STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

(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 No deficiencies were cited as a result of the Complaint Investigation. Event ID #NM1111.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair the footboard of a residents bed (Room 112-A), failed to repair 2 bathroom doors (room #124 and #128), failed to repair resident room doors with broken and splintered laminate and wood for 11 of 29 resident rooms in the skilled nursing section of the facility (Room #101,#105, #107, #108, #114, #117, #118, #121, #122, #126, #127) and failed to repair the shower door on the 100 hall and the smoke barrier doors at the 100 hall. The findings included: 1. a. Observations on 08/31/15 at 9:35 AM in room #112-A during the initial tour of the facility revealed the foot board of the bed had broken vinyl molding and broken wood on the left corner on the footboard at the bottom of the bed. Observations on 09/01/15 at 11:26 AM in room #112-A revealed the foot board of the bed had broken vinyl molding and broken wood on the left corner on the footboard at the bottom of the bed. Observation on 09/02/15 at 11:43 AM in room #112-A revealed the foot board of the bed had	F 253	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice: The bed in room 112-A was replaced with a different bed. The bed in room 112-A currently has a new footboard. An assessment of all resident room doors, central bathroom doors and fire doors was completed on 9/21/15. The following doors: central bath, room 130 entry door, and room 124 bathroom door will be replaced with new doors. All other doors cited (#101, 105, 107, 108, 114, 117, 118, 121, 122, 126 and 127) will be repaired with Inpro door edge protectors and vinyl half-door kick plates. The replacement doors and product for repair has to be ordered and manufactured. In discussion with Inpro, we are informed that it is a 3-4 week manufacturing and delivery process.	10/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/24/2015

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 253	Continued From page 1 broken vinyl molding and broken wood on the left corner on the footboard at the bottom of the bed. Observations during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator in room #112-A revealed the foot board of the bed had broken vinyl molding and broken wood on the left corner on the footboard at the bottom of the bed. 2. a. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the bathroom door of room #124 had a large area of broken and splintered laminate with sharp, pointed edges on the back side of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the bathroom door of room #124 had a large area of broken and splintered laminate with sharp, pointed edges on the back side of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the bathroom door of room #124 had a large area of broken and splintered laminate with sharp, pointed edges on the back side of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the bathroom door of room #124 had a large area of broken and splintered laminate with sharp, pointed edges on the back side of the bottom half of the door. b. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the bathroom door of room #128 had a large area of broken and splintered laminate on the back side of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the bathroom door of room #128 had a large area	F 253	To ensure safety of residents, all doors cited have been sanded and repaired with wood putty and varnish to remove all sharp edges/peeling laminate until permanent repair materials arrive. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All room and bathroom doors on the 100 hall unit have been assessed. Some are in need of repair and will be repaired in a phase 2 repair project. Phase 1 repair will be for the doors cited as in need of repair and will be completed by October 30th. Doors identified in Phase 2 will be repaired following repair of Phase 1. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Monthly physical plant quality assurance rounds will be completed by the administrator and maintenance director. These rounds will include inspection of all doors, including room doors, bathroom doors and central bath doors. Any doors identified as in need of repair will be repaired within a 4 week time period from the identification of the need for repair. If repair with wood putty, stripping and sanding, and reapplying wood stain and varnish can correct the identified issue, completion will be by October 1st. A list of all doors inspected monthly will be	

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F 253	Continued From page 2 of broken and splintered laminate on the back side of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the bathroom door of room #128 had a large area of broken and splintered laminate on the back side of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the bathroom door of room #128 had a large area of broken and splintered laminate on the back side of the bottom half of the door. 3. a. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #101 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #101 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #101 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #101 had broken and splintered laminate on the front of the bottom half of the door. b. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #105 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #105 had broken and splintered laminate on the front of the bottom half of the door.	F 253	presented at monthly QAPI committee meetings. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The QAPI Committee will be responsible for ensuring that a physical plant inspection report is received monthly from the administrator and/or maintenance director identifying any door or doors in need of repair. The maintenance director will submit to the QAPI meeting on a monthly basis that any needed repair has been completed. The QAPI committee will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance.	

