff #2). The facility failed to label and date an opened bag of mozzarella cheese located in the reach in refrigerator and 2 heads of lettuce in an opened bag located in the walk in refrigerator observed in two of three kitchen refrigerators. The facility failed to monitor freezer temperatures in two of	F 520		

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F 520	Continued From page 59 two resident nourishment refrigerators (Wing 1 and Wing 2) and failed to monitor refrigerator temperatures in one of two resident nourishment refrigerators (Wing 1). During the recertification survey 1/10/14, the facility was cited F371 for failing to maintain a sanitary condition in the kitchen. On 12/4/14 at 3:50 PM, administrative staff #2 was interviewed. She stated that she was just at the facility for three months as an administrator and didn't know what happened to the previous administration. She was aware of the housekeeping issues and she had been monitoring it for the past three months. Her nursing managers were new and didn't think that previous deficiencies had been monitored.	F 520		

F0253 Continued: Room 123: The floor in the room was cleaned, the corners and edges were specifically cleaned with a HSG-created stripping solution and then scraped to remove all wax/dirt residue. The room floor was cleaned to provide sanitation.
3. The use of walking rounds by department heads is used to monitor the corrective actions (noted above) taken by various departments and those department heads will report any negative findings to the administrator daily in the morning stand-up meeting. Any corrective action deemed necessary will be brought to the attention of the administrator who will have the appropriate department head resolve the noted issue.
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4. The Quality Assurance (QA) committee will monitor the effectiveness of the walking rounds and the consistency of the infection control program that has been put into place. The administrator or the director of nurses will review the round sheets for any discrepancies and take the appropriate actions to correct the noted discrepancies. These discrepancies and corrective actions will be monitored monthly for three months, then quarterly until compliance is attained.