

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

PRINTED: 04/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 000	INITIAL COMMENTS	F 000			
F 278 SS=D	<p>The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification survey from 3/16/15 through 3/19/15. The survey exit date was changed to 3/26/15 because the survey team received additional information from the facility to cite tags F 490 and F 520.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278		4/15/15	

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

TITLE

(X6) DATE

Electronically Signed

04/10/2015

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 278	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code Preadmission Screening Resident Review (PASRR) on the Minimum Data Set (MDS) for three of three residents admitted with a PASRR level 2 (Resident #37, #83 and #92). The findings included:</p> <p>Standards for determination of level 2 PASRR included mental illness, intellectual challenged and related conditions based on documentation or notification to the Division of Medical Assistance sent by the facility.</p> <p>1. Resident #37 was admitted to the facility of 10/9/2014. Cumulative diagnoses included bipolar disorder and schizophrenia.</p> <p>A review of Resident #37's admission PASRR screening form revealed she was admitted with a level 2 PASRR.</p> <p>An admission MDS dated 10/21/14 indicated "No" to question A1500 which asked if Resident #37 was PASRR level 2.</p> <p>On 3/18/15 at 4:02PM, administrative staff #3 stated that Resident #37 was PASRR level 2 when she was admitted to the skilled nursing unit on 10/9/14.</p> <p>On 3/19/15 at 8:22AM, the MDS nurse stated she looked in the medical chart and, sometimes, it was in the chart that a resident was PASRR level 2. She stated, sometimes, she also asked the</p>	F 278	<p>On 3/19/2015 , Resident # 37,#83, and #92 PASRR's were reviewed by the MDS Coordinator . Any incorrect code was corrected on the MDS on the same day.</p> <p>On 3/19/2015, 100 % current resident records were reviewed regarding level II PASRR dates by corporate MDS consultant and social worker on 2/20/2015. Any PASRR's found out of compliance were immediately flagged by social services and submitted.</p> <p>Any incorrect MDS's were also modified by the MDS Coordinator on 3/19/2015.</p> <p>Social services will fill out MDS section A1500-1550 on all comprehensive assessments effective 2/23/2015 and was instructed by the corporate MDS consultant on how to enter data in MDS. Resident requiring level II PASRR will be submitted and a colored paper will be placed in chart to identify a Level II PASRR for any reviewing charts.The director of medical records will place the colored paper in chart within 24 hours of resident admission</p> <p>Social Services will maintain a on-going list of PASRRs level II residents needing recertification and provide to MDS coordinator, Business Office Manager, DON, SDC, Compliance Nurse, Rehab Director and Administrator. This list will</p>		

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F 278	<p>Continued From page 2</p> <p>social worker. The MDS nurse stated the information was not in the chart for the admission assessment so she was not coded PASRR level 2.</p> <p>On 3/19/15 at 8:36AM, administrative staff #3 stated she had informed all staff of PASRR level 2 residents since the last recertification survey and all PASRR level 2 residents are reviewed during the daily morning meetings.</p> <p>2. Resident #83 was admitted to the facility admitted to facility 10/10/14. Cumulative diagnoses included bipolar disorder and depression.</p> <p>A review of Resident #83's admission PASRR screening form revealed she was admitted with a level 2 PASRR.</p> <p>An admission MDS dated 10/17/14 indicated "No" to question A1500 which asked if Resident #83 was a PASRR level 2.</p> <p>On 3/18/15 at 4:02PM, administrative staff #3 stated that Resident #83 was PASRR level 2 when she was admitted to the skilled nursing unit on 10/10/14.</p> <p>On 3/19/15 at 8:22AM, the MDS nurse stated she looked in the medical chart and, sometimes, it was in the chart that a resident was PASRR level 2. She stated, sometimes, she also asked the social worker. The MDS nurse stated the information was not in the chart for the admission assessment so she was not coded PASRR level 2.</p> <p>On 3/19/15 at 8:36AM, administrative staff #3</p>	F 278	<p>notify department managers of PASRR level II residents.</p> <p>Social Services started informing all managers about any individuals being admitted with a PASRR Level II during department managers meeting.4/7/2015</p> <p>Three comprehensive MDS assessments completed for residents with PASRR level II will be reviewed by MDS coordinator/director of medical records to ensure accurate coding weekly x4, then monthly x2, or until compliance is achieved. Results of this monitoring will be brought and discussed in the monthly QA meetings.</p>		

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F 278	Continued From page 3 stated she had informed all staff of PASRR level 2 residents since the last recertification survey and all PASRR level 2 residents are reviewed during the daily morning meetings. 3. Resident #92 was admitted to facility 2/6/14. Cumulative diagnoses included intellectually challenged. A review of Resident #92's admission PASRR screening form revealed she was admitted with a level 2 PASSR. An annual MDS dated 2/12/15 indicated "No" to question A1500 which asked if Resident #92 was a PASRR level 2. On 3/18/15 at 4:02PM, administrative staff #3 stated that Resident #92 was PASRR level 2 when she was admitted to the skilled nursing unit on 10/10/14. On 3/19/15 at 8:22AM, the MDS nurse stated she looked in the medical chart and, sometimes, it was in the chart that a resident was PASRR level 2. She stated, sometimes, she also asked the social worker. The MDS nurse stated the information was not in the chart for the assessment so she was not coded PASRR level 2. On 3/19/15 at 8:36AM, administrative staff #3 stated she had informed all staff of PASRR level 2 residents since the last recertification survey and all PASRR level 2 residents are reviewed during the daily morning meetings.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		4/15/15	

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F 279	<p>Continued From page 4</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care plan to address the limitation in range of motion for 1 (Resident #10) of 1 sampled resident with a left hand contracture. Finding included:</p> <p>Resident #10 was originally admitted to the facility on 10/15/09 and was readmitted on 6/16/10 with multiple diagnoses including Alzheimer's Disease, history of cerebrovascular accident (CVA) and left hemiparesis. The annual Minimum Data Set (MDS) assessment dated 12/19/14 indicated that Resident #10 had moderate cognitive impairment, had a functional limitation in range of</p>	F 279	<p>Resident #10 rehab screen of 6/9/14 was incorrectly documented as a contracture.</p> <p>On 3/18/15, a rehab screen was initiated on Resident # 10 for an assessment on a possible left hand contracture as well as for splint therapy.</p> <p>MDS Coordinator reviewed and identified all residents triggered for contractures on 672. This list was given to rehab director on 3/18/2015 to rescreen and verify whether those listed on the 672 were properly identified as having contractures.</p>		

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F 279	<p>Continued From page 5</p> <p>motion on one side of the upper extremity and was not on restorative nursing program for passive/active range of motion or splint or brace assistance.</p> <p>The occupational therapy notes (OT) were reviewed. The notes dated 10/15/09 revealed that Resident #10 was evaluated and was found to have a left hand contracture. The OT goals were for Resident #10 to safely wear a resting hand splint and finger separator on the left wrist and left hand for up to 8 hours with minimal signs/symptoms of redness, swelling, discomfort or pain. On 12/5/09, Resident #10 was discontinued from the OT services and was discharged to restorative nursing. The discharge recommendations were functional maintenance program for splinting and passive range of motion (PROM) 6-7 times per week, resting hand splint 6-8 hours maximum daily with skin integrity inspection. The notes further indicated that the restorative nursing was instructed on functional maintenance program for left upper extremity resting hand splint use, schedule and passive range of motion for contracture management.</p> <p>Review of the care plan dated 12/19/14 revealed that there was no care plan developed to address the limitation in range of motion on the left hand for Resident #10</p> <p>On 3/18/15 at 10:00 AM and 4:30 PM and on 3/19/15 at 8:05 AM, Resident #10 was observed in bed. Her left hand was in a fist position and there was no splint or roll noted.</p> <p>On 3/19/15 at 10:24 AM, Nurse #4 was interviewed. Nurse #4 stated that she was the care plan nurse. She stated that she was new to</p>	F 279	<p>on 3/24/2015, (30) additional residents who were triggered on the 672 for contractors were assessed by the rehab department for contractors on 3/30/15, (10) additional residents were assessed by the rehab department as they were due for quarterly assessments. On 04/10/15, (10) additional residents were assessed by the Rehab department as they were due for quarterly assessments. On 4/14/15, a complete list consisting of (41) remaining current residents were given to Rehab department to screen for contractures. (2) New contractures were found during quarterly assessments and care plans were created.</p> <p>On 3/27/2015, the rehab director in-serviced the MDS coordinator on using only Rehab quarterly screens to trigger contractures on 672.</p> <p>On 3/27/2015 the staff development coordinator in-serviced MDS coordinator on utilizing Rehab screens if she visually identifies a resident she thinks may qualify for contractures.</p> <p>On 3/27/15, Rehab Director in-serviced nursing & therapy staff on proper identification stages of tone</p> <p>Rehab department will follow MDS schedule and screen all residents quarterly. Screens will be turned in to restorative nurse weekly. MDS Coordinator will identify percentage of accuracy on 672 monthly x</p>		