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F 253	Continued From page 3 Observation on 09/02/15 at 11:43 AM revealed the door of room #105 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #105 had broken and splintered laminate on the front of the bottom half of the door. c. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #107 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #107 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #107 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #107 had broken and splintered laminate on the front of the bottom half of the door. d. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #108 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #108 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #108 had broken and splintered laminate on the front of the bottom half of the	F 253		

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F 253	Continued From page 4 door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #108 had broken and splintered laminate on the front of the bottom half of the door. e. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #114 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #114 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #114 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director revealed the door of room #114 had broken and splintered laminate on the front of the bottom half of the door. f. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #117 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #117 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #117 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance	F 253		

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F 253	Continued From page 5 Director and Administrator revealed the door of room #117 had broken and splintered laminate on the front of the bottom half of the door. g. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #118 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #118 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #118 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #118 had broken and splintered laminate on the front of the bottom half of the door. h. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #121 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #121 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #121 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #121 had broken and splintered laminate on the front of the bottom half of the door.	F 253		

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F 253	Continued From page 6 i. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #122 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #122 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #122 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #122 had broken and splintered laminate on the front of the bottom half of the door. j. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of room #126 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #126 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #126 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #126 had broken and splintered laminate on the front of the bottom half of the door. k. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the door of	F 253		

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F 253	Continued From page 7 room #127 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the door of room #127 had broken and splintered laminate on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the door of room #127 had broken and splintered laminate on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the door of room #127 had broken and splintered laminate on the front of the bottom half of the door. 3. a. Observation during the initial tour of the facility on 08/31/15 at 9:35 AM revealed the shower door for the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observation on 09/01/15 at 11:26 AM revealed the shower door for the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observation on 09/02/15 at 11:43 AM revealed the shower door for the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the shower door for the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. 4. a Observations on 08/31/15 at 9:35 AM revealed the smoke prevention doors at the 100 hall had broken and splintered laminate on the	F 253		

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F 253	Continued From page 8 edges of the bottom half of the doors. Observation on 09/01/15 at 11:26 AM revealed the smoke prevention doors at the 100 hall had broken and splintered laminate on the edges of the bottom half of the doors. Observation on 09/02/15 at 11:43 AM revealed the smoke prevention doors at the 100 hall had broken and splintered laminate on the edges of the bottom half of the doors. Observation during an environmental tour on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator revealed the smoke prevention doors at the 100 hall had broken and splintered laminate on the edges of the bottom half of the doors. During an interview on 09/03/15 at 3:33 PM with the Maintenance Director and Administrator the Maintenance Director stated the footboard on the bed in room #112-A needed to be replaced because it could not be repaired. The Maintenance Director stated he could use wood filler or patch for some of the damaged doors but if that didn't work or if they were in too bad a shape they would have to be replaced. He explained he was the only maintenance person at the facility and had been working on other maintenance projects. He confirmed the bathroom doors, resident room doors, the shower door and the smoke prevention doors needed to be repaired. The Administrator stated she was not aware the doors were in such bad shape. She explained the Maintenance Director had been working in other areas of the building and she should have had him work on the skilled side of the building first. She stated the bathroom doors, resident room doors, the shower room door and the smoke preventions doors all needed to be repaired.	F 253		

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a comprehensive care plan for mouth care for 1 of 4 sampled residents reviewed who required assistance with activities of daily living. (Resident #1). The findings included: Resident #1 was admitted on 02/05/14 with diagnoses which included heart disease, seizures, diabetes, chronic obstructive lung disease, depression, difficulty swallowing and a stroke. A review of the most recent annual	F 279	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice: The care plan was corrected on 9/3/15 for Resident #1 and updated to include oral care and brushing of teeth daily. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All care plans will be reviewed by the DON	10/1/15

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F 279 Continued From page 10

Minimum Data Set (MDS) dated 08/25/15 indicated Resident #1 was cognitively intact for daily decision making and required extensive assistance for activities of daily living (ADLs). A section labeled care area assessment (CAA) summary indicated dental care triggered and revealed Resident #1 had her own natural teeth that were in poor condition and proceed to care plan to assist Resident #1 with daily mouth care.

