STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH CARE CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 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 observations, staff interviews, and medical record review, the facility failed to ensure a meal tray was set up and within a dependent resident's reach for one (1) of eleven (11) sampled residents; the facility failed to supervise a resident during meals for one (1) of four (4) sampled residents; and the facility failed to ensure a dependent resident's fingernails were trimmed for one (1) or eleven (11) sampled residents. (Residents # 7, #9 and #21). The findings are: 1. An undated policy provided by the facility entitled Serving Meal Trays read in part: "Place the tray within the person's reach. Adjust the over bed table as needed. Remove food covers. Open cartons, cut meat, butter bread, and so on as needed. Place the napkin, clothes protector, adaptive equipment, and eating utensils within reach." Resident # 7 was admitted to the facility on 03/27/10 with diagnoses which included congestive heart failure, muscle weakness, and failure to thrive. The latest Minimum Data Set (MDS) dated 01/20/11 revealed the resident had severe cognitive impairment and required	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. RECEIVED MAY 02 2011 BY:_____	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Durham — TITLE: Administrator — (X6) DATE: 4/28/11

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.

Original Signature date 3-25-11

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F 312	Continued From page 1 extensive assistance with most activities of daily living. The MDS further revealed the resident required limited assistance with eating, and extensive assistance from one person to transfer in or out of bed or wheelchair. A review of the care plan for Resident # 7 revealed it addressed weight loss as a problem. Among the interventions were the following: "Provide assistance with meals as needed. Encourage resident in food related activities." A review of the resident's medical record revealed the resident's weight was currently stable. On 03/01/11 at 5:25 p.m. an aide delivered the evening meal tray to Resident # 7. Resident # 7 was lying in bed with her eyes closed. The head of bed was up approximately 30 degrees. Both side rails on the bed were in the up position. The over bed table was against the wall approximately two feet from the bed. The aide set the tray on the over bed table but did not move the table across the bed, open any of the items on the tray, or speak to the resident. The aide left the room. A continuous observation was conducted from 5:25 p.m. until 6:33 p.m. During that time the tray remained on the over bed table with items unopened and the over bed table remained out of reach of the resident against the wall. At 6:12 p.m. a staff member entered the room and fed the resident approximately a tablespoon of Magic Cup. She left the room at 6:14 p.m. The tray remained on the over bed table out of reach of the resident. At 6:28 p.m. Nursing Assistant (NA) # 9 entered the room and fed the resident a few bites of a fruit cup. She asked the resident if she wanted any more and the resident declined. NA # 9 removed the tray from the over bed table and	F 312	F 312 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice:** 1. A. Resident # 7 tray was set up and resident encouraged to feed herself with assistance to complete meal. B. Resident # 9 had an Occupational Therapy evaluation to assist in specific strategies for the resident. Staff education of how to best assist resident. C. Resident # 21 nails trimmed per resident preference. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:** 2. Administrative Nursing staff and the RD have QI monitored residents for tray delivery, set-up, meal assistance and appropriate devices. . Residents were QI monitored for nail care and care completed per resident preference.	

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F 312	Continued From page 2 the room. At that time, NA # 9 was interviewed and stated that the resident only ate a few bites of Magic Cup and oranges. She offered no explanation why the tray had not been set up within reach of the resident so she could feed herself. On 03/02/11 at 8:22 a.m. the Registered Dietician (RD) was interviewed. She stated that Resident # 7 is capable of feeding herself with proper set up. She stated that if Resident # 7 were eating in bed, she needed to be positioned upright with the tray in front of her and items opened and within reach. The RD also stated that she expected staff to awaken the resident and encourage her to eat. She stated she expected staff to set up each resident's tray and place it within reach of residents capable of feeding themselves safely. On 03/02/11 at 8:22 a.m. the interim Director of Nursing (DON) was interviewed. She stated that nursing assistants delivered trays to residents eating in their rooms. She stated that unless contraindicated she expected staff to open all items on the tray, and make sure the tray was within reach of the resident. The DON stated that any staff who had entered Resident # 7's room should have set up her tray and placed it within her reach so she could feed herself. 2. Resident #9 was readmitted to the facility on 04/27/2010 and diagnosed with Macular Degeneration, history of Stroke with right sided hemiplegia and Dementia. The Resident Assessment Protocol (RAP) dated 07/24/2010 indicated Resident #9 was extensive assist with eating. Resident #9 was on a regular diet with thin liquids in a sippy cup.	F 312	**Measures to be put in place or systemic changes made to ensure practice will not re-occur:** 3. Nursing Staff have been re-educated by the RD (Registered Dietician) on tray delivery and set-up, meal assistance and appropriate devices. Re-education of nursing regarding nail care/grooming and preference with showers and bathing. Tray delivery, set-up, assistive devices will be QI monitored by the RD/Designee and Nail Care will be monitored by the Charge nurse daily and QI monitored by the Unit Manager/Designee randomly 5 x week x 2, weekly x2, monthly x2, then quarterly x 3. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:** 4. DON will report findings of monitoring to the QA&A Committee quarterly x4 for continued compliance/revision to the plan.	3/31/11

