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	345291	A. BUILDING _____ B. WING _____	03/27/2014

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to provide medical justification for the use of a pommel cushion for 1 of 1 sampled resident with restraints (Resident #160). The findings included: Resident #160 admitted to the facility on 6/17/13. The diagnoses included alzheimer ' s dementia, osteoporosis and history of hip fracture. The quarterly Minimum Data Set (MDS) dated 1/3/14, indicated that Resident #160 had severe memory and decision making problems. She required assistance with all activities of daily living. Review of the care plan dated 6/28/13, identified the problem as: resident was at risk for falls characterized by the history of hip fracture and poor safety awareness. The goal included resident would not have any serious injuries related to falls. The approaches included referral to rehabilitation therapy, provision of divisional activities, bed/chair alarm, offer snacks to assist with diversion and use the fall decision tree to determine least restrictive device. Review of the physician ' s order dated 1/2/14, revealed the pommel cushion when out of bed	F 221	F221 1 Resident 160 is now free of any type of device that could be considered a restraint. Resident 160 was felt to be in a seating situation that would prevent falls and aid with positioning. The restraining of the resident was never the intent of the facility. Protection of the resident was the intended focus. 2 The facility has considered itself to be restraint free for over a year. Also alarms are no longer used. Any resident that is admitted to the facility that is at risk for falls will be considered to be our at risk population. The DON, ADON or designee will be responsible for assessment of any at risk residents. Each week any resident that has a restraint will be reviewed at the falls committee for any possibility of discontinuation of the restraint. The DON institutes a pre-restraint assessment prior to anyone being restrained. If the resident is shown to be an at risk resident, they will be referred to the falls committee in an effort to make them safe from falls. The falls committee will consist of the DON, ADON, MDS nurses, and Therapy. At this meeting, their assessment will be	4/24/14

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

Electronically Signed | 04/18/2014

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 221	Continued From page 1 and there was no medical justification for the use of the cushion. During a meal observation on 3/24/14 at 12:30PM, Resident #160 was in room alone seated geri-chair with leg rest extended backward and pommel cushion in place. Resident #160 attempting to reach for cushion to pull from underneath her and reaching all over the place trying to get up, arms and legs swinging over the side of chair as she attempted to get up. During an observation on 3/24/14 at 2:49PM, Resident #160 was in an activity seated in a geri-chair with a pommel cushion with her feet hanging over the side of the chair. The geri-chair was pulled back as well as the leg rest in an extended manner in which the resident ' s feet could not touch the floor. Resident #160 was attempting to get out of the chair with arms and legs swinging all over the place. Staff continuously told the resident to sit down or sit back. There was no attempt to determine Resident #160 ' s reason or need to get up from the chair. During an observation on 3/26/14 at 8:30AM, Resident #160 was seated in the lounge area outside of the nursing station attempting to climb out of the geri-chair that was extended all the way back to the third level with the leg rest and pommel cushion in place. Resident #160 was trying to scoot forward over the pommel cushion trying get to the front of the chair. Resident #160 continued to push forward until her feet reached the floor. There was no staff present and the resident sat without difficulty. During an observation on 3/26/14 at 10:10AM,	F 221	discussed and restraint free solutions will be decided upon and attempted to solve the problems that the resident may have. Any restrictive devices utilized for positioning and seating will be evaluated by therapy. If the device is determined to be a restraint a medical justification for this device will be noted and discussed with the resident□s physician and family. Inhouse residents that have a falls risk will be reassessed quarterly, by the administrative nurses (DON, ADON, Staff Developer, Restorative Nurse, and the RN Supervisor for appropriate interventions for their safety and lack of restraint. Any restrictive devices utilized for positioning and seating will be evaluated by therapy. The results of the assessments will be brought to the quality assurance committee monthly for 3 months for the first 3 months and then will be reviewed quarterly thereafter for a period of 1 year. 3 An audit of residents with restrictive devices will be completed for by the DON, ADON or Designee monthly. The DON and ADON are responsible for the monitoring and reduction of restraints. 4 Completion date is 4/24/14.	