A review of a care plan titled ADLs dated 06/05/15 indicated Resident #1 required extensive to total assistance with ADLs and was at risk for further decline in function. The goals indicated Resident #1 would do as much for herself and would allow staff to assist with completion of ADLs. The approaches indicated in part to give Resident #1 verbal cues as needed to assist with task completion, but there were no approaches to assist Resident #1 with daily mouth care. A review of all care plans revealed there were no new care plans or revisions to existing care plans that included mouth care since the CAA summary was done on 08/25/15.

During an interview on 09/03/15 at 1:28 PM with Resident #1 she stated she was not able to brush her teeth by herself because she had a stroke. She explained sometimes Nurse Aides helped her brush her teeth if she asked them but mouth care was not routinely provided for her. She further stated she could not remember when her teeth were last brushed but she wanted them to be brushed at least once every day.

During an interview on 09/03/15 at 1:36 PM the Director of Nursing verified Resident #1 had lower teeth that were in bad condition. She stated she was not sure why there was no care plan for

F 279

and MDS nurse to ensure that residents needing assistance with oral care/ brushing of teeth have their needs addressed on the care plan. Any resident found in need of assistance with daily mouth care will have their care plan updated to reflect their needs.

C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

An in-service was conducted on 9/14/15 and 9/15/15 to address oral care and grooming (ADLs) for residents for CNA and nursing staff. An additional mandatory in-service for all CNAs and nursing staff will be conducted on 9/25/15 and 9/26/15 to again address ADLs including shaving, grooming and oral hygiene of residents.

The DON/ADON and MDS nurse will meet weekly for a period of 2 months to review all newly admitted residents care plans to ensure all new care plans developed address the necessary triggered CAAS.

The DON/ADON and MDS will submit a list of all newly admitted residents care plans reviewed each week at the monthly QAPI committee.

D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained.

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ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 mouth care but it was her expectation that mouth care should have been addressed in the care plan. During an interview on 09/03/15 at 2:59 PM the MDS Coordinator stated the care plan for mouth care had been overlooked. She confirmed dental care had triggered on the CAA summary and there should have been a care plan developed for approaches for daily mouth care and the care plan would have to be revised to add mouth care. During an interview on 09/03/15 at 4:03 PM the Administrator stated she was not aware there was no care plan for mouth care for Resident #1. She further stated it was her expectation since dental care triggered on the CAA summary there should have been a care plan with approaches for staff to provide daily mouth care.	F 279	The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The QAPI committee will review the list of care plans audited by DON/ADON and MDS nurse for a period of 2 months. In addition, the QAPI committee will pull 3 care plans from the list provided by the DON/ADON and MDS nurse to ensure ADL needs are addressed appropriately. The QAPI committee will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide mouth care and failed to shave a resident for 1 of 4 sampled residents reviewed who required assistance with activities of daily living. (Resident #1 and #15). The findings included:	F 312	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice: Alexandria Place ensures that residents who are unable to carry out ADLs receive the necessary services to maintain good	10/1/15

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1. Resident #1 was admitted on 02/05/14 with diagnoses which included heart disease, seizures, diabetes, chronic obstructive lung disease, depression, difficulty swallowing and a stroke. A review of the most recent annual Minimum Data Set (MDS) dated 08/25/15 indicated Resident #1 was cognitively intact for daily decision making and required extensive assistance for activities of daily living (ADLs). A section labeled care area assessment (CAA) summary indicated dental care triggered and revealed Resident #1 had her own natural teeth that were in poor condition.