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F 312	Continued From page 3 A Care Plan intervention dated 11/21/06 noted Resident #9 needed assistance with meals as needed due to right hemiplegia. Resident #9 had impaired vision and had some self feeding difficulties with meals due to right hemiplegia. The Quarterly Minimum Data Set (MDS) Assessment dated 12/21/2010 assessed Resident #9 as having intact short term and long term memory with cognitive impairments. Resident #9 had visual impairment and right side hemiplegia. Resident # 9 was totally dependent on staff with one person physical assistance with eating. A Dietary Quarterly Nutritional Assessment dated 12/20/10 documented Resident # 9 used a three section plate, a sippy cup and built up utensil during meals. An observation in the dining room during lunch on 03/01/11 at 12:30 PM revealed Resident # 9 eating pudding with his left fingers. Further observations from 12:30 PM. to 12:50 PM revealed staff did not offer or provide Resident # 9 with any feeding assistance. Resident # 9 did not attempt to use the built up fork and continued eating foods with his fingers. An observation in the dining room during dinner on 03/01/11 from 5:07 PM to 5:17 PM, revealed Resident # 9 eating peas and mash potatoes with his left fingers. During this observation, staff did not offer assistance to Resident #9 and the resident did not attempt to use the built up fork. Nurse aide (NA) #1 was observed on 03/01/11 at 5:17 PM, assisting and feeding Resident #9 and the resident allowed NA #1 to feed him. Resident # 9 was observed on 03/02/11 from 7:57 AM to 8:17 AM eating eggs and grits with his left	F 312		

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F 312	Continued From page 4 fingers in his room. Resident # 9 did not attempt to use his built up fork and did not receive feeding assistance from staff. During an interview with nurse aide (NA) #1 on 03/01/11 at 5:23 PM, she revealed she was familiar with Resident # 9 and he required assistance with feeding. NA # 1 revealed Resident # 9 refused assistance with feeding at times. NA # 1 revealed she is aware that Resident # 9 refused to use his built up fork and ate with his fingers occasionally. During an interview with Registered Dietician (RD) on 03/02/11 at 9:05 AM, she revealed Resident # 9 is able to feed himself and refused staff assistance at times. She revealed Resident # 9 in the past had refused to use the built up fork due to frustration with the weight of the built up fork. She revealed she would make a referral to occupation therapist to evaluate. She revealed Resident # 9 ate during first dining which is for residents that are independent eaters and need assistance with meal set up. During an interview with the Administrator on 03/02/11 at 11:26 AM, she revealed the built up fork may be too heavy for Resident # 9 and he may become frustrated with not being able to scoop with the built up fork. She revealed he does not like attention from staff when they try to assist him. She revealed she was aware that Resident # 9 would alternate between using his fingers and the built up fork for eating. She further revealed Resident #9's eating habits will be discussed in the upcoming care plan meeting. During a lunch observation on 03/03/11 from 12:03 PM to 12:35 PM, the occupational therapist	F 312		

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F 312	Continued From page 5 (OT) evaluated Resident # 9's eating habits. During the evaluation, the OT staff cued and assisted Resident # 9 by instructing him on how to scoop the spoon. She would scoop the food, and Resident # 9 would bring the spoon to his mouth. OT staff used a regular spoon during the evaluation. Resident # 9 was observed trying to scoop his food off his plate without success at times because off his visual impairment. OT staff asked him if he can see the food on his plate and Resident # 9 shook his head no. During an interview with OT staff on 03/02/11 at 12:35 PM, she revealed that Resident # 9 would benefit from staff scooping his food and allowing Resident # 9 to feed himself so that he will feel empowered. She revealed the built up fork will be discontinued and Resident # 9 will be given a regular spoon. She revealed Resident # 9 becomes frustrated with the built up fork because of the weight and he may not be getting enough food on his fork due to his visual impairment. She further revealed he refused staff assistance at times. 3. Resident # 21 was admitted to the facility on 09/13/10 with diagnoses of Alzheimer's Disease and congestive heart failure. The latest Minimum Data Set (MDS) dated 03/01/11 revealed the resident had severe cognitive impairment and required limited assistance with most activities of daily living including hygiene. A review of the resident's care plan revised 03/03/11 revealed activities of daily living were addressed. One intervention read "Keep nails trimmed and clean." On 03/01/11 at 8:35 a.m. Resident # 21 was observed sitting on his bed. His fingernails were	F 312		