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Resident #160 was in the activity room with geri-chair pulled back with leg rest extended and the pommel cushion in place. Resident #160 ' s feet were unable to touch the floor, but she continued her attempts to scoot to the front of the chair over the pommel cushion or throw her legs over the side of the chair. Resident#160 was removed from the activity and placed at the nursing station, however, the chair remained in the extended position and the resident continued to attempt to get out of chair.

During an interview on 3/26/14 at 10:12AM, the Activity Director indicated that Resident #160 was never taken out of the chair during any activity, meals or etc. The activity director indicated that on occasion she had to pull Resident #160 ' s chair back and extra level to make sure that she did not get out of the chair. She added that Resident#160 was generally watched very closely by the nursing staff at the nurse's station because she continued to attempt to get up. The pommel cushion was used for Resident#160 safety and to prevent her from getting up and falling.

During an observation on 3/26/14 at 10:32AM, Resident #160 sitting in the area outside of nursing station attempting to climb over the pommel cushion and the chair with the leg rest and the chair extended backward.

During an interview on 3/26/14 at 10:33AM, NA #1 indicated the pommel cushion was in place to prevent Resident #160 from sliding out of the chair and safety. The pommel cushion has not stopped her from sliding out of the chair. Resident #160 was placed at the nursing station so that she could watch the resident closer. NA#1 added that if nursing assistants were in other

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F 221	Continued From page 3 rooms the nursing staff would be the one watching the resident. During an observation on 3/26/14 at 11:15AM to 11:31AM, Resident #160 was seated in lounge area at nursing station alone with cup of juice in hand calmly with the geri-chair/leg rest extended backward and pommel cushion in place. The charge nurse who had been in and out of the area providing medications to other residents came in the area briefly and later went into another resident ' s room at 11:40AM. Resident #160 was left again while the charge nurse provided assistance to another resident. Multiple staff passed the area, however there was no other assigned staff with Resident #160 while the charge nurse assisted another resident. During an interview on 3/26/14 at 11:40AM, Nurse #1 indicated the pommel cushion in Resident #160 geri-chair was for safety and to prevent the resident from falling. The nurse added that the geri-chair/leg rest should not be extended back while the resident was sitting in the chair and her leg rest should be down so that her feet reached the floor. She confirmed that when the chair/leg rest were extended backward the resident feet did not touch the floor which meant the resident would need to scoot forward to reach the floor. She added that the extension of the chair and the pommel cushion would be considered a restraint. During an interview on 3/26/14 3:01PM, the physical therapy director indicated that the pommel cushion was use for resident safety and to prevent Resident #160 from getting up and falling. The therapy director further stated that Resident #160 did not have any positioning concerns since last evaluation done on 7/13/13.	F 221		

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F 221	Continued From page 4 He added that Resident #160 had not been evaluated for the use of the pommel cushion. In addition, there was no medical justification for the use of the pommel cushion. During an interview on 3/26/14 at 4:18PM, Nurse#2 indicated the pommel cushion was in place for positioning, safety and prevention of falls. Nurse# 2 further stated that Resident #160 had not been referred to the restorative program for positioning/ambulation. The pommel cushion was for in relation to the resident movements and sliding downward in the chair. Nurse #2 added that she was unaware of Resident #160 being assessed for the pommel cushion and/or any referrals from therapy for restorative services. Nurse: #2 indicated there was no medical justification for the use of the pommel cushion. During an interview on 3/26/14 on 4:33PM, Nurse#3 indicated that she did not know why or how long Resident #160 had the pommel cushion in place, so she wrote the physician order as a pressure reduction device. She further stated that she was unaware of whether a referral/assessment had been done by the therapy department for the use of the pommel cushion. She indicated that if the geri-chair was in a reclined position and the pommel cushion was in place it was considered a restraint. During an interview on 3/26/14 at 5:00PM, NA#2 indicated that Resident #160 had the blue cushion between her legs for a long time and it was to prevent the resident from falling and safety. She indicated that staff would not directly sit with the resident but would keep a check on the resident because she liked to slide forward and try to get out of chair.	F 221		