A review of a care plan titled ADLs dated 06/05/15 indicated Resident #1 required extensive to total assistance with ADLs and was at risk for further decline in function. The goals indicated Resident #1 would do as much for herself and would allow staff to assist with completion of ADLs. The approaches indicated in part to give Resident #1 verbal cues as needed to assist with task completion, but there were no approaches to assist Resident #1 with daily mouth care.

A review of the Nurse Aide Care Guide for daily care revealed there were no instructions to provide daily mouth care.

During an observation on 09/01/15 at 09:59 AM Resident #1 was seated in a recliner chair in the hallway and when she spoke she had a heavy accumulation of white debris along the gum line and in between her lower teeth.

During an observation on 09/02/15 at 3:46 PM Resident #1 was seated in a recliner chair in the hallway. When she spoke she had a heavy

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nutrition, grooming and personal and oral hygiene. Oral care was provided immediately to resident #1 on 9/3/15. Resident #15 was shaved immediately on 9/3/15.

B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.

CNAs have been in-serviced on 9/14/15 and 9/15/15 on ADL care for dependent residents. Another in-service is scheduled for 9/25/15 and 9/26/15 concerning oral care, grooming and shaving for male residents daily who are unable to carry out their own oral care or grooming/shaving.

C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

On 9/15/15 the CNAs and nursing staff were in-serviced regarding oral care/hygiene to residents who are unable to carry out their ADLs. The nurse manager will complete personal care QA rounds on 5 residents weekly and will initiate interventions as deemed necessary to ensure the deficient practice does not reoccur. The results of these weekly rounds will be turned in to the QAPI committee monthly, at which time the committee will evaluate and make recommendations to ensure compliance.

D. Indicate how the facility plans to

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accumulation of white debris along the gum line and in between her lower teeth.

During an observation on 09/03/15 at 8:26 AM Resident #1 was seated in a recliner chair at the nurse's station. When Resident #1 spoke she had a heavy accumulation of white debris along the gum line and in between her lower teeth.

During an interview on 09/03/15 at 1:23 PM with Nurse Aide #2 who was assigned to care for Resident #1 she stated she did not know if Resident #1 could brush her teeth. She confirmed she had not brushed Resident #1's teeth or assisted her with brushing her teeth and was not sure when Resident had previously had her teeth brushed.

During an interview on 09/03/15 at 1:28 PM with Resident #1 she stated she was not able to brush her teeth by herself because she had a stroke. She explained sometimes Nurse Aides (NAs) helped her brush her teeth if she asked them but mouth care was not routinely provided for her. She further stated she could not remember when her teeth were last brushed but she wanted them to be brushed at least once every day.

During an interview on 09/03/15 at 1:36 PM the Director of Nursing verified Resident #1 had lower teeth that were in bad condition. She stated it was her expectation that NAs should provide daily mouth care for Resident #1 and they should brush her teeth at least daily.

During an interview on 09/03/15 at 4:03 PM the Administrator stated it was her expectation for staff to provide daily mouth care to Resident #1 and to brush her teeth routinely.

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monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility.

On 9/14/15 and 9/15/15 an in-service for CNA and nursing staff was conducted regarding oral hygiene and mouth care. On 9/25/15 and 9/26/15 all CNAs and Nursing staff will be in-serviced regarding providing oral hygiene and mouth care, grooming and shaving of male residents who are unable to carry out their ADLs independently.

The nurse manager will complete weekly personal care QA rounds on 5 residents and will initiate any interventions deemed necessary at that time. The results of these QA rounds will be reviewed in the monthly QAPI committee meeting. The QAPI committee will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance.

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2. Resident #15 was admitted to the facility on 04/07/14 with diagnoses which included dementia, Alzheimer's disease and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/08/15 indicated Resident #15 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #15 required extensive assistance with activities of daily living.

A review of the Nurse Aide Care Guide for daily care indicated to shave Resident #15 daily.