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F 312	Continued From page 6 observed to be approximately ¼ longer than the ends of his fingers, with jagged edges. He stated, "They need to be trimmed." On 03/02/11 at 6:10 p.m. the evening shift Charge Nurse for the unit where Resident # 21 resided was interviewed. He stated that nursing assistants did head to toe resident assessments twice a week for each resident during their shower. He stated they reported any nails that needed trimming to the nurse who would then trim them. The Charge Nurse observed Resident # 21's fingernails and stated they "definitely need cutting." He stated that he would cut them that evening. The Charge Nurse also stated the resident's long fingernails should have been reported to him by the nursing assistants. On 03/03/11 at 9:25 a.m. the interim Director of Nursing (DON) was interviewed. She stated skin and nails were assessed twice weekly during resident showers by nursing assistants. She stated the nursing assistants can cut resident nails as long as the resident was not diabetic. The DON stated that she expected the resident's nails to be cut whenever they needed it.	F 312	F314- **How corrective action will be accomplished for resident affected:** 1. Resident was turned and positioned regularly with staff assistance. **How corrective action will be accomplished for those residents with potential to be affected:** 2. Staff re-educated on routinely turning and repositioning residents. **Measures put into place or systemic changes made to ensure deficient practice will not occur:** 3. Administrative staff routinely rounding to assure compliance with routine turning and repositioning. Any deviation of plan will be addressed at that time by UM or designee with oversight of DON.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to turn and reposition a resident which resulted in the development of two (2) new pressure ulcers in one (1) of seven (7) sampled residents. (Resident # 2). The findings are: Resident # 2 was re-admitted to the facility on 11/10/10 with diagnoses of dementia, stroke, bladder incontinence, and hypothyroidism. The most recent quarterly Minimum Data Set dated 02/09/11 indicated severe impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident required extensive assistance by staff for personal care, had a Foley catheter, colostomy, a feeding tube with continuous feedings and oxygen by nasal cannula. The plan of care regarding skin ulcers revealed the resident was re-admitted with multiple pressure ulcers. Care plan goals indicated "progress in healing will be evident by next review date of 02/14/2011." Approaches and interventions were to float heels when in bed as tolerated, pressure reduction surface to bed and chair, assist with turning and positioning as needed, skin assessment weekly and treatments per physician orders. Interdisciplinary care plans dated February 2011 indicated Resident # 2 received care by hospice. Wound treatment records dated 02/04/11	F 314	**How facility plans to monitor performance to assure correction is achieved and sustained:** 4. QI rounding audits to observe for regular turning and repositioning will be conducted by administrative nursing staff and/or designee 5 x week for 2 weeks, weekly x 2 weeks, monthly x 2 months and then quarterly x 3 quarters. Results of QI monitoring will be reported to QAA committee quarterly x 4 for continued compliance/revision of plan.	3/31/11

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F 314	Continued From page 8 indicated Resident # 2 had a stage two (II) pressure ulcer on his right (R) foot and a stage two (II) pressure ulcer on his left (L) ankle and (L) heel. Wound treatment records dated 02/08/11 indicated Resident # 2 had a stage three (III) pressure ulcer on his sacrum. A review of physician's orders dated March 2011 included weekly skin assessments; apply skin prep to both heels twice a day; cleanse outside of right (R) foot, left (L) ankle, and (L) heel with wound cleanser, apply Allevyn dressing and change every three days. Cleanse coccyx wound with wound cleanser, apply Hydrogel in wound bed, lightly pack with alginate, cover with Allevyn and change every five (5) days and as needed. On 03/01/11 at 8:35 a.m., 12:13 p.m., 1:25 p.m., 3:00 p.m., 3:50 p.m., 5:17 p.m., and 6:11 p.m. Resident #2 was observed lying flat on his back in bed. No licensed nurses or nursing assistants were observed to enter or exit Resident # 2's room during these times. A sign over the head of his bed stated to keep the head of the bed up at 45 degrees or higher at all times. An air mattress was on the bed and Resident # 2 had a pillow under his lower legs and foam booties on both feet. On 03/02/11 at 8:25 a.m., 11:08 a.m., 12:22 p.m. and 2:27 p.m. Resident # 2 was observed lying flat on his back in bed with the head of the bed up at 45 degrees. No licensed nurses or nursing assistants were observed to enter or exit Resident # 2's room during these times. On 03/02/11 at 2:28 p.m. NA # 1 was observed bathing Resident # 2. She turned him on his left side and the pad underneath his buttocks was	F 314		

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F 314	Continued From page 9 observed to be soiled with bloody drainage. An open wound was visible on his right lower buttock and a second open wound was visible on the inside lower crease of his left buttock. A dressing was intact to Resident # 2's sacrum. NA # 1 stated that she had to go and get the nurse. At 2:58 p.m. NA # 1 repositioned Resident # 2 on his back and covered him with a sheet and blanket and went to the nurse's station to get a nurse. NA #1 came back to the Resident # 2's room to wait for the nurse to come. At 3:05 p.m. LN # 3 entered Resident # 2's room carrying dressing supplies. NA # 1 and LN # 3 turned Resident # 2 to his left side. LN # 3 washed her hands and put gloves on. She removed the dressing on his sacrum. A foul odor was apparent when the dressing was removed. She cleaned the wound on his sacrum with wound cleanser, placed hydrogel into the wound, put Alginate dressing into the wound and covered it with Allevyn. LN # 3 cleaned the open wound on his right buttock with wound cleanser and applied a protectant skin cream around the open wound. She next cleaned the wound on his left buttock with wound cleanser and applied a protectant skin cream around the wound. She discarded her supplies into a trash bag, removed her gloves and washed her hands. LN # 3 left Resident # 2's room and went back to the nurse's station. On 03/02/11 at 3:12 p.m. LN # 3 was interviewed. She stated that she thought the dressing on Resident # 2's sacrum needed to be changed and when she saw the open areas on his buttocks she cleaned them with wound cleanser and put the protectant skin cream around each wound. On 03/02/11 at 4:30 p.m. the Interim DON was interviewed. She stated that when a resident is	F 314		

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admitted to the facility a skin assessment is done and if pressure sores are found they are documented on a treatment record. Weekly skin assessments are then done and any pressure sores are documented on an ulcer and wound record. She verified Resident # 2's wound treatment records indicated he had a pressure sore on his sacrum, right (R) foot, left (L) ankle, and (L) heel. She stated it is her expectation for nurses to notify the physician and supervisor immediately when new pressure sores are found.