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F 279	Continued From page 6 the facility and was not familiar with all the residents yet. She indicated that she was not aware that Resident #10 had a left hand contracture and therefore she did not develop a care plan for contracture management.	F 279	3 months, to include quarterly QA review and will continue until compliance is ensured. The compliance/care plan nurse will be responsible to develop the care plan of residents with contractures. S/he will receive a copy from the rehab departments completed assessment as well as attend the daily clinical meeting. Residents will be identified with contractures by rehab, have had a care plan developed Compliance/care plan nurse will audit all 16 care plans in comparison to the 672 to ensure all residents identified with contractures and compliance/care plan nurse will have care plans in place monthly x 3 months, to include quarterly QA reviews presented by the compliance/care plan nurse and will continue until compliance is ensured.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain laboratory tests as ordered by the physician for 1 of 5 sampled residents (resident #91) reviewed for unnecessary medications. The findings included:	F 281	On 3/18/15, orders for labs reviewed by staff development coordinator on Resident # 91. Identified missing lab results for TSH, CBC, & Renal. Order written 3/18/15. Lab results received & faxed	4/15/15	

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F 281	<p>Continued From page 7</p> <p>Resident #91 was admitted to the facility on 12/16/13 with multiple diagnoses including hypothyroidism, pressure ulcer, chronic malnutrition, history of a urinary tract infection, abdominal pain, urinary incontinence and Alzheimer's disease.</p> <p>A review of the Physician's Orders revealed an order dated 1/7/15 which read " Renal, Complete Blood Count (CBC) 4 weeks. " Renal panel is used to help diagnose and manage conditions affecting the function of the kidneys. CBC is used to detect and monitor different health conditions including infections, allergies, blood disorders like anemia and the production and/or destruction of red blood cells.</p> <p>A review of the laboratory results from 1/7/15 to 3/18/15 revealed there were no documented laboratory results for the renal panel or the CBC ordered by the physician on 1/7/15.</p> <p>An interview was conducted with Nurse #4 on 3/18/15 at 9:58 AM. Nurse #4 stated the laboratory tests ordered for Resident #91 on 1/7/15 were " overlooked " and not obtained by the facility.</p> <p>An interview was conducted with Nurse #5 on 3/18/15 at 4:01 PM. Nurse #5 stated the nurse on duty was expected to complete the laboratory slip when laboratory tests were ordered. She stated a laboratory slip was not completed for the laboratory tests ordered by the physician on 1/7/15. Nurse #5 stated she contacted the laboratory on 3/18/15 and was told the laboratory specimen was not collected.</p> <p>An interview was conducted with Administrative</p>	F 281	<p>to MD 3/19/15 by SDC nurse</p> <p>On 4/8/2015, 100% of current resident charts were audited by medical records director for missing labs. All labs ordered by MD were reconciled</p> <p>SDC nurse had in-serviced all nurses and shift supervisors on how to process & track labs using Lab Book. completed on 3/27/2015</p> <p>Lab orders will be reviewed by Dayshift supervisor, SDC and compliance nurse daily & entered into lab book. Labs to be drawn on next lab day.</p> <p>Night shift supervisor will be responsible to review all lab orders and to ensure lab slips are completed & place initials on top of yellow copies of MD orders.</p> <p>Day shift supervisor will then collect orders and take it to the clinical meeting where they will be reviewed for compliance or follow-up.</p> <p>Medical records director will be auditing 10 medical records listed in lab book to ensure that labs ordered were drawn and results were on file weekly X4-then monthly X4 until compliance is achieved. Results of the monitoring will be brought and discussed By medical records director in monthly QA meeting- will be responsible for auditing</p>		

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F 281	Continued From page 8 Staff #2 on 3/18/15 at 4:52 PM. She stated the nurse on duty was expected to complete a laboratory slip for the laboratory tests when ordered by the physician.	F 281	the lab book on a weekly basis to ensure compliance is met. Monthly lab log will be part of QAPI process for auditing. This practice will list amount of labs ordered, amount of lab results received, and/or missing labs. This will be done x 3 months, to include quarterly QA review and will continue until compliance is ensured.		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental	F 285		4/15/15	

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F 285	<p>Continued From page 9</p> <p>retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and staff interview, the facility failed to coordinate with the Preadmission Screening and Resident Review Program (PASRR) for reevaluation of PASRR for continued stay at the facility for one of three sampled residents with a level two screening (Resident #37). The findings included:</p> <p>Resident #37 was admitted to the facility 10/09/14. Cumulative diagnoses included: bipolar disorder and schizophrenia.</p> <p>An Admission Minimum Data Set (MDS) dated 10/21/14 indicated preadmission screening and resident review (PASRR) as "0". No mood or behaviors were noted during the assessment period.</p>	F 285	<p>on 3/19/2015, social worker had been instructed by PASRR representative on how to enter resident #37 for timely PASRR recertification.</p> <p>A request for reevaluation was submitted on 3/13/2015 for resident #37.</p> <p>Resident was seen on 3/19/2015 by PASRR evaluator and an approval for a PASRR level II was given on 3/31/2015 for another 60 days.</p> <p>Social worker has created an outlook calendar reminder for resident #37 <input type="checkbox"/> PASRR II recertification submission 5 days prior to due date.</p>		

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F 285	<p>Continued From page 10</p> <p>The medical record was reviewed and revealed the following PASRR and screening history: Resident #37 was admitted to the facility on 10/09/14 with a PASRR # _____ F. A change in condition review (PASRR only) submitted on 10/01/14 and completed 10/06/14 with PASRR # _____ F with expiration date 12/05/14. A resubmission for reevaluation of PASRR for continued stay at the facility was submitted on 12/06/14 and completed 12/12/14 with a PASRR # _____ F with expiration date of 3/12/15. A resubmission for reevaluation of PASRR for continued stay at the facility was submitted on 03/13/15 and was still pending at the time of the survey.</p> <p>On 3/18/15 at 4:30PM, administrative staff #3 stated the level 2 PASRR # _____ F for Resident #37 was accepted 10/6/14 with an expiration date of 12/5/14. The next accepted PASRR was dated 12/12/14 to 3/12/15. She stated she tried to resubmit the PASRR information on 3/11/15 and the system would not let her submit the information and gave her a statement in red letters that the resident already had an approved PASRR for that time. Administrative staff #3 stated she submitted the request for PASRR level 2 on 3/13/15 and PASRR sent her a notification through PASRR that an evaluator from mental health would have to come out and assess the resident prior to approval. As of 3/18/15, the evaluator had not been to the facility to assess the resident.</p> <p>On 3/19/15 at 8:36AM, administrative staff #3 stated she had spoken to someone at PASRR and had been instructed on how to complete a resubmission for reevaluation of PASRR prior to</p>	F 285	<p>Social worker was given instructions on entering requests for all PASRR recertification's prior to expiration on 3/19/2015.</p> <p>An audit for all PASRR recertification was completed on 2/15/2015 and 4/8/2015- by MDS consultant and social worker.</p> <p>the social worker will provided a running list with all residents with a PASRR level II and the list will be reviewed monthly to capture any upcoming recertification Department manager were a given a form on 4/8/2015 via email to review all PASRR Level II residents.</p> <p>Monthly Audits by director of medical records/social worker will be completed for any upcoming PASRR Level II to identify dates for recertification and earlier submission for continued stay.</p> <p>During the admission process anyone identified as having a PASRR level II will have a colored sheet placed by director of medical records in chart indicating that the resident has a PASRR level II.</p> <p>The Director of Medical Records will have Monthly Audits completed for any upcoming PASRR Level II to identify dates for recertification and earlier submission for resident continued stay.</p> <p>PASRR level II information will be presented by social worker and reviewed</p>		

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F 285	Continued From page 11 the expiration date for level 2 PASRR.	F 285	during department managers meeting to discuss any new admits as well as any recertification dates. An Outlook calendar alert by social worker will be sent to the clinical team - <input type="checkbox"/> administrator, medical records director, director of nursing, rehab director, dietary manager, and MDS coordinator a month prior to the recertification date to facilitate a PASRR review meeting and another reminder 5 days prior to PASRR expiration date of each resident for timely submission. the social worker will submit the application for the recertification when due. PASSR will be reviewed and presented to by social worker quarterly through the quality assurance committee meetings.		
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, staff and resident interviews, the facility failed to provide	F 318	Resident #10 rehab screen of 6/9/14 was incorrectly documented as a contracture.	4/15/15	