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F 221	Continued From page 5 During an interview on 3/26/14 at 5:21PM, the director of nursing(DON) indicated that she was uncertain why the pommel cushion was in place. She indicated that before a device was implemented there should be an evaluation and medical justification for the use of the device per the restraint policy. The DON further stated if the geri-chair was in a reclined position with a pommel cushion in place it was considered a restraint. The DON confirmed that there was no evaluation/assessment or medical justification for the use of the pommel cushion. During an interview 3/27/14 at 3:10PM, the Administrator indicated that therapy should complete an evaluation/assessment and discuss with the physician the medical reason for the device prior to the implementation of any potential restraint or device.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		4/24/14

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F 225	Continued From page 6 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and telephone interviews, the facility failed to submit the 24 hour initial report for 1 of 3 residents who experienced an incident involving alleged abuse to the Health Care Personnel Registry (HCPR) (Resident#45). Findings included: Resident #45 was admitted in the facility on 09/09/2011 with diagnoses that included gout, end-stage renal disease, muscle weakness dysphagia, and subdural hematoma. The most recent minimum data set (MDS) completed on 01/06/14 specified that the resident ' s cognition was not impaired.	F 225	F225 1 Resident 45 showed no evidence of injury from his alleged abuse. Resident 45 has a history of being accusatory of staff handling him roughly, however all investigations have not been substantiated. 2 The administrator of the facility faxed the 24 hour report to the NC Health Care Personnel Registry as required within the 24 hour time frame. There was notation stamped on the document that stated Faxed and the date it was faxed to the registry. The facility has completed these	

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F 225	Continued From page 7 A review of the 24-hour initial report submitted to the healthcare personnel registry (HCPR) by the facility administrator signed and dated 3/21/14 revealed an allegation of resident abuse. The administrator ' s investigation statement read, in part, " resident states that CNA slammed him into the wall while turning him for care and that CNA had a bad attitude. " The facility social worker had received via telephone from the dialysis social worker, an allegation of resident abuse incident report dated 3/20/2014. The attached statement documented that the resident told the nurse at dialysis that an aide slammed him into the wall. A review of the 24-hour initial report signed and dated 3/21/14 read in part " Certified nursing assistant turn him over roughly into wall. No physical injury, pt [patient] was upset at dialysis. " During an interview with resident #45 on 3/25/14 at 8:19 am, the resident reported that the aide had been rough and slammed him into the wall while turning him for care and that the aide had a bad attitude. The resident stated that the aide hurt his knee and he is afraid of her. He added that she is working on his hall; he sees her going into residents ' room and he did not want her in his room. In an interview on 3/26/14 at 8:42 am, the facility social worker stated, " I received a conference call on Thursday from the dialysis social worker on 3/20/14. The resident ' s family was also on the call. She stated that the resident had told a nurse at the dialysis center that Aide #1 slammed him into the wall. I was surprised because I talk to the resident every day. " The surveyor asked the facility social	F 225	reports for years with no concerns from any regulatory agency. In the future the facility will fax reports to the HCPR and print a fax transmission sheet to attach for our records as additional proof that the report has been sent. Any resident that indicates the possibility of abuse could be affected. Reports will be sent timely and in a way that can prove to any state agency that the reports have been sent. 3 All future reports of abuse will have a fax transmittal sheet attached and a human witness will be present to observe the reports being sent Each month, any reports faxed to the NCPR will be brought to the quality assurance committee for discussion. This will be brought to the committee each month for 3 months and then quarterly thereafter. 4 Completion date is 4/24/14	

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worker what the outcome of the present allegation was. The facility social worker stated that her responsibility is if she witnesses abuse of a resident she makes sure the resident is safe, and then she reports it. If an abuse allegation is reported to her, she writes the allegation up and turns it in to the administrator or the DON. She further stated that she does not follow up on allegations nor does she fire anyone. She further stated that she is in-serviced on abuse annually.