During a family interview on 09/01/15 at 11:12 AM they stated they had problems with getting staff to shave Resident #15. They explained he had to be shaved every day because his facial hair grew fast and they had reminded staff every time they visited that he needed to be shaved every day but it was not done. They further stated they expected for Resident #15 to be clean shaven because that was his previous routine before he was admitted to the facility.

During an observation on 09/01/15 at 4:16 PM Resident #15 was seated in a wheelchair in the main dining room and had approximately a day's growth of facial hair on his face, chin and upper lip.

During an observation on 09/02/15 at 12:07 PM. Resident #15 was seated in a wheelchair in the hallway with increased growth of facial hair and there were dark stains on the facial hair on the left corner of his mouth.

During an observation on 09/03/15 at 9:34 AM Resident #15 was seated in a wheelchair in the

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F 312	Continued From page 15 hallway at the nurse's station with increased facial hair since yesterday. During an interview on 09/03/15 at 1:22 PM with Nurse Aide #2 she explained she usually worked on the weekend but had been called in to work today and was assigned to care for Resident #15. She explained she had noticed Resident #15 looked like he had several days of facial hair growth and was not sure when he had been shaved last because they did not document it. She stated Resident #15 was supposed to be shaved every day and she was not sure why it had not been done. During an interview on 09/03/15 at 1:36 PM the Director of Nursing stated it was her expectation for Resident #15 to be clean shaven and she confirmed Resident #15's family had requested he be shaved daily. She further stated it was her expectation for staff to shave residents according the daily care guide.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		10/1/15

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given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on observations, record reviews, nurse practitioner, pharmacist and staff interviews the facility failed to monitor blood pressures prior to administration of a blood pressure medication and failed to get clarification of physician's orders for blood pressure checks prior to administration of blood pressure medications for 1 of 6 resident's sampled for unnecessary medications. (Resident #27).

The findings included:

Resident #27 was re-admitted to the facility on 02/17/14 with diagnoses of heart failure, high blood pressure, diabetes, dementia, depression and Parkinson's disease. The most recent quarterly Minimum Data Set (MDS) dated 08/06/15 indicated Resident #15 was cognitively intact for daily decision making.

A review of a physician's order with a start date of 03/04/15 at 8:00 AM indicated Isosorbide 20 milligrams (mg) by mouth twice a day for high blood pressure (BP) and hold medication if

F 329

A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice:

The order for resident #27 was clarified on 9/3/15 and the parameters for blood pressures were discontinued as per physician order. On 9/3/15 the MD order now states ¿Order Clarification- Isosorbide 20mg / po BID at 8:00 AM and 4:00 PM.¿

B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.

DON and ADON will review all MARS in order to identify any further potential errors in implementing the parameters ordered by MD/NP. This comprehensive audit will be completed by October 1st. An audit of 10 MARS will be completed weekly after October 1st for 2 months to

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F 329	Continued From page 17 systolic BP was less than 110 or diastolic BP was less than 60. The order also indicated to check vitals every 4 hours for 24 hours. A review of blood pressures were documented as follows: 03/12/15 indicated BP 138/70 on a nurse's vital sign sheet 03/191/5 indicated BP 148/62 on a nurse's vital sign sheet A review of a monthly medication administration record dated from 04/01/15 through 04/30/15 indicated Isosorbide 20 mg by mouth twice daily. Hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24 hours. A review of blood pressures were documented as follows: 04/02/15 indicated BP 110/70 on a nurse's vital sign sheet 04/09/15 indicated BP 140/80 on a nurse's vital sign sheet 04/23/15 indicated BP 105/60 on a nurse's vital sign sheet 04/30/15 indicated BP 108/62 on a nurse's vital sign sheet A review of a physician's telephone order dated 05/06/15 indicated Isosorbide: hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24 hours. A review of a monthly medication administration record dated from 05/01/15 through 05/31/15 indicated Isosorbide 20 mg by mouth twice daily. Hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24	F 329	ensure all residents are receiving medication appropriately according to physician orders. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Mandatory in-services are scheduled for 9/25/15 and 9/26/15 to cover how to properly process orders with specific parameters in the Daverci e-MAR system and when to obtain clarification orders to ensure no deficient practice reoccurs. This includes effective documentation procedures to ensure that all residents are receiving medication appropriately according to physician orders. The DON and MDS nurse will audit for proper processing of orders that have parameters with each order entry check weekly. The DON and/or ADON will review 10 MARS weekly and apply any appropriate interventions to ensure that deficient practice does not reoccur. This weekly audit will be completed for 2 months to confirm that there are no discrepancies. The weekly QA reports will be given to the QAPI committee for review and recommendation on a monthly basis. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that	