On 03/02/11 at 6:06 p.m. the Interim DON confirmed Resident # 2 had a new stage two (II) pressure sore on his right (R) buttock and a new stage two (II) pressure sore on his (L) buttock. She also confirmed there were no physician orders and no nursing documentation regarding these pressure sores in the medical record. She stated LN # 3 should have notified the physician and nursing supervisor immediately after she observed the new pressure sores.

On 03/03/11 at 7:52 a.m. and 8:42 a.m. Resident # 2 was observed lying flat on his back in his bed with the head of the bed up at 45 degrees. No licensed nurses or nursing assistants were observed to enter or exit Resident # 2's room during these times.

On 03/03/11 at 7:54 a.m. an interview with NA # 4 revealed that she has bathed Resident # 2 in the past. She stated that he should be turned every two (2) hours and documented according to the care plan.

On 03/03/11 at 8:58 a.m. an interview with NA # 1 revealed that she has been instructed to turn Resident # 2 every two (2) hours but sometimes

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F 314	Continued From page 11 it's longer than two (2) hours. On 03/03/11 at 9:02 a.m. an interview with the Interim DON stated that it was her expectation that Resident # 2 be turned at least every two (2) hours. On 03/03/11 at 10:05 a.m. an interview with a private sitter for Resident # 2 revealed that she sits with him two days a week from 9:30 a.m. until 1:30 p.m. at the request of his family. She stated facility staff is supposed to turn him every two (2) hours but every time she comes he's on his back. She stated that she goes and asks staff to come and turn him when she visits. On 03/03/11 at 10:40 a.m. an interview with a hospice NA revealed that she gives Resident # 2 a complete bed bath two (2) days per week. She explained that when she bathed him earlier this week on Tuesday his bottom was very red and she told the hospice nurse, a nurse aide and nurse in the facility about it. She verified that when she bathed him on Tuesday he did not have any open wounds on his bottom except for the one on his sacrum and it had a dressing on it. She explained that she has told the staff numerous times that he needs to be turned at least every two (2) hours but he was flat on his back in bed like always when she arrived this morning. On 03/03/11 at 1:50 p.m. an interview with LN # 3 confirmed that she used wound cleanser to clean the new pressure sores and applied a protective barrier cream around them. She stated she did not recall if she told Resident # 2's physician yesterday about the new open wounds but she knew he was in the building and she was waiting	F 314		

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	345471	A. BUILDING _____ B. WING _____	03/03/2011

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F 314	Continued From page 12 for him to come to her hall to notify him.	F 314	F- 315 **How corrective action will be accomplished for resident affected:** 1. Residents #3 and #5 catheter and privacy bags/beds were adjusted to prevent bags from touching floor. **How corrective action will be accomplished for those residents with potential to be affected:** 2. Each resident with a catheter was evaluated with necessary adjustments made to assure no catheter bags touch floor. Staff re-educated regarding requirement to take necessary measures to prevent catheter bag from touching floor. **Measures put into place or systemic changes made to ensure deficient practice will not occur:** 3. Staff re-educated regarding requirement that catheters/beds be adjusted to prevent catheter bags from touching the floor.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to position urinary catheter bags off the floor for two (2) of five (5) sampled residents with indwelling urinary catheters (Resident #3 and Resident #5). The findings are: Review of the facility's Infection Control Policies and Procedures for urinary tract infection prevention dated 12/18/09 revealed urinary catheter bags and tubing were to be positioned off of the floor. 1. Review of Resident #3's record revealed an admission date of 10/28/10. The most recent quarterly Minimum Data Set dated 1/26/11 coded Resident #3 with an indwelling urinary catheter. Review of the care plan dated 11/8/10 revealed Resident #3's catheter care required the following interventions: catheter care every shift, keep	F 315		

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F 315	Continued From page 13 catheter bag below level of bladder and maintenance of a closed system. Observation at 8:32 AM on 3/1/11 revealed Resident #3 in a low bed. The catheter bag with privacy cover was on the floor. Observations at 1:45 PM, 3:50 PM, 5:30 PM and 6:30 PM on 3/1/11 and at 7:55 AM on 3/2/11 revealed Resident #3 in a low bed with the catheter bag with privacy cover on the floor. Observation at 9:30 AM on 3/2/11 revealed Nursing Assistant (NA) #2 and NA #3 gave Resident #3 a bed bath. When NA #2 lowered the bed, the catheter bag with privacy cover lowered to the floor. Observation at 1:45 PM on 3/2/11 revealed Resident #3's catheter bag with privacy cover on the floor. Interview with NA #2 at 1:50 PM on 3/2/11 revealed she was aware the catheter bag was to be off the floor. She explained she did not notice the bag on the floor. She reported it was difficult to keep the bag off the floor with a low bed. Interview with Licensed Nurse #1 at 1:55 PM on 3/2/11 revealed catheter bags were to be off of the floor. Upon observation of Resident #3's catheter bag, LN #1 adjusted the Velcro straps and positioned the bag off of the floor. LN #1 reported she did not notice the bag placement during her nursing rounds. Interview with the Interim Director of Nursing at 2:10 PM on 3/2/11 revealed catheter bags should be positioned off of the floor. She explained the	F 315	Administrative staff frequently rounding, to assure compliance with catheter bags not touching floor. Any deviation of plan will be addressed at that time by UM or designee with oversight of DON. **How facility plans to monitor performance to assure correction is achieved and sustained:** 4. QI rounding audits to observe for catheter bags touching floor will be conducted by administrative nursing staff and/or designee 5 x week for 2 weeks, weekly x 2 weeks, monthly x 2 months and then quarterly x 3 quarters. Results of QI monitoring will be reported to QAA committee quarterly x 4 for compliance/ revision of plan.	3/31/11