During a telephone interview with the social worker at the dialysis center on 3/26/14 at 9:08 am, she stated that a nurse on the floor came to her and said that Resident #45 asked her staff to be careful when transferring him from the wheelchair to the treatment chair, because earlier that morning at his nursing home someone had been rough and slammed him into the wall while giving care. He stated he did not want to get hurt again. The nurse stated she gave him 2 Tylenol. I called his spouse and conference the call with the facility. The family member stated that the facility had not called. Facility social worker stated that she had not heard anything, but something had happened a couple months ago and she had initially reported it; she was not sure about the outcome. The family member stated that the aide had worked with Resident #45 since the incident. The dialysis social worker stated that Resident #45 is a " true historian. " He gives accurate accounts of events in his life, about friends ' deaths, about names and when events happen. She added that there is some cognition impairment, but he remembers names and events.

In an interview with the administrator on 3/26/14 at 12:38pm, he stated that a 24-hour initial report

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F 225	Continued From page 9 was submitted on 3/21/14 to HCPR, but he was unable to produce the transmission verification report, because his fax machine was not capable of producing one. In a telephone interview on 3/28/14 at 2:10 pm, the HCPR staff confirmed that there was no record that a 24-hour report was faxed by the facility.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and record review, the facility failed to implement their abuse policy and procedure to protect and assess 1 of 3 residents during an abuse investigation. [Resident#45] Findings included: The facility policy titled Abuse and Neglect Prohibition Policy, undated, page 8, read in part "Procedure -Protection 1. The facility will protect residents from harm during the investigation. Steps to operationalize the component may include: the suspension of a suspected employee. " Resident #45 was admitted in the facility on 9/9/11 with diagnosis that included gout,	F 226	F226 1. Resident 45 had the staff member in question removed from his assignment immediately after the facility was made aware of the alleged abuse. The CNA was assigned to another area and had no further contact with resident 45 during or since the investigation. Resident 45 did not notify anyone in the facility of his concerns although most of the facility nurses and administrative staff interact with him each day.The facility protects any resident from harm immediately during its investigation of any abuse claims. The facility determined that upon notification of	4/24/14

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F 226	Continued From page 10 end-stage renal disease, and subdural hematoma. The most recent minimum data set (MDS) dated 01/06/14 specified the resident ' s cognition was not impaired. A review of social worker notes dated 3/17/14 read in part " resident has resided in nursing facility since 9/2011. The resident cognition is intact. Resident recall is amazing and never forgets names. Resident easily engages in conversation and can make his needs known Social worker hears resident daily calling out to people who pass by his door loudly. Every time social worker passes by resident ' s door he calls out loudly social worker ' s name. This behavior is disruptive to others in living environment. Resident is also very demanding with staff. During a resident interview on 3/25/14 at 8:19 am, resident reported that the aide had been rough and slammed him into the wall while turning him for care and that the aide had a bad attitude. The resident stated that the aide hurt his knee and he is afraid of her. He added that she is working on his hall; he sees her going into residents ' room and he did not want her in his room. A review of the 24-hour initial report signed and dated 3/21/14 read in part " Certified nursing assistant turn him over roughly into wall. No physical injury, pt [patient] was upset at dialysis. " During a telephone interview with the social worker at the dialysis center on 3/26/14 at 9:08 am, she stated that a nurse on the floor came to her and said that Resident #45 asked her staff to	F 226	the alleged abuse the staff member accused of the abuse also had two (2) witnesses in the room at the time of the alleged abuse. The DON interviewed the 2 witnesses and found that neither witness saw any type of abuse. The witnesses were in the room with the accused because this resident often accuses staff of misconduct. It is the facility policy to send a second staff members in with a resident, as a witness, that is accusatory of inappropriate deeds of any staff members. The administrator or DON initiates the abuse protocol after an allegation of abuse is made. 2. The facilities policy states that the administrator may suspend anyone for allegations of abuse during the investigation. The administrator did protect the resident by not allowing the CNA to continue working with the resident during the investigation or any time thereafter. The investigation revealed that abuse by this CNA was not substantiated. Our policies worked, notifications of the abuse led to removing the resident from any potential harm, an investigation was conducted which included interviews with 2 witnesses that were in the room at the time of the alleged incident as well as nurses and social workers familiar with the allegation. The 2 CNA□s in the room were there because of resident 45 previous history of making these accusations about other staff. Any resident has the potential to be affected by this policy. The policy will be followed as currently outlined. Any new complaints	