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hours. Further review of the MAR revealed there were no BPs documented.

A review of monthly pharmacist's reviews indicated on 05/06/15 hold Isosorbide for systolic blood pressure less than 110 or systolic BP less than 60.

A review of blood pressures were documented as follows:
05/07/15 at 10:30 PM indicated BP 104/66 in nurse's notes
05/11/15 at 6:40 PM indicated BP 120/68 on a nurse's vital sign sheet
05/14/15 at 9:50 PM indicated BP 106/64 in nurses notes
05/21/15 at 10:45 PM indicated BP 100/60 in nurse's notes
05/28/15 at 10:41 PM indicated BP 110/60 in nurse's notes

A review of a monthly medication administration record dated from 06/01/15 through 06/30/15 indicated Isosorbide 20 mg by mouth twice daily. Hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24 hours. Further review revealed there were no BPs documented. on the MAR.

A review of blood pressures were documented as follows:
06/11/15 at 6:45 PM indicated BP 120/68 on a nurse's note
06/18/15 at 11 PM indicated BP 100/62 on a nurse's vital sign sheet
06/25/15 with no time recorded indicated BP 110/64 on a nurse's vital sign sheet

A review of a monthly medication administration

F 329

corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility.

The DON and MDS nurse will audit daily orders via the physician telephone order pink slips for proper processing of orders that have parameters.

The DON and/or ADON will audit 10 MARS weekly for a time period of 2 months to ensure that deficient practice does not reoccur. After completion of the 2 month audit, the DON/ADON will audit 2 MARS per week for the next 2 months.

The weekly QA reports on monthly MARS will be given in the monthly QAPI meetings for review and recommendation. The QAPI committee and DON will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance.

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record dated from 07/01/15 through 07/31/15 indicated Isosorbide 20 mg by mouth twice daily. Hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24 hours. Further revealed there were no BPs documented on the MAR.

A review of blood pressures were documented as follows:
07/02/15 at 10:25 PM indicated BP 124/68 on a nurse's vital sign sheet
07/09/15 at 10:35 PM indicated BP 116/64 on a nurse's vital sign sheet
07/30/15 at 9:55 PM indicated BP 108/66 on a nurse's vital sign sheet
08/06/15 at 11:00 PM indicated BP 104/60 on a nurse's note

A review of a monthly medication administration record dated from 08/01/15 through 08/31/15 indicated Isosorbide 20 mg by mouth twice daily. Hold if systolic BP less than 110 or diastolic BP less than 60. Check vitals every 4 hours for 24 hours. Further review revealed there were no BPs documented on the MAR.

