

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

AMENDED

PRINTED: 03/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345424	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/08/2011
NAME OF PROVIDER OR SUPPLIER  AMH SEGRAVES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL AVE JEFFERSON, NC 28640	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 161 SS=B	<p>The original recertification/complaint survey was conducted from January 18-20, 2011. Based upon management review, the survey dates were extended and the CMS 2567 was amended to reflect the change in the s/s of F441 to immediate jeopardy. The survey team reentered the facility on March 7, 2011 and notified the administrator of the IJ. The exit date was extended to March 8, 2011 at which time the jeopardy was removed and F441 was left out of compliance at a lower scope and severity.</p> <p>No deficiencies were cited as a result of the complaint investigation. Event ID Y92V11.</p> <p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS</p> <p>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility failed to have a surety bond which designated the obligee (recipient of the bond) as the residents whose monies were managed by the facility. The facility had resident trust fund accounts for fifteen (15) of fifty six (56) residents in the facility.</p> <p>The findings are:</p> <p>Review of the current "Patients' Fund Bond," held by the facility effective from August 28, 2010 to August 28, 2011 revealed the obligee was listed as the "Division of Medical Assistance</p>	<p>Tag #</p> <p>F161</p>	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>The Surety Bond will be corrected to designate as Obligee "All the Residents, in aggregate, of AMH Segraves Care Center." (Completed)</i></p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p><i>The Surety Bond will be corrected to designate as Obligee "All the Residents, in aggregate, of AMH Segraves Care Center." Any resident and / or their responsible party who have entrusted funds to the facility will be notified of the corrected Obligee. (Completed)</i></p> <p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p>	<p>01/28/2011</p> <p>01/28/2011</p> <p>01/28/2011</p>

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

✓ *Dr. Williams*

TITLE

✓ CEO

(X6) DATE

✓ 4/6/11

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: 3-30-11

APR 07 2011

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F 161	Continued From page 1 Certification," not the residents of the facility as required.	F 161	<i>The Surety Bond has been corrected to designate the residents in aggregate as Obligee. (completed)</i>	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to treat residents with dignity. The facility failed to serve six of (6) residents in the dining room in a timely manner and left residents who needed assistance, watching while other residents were assisted with their meals. (Residents #2, #3, #4, #5, #21 and #22.)  The findings are:  1. Review of Resident 3's quarterly Minimum Data Set dated 10/11/10 assessed the resident as needing extensive assistance with eating and as having memory problems. Mealtime observations on 01/18/11 at 5:45 p.m., revealed Resident #3 was seated in a Geri chair at a table with another dependent resident for her supper meal. Resident #3 was observed being fed by staff and slowly eating from 5:45 p.m. until 6:00 p.m. At 6:00 p.m., staff assisting Resident #3 was observed to turn their back to Resident #3 and began feeding another dependent resident seated on the	F161  F161  F241	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.  <i>The CFO will monitor the resident accounts in aggregate on a monthly basis, notifying the CEO if the balance becomes within \$5000 of the Surety Bond Coverage. The CEO will review the surety bond upon request, and at renewal to assure continued accuracy of designated Obligee. The results of the monitoring activity will be reported to the quality assurance committee by the CEO on a quarterly basis.</i>  1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>Resident #3 - prefers to stay in her room and eat her meals there. She does not want to come to the dining room at meal time. Staff have been reminded of Resident #3's preferences, and her care plan has been updated to reflect that it is her preference to consume her meals in her room.</i>	01/28/2011  1/28/2011