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F 226	Continued From page 11 be careful when transferring him from the wheelchair to the treatment chair, because earlier that morning at his nursing home someone had been rough and slammed him into the wall while giving care. He stated he did not want to get hurt again. The nurse stated she gave him 2 Tylenol. I called his spouse and conference the call with the facility. The family member stated that the facility had not called. Facility social worker stated that she had not heard anything, but something had happened a couple months ago and she had initially reported it; she was not sure about the outcome. The family member stated that the aide had worked with Resident #45 since the incident. The dialysis social worker stated that Resident #45 is a " true historian. " He gives accurate accounts of events in his life, about friends ' deaths, about names and when events happen. She added that there is some cognition impairment, but he remembers names and events. In an interview on 3/26/14 at 8:42 am, the facility social worker stated, " I received a conference call on Thursday from the dialysis social worker on 3/20/14. The resident ' s family was also on the call. She stated that the resident had told a nurse at the dialysis center that Aide #1 slammed him into the wall. I was surprised because I talk to the resident every day. " The facility social worker said that she talked to the resident, and he told her the same scenario. The facility social worker further added she had a grievance a month ago about a similar situation with the resident: " I copied it and gave it to the administrator and director of nursing [DON] and have not heard about it since. " The surveyor asked the facility social worker what the	F 226	of abuse will be reviewed by the Regional Nurse consultant for Choice Health for adherence to the policy and proper investigation. All residents will continue to be free of harm by removal of the alleged offender. The social worker or designee will meet with residents concerning abuse. Any resident that presents a concern will have an investigation initiated. The staff will be inserviced again on abuse and neglect by the staff developer. 3. Any allegations of abuse will be reviewed by the quality assurance committee for compliance with the policy and procedure. The Regional nurse consultant will also review the adherence to the facility policy and procedure. This will occur every month for 4 months and then quarterly thereafter for a period of 1 year. 4. Completion will be 4/24/14.	

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outcome of the present allegation was. The facility social worker stated that her responsibility is if she witnesses abuse of a resident she makes sure the resident is safe, and then she reports it. If an abuse allegation is reported to her, she writes the allegation up and turns it in to the administrator or the DON. She further stated that she does not follow up on allegations nor does she fire anyone. She further stated that she is in-serviced on abuse annually. have a copy.

Review of CNA #1 written statement dated 1/20/14 [error in the date] reads " I was assigned to [resident name] on March 19, 2014. I asked [resident name] to turn over, and he said I threw him into the brick, which I didn ' t. [Aide #2 name] was in the room to be a witness with me because I was not going into the room by myself. "

In an interview with Aide #1 on 3/26/14 at 9:30 am, she stated, " I always have someone to go in the room with me because the Director of Nursing [DON] and Assistant DON want me to do that. I was bathing the resident and I asked him to turn over and he said I slammed him in the brick. " The state surveyor asked the aide what that meant. She replied, " That his leg hit the wall. I told him his leg did not touch the wall, it did not go near the wall. " The surveyor asked Aide #1 to demonstrate what she did. She indicated that she took the bed pad and just flipped him over towards the wall. She added that he did not hit the wall. The aide further stated that Aide #2 was sitting on a chair in the room at the resident ' s headboard. Aide #1 further stated that when she enters the resident ' s room, she does not talk to the resident because the resident will change her words; she only responds to him [hum ahooo], no verbal " yes " and " no. " Record review