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F 315	Continued From page 14 plastic privacy cover provided a barrier but she expected the catheter bag to be off the floor. 2. Review of Resident #5's record revealed an admission date of 5/27/04. Resident #5's most recent quarterly Minimum Data Set dated 1/3/11 listed an indwelling urinary catheter. The care plan dated 10/22/10 listed the following catheter care interventions: changing bag per orders, empty bag every shift and perineal care every shift. Observation at 8:55 AM, 12:10 PM and 6:05 PM on 3/1/11 revealed Resident #5 in a low bed with the catheter bag with privacy cover on the floor. Observations at 7:50 AM and 9:30 AM on 3/2/11 revealed Resident #5 in a low bed with the catheter bag on the floor. Observation at 9:45 AM on 3/2/11 revealed Nursing Assistant (NA) #4 provided catheter care to Resident #5. After the care, NA #4 lowered the bed and left the room. The catheter bag was on the floor. Interview at 10:00 AM on 3/2/11 with NA #4 revealed Resident #5's catheter bag was routinely on the floor. NA #4 explained the bag was on the floor because Resident #5 used a low bed. NA #4 reported she could not adjust the straps to raise the bag off of the floor. Observation at 11:10 AM and 1:40 PM on 3/2/11 revealed Resident #5 in a low bed with the catheter bag on the floor. Interview at 1: 45 PM on 3/2/11 with Licensed Nurse (LN) #2 revealed the catheter bag should	F 315		

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F 315	Continued From page 15 be placed off the floor. Upon observation of the catheter bag, LN #2 adjusted the Velcro strap and positioned the catheter bag off of the floor. Interview with the Interim Director of Nursing at 2:10 PM on 3/2/11 revealed catheter bags should be positioned off of the floor. She explained the plastic privacy cover provided a barrier but she would expect the catheter bag to be off the floor.	F 315	F323- **How corrective action will be accomplished for resident affected:** 1. Resident was provided with bedside mats, has low bed. Staff education included providing two assists with ADL care with resident.	
F 323 SS=G	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 observation, staff interviews and record review, the facility failed to provide a floor mat and prevent a fall during care for one (1) of four (4) sampled residents who were identified as being at risk for falls (Resident #3). The findings are: Review of Resident #3's record revealed an admission date of 10/28/10. Resident #3's admission Minimum Data Set (MDS) dated 11/4/10 and most recent quarterly MDS dated 1/26/11 revealed the resident had severe cognitive impairment and required the extensive assistance of two persons for bed mobility, dressing and personal hygiene. The MDSs	F 323	**How corrective action will be accomplished for those residents with potential to be affected:** 2. Residents identified as fall risk re-assessed to assure that all necessary interventions are in place. **Measures put into place or systemic changes made to ensure deficient practice will not occur:** 3. Staff re-educated regarding requirement to maintain all interventions and monitoring "Resident Information Sheet" for any changes. Education regarding "Resident Information Sheet" will be incorporated in new employee orientation.	

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F 323	Continued From page 16 further revealed the resident required two persons transfers and was totally dependent for bathing. The admission MDS dated 11/4/10 assessed Resident #3 required two persons for bathing; the quarterly MDS dated 1/26/11 assessed one person was required for bathing. Review of the care plan dated 11/8/10 and updated on 2/28/11 revealed Resident #3 was at risk for falls. Fall prevention measures listed were: frequent bed checks, assistance with transfers, floor mats at bedside and bed alarm. Further review of the care plan revealed use of a low bed was added as an intervention on 12/13/10. The use of two staff during all care was added to the care plan as an intervention on 2/28/11. Review of Resident #3's nursing notes and fall investigation reports revealed the following: · On 11/5/10 at 8:30 AM, Resident #3 fell out of the air mattress bed onto the floor. This fall was not witnessed and there was no injury. Floor mats were added as a care plan intervention. · On 11/9/10 at 1:30 AM, a fall from the bed onto a floor mat occurred. A bed alarm was added as a care plan intervention. Resident #3 was on the floor mat when the Nursing Assistant made her usual rounds. There was no injury. A bed alarm was added as a care plan intervention. · On 12/10/10 at 4:12 AM Resident #3 fell out of bed onto a floor mat. Resident #3 received a low bed. The type of alternating air mattress was exchanged to an air mattress with no raised vertical columns. · On 2/25/11 at 10:15 AM, Resident #3 fell out of bed during a bed bath given by a Nursing	F 323	Administrative staff, frequently rounding to assure compliance with mats in place, beds in low position etc. Any deviation of plan will be addressed at that time by UM or designee with oversight of DON. **How facility plans to monitor performance to assure correction is achieved and sustained:** 4. QI rounding audits to observe for resident specific interventions will be conducted by administrative nursing staff and/or designee 5 x week for 2 weeks, weekly x 2 weeks, monthly x 2 months and then quarterly x 4 quarters. Results of QI monitoring will be reported to QA&A Committee quarterly x 4 for compliance/revision of plan.	3/31/11

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F 323	Continued From page 17	F 323		

Assistant (NA) onto the floor. There was no floor mat on the side of the bed where he fell. Resident #3 was transferred to the hospital for evaluation.