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F 318	<p>Continued From page 12</p> <p>care to prevent further decline in range of motion for 1 (Resident #10) of 1 sampled resident with a limitation in range of motion on the left hand. Finding included:</p> <p>Resident #10 was originally admitted to the facility on 10/15/09 and was readmitted on 6/16/10 with multiple diagnoses including Alzheimer ' s Disease, history of cerebrovascular accident (CVA) and left hemiparesis. The annual Minimum Data Set (MDS) assessment dated 12/19/14 indicated that Resident #10 had moderate cognitive impairment, had a functional limitation in range of motion on one side of the upper extremity and was not on restorative nursing program for passive/active range of motion or splint or brace assistance.</p> <p>Review of the care plan revealed that there was no care plan developed to address the limitation in range of motion on the left hand for Resident #10.</p> <p>The occupational therapy notes (OT) were reviewed. The notes dated 10/15/09 revealed that Resident #10 was evaluated and was found to have a left hand contracture. The OT goals were for Resident #10 to safely wear a resting hand splint and finger separator on the left wrist and left hand for up to 8 hours with minimal signs/symptoms of redness, swelling, discomfort or pain. On 12/5/09, Resident #10 was discontinued from the OT services and was discharged to restorative nursing. The discharge recommendations were functional maintenance program for splinting and passive range of motion (PROM) 6-7 times per week, resting hand splint 6-8 hours maximum daily with skin integrity</p>	F 318	<p>On 3/18/15, a rehab screen was initiated on Resident# 10 for an assessment on a possible left hand contracture as well as for splint therapy.</p> <p>On 3/18/15, rehab screen notes resident left hand was carefully assessed. OT states no contracture noted. PROM easily applied without resistance. Care plan nurse also verified no contracture.</p> <p>On 3/24/2015, MDS Coordinator reviewed and identified all (30) residents triggered for contractures on 672. List given to Rehab to rescreen and verify whether they have contractures or not.</p> <p>MDS Coordinator did not code contracture on the MDS. Software pulled wrong info to 672.</p> <p>MDS Coordinator in serviced by SDC-3/25/2015 on using only Rehab quarterly screens to trigger contractures on 672.</p> <p>(2) New contractures were found during quarterly assessments and care plans were created</p> <p>MDS Coordinator also in serviced on utilizing Rehab screens by SDC-3/25/2015 if she visually identifies a resident she thinks may qualify for contractures.</p>		

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F 318	<p>Continued From page 13 inspection. The notes further indicated that the restorative nursing was instructed on functional maintenance program for left upper extremity resting hand splint use, schedule and passive range of motion for contracture management.</p> <p>The restorative nursing program notes were reviewed. The facility provided restorative nursing notes dated 8/23/12 and 9/24/12. The notes indicated that Resident #10 had tolerated the PROM and the splinting. There were no other notes provided by the facility.</p> <p>On 3/18/15 at 10:00 AM, Resident #10 was interviewed. She stated that she used to wear a splint long time ago but was unable to remember as to when it was stopped. She also stated that the staff used to exercise her left hand but not lately. The left hand of Resident #10 was observed in a fist position and there was no splint or roll noted.</p> <p>On 3/18/15 at 10:05 AM, NA # 5 was interviewed. She stated that she was assigned to Resident #10. She revealed that Resident #10 was not on any splint or roll or on PROM.</p> <p>On 3/18/15 at 10:35 AM, restorative aides #1 and #2 were interviewed. They both stated that Resident #10 was not on their work load at this time. They stated that they used to work with the resident long time ago on splinting and PROM. They stated that they could not remember when and why restorative splinting and PROM were discontinued.</p> <p>On 3/18/15 at 10:38 AM, Nurse #3 was interviewed. He stated that he was responsible for the restorative nursing. He indicated that</p>	F 318	<p>On 3/27/15, Rehab Director in-serviced nursing & therapy staff on proper identification stages of tone.</p> <p>Rehab department will follow MDS schedule and screen all residents quarterly. Screens will be turned in to Restorative nurse weekly. MDS Coordinator will identify percentage of accuracy on 672 monthly x 3 months, a monitoring results to be presented to quarterly QA meeting and will continue monitoring and reporting to QA until compliance is ensured.</p> <p>Care plan nurse will monitor new implementations daily x 3 days, and then weekly x 4 weeks. all new identified with contractures will be observed that MD orders/Care plans interventions for contractures were implemented daily x3, weekly x4 month or until compliance is achieved. results of monitoring will be brought to QA monthly x3 until compliance is achieved.</p> <p>on 3/24/2015, corporate MDS consultant in-serviced MDS coordinator on how to pull 672 from MDS</p>		

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F 318	Continued From page 14 Resident #10 was not on the restorative nursing load at this time. He acknowledged that Resident #10 had a left hand contracture and was not receiving a splint/roll or PROM to prevent decline in ROM. He added that he would refer Resident #10 to OT to screen.	F 318			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview with the staff, residents and the plumber and record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in 8 of 11 resident's rooms (#102, #103, #114, #201, #202, #203, #215, #302) and 2 of 2 central bathrooms (100 and 400 hall). Immediate Jeopardy began on 3/17/15 at 9:30 AM when elevated hot water temperatures were identified in room #102 at 138 degrees F and in room #114 at 130 degrees F. The administrator was notified of immediate jeopardy on 3/17/15 at 3:14 PM. Immediate jeopardy was removed on	F 323	3/19/15-water mixing valve was repaired and water temperature brought back to regulated temperatures of 100-116 degrees. 3/19/15- an in-service to all staff began regarding policy and procedure on preventative hot water temperatures by SDC nurse-completed by 3/23/2015- any PRN staff that were not available will be in-serviced prior to start of work. this will be monitored by scheduler.	4/15/15	

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F 323	<p>Continued From page 15</p> <p>3/19/15 at 4:45 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective and all staff were in serviced.</p> <p>Findings Include: Observation on 3/17/15 starting at 9:20 AM, revealed the hot water temperature coming from the sink in room #201 was 122 degrees F, and in room #202 was 120 degrees F. The temperatures were obtained by the surveyor after the thermometer was calibrated in ice water. Observation on 3/17/15 starting at 9:30 AM using a calibrated thermometer, of the hot water temperatures in various residents ' rooms and in the central bath room revealed:</p> <table border="1"> <thead> <tr> <th>Room #s</th> <th>Location</th> <th>Water Temperature</th> </tr> </thead> <tbody> <tr> <td>201</td> <td>sink</td> <td>120 degrees F</td> </tr> <tr> <td>202</td> <td>sink</td> <td>120 degrees F</td> </tr> <tr> <td>203</td> <td>sink</td> <td>120 degrees F</td> </tr> <tr> <td>215</td> <td>sink</td> <td>118 degrees F</td> </tr> <tr> <td>102</td> <td>sink</td> <td>138 degrees F</td> </tr> <tr> <td>114</td> <td>sink</td> <td>130 degrees F</td> </tr> <tr> <td>302</td> <td>sink</td> <td>120 degrees F</td> </tr> <tr> <td colspan="2">Central Bath-sink (100 hall)</td> <td>124 degrees F</td> </tr> </tbody> </table> <p>Interview on 3/17/15 at 10:00 AM with NA #1 on 100 hall was conducted. NA #1 reported the water temperatures were real hot in the sink when you run the water for 10 minutes. The water was hot at times but, not every day. He indicated that he always made sure to mix the hot water with the cold water before bathing a resident. NA #1 indicated that he informed the Maintenance Supervisor 2 weeks ago.</p>	Room #s	Location	Water Temperature	201	sink	120 degrees F	202	sink	120 degrees F	203	sink	120 degrees F	215	sink	118 degrees F	102	sink	138 degrees F	114	sink	130 degrees F	302	sink	120 degrees F	Central Bath-sink (100 hall)		124 degrees F	F 323	<p>3/19/15-plumbing technician in serviced maintenance director on mixing valve as written in the manufactures manual</p> <p>3/19/2015-Water temperature checked and readings indicated with in required temperatures.</p> <p>Weekly water temperature checks will be conducted by director of maintenance on at least one room from Greenbrier, TangleWood, Somerset, and Willow Springs halls along with each Central Bath(2). Also, maintenance director will check temperatures as requested via maintenance work request.</p> <p>If maintenance director is not present for the weekly temperature checks, than the maintenance assistant or administrator will complete temperature checks.</p> <p>Mixing valve will be monitored daily by maintenance director as well as preventative maintenance completed monthly. a log for preventative maintenance will also be completed.</p> <p>Any time mixing valve is adjusted, water temp checks will be completed as well monthly water temperature audits completed weekly and placed in log.</p> <p>Monthly mixing valve preventative maintenance log also added</p> <p>Water thermometer calibration log implemented on 3/26/2015</p>	
Room #s	Location	Water Temperature																													
201	sink	120 degrees F																													
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F 323	<p>Continued From page 16</p> <p>Interview on 3/17/15 at 10:15 AM with NA #2 (shower aide) was conducted. NA #2 revealed the water in the shower room was sparkling hot that you could see the steam. After 5 minutes it would cool down a little bit and it fluctuated from very hot to cold. The fluctuation of the water temperature did not happen every day, however, it happened about 2-3 times a week. She indicated that she always checked the water temperature before the shower. Today (3/17/15) the water was hot. NA #2 indicated that she had informed the Maintenance Supervisor 2 weeks ago.</p> <p>Interview on 3/17/15 at 10:16 AM with NA #4 on 200 hall was conducted. NA #4 reported the water was too hot in the shower room. She had to mix it with cold water to give a shower. The hot water was real hot some days. NA #4 didn't inform the maintenance supervisor because the shower team had already informed him. NA #4 worked on floor but had to give showers when the shower team was not available. She added that the water in the shower in room #211 was hot yesterday (3/16/15)</p> <p>Interview on 3/17/15 at 10:17 AM with Resident #47 (resided in room 211) was conducted. Resident #47 stated that the water in the shower was hot but the aides mixed it with cold water during shower.</p> <p>On 3/17/15 at 10:19 AM, water temperatures were checked with administrative staff #1. The temperature of the water in the sink in room 102 fluctuated from 130 degrees F down to 111 degrees F. In the central bath tub in 100 hall, a button was pushed to turn on the water in the bath tub to check the water temperature. The</p>	F 323	<p>Semi annual inspection by certified plumber has been scheduled for June 1st and December 1st. He will check mixing valve and water system.</p> <p>Monthly water temperature checks with maintenance director and administrator will be completed and presented during safety committee meeting</p> <p>Monthly review of weekly water temperature logs, mixing valve preventative maintenance logs and thermometer calibration logs will be completed by maintenance director and presented by him during safety committee meetings and quarterly during quality assurance committee meetings.</p>		