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F 226	Continued From page 13 revealed aide was in-serviced on abuse 12/13/13 and 9/9/13. During an interview on 3/26/14 at 11:15pm with the charge nurse, she stated that she received a call on 3/20/14 from the dialysis social worker about alleged abuse of Resident #45. She forwarded the call to the social worker. In a follow-up interview with the charge nurse on 3/26/14 at 2:30 pm, the charge nurse indicated that she went into the resident ' s room and she saw the resident sitting in the wheelchair with his clothes on. She looked at him, and there were no bruises, no marks no welts, no injuries. The resident did not have any complaints. The resident said he was okay, he had no pain. She left the room. The charge nurse further stated that no vital signs and skin check were not done on resident#45 the aide would check his skin when his bath was given. When the surveyor asked the charge nurse if her observation of resident #45 was documented in the resident ' s chart, she stated no, because she would sign the aide ' s bath sheet. A review of Aide #3 ' s assessment for showers for resident #45 dated 3/20/14 (7-3 shift) stated that the resident refused his bed bath. In an interview on 3/26/14 at 12:38 pm with the administrator [accompanied by the DON], the administrator acknowledged that aide was on the schedule and still working on the same hall with the resident but with other residents. When asked how the residents were being protected during an abuse investigation, the administrator stated that depending on the severity of the abuse claim he would isolate the alleged staff, separate the staff	F 226		

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from the resident by assigning the alleged employee to another unit/set on the same hall. " If we find something major we would send the staff home. It is our discretion that we reassign, fire, or hire an aide during an abuse allegation. " Surveyor referred to facility policy section on " protection. " The administrator then stated that the staff should have been separated from the resident, suspended pending investigation, and he added, " I guess we need to send her home. "

During an interview with the DON on 3/26/14 at 4:00 pm, she indicated that during an investigation into an abuse allegation, she would have expected that the nurse would do a head-to-toe assessment, take a skin assessment, take the resident ' s vital signs, and document findings in the resident ' s chart.
The DON also added that she completed the alleged abuse investigation for resident #45 and she unsubstantiated it because she could not find any evidence that the resident was slammed against the wall.

In an interview with Aide #2 on 3/26/14 at 9:30 am, he stated, " Aide #1 asked me to come in the room with her while she provided care for the resident. She was changing [name of the resident] and she asked him to turn over, while turning I heard the resident mentioned something about his leg touching the brick wall but he was no where near the wall. " During a follow up abuse prohibition interview on 3/27/14 at 2:15PM the surveyor asked Aide #2 what his responsibilities in reporting alleged resident abuse are. Aide #2 responded if I do not think it is abuse I will not report it. He added " I have problems reporting something I do not believe happened. "

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of housekeeping/maintenance records, the facility failed to clean and repair heating/air condition systems for the following rooms (102, 105, 202, 211, 212, 213, 216, 221, 302, 305,309, 310,314,315,316,318,321,322, 401,403,404, 406, 408, 410, 411,413,414,415, 501, 507, 508, 509, 511,514 and 515) for 5 of 5 halls. The findings included: During initial tour on 3/24/14 at 9:45AM, observations in the following rooms (102, 105, 202, 211, 212, 213, 216, 221, 302, 305,309, 310,314,315,316,318,321,322, 401,403,404, 406, 408, 410, 411,413,414,415, 501, 507, 508, 509, 511, and 514,515) had a large volume of heavy build of gray dirt/dust on the front panels of the heating system and food/trash on the inside. The heat was on and gray dirt/dust blowing throughout the rooms. The following rooms (105, 202, 303,309, 406,501,509 and 515) had very sharp edges exposed due to broken grill slates or broken sections within the heater casing. During a follow- up observation on 3/26/14 at 7:30AM to 10:00AM, the condition of the heating systems remained dirty/dusty and blowing particles throughout the rooms. The broken pieces from the system remained unrepaired.	F 253	F253 1. No resident was named in this deficiency. Rooms 102, 105, 202, 211, 310, 314, 315, 316, 318, 321, 322, 401, 403, 404, 406, 408, 410, 411, 413, 414, 415, 201, 507, 508, 509, 511, 514, and 515 have been cleaned on the exterior as well as the interior on the night of 3/26/14. All resident room air units were cleaned throughout the facility. Rooms 105, 202, 303, 309, 406, 501, and 515 have had their covers reattached and any sharp areas padded to prevent exposed sharp edges. 2. Room air conditioners are normally cleaned on a quarterly basis for filters and behind the air discharge vent. At the time of the survey, sprinkler work had just been completed throughout the building, creating dust and dirt from removal of ceiling tiles in each room and hallway. The quarterly cleaning had not occurred on date of the survey. Any air conditioner /heater has the potential of becoming dusty from exterior causes. The units will be cleaned by maintenance and housekeeping quarterly or more frequently if necessary. Records will be maintained to provide proof of preventive maintenance to these units. The	4/24/14