Review of the emergency department report dated 2/25/11 revealed Resident #3 received one staple for a scalp laceration and returned to the facility.

Interview at 9:15 AM on 3/2/11 with Licensed Nurse (LN) #1, who was on duty when the 2/25/11 fall occurred, revealed she had been called to the room by NA #5. LN #1 reported Resident #3 was lying on the floor next to his bed. His head was against the bedside table and there was bleeding from a cut. LN #1 explained the floor mat had not been on the side of the bed where the fall occurred. A floor mat was on the other side of the bed.

Continued interview with LN #1 revealed she assessed Resident #3 after the fall and transferred him to the hospital. LN #1 revealed one or two Nursing Assistants bathed and dressed Resident #3 prior to this fall. LN #1 explained the number of persons required varied because nursing assistant would decide if help was required. Some Nursing Assistants did not need help with the bed bath. She explained she did not direct the number of staff required for care. LN #1 reported the care plan for Resident #3 required two persons during care at all times after the 2/25/11 fall.

Observation at 9:30 AM on 3/2/11 revealed Nursing Assistant (NA) #2 and NA #3 gave Resident #3 a bed bath. Resident #3 did not move during the bed bath. Both legs were contracted and a splint was on his left hand.

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F 323	Continued From page 18 There was a floor mat on one side of the bed. Interview with Nursing Assistant (NA) #2 at 9:40 AM on 3/2/11 revealed Resident #3 required one or two staff persons for assistance during care prior to the 2/25/11 fall. NA #2 reported she cared for Resident #3 without assistance until after the 2/25/11 fall. NA #2 explained Resident #3 did not move during care and required total assistance. NA #2 did not know how Resident #3 was able to fall out of bed during care. NA #2 explained she could not remember if she had told NA #5 one or two persons were required for a bed bath. Interview with the interim Director of Nursing (DON) at 11:45 AM on 3/2/11 revealed the 2/25/11 fall investigation was not complete and NA #5 was suspended pending the investigation's outcome. She stated that Resident #3's care plan now required two persons during all care at bedside. The DON reported Resident #3 had required one staff person during a bed bath prior to this fall. She explained new Nursing Assistants followed the lead of experienced Nursing Assistants for training. The DON revealed she expected the Licensed Nurses to give report at the beginning of the shift with instructions for resident care. She expected this instruction to include the number of staff required if the Nursing Assistant was new. Interview with the MDS Coordinator at 12:15 PM on 3/2/11 revealed she used her direct observations and interviews with Nursing Assistants to determine the number of persons required during the bath. She assessed Resident #3 required one person during the bath for the most recent MDS.	F 323		

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F 323	Continued From page 19 Telephone interview with NA #5 at 12:20 PM on 3/2/11 revealed Resident #3 fell out of bed when she turned him during a bed bath. NA #5 explained she thought the water on the air mattress contributed to the fall because it was "slick." She reported Resident #3 was in the middle of the air mattress and she turned Resident #3 away from her toward the window. NA #5 explained Resident #3's legs came off the bed and she could not stop the fall. NA #5 reported there was no floor mat on the side of the bed where Resident #3 fell. NA #5 revealed she was new to Resident #3 and thought she did not need help during the bed bath. NA #5 reported she received instructions from other Nursing Assistants regarding Resident # 3's care. Observation at 7:55 AM on 3/3/11 revealed Resident #3 in bed with floor mats on each side. A second interview with the DON at 9:50 AM on 3/3/11 revealed Resident #3's second floor mat was placed yesterday (3/2/11). She explained Resident #3 had one floor mat on 2/25/11 because his other falls occurred on the same side of the bed. The DON reported the facility placed floor mats on the side of the bed where residents fell. The DON explained the second floor mat was to be placed after the 2/25/11 fall but it was delayed due to delivery issues and need for cleaning prior to use.	F 323		
F 431 SS=D	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	F 431		

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F 431	Continued From page 20 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to date multi-dose injectable vials (Tuberculin Purified Protein Derivative) per the manufacturer guidelines for one (1) of two (2) medication room refrigerators and failed to store ophthalmic medications securely for one (1) of eleven (11)	F 431	F431 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice** 1. Undated vial of PPD (Purified Protein Derivative) was discarded. The eye drops were securely stored. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.** 2. Medication Rooms were Q I (Quality Improvement) audited for any undated multi-dose vial. No other undated vials were noted. Licensed Nurse have been re-educated regarding securing medications during the medication pass.	