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F 323	<p>Continued From page 17</p> <p>water ran for few seconds, but automatically shut off before the water temperature could be checked. At the time the water shut off, a display of water temperature of 115 F showed on a lighted panel on the tub. After pushing the tub water button to turn the water on several times, the temperature was 120 degrees F, then it dropped to 116 degrees F.</p> <p>Observation on 3/17/15 starting at 10:50 AM with the Maintenance Supervisor and Administrative staff #1 of water temperatures, using the facility ' s calibrated thermometer, in various residents ' rooms revealed the following:</p> <table border="1"> <thead> <tr> <th>Room #s</th> <th>Locations</th> <th>Water Temperature</th> </tr> </thead> <tbody> <tr> <td>302</td> <td>sink</td> <td>127 degrees</td> </tr> <tr> <td>114</td> <td>sink</td> <td>127 degrees</td> </tr> <tr> <td>202</td> <td>sink</td> <td>127 degrees</td> </tr> </tbody> </table> <p>In the Central Bath on 400 hall, the water temperature from the sink was 117 degrees F. A button was pushed to turn on the water in the bath tub to check the water temperature. The water ran for few seconds, but automatically shut off before the water temperature could be checked. At the time the water shut off, a display of water temperature of 115 F showed on a lighted panel on the tub. After pushing the tub water button to turn the water on the water temperature was 120 degrees F, then dropped to 118 degrees F.</p> <p>Interview on 3/17/15 at 11:35 AM with the Maintenance Supervisor revealed that the water system for this facility had two main water lines, one line for the kitchen and laundry and one line for the rest of the facility. It ran off of 2 hot water heaters that were tied in together. It was a circulatory system that had a mixing valve which had a knob that can be adjusted to control the mixing of hot and cold water. There were also</p>	Room #s	Locations	Water Temperature	302	sink	127 degrees	114	sink	127 degrees	202	sink	127 degrees	F 323		
Room #s	Locations	Water Temperature														
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F 323	<p>Continued From page 18</p> <p>two temperature gauges, one temperature gauge which indicated the temperature of the water going out of the mixer to the facility and another temperature gauge which indicated the temperature of the water coming back in. The temperature gauge to the water going out of the mixer normally read 120 degrees F and the temperature gauge for the water coming in was normally at 110 degrees F. The water was heated by propane and the facility used city water. The cartridge which fits inside of the mixing valve was replaced on 10/16/13. He reported that the shower team had complained that the water was too cold but, it had been a while and that he fixed problems by adjusting the mixing valve as soon as any issues were reported to him. He checked the water temperature in the resident room sink every Wednesday and maintained a water temperature log. He calibrated his thermometer monthly. He notified the administrator of any issues and neither were previously aware of the temperature fluctuation problem or high water temperatures. He reported that on 3/17/15 at 11:30 AM the mixing valve outgoing temperature gauge was 140 degrees F, however, he adjusted the valve on the mixer so the water temperature gauge read 120 degrees F and noticed there was a leak around the mixing valve knob.</p> <p>Observation on 3/17/15 at 11:45 AM of the mixing valve with the Maintenance Supervisor revealed he demonstrated how he adjusted the mixing valve by turning the knob ½ of a turn. The outgoing temperature on the mixing valve temperature gauge read 120 degrees F and the incoming temperature read 110 degrees F. There was no leaking water coming from the mixing valve knob during this observation. There was a sheet of paper, attached to the wall beside</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>the mixing valve, on which it was written that on 10/16/13 a new cartridge had been installed and on 3/17/15 the knob had been turned ½ of a turn to adjust the cold water coming in.</p> <p>Review of maintenance receipts from 10/4/13 to present revealed there were no receipts for the replacement of the mixing valve cartridge.</p> <p>Review of facility's water temperature logs for the months of January 2015, February 2015 and March 2015 revealed water temperature recordings ranged from 102 degrees F to 108 degrees F in residents ' rooms. There was no Central Bath water temperatures recorded on the logs.</p> <p>Interview on 3/17/15 at 12:25 PM with Administrative Staff #1 revealed the Maintenance Supervisor kept a log of the recorded water temperatures. He was not aware of any problems with the hot water and they were working on getting a plumber in on 3/17/15 to assess the problem. He reported that when or if there was a problem, staff reported it to their supervisor who relayed the information to the maintenance department either verbally or in writing.</p> <p>Interview on 3/17/15 at 12:35 PM with the Maintenance Supervisor revealed there were no manufacturer's instructions available for the mixing valve. He added that the cartridge had not had a routine maintenance since 2013 when it was installed. He reported that the last time he checked the mixing valve was last week (Thursday or Friday) by checking the temperature on the gauge. He reported that he adjusted the mixing valve according to what they needed the water temperature to be. He didn't have anything in writing indicating the recommended temperature setting. He normally adjusted the mixing valve so that the water temperature going</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>out is at 120 degrees F and 110 degrees F for incoming based on knowledge. He reported that he turned the water temperature all the way down at 12:20 PM (3/17/15) because the water was not cooling and the mixing valve temperature gauge was up to 140 degrees F.</p> <p>Observation on 3/17/15 starting at 12:43 PM revealed the following:</p> <p>Room #102 sink 130 degrees F for 9 seconds dropped to 111 degrees F rose to 120 degrees F for 27 seconds rose to 122 degrees F for 13 seconds rose to 130 degrees for 15 seconds rose to 140 degrees for 60 seconds.</p> <p>Room #103 bath-sink 120 degrees F for 30 seconds.</p> <p>Interview on 3/17/15 at 1:00 PM with NA #3 (shower aide) was conducted. NA #3 revealed the water in the shower room was hot. She always checked the water temperature before the shower. NA #3 informed the Maintenance Supervisor 2 weeks ago.</p> <p>Interview on 3/17/15 at 3:05 PM with the plumber revealed the mixing valve was brass and the cartridge/control stem (regulates the water temperature) was messed up. The cartridge/control stem which was inside the mixing valve was stuck and he was not able to take it out. The only way to fix it was to replace the mixing valve. He reported that the mixing valve was cut back off after working on it at 2:50 PM. He also reported that the mixing valve should be checked at least every 3 months.</p> <p>Interview on 3/17/15 at 3:14 PM with the Maintenance Supervisor revealed that he</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>checked the mixing valve last Friday as a normal routine check and the outgoing temperature gauge was at 120 degrees F and the incoming temperature gauge was at 110 degrees F. He reported that he usually checks the temperature gauges 2-3 times per week.</p> <p>Interview on 3/17/15 at 3:15 PM with Administrative Staff #1 revealed he will put up signs to notify everyone that the hot water is currently off until 3/18/15 after repairs are done. It was discussed that the facility will be using bath wipes for activity of daily living (ADL) care.</p> <p>Interview on 3/18/15 at 8:20 AM with NA #2 revealed that she had been a shower aide for 8 months. NA #2 reported the water was hot then but, not as hot as it had gotten to be as of 2 weeks ago. It was so hot that you can see the steam.</p> <p>Interview on 3/18/15 at 8:25 AM with NA #3 revealed that the water had been hot but lately, as of 2 weeks ago, it was real hot in the shower room and in the resident's sink. It was too hot you could see the steam coming out and the water fluctuated from being too hot to cold. NA #3 was aware that she should have written it in the book (communication book for the maintenance supervisor) but because she saw the Maintenance Supervisor on the floor she just informed him verbally. The Maintenance Supervisor informed NA #3 that he already adjusted the water temperature. The previous director of nursing (DON) and unit managers were aware of the hot water and when the water temperature was too hot, she was told not to give shower.</p> <p>Interview on 3/18/15 at 8:30 AM with NA #4</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>revealed the water was hot in the sinks and in the shower rooms. It fluctuated from being too hot to cold, when it was hot you could see the steam.</p> <p>On 3/18/15 at 8:33 AM, Resident #22 was interviewed. She stated that she used the water in the bathroom sink. She indicated the water was real hot especially for her with tender skin but she knew how to mix it with cold water.</p> <p>Interview on 3/18/15 at 9:15 AM with the Maintenance Supervisor revealed that he did not check the temperature on Central Bathroom. He reported that he checked the water temperatures in the rooms and did not know that he needed to check the central bathrooms.</p> <p>Observation on 3/18/15 at 2:45 PM of Maintenance Supervisor calibrating his thermometer revealed that he used a cup of small cubed ice (with no water) and inserted the thermometer probe approximately 2 inches into the center of the cup of ice until the thermometer read 32 degrees, then removed the thermometer. He checked the water temperature by holding the thermometer probe directly in the center of the water flow so that the water actually fell on the middle of the stem of the probe and the tip of the probe was not in the stream of water.</p> <p>On 3/18/15 at 3:14 PM, the Administrator was informed of immediate jeopardy. The facility provided a credible allegation of compliance on 3/19/15 at 4:45 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.</p> <p>Credible Allegation of Compliance:</p> <ul style="list-style-type: none"> 3/17/2015- Maintenance director immediately lowered water temperature valve to reduce hot water temperatures immediately there-after. 	F 323			