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F 253	Continued From page 16 During an interview on 3/26/14 at 10:03AM, HK#1(housekeeper) indicated that the expectation for cleaning resident rooms included, bathrooms, trash, high dust of doors, furniture, sweep/mop and window sills. She indicated that she was not responsible for cleaning the heating systems. She indicated that maintenance was responsible for cleaning and changing the filters and cleaning out the system. During an interview on 3/26/14 at 10:17AM, HK#2, indicated housekeepers was responsible for cleaning the wardrobes, dresser, bed, high/low dusting, baseboards, bathroom, deep cleaning bed frames, maintenance responsible for vacuuming out the dust inside. HK#2 added that housekeeping was only responsible for wiping down the outside of the heating system. HK#2 did not clean/wipe the outside of the system during the observation/interview. During an interview on 3/26/14 at 10:37AM, HK#3 indicated that the general room cleaning including high/low dusting, bathrooms, floors and wipe down the fronts and tops of heating system when they were able to get to them. She was observed in residents ' room cleaning, but she did not dust or clean any of the areas on the heating systems. During an interview on 3/26/14 at 10:53AM, the HK supervisor toured the facility and confirmed the heating and conditioning systems needed to be cleaned and repaired. The HK supervisor indicated that the housekeeping staff was expected to wipe down the tops/fronts of the heating system. He indicated that he did not have a system in place to ensure that the current weekly housekeeping daily routine was being	F 253	maintenance director and housekeeping director will be responsible to develop a schedule that will keep the units clean and safe. They will keep records of this preventative maintenance as it is completed. The records will be presented to the administrator as the maintenance is completed for verification. The administrator will spot check rooms at the rate of 4 rooms per hall each week for a period of 3 months. Any problems will be brought to the attention of housekeeping and maintenance for immediate correction. 3. The administrator will bring before the quality assurance committee the results of his rounds as well as a copy of the preventive maintenance documentation. This will occur each month for 3 month and then quarterly thereafter for one year. 4. Competition will be 4/24/14	

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F 253	Continued From page 17 followed on a regular basis. During an interview on 3/26/14 at 11:00AM, the maintenance director toured the facility and indicated that he was unaware that the inside of the heating system needed to be cleaned. The maintenance director added the expectation was housekeeping or any staff that saw the residents heating system needed to be cleaned should reported to him or the housekeeping supervisor and/or or put a work order slip in for cleaning and repairs. He indicated that on a quarterly basis that an outside contractor came in to clean out the filters. He confirmed that several of the heating systems had broken pieces with sharp edges. In addition, acknowledged that he could not confirm the current cleaning system or repair of the heating systems were being done routinely unless being told or receipt of work order. During an interview 3/27/14 at 3:10PM, the Administrator indicated that maintenance slip should be submitted for heating systems that need to be repaired. He added that housekeeping supervisor was responsible for ensuring the heating systems were cleaned in accordance to the housekeeper daily routine and filters to cleaned and checked monthly.	F 253		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 372	F372	4/24/14