A review of blood pressures were documented as follows:
08/13/15 at 11:00 PM indicated BP 110/62 on a nurse's vital sign sheet
08/20/15 at 11:00 PM indicated BP 108/66 on a nurse's note

During an observation of a medication pass on 09/02/15 at 2:00 PM Nurse #1 administered Isosorbide 20 mg by mouth to Resident #27 but did not check the resident's blood pressure before administration of the medication. During an interview with Nurse #1 immediately after she

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F 329	Continued From page 20 gave the medication she stated she thought the BP checks had been stopped a while ago. She confirmed she had not been checking Resident #27's blood pressure before she administered the medication and she was not sure why the MARs still had the BP checks listed. During an interview on 09/03/15 at 9:59 AM with an Administrative Nurse after review of the monthly MAR for Resident #27 she stated she would take the BP before each dose of the medication because there were parameters listed for when to hold the medication. She explained when a nurse received a physician's order they entered the orders in the computer system with the instructions to be printed on the MAR. During an interview on 09/03/15 at 11:14 AM with a Nurse Practitioner she explained the Nurse Practitioner who wrote the orders for Isosorbide and to hold the medication if the systolic BP was less than 110 or the diastolic BP was less than 60 no longer worked at the facility. She stated since there were BP parameters to hold the medication she would expect for the BP to be checked before nurses gave the medication. She further stated the statement to check vitals every 4 hours for 24 hours should have been removed from the MAR or the nurses should have called for clarification of the orders. After review of blood pressures that were documented in the nurses notes or on the vital sign sheets she stated Resident #27's blood pressure was running lower that what they expected because they usually liked to see the systolic BP around 130 for his age population. She explained she would expect to see the blood pressures documented and if it was low then the BP medication should have been held as ordered and if there were questions she expected staff to	F 329		

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get clarification for orders that were not clear.

During a telephone interview on 09/03/15 at 10:44 AM with the Consultant Pharmacist she stated she had made general recommendations for nursing staff to check Resident #27's blood pressure before they administered his blood pressure medication but the recommendations had not been followed. She stated it was her expectation that Resident #27's BP should be documented on vs sheet and she had written a note to make sure staff were checking his BPs. She explained nursing staff should have called the physician or nurse practitioner to discontinue the order or get clarification of the order and the notes to hold the medication if the systolic BP was less than 110 or the diastolic BP was less than 60 should have been taken off the MAR if they were not going to check them. She further emphasized staff should make sure everything was taken off the MAR if they were not going to do them and staff should get clarification with the physician if the order was unclear or confusing.

During an interview on 09/03/15 at 11:31 AM the Director of Nursing stated it was her expectation for nursing staff to enter the physician's orders in the computer system. She explained third shift nursing staff were expected to check the orders and the MDS nurse checked the orders a third time to make sure they were entered correctly. She confirmed the nurse who took the original order on 03/04/15 was no longer employed by the facility. She further explained when the monthly orders were checked by nursing staff the instructions to hold the BP medication did not show up and would have been missed. The DON confirmed after review of physician's orders there were no orders to discontinue the BP checks.

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F 329	Continued From page 22 During a follow up interview on 09/03/15 at 1:36 PM the DON explained it was her expectation for the 05/06/15 physician's order for nursing staff to check Resident #27 vital signs every 4 hours for 24 hours and should have left the documentation in the physician's communication book for review. She further explained if the vital signs were abnormal she would have expected for nursing staff to call the physician or nurse practitioner. She stated the nurse would have had to discontinue the text on the MAR so that it would not continue to appear each month because there was no other way to stop the instructions. She further stated she expected for nursing staff to consistently document BPs and vital signs as ordered by the physician and they should have gotten clarification as to whether to continue the blood pressure checks.	F 329		
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.	F 441		10/1/15

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	345441	A. BUILDING ______ B. WING ______	C 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 441	Continued From page 23 (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to disinfect shared resident equipment (a mechanical lift with scale) and the over the bed table used for dressing changes for 1 of 1 resident on contact precautions in the facility (Resident #48). The findings included: Review of the facility's policy and procedure for prevention of transmission of Clostridium Difficile revised 04/01/06 revealed direction to disinfect shared items and maintain contact precautions. Resident #48 was admitted to the facility on 07/28/15 with diagnoses which included	F 441	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice: Alexandria Place has established and will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and/or transmission of disease and infection. On 9/1/15, a different disinfectant was obtained and the lift and over-bed table for Resident #48 were cleaned with this bleach-based wipe that specifically kills C-Diff as per manufacturer guidelines. No other residents were affected.	