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F 323	<p>Continued From page 23</p> <ul style="list-style-type: none"> · 3/17/2015- 2:50 pm - Plumber arrived to assess heating unit for repair and found that the mixing valve needed replacement. Valve had to be special ordered for over-night delivery and plumber would make repair on 3/18/2015. · 3/17/2015- 3 pm-Maintenance director informed administrator that hot water valve was turned off from residential areas to eliminate risk of hot water temperatures. · 3/17/2015- A memorandum was posted throughout the facility to notify all residents, family members, visitors, and staff of the hot water valve being shut down and its repair. · 3/18/2015- 4 pm- Administrator made several follow-up calls to the plumber regarding service repair starting around 10 am. The plumber did not make facility visit as scheduled but informed writer at 4 pm that the wrong valve was delivered and another mixing valve was reordered for 3/19 delivery. · 3/18/2015- The facility ' s corporate office provided policies on Water Temperature-Safety, Preventive Maintenance of Hot Water, and Elevated Hot Water Readings. · 3/18/2015-All staff on floor was in-serviced on policy and procedures regarding elevated hot water by staff development coordinator, and nurse supervisors. Staff not in-serviced will be in-serviced prior to working on floor. · 3/18/15-Revised memos were posted with new repair date of 3/19/2015. Once repairs are completed, the plumber has agreed to instruct maintenance director to complete monthly preventative maintenance as recommended by the mixing valve ' s operations manual. · 3/19/15-11:15 are- plumbers confirmed 11:30 am start of service repair for mixing valve. · 3/19/15- 1 pm- Plumber completed repair and provided operation and maintenance manual. 	F 323			

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F 323	<p>Continued From page 24</p> <ul style="list-style-type: none"> · 3/19/15-1 pm- Maintenance director provided temperatures checks upon completion of the repairs and the readings indicated 113 degrees. · The owner and maintenance manual provide the following instruction for preventative maintenance: <ul style="list-style-type: none"> o The cartridge unit contains the entire valve control mechanism. For non-interrupted services, keep a spare cartridge at hand o Temp Control valve control mechanism must be kept clean and free from deposits and any foreign matter build-up that will be present in many water systems o Inspect within 30 days of initial installations or operation. o If inspection determines that your water system causes deposits and foreign matter build-up monthly, then valve should be cleaned monthly as follows <ul style="list-style-type: none"> § Remove cartridge (see page 11 for cartridge removal and replacement section). § Soak in any acceptable de-liming agent or regular household vinegar. § Wash off deposits § Be sure piston is moving freely in its sleeve § Replace cartridge § Clean more frequently if your system so demands § Do not completely remove piston from cartridge · A copy of the operation and maintenance manual will be kept next to the mixing valve and the maintenance director ' s office. · Facility will have a spare cartridge as recommend in operations manual. · Facility expects to be in compliance from the immediate jeopardy on 3/19/15. <p>On 3/19/15, validation of the credible allegation</p>	F 323			

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F 323	Continued From page 25 was conducted. Review of the in-service records revealed that 58 employees were already in-serviced on the facility ' s policy on elevated hot water readings, preventative maintenance of hot water and safety of water temperatures on 3/18/15. Staff interviews were conducted with the staff (nursing and non-nursing) on reporting of hot water temperature and with the maintenance supervisor on the maintenance of the mixing valve per manufacturers ' instruction and monitoring of water temperature to include the central bath. The water temperature in the residents ' rooms and central bath were checked and it ranged from 104-114 degrees F.	F 323			
F 329 SS=D	483.25(I) 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.	F 329		4/15/15	

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain laboratory tests as ordered by the physician for 1 of 5 sampled residents (resident #91) reviewed for unnecessary medications. The findings included: Resident #91 was admitted to the facility on 12/16/13 with multiple diagnoses including hypothyroidism, pressure ulcer, chronic malnutrition, history of a urinary tract infection, abdominal pain, urinary incontinence and Alzheimer's disease. A review of the Physician's Orders revealed an order dated 1/7/15 which read " Increase levothyroxine to 200 micrograms by mouth every day. Thyroid Stimulating Hormone (TSH) 4 weeks. " Levothyroxine, a thyroid replacement medication, is a man-made version of the hormone thyroxine (T4). T4 is a hormone produced by the thyroid gland to help keep many of the body's systems working properly. TSH is a laboratory test performed to monitor treatment of thyroid disorders with thyroid replacement medication. The order was handwritten by the physician. The physician did not record the time the order was written. A review of the laboratory results from 1/7/15 to 3/18/15 revealed there were no documented laboratory results for the thyroid stimulating hormone ordered by the physician on 1/7/15.	F 329	On 3/18/15, orders for labs reviewed by staff development coordinator on Resident # 91. Identified missing lab results for TSH, CBC, & Renal. Order written 3/18/15. Lab results received & faxed to MD 3/19/15 by SDC nurse On 4/8/2015, 100% of current resident charts were audited by medical records director for missing labs. All labs ordered by MD were reconciled SDC nurse had in-serviced all nurses and shift supervisors on how to process & track labs using Lab Book. completed on 3/27/2015 Lab orders will be reviewed by Dayshift supervisor, SDC and compliance nurse daily & entered into lab book. Labs to be drawn on next lab day. Night shift supervisor will be responsible to review all lab orders and to ensure lab slips are completed & place initials on top of yellow copies of MD orders. Day shift supervisor will then collect orders and take		

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F 329	Continued From page 27 An interview was conducted with Nurse #4 on 3/18/15 at 9:58 AM. Nurse #4 stated the laboratory test ordered for Resident #91 on 1/7/15 was "overlooked" and not obtained by the facility. An interview was conducted with Nurse #5 on 3/18/15 at 4:01 PM. Nurse #5 stated the nurse on duty was expected to complete a laboratory slip when laboratory tests were ordered. She stated a laboratory slip was not completed for the laboratory test ordered by the physician on 1/7/15. Nurse #5 stated she contacted the laboratory on 3/18/15 and was told the laboratory specimen was not collected. An interview was conducted with Administrative Staff #2 on 3/18/15 at 4:52 PM. She stated the nurse on duty was expected to complete a laboratory slip for a laboratory test when ordered by the physician.	F 329	it to the clinical meeting where they will be reviewed for compliance or follow-up. Medical records director will be auditing 10 medical records listed in lab book to ensure that labs ordered were drawn and results were on file weekly X4-then monthly X4 until compliance is achieved. Results of the monitoring will be brought and discussed By medical records director in monthly QA meeting- will be responsible for auditing the lab book on a weekly basis to ensure compliance is met. Monthly lab log will be part of QAPI process for auditing. This practice will list amount of labs ordered, amount of lab results received, and/or missing labs. This will be done x 3 months, to include quarterly QA review and will continue until compliance is ensured.		
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	F 431		4/15/15	