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F 372	Continued From page 18 facility failed to create an environment in the dumpster area and the area surrounding the loading dock free of conditions that might contribute to the growth and infestation of pests and rodents for 3 of 3 dumpsters. The findings included: During an observation on 3/24/14 at 10:00 am three dumpsters were observed behind the kitchen. The dumpster on the right was observed with both doors open halfway and a closed bag of trash on top of the dumpster. Six disposable gloves were observed between the rear of dumpsters. Left of the left-hand dumpster, five disposable gloves and six plastic medicine cups were observed on the ground. A brownish-whitish substance with a thick consistency like dough 2 x 1 feet was observed outside the dumpster to the left. There were 10 broken wooden crates about 10 feet from the dumpsters. There was standing water between two of the dumpsters. The pool of water was approximately 4 x 4 feet with a depth of approximately three fourths of an inch at its deepest. Around the loading dock below the platform were many cigarette butts, ten straws, and four disposable gloves. During an observation on 3/26/14 at 12:05 am with the certified dietary manager (CDM), three dumpsters were observed behind the kitchen. The dumpster on the right was observed with both doors open halfway and the closed bag of trash on top of the dumpster. Six disposable gloves were observed between the rear of dumpsters. Left of the left-hand dumpster, five disposable gloves and 6 plastic medicine cups were observed on the ground. A brownish-whitish substance with a thick consistency like dough 2 x	F 372	1. No resident was named in this deficiency. On the week of the survey, Waste Industries did not empty the dumpsters for 3 days of the survey or on Saturday and Sunday prior to the survey. Numerous calls were made to them insisting that they empty the dumpsters. They stated that a delivery truck was in the way of the dumpsters and they could not empty them. Finally they were emptied on the third day. They were overflowing. The dumpster driver did not attempt to close the lid or correct the bag hanging out when he emptied them. Just after they were emptied, staff were dispatched to clean up the area. Water was on the ground due to heavy rains during the survey. The water had dried up by the end of the survey. Grass was planted in the area in an attempt to minimize the flow of water in the area. The dumpster area is now clean. There have been no reports of insects or rodents during the survey or after. 2. The dietary department and the housekeeping department will be responsible to check for cleanliness of the dumpster area. A check list has been developed that will ensure that this task is completed each day. The dietary department will be responsible for morning clean up and the housekeeping department will be responsible to clean on the afternoons. The final responsibility to ensure that the dumpster area is cleaned up will be the Housekeeping Supervisor. He or his Assistant will monitor the dumpster area	

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F 372	Continued From page 19 1 feet was observed outside the dumpster to the left. There were 10 broken wooden crates about 10 feet from the dumpsters. There was standing water between two of the dumpsters. The pool of water was approximately 4 x 4 feet with a depth of approximately three fourths of an inch at its deepest. Around the loading dock below the platform were many cigarette butts, ten straws, and four disposable gloves. In an interview with the CDM on 3/26/14 at 12:09 pm, she stated, " If my staff saw the dumpster needed cleaning up, I would expect them to tell someone. Housekeeping is responsible for taking care of the dumpsters. " In an interview with the Housekeeping Supervisor on 3/26/14 at 12:15 pm, he stated, " There is no set schedule for cleaning outside of the building, the housekeeping staff goes out several times a day to make sure the dumpster doors are closed and everything is picked up around the dumpsters. I expect staff to close the doors of the dumpsters and pick up all the trash. " The housekeeping supervisor further stated that the water around the dumpster might have come from the rain and snow. During an observation on 3/27/14 at 12:00 noon with the CDM, the dumpster area was observed. Observed on the ground between two of the three dumpsters were two disposable gloves, a brown paper bag, 1 plastic medication cup lid, and 10 wooden crates about 10 feet from the dumpsters.	F 372	for cleanliness daily. Any problems will be immediately corrected and reported to the administrator. 3. Each week the checklist will be turned in to the administrator Cfor review. The administrator will take the results of his review of the dumpster area and the forms completed to the quality assurance committee for review. This will be brought to the committee each month for 3 months and then quarterly thereafter 4. Completion date 4/24/14	