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Alzheimer's Disease.

Review of a physician's order dated 08/13/15 revealed Resident #48 required contact precautions for suspected C-difficile.

Review of Resident #48's stool culture obtained on 08/13/15 revealed a positive result for C-difficile. The report indicated the requirement of contact precautions.

Review of a physician's order dated 08/28/15 revealed direction to cleanse Resident #48's Stage 2 pressure sore with normal saline, apply hydrogel and cover with a foam dressing every 3 days.

Observation of the personal protection equipment for Resident #48 revealed a purple top container of wipes. Review of the purple top container's label revealed the viruses and bacteria which the wipes effectively eliminated did not include C-difficile.

Observation on 09/01/15 at 12:15 PM revealed the wound nurse completed a dressing change for Resident #48. Resident #48 did not have visible stool. The wound nurse used Resident #48's over the bed table to set up the dressing change. The wound nurse used wipes from the purple top container to wipe down the over the bed table after completion of the dressing change.

Observation on 09/01/15 at 2:54 PM revealed Nurse Aide (NA) #1 weighed Resident #48 with a lift. NA #1 used wipes from the purple top contained to wipe the lift frame and handles after use.

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B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.

Any resident has the potential to be affected. However, disinfectant wipes that kill C-Diff spores were obtained on 9/1/15 and put to use immediately.

On 9/14/15 an in-service was conducted on infection control policies and procedures. An additional mandatory in-service is scheduled for 9/25/15 and 9/26/15 for all CNA and Nursing staff on infection control policies and procedures, including manufacturer guidelines concerning the appropriate use of products when cleaning items exposed to C-Diff spores and other contaminants. On 9/1/15 housekeeping and CNA staff were in-serviced on proper disinfectant to be used on Hoyer lift and other equipment such as over-bed tables on any resident with the diagnosis of C-diff. They were in-serviced on standard precautions as well.

C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

On 9/2/15, CNA and nursing staff were in-serviced on proper infection control procedures for standard precautions and procedures for residents with C-Diff. The facility switched from the previous

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Interview with NA #1 on 09/01/15 at 2:57 PM revealed she used the wipes to wipe down the lift equipment after use. NA #1 explained the purple top container sanitized the lift and the lift was used for other residents.

Interview with the wound nurse on 09/01/15 at 3:02 PM revealed she used the purple top wipes to wipe down the over the bed table after the dressing change. The wound nurse reported the over the bed table was used for the daily dressing change. The wound nurse explained she thought the wipes were effective against C-difficile.

Interview with the Director of Nursing (DON) on 09/01/15 at 3:20 PM revealed she expected staff to use bleach wipes and not the purple top container wipes. The DON explained the wipes used by the staff were not effective against C-difficile.

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cleaning wipes to Sani-Cloth bleach-based germicidal disposable wipes that are specifically manufactured and labeled to kill C-Diff as well as other infectious spores. Safety Data Sheets were reviewed with CNA and nursing staff outlining each cleaning product/agent, its location and proper use.

On 9/22/15, housekeeping staff was in-serviced on the proper use of Sani-Cloth bleach-based germicidal wipes and infection control procedures. Safety Data Sheets for Sani-Cloth bleach-based wipes were also reviewed with housekeeping staff which outlined the cleaning product.

A mandatory in-service for all departments is scheduled for 9/25/15 and 9/26/15 to review infection control procedures and standard precautions.

D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility.

A weekly QA round will be conducted by the housekeeping supervisor and nurse manager to ensure all equipment used on residents is being cleaned correctly and with the proper product and standard

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F 441	Continued From page 26	F 441	precautions. Interventions will be initiated as deemed necessary. The results of the QA rounds will be brought to the monthly QAPI committee meeting for review and recommendation to ensure that the infection control policies are being followed. The QAPI committee will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance.	