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F 431	<p>Continued From page 28</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions and staff interview, the facility failed to label and date multi-dose vials and discard expired medications in two of two medication rooms (main medication room refrigerator and 400 medication room) and failed to discard expired medications in three of five medication carts (100, 300 and 400 medication carts). The findings included:</p> <p>1. On 3/19/15 at 10:30AM, an observation of the medication room refrigerator was conducted with Nurse #1. An opened/ undated vial of Aplisol</p>	F 431	<p>On 3/19/15, main medication room refrigerator & 400 medication room multi-dose vials were audited & if found, all expired medications or those unmarked were discarded immediately.</p> <p>On 3/19/15, med carts (100, 300, & 400) were audited & if found, all expired medications were discarded immediately.</p> <p>On 3/19/15, 100% of all med carts & med storage refrigerators were audited and if</p>		

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F 431	<p>Continued From page 29 vaccine (tuberculin vaccine used for skin testing in the diagnosis of tuberculosis) was noted.</p> <p>The manufacturer's product information was reviewed and indicated opened vials should be discarded after thirty (30) days.</p> <p>On 3/19/15 at 10:30AM, Nurse #1 stated multi-dose vials were supposed to be dated when they are opened.</p> <p>On 3/19/15 at 11:45AM, Administrative staff #2 stated she expected nursing staff to date all multi-dose vials when they were opened.</p> <p>2. On 3/19/15 at 10:30AM, an observation of the 100 hall medication cart was conducted with Nurse #1. A bottle of multivitamin/ multimineral supplement tablets was opened and being used with an expiration date of 1/15. There was also one bottle of Geri-lanta (antacid medication) opened and being used with an expiration date of 10/13.</p> <p>On 3/19/15 at 10:30AM, Nurse #1 stated all medications were supposed to be checked for the expiration date prior to putting the medications in the cart and the medications should not be close to the expiration date. She stated she had not checked the medications for their expiration date.</p> <p>On 3/19/15 at 11:45AM, Administrative staff #2 stated the nursing staff of night shift performed audits on every cart and medication room nightly and the expired medications should have been discarded.</p> <p>3. On 3/19/15 at 10:30AM, an observation of the 300 hall medication cart was conducted with</p>	F 431	<p>found unmarked or expired, the medications were discarded.</p> <p>3/19/2015 All nursing staff will be in serviced on medication storage by SDC nurse. completed by 4/8/2015</p> <p>3/18/2015 the night shift supervisor was reminded of her responsibilities by DON to audit medication carts nightly and was educated on using the Omnicare medication storage audit and guidelines as she will be responsible for this task on an ongoing weekly basis.</p> <p>the night shift supervisor will submit to D.O.N.'s office a signed medication storage audit weekly.-this will be ongoing</p> <p>D.O.N. will bring weekly Night shift supervisor's medication storage audit, along with Omnicare Pharmacy medication storage audits to monthly QA meetings x 3 months, to include quarterly until compliance is met.</p> <p>Omnicare Pharmacy Services will also continue to do random cart medication storage audits every 60 days.</p>		

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F 431	<p>Continued From page 30</p> <p>Nurse #1. A bottle of ranitidine (acid reducer) was opened and being used by nursing staff with an expiration date of 1/15.</p> <p>On 3/19/15 at 10:30AM, Nurse #1 stated all medications were supposed to be checked for the expiration date prior to putting the medications in the cart and the medications should not be close to the expiration date. She stated she had not checked the medications for their expiration date.</p> <p>On 3/19/15 at 11:45AM, Administrative staff #2 stated the nursing staff of night shift performed audits on every cart and medication room nightly and the expired medications should have been discarded.</p> <p>4. On 3/19/15 at 10:40 AM, the medication cart on 400 hall was observed. There was a bottle of Vitamin D3 with vitamin A with an expiration date of 1/2015 observed. At 10:50 AM, Nurse # 2 was interviewed. She observed the bottle and acknowledged that it was expired. She revealed that the night nurse was responsible for checking the medication carts and the medication room for expired and undated medications.</p> <p>On 3/19/15 at 11:45AM, Administrative staff #2 stated the nursing staff of night shift performed audits on every cart and medication room nightly and the expired medications should have been discarded.</p> <p>5. On 3/19/15 at 10:45 AM, the medication room was observed. There was a bottle of Calcium Citrate with an expiration date of 10/2014 observed in the medication room. Nurse #2 observed the bottle and acknowledged that it was</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
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F 431	Continued From page 31 expired. She revealed that the night nurse was responsible for checking the medication cart and medication room for expired and undated medications. On 3/19/15 at 11:45AM, Administrative staff #2 stated the nursing staff of night shift performed audits on every cart and medication room nightly and the expired medications should have been discarded.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		4/15/15	

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F 441	<p>Continued From page 32</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions and staff interview, the facility failed to follow manufacturer's instructions for the disinfection of the blood glucose meter (glucometer) after obtaining a fingerstick blood sugar on Resident #44 (Nurse #1) and Resident #43 (Nurse #2). The findings included:</p> <p>A facility policy titled " Obtaining a fingerstick glucose level " (revised December 2011) stated, in part, "18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. "</p> <p>Manufacturer's instructions for (name) germicidal disposable wipes stated "To disinfect nonfood contact surfaces only: use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe (s) if needed to assure continuous two (2) minute wet contact time. Let air dry."</p> <p>1. An observation of Nurse #1 obtaining a</p>	F 441	<p>On 3/18/15, Nurse #1 & Nurse #2 completed an in-service provided by SDC nurse on disinfecting glucometer, followed by practical return demonstration.</p> <p>All nurses scheduled including (PRN and weekend staff) to work will complete an in service by SDC on disinfecting glucometer, followed by practical return demonstration. all staff will be in-serviced prior to working on floor</p> <p>Sanitizing Glucometer Machine was a new skill added on original Orientation Skills Checklist for LPN/RN for all new employed nurses.</p> <p>The same Orientation Skills Checklist for LPN/RN will be completed on an annual basis thereafter and stored in the employee file. SDC will ensure all new nurse employees have completed the new Orientation Skills Checklist for LPN/RN prior to working on the floor.</p>		

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F 441	<p>Continued From page 33</p> <p>fingerstick blood sugar for Resident #44 was conducted on 3/18/15 at 11:45AM. Following the procedure, Nurse #1 cleaned the glucometer machine with a (name) germicidal disposable wipe, disposed of the germicidal wipe and left the glucometer to air dry on top of the medication cart. Nurse #1 proceeded to prepare to perform a fingerstick glucose level test on the next resident and was stopped. When asked regarding the procedure for disinfection of the glucometer, Nurse #1 stated she usually cleaned the glucometer with the germicidal wipe and let it air dry while she went on to the next resident. She stated she usually waited at least a minute prior to performing the next fingerstick glucose level. She was not aware of the instructions on the germicidal disposable wipe container. Nurse #1 stated she had received an in-service on the infection control for the glucometers but was not sure exactly when she had received it.</p> <p>On 3/18/15 at 1:15PM, Administrative staff #2 stated she expected staff to follow the manufacturer's instructions on the germicidal disposable wipes for cleaning of the glucometers.</p> <p>On 3/18/15 at 1:15 PM, Nurse #3 (clinical coordinator) stated the procedure for cleaning the glucometers included wiping the glucometer with a disinfecting sanitary wipe, wrapping it for 5 minutes, then allowing the glucometer to dry before proceeding to the next resident. Nurse #3 stated he could not find any in-services regarding cleaning of the glucometers.</p> <p>2. An observation of Nurse #2 obtaining a fingerstick blood sugar on Resident #43 was conducted on 3/18/15 at 12:05PM. Following the</p>	F 441	<p>monitoring will be completed by SDC to ensure accuracy of process 4-5 per week x 4 weeks, then monthly x 3 months, then quarterly until compliance is substantiated. These results will be presented by SDC during quarterly QA meetings.</p> <p>Staffing Coordinator will ensure Orientation Skills Checklist for LPN/RN is completed prior to scheduling new nurses to an independent assignment.</p>		

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F 441	Continued From page 34 procedure, Nurse #2 cleaned the glucometer with a (name) disposable germicidal wipe and discarded the germicidal wipe. Nurse #2 proceeded to obtain the supplies to perform the next fingerstick glucose monitoring test. Approximately one minute had elapsed since she cleaned the glucometer with the (name) disinfecting wipe. Nurse #2 was stopped prior to performing the next fingerstick glucose monitoring test. Nurse #2 stated the procedure for cleaning the glucometer was to wipe it with a disinfectant wipe between residents. She indicated she did not know if there was a time frame for the glucometer to remain wet prior to using it for the next resident. On 3/18/15 at 1:15PM, Administrative staff #2 stated she expected staff to follow the manufacturer's instructions on the germicidal disposable wipes for cleaning of the glucometers. On 3/18/15 at 1:15 PM, Nurse #3 (clinical coordinator) stated the procedure for cleaning the glucometers included wiping the glucometer with a disinfecting sanitary wipe, wrapping it for 5 minutes, then allowing the glucometer to dry before proceeding to the next resident. Nurse #3 stated he could not find any in-services regarding cleaning of the glucometers.	F 441			
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		4/15/15	