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F 431	Continued From page 21 residents observed during medication pass. (Resident #21) The findings are: 1. The facility did not have any policy and procedures related to multi-dose injectable vials storage and dating. A review of the manufacturer product insert and the product label for Tuberculin PPD (Purified Protein Derivative) had a black box warning to discard the opened vials in 30 days due to oxidation and degradation which may affect potency. Observation of the 100-hall medication storage area refrigerator on 3/01/2011 at 8:15 AM revealed the following: · One bottle of Tuberculin Purified Protein Derivative (PPD) opened and not dated. Further, the product label disclosed a warning to discard the vials in 30 days after opening due to possible oxidation and degradation which may affect the potency. An interview with the licensed nurse #3 (LN #3) on 3/01/2011 at 8:17 AM revealed that she was not aware that PPD bottles became outdated in 30-days and was not aware why the vial was not dated when opened. LN #3 was also not sure when it was dispensed from the pharmacy. An interview with interim Director Of Nursing (DON) on 3/2/2011 at 4:20 PM revealed that it was her expectation that all multi-dose injectable vials had to be dated when opened and discarded after 30-days. The interview revealed that all nurses had been educated on dating the PPD	F 431	**Measures to be put in place or systemic changes made to ensure practice will not re-occur.** 3. The 11-7 Charge Nurses will QI audit opened multi-dose vials nightly for dates. Medication Carts will be QI audited during medication passes to ensure medications are secured. The DON (Director of Nursing) / Designee will QI audit med rooms refrigerators and Medication Carts daily 5 x wk x 2 weeks, weekly x 2, monthly x 2, then quarterly x 3. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.** 4. The DON will report results of findings to the QA&A (Quality Assessment and Assurance) Committee quarterly x 4 for continue compliance/ revision to the plan	3/31/11

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F 431	Continued From page 22 vials when open. 2. Resident #21 was admitted to the facility on 9/14/2010. Resident's admitting diagnoses included Conjunctivitis, Glaucoma and eye infections. Resident #21 was observed for medication pass on 3/1/2011 at 3:40 PM. Licensed Nurse #7 (LN #7) was seen administering medications to Resident #21. LN #7 removed the following eye drops from the medication cart: · Brominidine Tartrate 0.2% eye drops · Dorzolamide/Timolol (Cosopt) 2%/0.5% eye drops · Gentamycin 0.3% eye drops LN #7 was seen administering the eye drops one at a time at appropriate time intervals as ordered. The observation revealed that LN #7 left the medication bottles on the top of the medication cart to administer one product at a time. At least two of the eye drops were left on the medication cart without any attention for over 10-12 minutes outside the Resident ' s room. The cart was parked outside Resident #21's room and several residents were observed passing by. Licensed Nurse #7 was interviewed on 3/1/2011 at 3:55 PM. The interview revealed that she normally would not leave any medications on the cart without her complete attention. The nurse stated that she forgot to carry them with her and she was more focused to the spacing of the eye drops and hence left the bottles by mistake. LN #7 was aware that several confused residents were in the area and was aware that prescribed medications had to be secured and stored appropriately.	F 431		

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(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 431	Continued From page 23 An interview with the interim Director of Nursing (DON) on 3/2/2011 at 11:05 AM revealed that it was her expectation that no medications were left un-attended at the time of medication administration. The DON also stated that all nurses had been in-serviced on medication storage and security.	F 431	F 463 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice.** 1. Public bathroom doors were secured.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and medical record review, the facility failed to provide a functioning call system in two (2) of four (4) public toilets available for use by residents. The findings are: Resident # 20 was admitted to the facility on 12/10/10 with diagnoses of congestive heart failure and anemia. The most recent Minimum Data Set dated 01/17/11 revealed the resident was cognitively intact with no short or long term memory problems. On 03/01/11 at 4:30 p.m. an observation was made of two unlocked toilets, available to the public, one located on the 100 wing, and the other located on the 200 wing of the facility. Neither toilet had a call bell system or an emergency	F 463	**How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.** 2. Public bathrooms were audited to ensure they were secured if no nurse call system was available in the bathroom. **Measures to be put in place or systemic changes made to ensure practice will not re-occur.** 3. Self-locking locks were installed on bathroom doors that did not have a nurse call system available. Maintenance will randomly QI monitor public bathrooms quarterly x 4 to ensure locking mechanism is operable.	

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	345471	A. BUILDING _____ B. WING _____	03/03/2011

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F 463	Continued From page 24 alarm system available. Further observations were made of both toilets on 03/02/11 at 12:30 p.m. and on 03/03/11 at 11:30 a.m. All observations revealed the toilets remained unlocked and available for use by anyone and neither toilet had a call bell system or emergency alarm system available. On 03/03/11 at 12:45 p.m. Resident # 20 was interviewed. She stated she often used the public toilet on the 200 wing which was where she resided. She stated she did this whenever the toilet in her room was occupied. Resident # 20 stated that if someone was using the toilet on the 200 wing, she used the other public toilet on the 100 wing instead. She stated that neither toilet had a call bell system to notify staff in case of needing help or an emergency. On 03/03/11 at 1:23 p.m. the Maintenance Director was interviewed. He stated that a functioning call bell system should be in any toilet accessible to residents for safety reasons. The Maintenance Director stated he was not aware that there was no call system in these toilets. He stated he would immediately lock these toilets until a call system could be installed.	F 463	**How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.** 4. Maintenance will report findings of audit to the QA&A Committee quarterly x 4 to ensure continued compliance/revision to the plan.	3/31/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 25 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately transcribe, physician orders for one Gastrostomy tube (G-tube) fed resident and the medication (Methadone) administration times for one resident, for a total of two (2) of sixteen (16) sampled residents. (Resident #3 and Resident #16) Findings include: 1. Resident #3 was admitted to the facility on 10/28/2010. The Resident's diagnoses included status post Gastrostomy care, Dysphagia with PEG (Percutaneous Endoscopic Gastrostomy) tube, Parkinson's disease, History of Cardiovascular Accident, Subarachnoid Hemorrhage and Hypertension. A review of the care plan revealed that Resident #3 was dependent on enteral feeding for nutrition. All medications were to be given through Gastrostomy tube (G-tube). The care plan indicated that Resident #3 was a NPO (Nothing by mouth) and all administrations were through the G-tube only. A review of the March 2011 monthly physician orders revealed the following medication orders transcribed as to be given by mouth: 1. Carbidopa/Levo 25mg/100mg (Sinemet) one tablet by mouth five times daily	F 514	F 514 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice.** 1. A. Resident # 3 Physician Orders and Medication Administration Records were corrected to denote via tube. B. Resident # 16 physician contacted to clarify methadone order and order transcribed per physician orders. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.** 2. A. Residents with feeding tubes orders were monitored to ensure all medications read via tube. B. New orders have been monitored to ensure order transcribed appropriately	