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F 490	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's administration failed to utilize manufacturer's instructions to maintain and monitor hot water system, failed to have a policy and procedure to address notification of administration when the hot water problem was not promptly resolved and failed to monitor and train the maintenance supervisor on how to calibrate the thermometer, monitor the water temperature, and provide preventative maintenance on the mixing valve. The administrator was not aware of the hot water problem in the resident's rooms and shower rooms, not aware that the maintenance supervisor was not providing preventative maintenance on the mixing valve and was not aware that the maintenance supervisor was not monitoring the water temperature in the shower rooms. Findings included: Immediate Jeopardy began on 3/17/15 at 9:30 AM when elevated hot water temperatures were identified in room #102 at 138 degrees F and in room #114 at 130 degrees F. On 3/26/15 at 11:30 AM, the administrator was informed of the immediate jeopardy. Immediate jeopardy was removed on 3/26/15 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective and all staff were in serviced.	F 490	3/19/2015 plumbing technician instructed maintenance director on how to monitor and complete preventive maintenance on the mixing valve according to the manufactures manual. 3/25/2015 Maintenance Director instructed on how to calibrate Thermometers by Administrator via USDA instructions on calibrating thermometer. 3/19/2015 maintenance director modified water temperature log to list reading for the shower rooms. 3/18/2015- an all staff in-serviced on policy and procedures on water system and inform maintenance director or administration immediately if there were concerns with elevated temps.- there are only PRN staff that have not been in-serviced. however, scheduler will monitor PRN staff for in-service prior to starting work. Semi annual hot water system checks by plumbing technician -dates have been scheduled for 6/1/2015 and 12/1/2015. Maintenance director will complete monthly mixing valve maintenance by soaking cartridge with operational manual's preferred cleaning agent. a replacement cartridge will be inserted in the mixing valve so that there would not		

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F 490	<p>Continued From page 36 This tag is cross referred to F323</p> <p>Based on observations, staff interviews and record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in 8 of 11 resident's rooms checked (#102, #103, #114, #201, #202, #203, #215, #302) and 2 of 2 central bathrooms (100 and 400 hall).</p> <p>On 3/26/15 at 9:25 AM, the maintenance supervisor was interviewed via phone. He stated that nobody from the facility had trained him and that he had learned his job especially on how to calibrate the thermometer and how to check the water temperature from his previous job as a maintenance person. He indicated that he didn't see manufacturer's instructions for the mixing valve when he started. When the cartridge was installed on 10/16/13, there was a manual that came with it but he didn't read the manual. During the survey (3/17/15), he was looking for the manual and could not find it. He revealed that he didn't know that he had to provide preventative maintenance such as cleaning the cartridge on a regular basis. He indicated that nobody had told him that he had to check the water temperature in the shower rooms. He added that if he had some questions regarding his job, he went to the administrator or the director of nursing.</p> <p>On 3/26/15 at 10:06 AM, the administrator was interviewed via phone. He stated that he was not aware that the facility had no manufacturer's instruction/manual for the mixing valve. He also revealed that the facility had no policy and procedure to address notification of the</p>	F 490	<p>be any interrupted service with water. the cartridge will need to be soaked overnight and it can be inserted back to mixing valve. the date of when the mixing valve has been serviced will be logged the preventative maintenance is scheduled on 4/20/15 and monthly thereafter.</p> <p>Water temperatures will be listed in a weekly log. they will be audited monthly by administrator.</p> <p>The maintenance director will also calibrate Thermometers prior to completing water temperature checks and information logged. Administrator will audit monthly for accuracy.</p> <p>Monthly water temperature checks will be conducted by administrator and maintenance director.</p> <p>Audits of water temperature logs completed monthly by administrator.</p> <p>Water temp log, mixing valve, preventative maintenance log and thermometer calibration log will be presented by maintenance director during QA and safety meetings on a monthly basis to address proper functioning of Hot water system.</p>		

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F 490	<p>Continued From page 37</p> <p>administration when hot water problem not promptly resolved. The administrator further indicated that the maintenance supervisor was already employed at the facility before he started as the administrator, so he didn't know who trained him and what training he had received. He also revealed that he was not aware that the maintenance supervisor was not providing preventative maintenance on the mixing valve like routine cleaning but he was aware that he was checking it for leaks or other problems. He also indicated that he was not aware of the hot water problems in the resident's rooms and shower rooms. He stated that he was aware that the maintenance supervisor was checking the water temperature in the resident's rooms but he was not aware that he was not checking the shower rooms.</p> <p>On 3/26/15 at 3:14 PM, the Administrator was informed of immediate jeopardy. The facility provided a credible allegation of compliance on 3/26/15 at 8:06 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.</p> <p>Credible Allegation of Compliance:</p> <ul style="list-style-type: none"> · 3/18/15- The facility ' s corporate office provided policies on Water Temperature-Safety, Preventive Maintenance of Hot Water, and Elevated Hot Water Readings. · 3/18/15- One policy refers employee to call their immediate supervisor if there is any concerns regarding hot water. Also, if hot water continues -residents, family and staff will be notified of the matter and completion of the repairs by administration. · 3/18/15-When water temps were high- a memo was posted to notify residents, families, 	F 490			

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F 490	<p>Continued From page 38</p> <p>visitors and staff with the time of repair completion.</p> <ul style="list-style-type: none"> · 3/18/2015-All staff on floor was inserviced on policy and procedures regarding elevated hot water by staff development coordinator, and nurse supervisors. Staff not inserviced will be inserviced prior to working on floor. · 3/19/15- 1 pm- Plumber completed repair of Mixing Valve and provided operation and maintenance manual. He also instructed maintenance director on how to complete a preventative maintenance on the Mixing Valve. · 3/19/15-1 pm- Maintenance director provided temperature checks upon completion of the repairs and the readings indicated 113 degrees. · The owner and maintenance manual provide the following instruction for preventative maintenance: <ul style="list-style-type: none"> o The cartridge unit contains the entire valve control mechanism. For non-interrupted services, keep a spare cartridge at hand o Temp Control valve control mechanism must be kept clean and free from deposits and any foreign matter build-up that will e present in many water systems o Inspect within 30 days of initial installation or operation. o If inspection determines that your water system causes deposits and foreign matter build-up monthly, then valve should be cleaned monthly as follows <ul style="list-style-type: none"> § Remove cartridge (see page 11 for cartridge removal and replacement section). § Soak in any acceptable de-liming agent or regular household vinegar. § Wash off deposits § Be sure piston is moving freely in its sleeve § Replace cartridge § Clean more frequently if your system so 	F 490			

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F 490	<p>Continued From page 39</p> <p>demands</p> <p>§ Do not completely remove piston from cartridge</p> <ul style="list-style-type: none"> · 3/19/15- A copy of the operation and maintenance manual will be kept next to the mixing valve and the maintenance director ' s office. · 3/19/15- Facility will have a spare cartridge as recommend in operations manual. · 3/19/2015- Water temperature Log was modified to include both central shower rooms for water temperature checks. · 3/24/15- Water temperature readings averaged 112 degrees · 3/26/15- Water temperature checked and read an average of 105 degrees F · 3/26/15- Maintenance Director reviewed United States Department of Agricultures printed instructions on thermometer calibration and reviewed both process of thermometer calibration and water temperature checks . · 3/26/15- A revised thermometer calibration log was created for weekly checks prior to water temperature checks · 3/26/15- QAA committee reviewed water temperature monitoring tools, and discussed water temperature checks, the implementation of policy and procedure · 3/26/15 Maintenance director was in-serviced on monitoring of water temperatures and on the thermometer calibration using the new log weekly by administrator. These logs will be monitored by the administrator monthly and in QA meetings. · 3/26/15 - Facility alleged to be in compliance. <p>On 3/27/15 at 3:09 PM - validation of the credible allegation was conducted. The maintenance supervisor was interviewed and revealed that he had been in-serviced by the administrator on how</p>	F 490			

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F 490	Continued From page 40 to calibrate the thermometer and on how to check the water temperatures. A new weekly thermometer calibration form was created and the water temperature form was revised to include the central shower rooms. These forms will be brought to QA monthly. He also stated that he was already instructed by the plumber on the preventative maintenance of the mixing valve and the manual was kept beside the mixing valve. The administrator was interviewed and revealed that the policy was revised as well as the monitoring tools. He further stated that he will be monitoring these tools monthly as well as in the QA meeting. The revised policy, revised water temperature log and new thermometer calibration logs were reviewed. The in-service records of the staff and the maintenance supervisor were also reviewed.	F 490			
F 518 SS=C	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to train and drill all staff for emergency preparedness (disaster) drills. The findings included: An Administrative Policy and Procedure titled "Drills" undated, stated, in part, "The following drills will be conducted at our facility to assist	F 518	On 3/19/2015 an in-service on disaster preparedness and fire safety was initiated and was completed 4/15/2015 by SDC nurse. 4/6/15-safety committee met and scheduled an all staff in-service on disaster preparedness- 4/23/15.	4/23/15	

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F 518	<p>Continued From page 41</p> <p>personnel in preparing for emergency or disaster situations that could occur or affect out routine operations: fire drills-quarterly on each shift and disaster drills-biannuallyAppropriate documentation will be maintained for each drill conducted."</p> <p>On 3/19/15 at 1:30 PM, Fire and emergency preparedness (disaster) logs from July 2014 through 2/14/15 were reviewed. There was no documentation that the facility had trained the facility staff and/ or conducted any disaster drills from July 2014 through 2/14/15.</p> <p>On 3/19/15 at 2:00 PM, an interview was conducted with the Administrator who stated the maintenance supervisor was in charge of training and conducting the fire and emergency preparedness (disaster) drills. He stated all drills should be conducted as per facility policy.</p> <p>On 3/19/15 at 2:06 PM, cook #1 was interviewed regarding fire drill protocol and protocol for emergency preparedness (missing person/tornado). Cook #1 stated, in the case of a fire, she would announce code red and the location of the fire on the overhead speaker. Someone in the kitchen would grab the fire extinguisher and go to the location of the fire. If the fire was in a resident's room, she would remove the resident from the room. Cook #1 knew the location of the fire alarms and extinguishers and how to use the fire extinguisher. In the case of a tornado, cook #1 stated she would close the doors and make the residents safe.</p> <p>On 3/19/15 at 2:18 PM, NA#7 was interviewed regarding fire drill protocol and protocol for</p>	F 518	<p>4/17/2015- missing person drill will be conducted will be conducted by SDC nurse.</p> <p>4/21/2015- Tornado Drill will be conducted by maintenance director.</p> <p>All new employees received disaster training during orientation on 3/26/2015 by maintenance director/SDC nurse</p> <p>Semi-annual emergency Preparedness drills will be conducted in June and December of 2015.</p> <p>Ongoing employee orientation training on emergency preparedness to be held monthly by SDC nurse/maintenance director</p> <p>Continued Fire drills to be conducted quarterly by maintenance director.</p> <p>upon completion of emergency preparedness drill the maintenance director will present results to the safety committee where discussions to improve systems will be held. department managers involved in the safety committee are therapy director, DON, SDC, HR, dietary, housekeeping, activities director and administrator</p> <p>Administrator will monitor in-service/drills completed by maintenance director or SDC nurse monthly x3 and quarterly thereafter.</p>		

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NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
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F 518	Continued From page 42 emergency preparedness (tornado). NA #7 stated she would check on the residents in her work area, locate the fire, alert the supervisor and check with other nursing assistants and staff. She would ensure the safety of the residents and then try to extinguish the fire. NA #7 knew the location of the fire alarms and extinguishers and how to use the fire extinguisher. In the case of a tornado, NA #7 stated she would secure the windows and doors and make sure the residents were away from the windows and doors. On 3/19/15 at 2:23 PM, an interview was conducted with the Maintenance supervisor. He stated he had not trained the facility staff regarding emergency preparedness (disasters) or conducted any disaster drills since he had been employed at the facility which was four years. He stated he verbally reviewed the disaster drill procedure during the fire drills but had never documented it and had never reviewed the emergency preparedness drill for missing person. He stated they had talked about having disaster drills but just hadn't done it.	F 518	In-serving and emergency preparedness drills will be presented by maintenance director/SDC nurse and reviewed quarterly during quarterly quality assurance meetings and monthly in safety committee meetings.		
F 520 SS=K	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	F 520		4/15/15	

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F 520	<p>Continued From page 43 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require 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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's quality assessment and assurance committee (QAA) failed to have systems in place to identify problems with water temperatures. The facility's QAA committee had no system in place to evaluate and monitor the performance of the maintenance supervisor.</p> <p>Immediate Jeopardy began on 3/17/15 at 9:30 AM when elevated hot water temperatures were identified in room #102 at 138 degrees F and in room #114 at 130 degrees F. The administrator was notified of immediate jeopardy on 3/26/15 at 11:30 AM. Immediate jeopardy was removed on 3/26/15 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective and all staff were in serviced.</p>	F 520	<p>3/26/15 Quality assurance meeting held to discuss water temperature and mixing valve repair.</p> <p>3/26/26/2015 a quarterly performance checklist was created to address maintenance director's completion of fire drills, emergency preparedness drills, and water temperatures are included in checklist which was completed with maintenance director on above date</p> <p>Administrator will review and complete performance checklist with maintenance director quarterly.</p> <p>Work orders log will be discussed daily to address any maintenance concerns via morning meeting.</p> <p>Administrator will be reviewing all maintenance logs on water temperatures,</p>		

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F 520	<p>Continued From page 44</p> <p>Findings included:</p> <p>Cross refer to F323. Based on observations, staff interviews and record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in 8 of 11 resident's rooms (#102, #103, #114, #201, #202, #203, #215, #302) and 2 of 2 central bathrooms (100 and 400 hall).</p> <p>On 3/19/15 at 3:59 PM, the administrator was interviewed. He stated that he was the head of the QAA committee. He stated that the committee consisted of all the department heads including the medical director. The committee had met every third Wednesday of the month. The department heads identified issues in their department and brought the issues to QAA meeting. The committee implemented interventions if there were issues and the specific department (with issues) was responsible for the monitoring and evaluation if interventions were effective or not. The maintenance supervisor was responsible to identify issues in his department to include the hot water temperature. The maintenance supervisor had brought his temperature log to the meeting every month and there were no issues noted. The committee also had identified problems by their satisfaction surveys from the family members and by the reports from the sub committees like falls/wounds.</p> <p>On 3/26/15 at 9:25 AM, the maintenance supervisor was interviewed via phone. He stated that aside from checking the water temperature in the resident's rooms once a week, he also</p>	F 520	<p>calibration, and preventative maintenance of mixing valve.</p> <p>Safety Committee will also meet monthly and address any immediate concerns pertaining elevated water temperatures or like concerns with maintenance director - meeting held on 4/6/2015.</p> <p>Checklist and created logs for water temperatures, thermometer calibration, mixing valve maintenance will be presented by maintenance director and reviewed by committee during quarterly quality assurance meetings and monthly safety meetings.</p>		

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F 520	<p>Continued From page 45</p> <p>checked the gauge on the mixing valve to make sure it was set at 120 degrees F going out and 110 degrees F going in.</p> <p>On 3/26/15 at 10:06 AM, the administrator was interviewed via phone. He stated that he had no other system in place to identify problems with hot water aside from the checking of the water temperature by the maintenance supervisor on a weekly basis. He was not informed that the staff and the residents were experiencing hot water temperatures in the resident's room and shower rooms. He also stated that he had monitored the maintenance supervisor by checking his water temperature logs and repair logs. He revealed that he had not observed the maintenance supervisor in calibrating the thermometer.</p> <p>On 3/26/15 at 11:30 AM, the Administrator was informed of immediate jeopardy. The facility provided a credible allegation of compliance on 3/26/15 at 8:06 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy. Credible Allegation of Compliance:</p> <ul style="list-style-type: none"> · 3/26/2015- The QAA Committee had met and addressed the identified concern regarding water temperatures; <ul style="list-style-type: none"> o Facility has established a Calibration Log for facility thermometers and revised the water temperature log to include the central shower rooms and committee will be reviewing completed logs on the monthly QA meetings o Weekly water temperature Logs for 3/19, 3/24 and 3/26- Temps were within 100-116 o Policy and Procedures were reviewed on hot temperatures and reporting to immediate supervisor as well. Committee established to 	F 520			

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F 520	<p>Continued From page 46</p> <p>have monthly water temperature checks by both Administrator and Maintenance Director.</p> <ul style="list-style-type: none"> o United States Department of Agriculture guidelines on how to calibrate thermometer was reviewed during meeting o Committee discussed that Plumbing Technician would do semi-annual checks to monitor maintenance director's performance on water system and temperature checks <ul style="list-style-type: none"> · 3/26/2015- A quarterly maintenance performance checklist was completed today by this administrator which will be reviewed during the QA meetings. · 3/26/2015- facility alleged to be in compliance. <p>On 3/27/15 at 3:09 PM - validation of the credible allegation was conducted. The maintenance supervisor was interviewed. He stated that he was a member of the QA committee. He indicated that the QA committee had met and discussed the hot water temperature issue. The committee had revised and created new forms for the monitoring of the hot water temperature. He indicated that these forms will be presented to the QA meetings monthly. He also stated that he was already instructed by the plumber on the preventative maintenance of the mixing valve and the manual was kept beside the mixing valve. The administrator was interviewed and revealed that the policy was revised as well as the monitoring tools. He further stated that he will be monitoring these tools monthly as well as in the QA meeting. The revised policy, revised water temperature log and new thermometer calibration logs were reviewed. The in-service records of the staff and the maintenance supervisor were also reviewed.</p>	F 520			

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