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F 514	Continued From page 26 2. Methylphenidate HCl (Ritalin) 12.5mg tablet by mouth at noon and 10mg tablet at 10:00 AM by mouth 3. Citalopram HBr (Celexa) daily 40mg by mouth 4. Baclofen 20mg tablet three times daily by mouth 5. Lorazepam 0.5mg tablet by mouth as needed for anxiety 6. Hydrocodone-Acetaminophen (Vicodin) 5/500mg tablet by mouth every 4 hours as needed for pain. Further review of the physician orders of previous months from November 2010 to March 2011 had the above medication orders transcribed as to be given by mouth. Review of the Medication Administration Records (MAR) of all the previous months including for the month of March 2011 had the above medication orders transcribed as to be given by mouth. A continued review of the physician admission orders the medications were handwritten and were correctly ordered as to be given via the G-tube. An interview with licensed nurse #1 on 3/2/2011 at 4:05 PM revealed that Resident #3 was a NPO (Nothing by mouth) from the time of admission and all medications were administered through G-tube only. Further she stated that no medication had been given to Resident #3 by mouth. An interview with the Director of Nursing (DON) on 3/3/2011 at 12:05 PM revealed that monthly physician order sheets and Medication Administration Records (MAR) were printed at the facility. The accuracy and correctness of all physician orders was checked by two assigned	F 514	**Measures to be put in place or systemic changes made to ensure practice will not re-occur.** 3. A. Nursing Staff have been re-educated by the corporate nurse on checking monthly orders and transcribing orders. Monthly orders will have a first check by the charge nurses, a second check will be done by the administrative nurses, and a third check will be done by the 11-7 charge nurses when the monthly change over occurs. B. The third shift charge nurses will do a 24 hour chart check to ensure orders are carried out as ordered. The Unit Manager/ Designee will review new orders on the next business day. The DON/Designee will randomly monitor orders 5 x week x 2 weeks, weekly x 2 weeks, monthly x 2, then quarterly x 3.	

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F 514	Continued From page 27 supervisory nurses at the beginning of the month when printed. The interview also revealed that it was her expectation that the documents had to be accurate and correct and any error was immediately corrected and brought to her attention. The interview revealed that she was not aware of these errors in the physician orders and MAR's for Resident #3. 2. Resident #16 was admitted to the facility on 2/11/2011. Resident #16 had admitting diagnoses including chronic Back pain, Lupus, Aftercare for Traumatic Fractures, Osteoporosis and Sickle Cell Trait. A review of Resident #16's admission orders included Methadone 15mg three times daily. A review of the Medication Administration Record (MAR) for the month of March 2011 revealed that the order was documented as 'Methadone 15mg po (per oral) BID (two times daily)'. Further review revealed that the nurse who transcribed the order to the MAR had written only 8:00 AM and no other time was entered. The review revealed that the physician order was not transcribed correctly and accurately to the MAR. Resident #16 was observed for medication pass on 3/1/2011 at 4:20 PM. Licensed nurse #5 (LN #5) was observed passing medications to Resident #16. The nurse pulled several medications as ordered by the physician and stated that Resident #16 requested a pain medication. The nurse stated that she was going to give a dose of Methadone 15mg which was a PRN (as needed medication) and administered the dose correctly. An interview with LN #5 on 3/1/2011 at 4:25 PM	F 514	**How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.** 4. The DON will report findings to the QA&A Committee quarterly x 4 for continued compliance/ revision to the plan	3/31/11

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F 514	Continued From page 28	F 514		

revealed that the Methadone dose given was a routine order which was scheduled at 4:00 PM and the nurse transcribing the Methadone order had not entered the times accurately and hence there was a confusion to decide whether it was a routine or PRN order. LN #5 later confirmed that there was an inaccuracy in the entries and got the orders clarified by the physician as a 'Methadone TID (three times daily)' order.

An interview with the licensed nurse #6 who had transcribed order revealed that she had wrongly transcribed the Methadone order as 'Methadone 15mg BID' and had written only 8:00 AM in the times column and had not written the other times. The interview revealed that she was distracted due to an emergency and she had transcribed the order incorrectly.

An interview with the Director of Nursing (DON) on 3/3/2011 at 12:05 PM revealed that monthly physician order sheets and Medication Administration Records (MAR) were printed at the facility. The accuracy and correctness of all physician orders was checked by two assigned supervisory nurses at the beginning of the month when printed. The interview also revealed that it was her expectation that the documents had to be accurate and correct and any error was corrected immediately and brought to her attention. The interview confirmed that there was an error in transcription of the Methadone order for Resident #16 in the March 2011 MAR for Resident #16.