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F 241	<p>Continued From page 2</p> <p>opposite side of the same table until 6:20 p.m. Resident #3 was observed to be unable to reach the food on the table from her position in her Geri chair and to quietly watch staff until they finished feeding the other resident at 6:20 p.m.</p> <p>Staff turned back to Resident #3 at 6:20 p.m., and asked her if she wanted anymore of her food. Resident #3 refused to eat more of the food from her tray, leaving approximately 1/2 of her milk, all of the chopped ham, a fruit cup, and a pastry untouched.</p> <p>During an interview on 01/20/11 at 9:00 a.m., the Director of Nurses stated, "I agree there is a dignity issue going on in the dining room at meal times. There is only one feeding in the dining room. Staff say if they don't bring the dependent residents in Geri chairs in first, they can't get them into the dining room, after all the other residents come into room. There is nothing for the residents to do except wait for their meals."</p> <p>2. Review of Resident #4's quarterly Minimum Data Set dated 11/02/10 revealed the resident was totally dependent on staff for all activities of daily living and was severely impaired in making decisions. On 1/20/11 at 12:30 p.m., Resident #4 was observed in a Geri chair in the dining room seated at the same table opposite another Resident. Staff were observed placing Resident # 4's food tray on the table in front of the resident at 12:30 p.m. Resident #4 was observed quietly watching other residents eating their meals from 12:30 p.m., until 1:00 p.m., before being assisted by staff to eat their food.</p> <p>When asked during an interview on 01/20/11 at 1:20 p.m., why residents were taken to the dining</p>	<p>F241</p> <p>F241</p>	<p><i>Resident #3, #4 &amp; #22 will not have their meal tray delivered to them until they are ready to be served and assisted with there meal.</i></p> <p><i>Residents #2,#5 and #21 will be staged for entry into the dinning facility. Resident # 5 will enter the dining facility with the 2<sup>nd</sup> tray cart. Residents # 2 and #21 will enter the dining facility with the 3rd tray delivery cart.</i></p> <p><i>Resident #22's position at meal time has been adjusted. He is now positioned where he may observe and participate in the activity occurring during meal time</i></p> <p><i>Direct care staff have been encouraged to communicate with resident while assisting with meals.</i></p> <p><i>Direct care staff have been instructed to offer resident re-heating or replacement of meal trays which have been delivered for 20 minutes or more.</i></p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p><i>The meal process has been reevaluated. All residents and their preferences have been reviewed to establish what their meal time preferences are. Reviewing whether they prefer to dine in the dining room, their room, or another location. The resident's meal tray will be delivered to them in their preferred location.</i></p>	<p>2/10/2011</p> <p>1/28/2011</p>

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F 241	<p>Continued From page 3</p> <p>room so early for meals Nurse Aide #1 stated, "I don't know. That is the way it was being done when I first came to work here."</p> <p>In an interview on 01/20/11 at 1:26 p.m., NA #2 stated "I don't know why residents are taken to the dining room so early for mealtime."</p> <p>During an interview on 01/20/11 at 9:00 a.m., the Director of Nurses stated, "I agree there is a dignity issue going on in the dining room at meal times. There is only one feeding in the dining room. Staff say if they don't bring the dependent residents in Geri chairs in first, they can't get them into the dining room, after all the other residents come into room. There is nothing for the residents to do except wait for their meals."</p> <p>3. Review of Resident #21's quarterly Minimum Data Set dated 01/06/11 assessed the resident as being totally dependent in all activities of daily living and as being severely impaired in making decisions. Resident #21 was observed in a Geri chair in the dining room on 01/20/11 at 12:30 p.m., with her food tray sitting in front of her until 1:00 p.m., before being assisted by staff to eat her food.</p> <p>When asked during an interview on 01/20/11 at 1:20 p.m., why residents were taken to the dining room so early for meals Nurse Aide #1 stated, "I don't know. That is the way it was being done when I first came to work here."</p> <p>In an interview on 01/20/11 at 1:26 p.m., NA #2 stated "I don't know why residents are taken to the dining room so early for mealtime."</p> <p>During an interview on 01/20/11 at 9:00 a.m., the</p>	F241	<p><i>The seating arrangement in the dining room has been modified to assure that all residents have a view of the activities of the dining room during meal time.</i></p> <p><i>The meal time process is being modified to a staged tray delivery approach to assure that trays are not getting cold before the resident is seated and ready for their tray.</i></p> <p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p> <p><i>Staff were in-serviced on the importance of offering to reheat or replace food trays that have had the opportunity to cool. They were also reminded of the importance of interacting and communicating with the residents as they assist them with their meals.</i></p> <p><i>The dining room set-up and meal time processes have been evaluated. The dining room seating arrangement has been rearranged to assure that all residents have a view of the surrounding activities.</i></p> <p><i>Upon evaluation it was determined that a staged approach with tray delivery and resident arrival to the dining room would help in assuring that residents were not sitting for long periods of time awaiting their meals and that the trays weren't sitting a long time waiting to be passed to the residents. The first wave of residents begin arriving in the dining room shortly before the arrival of their meal trays. Each wave includes a mix of ambulatory independent residents, residents who need to be cued during mealtimes and residents who must be assisted with their meals. As residents from this first wave begin to complete their meals they return to their rooms or other locations</i></p>	<p>2/16/2011</p> <p>2/10/2011</p> <p>2/10/2011</p> <p>2/14/2011</p>



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F 241	<p>Continued From page 5</p> <p>no activity provided and nothing for the resident's to do but wait for their meals."</p> <p>5. Resident #2 was re-admitted to the facility on 10/20/10 with diagnoses of congestive heart failure, aortic stenosis, pulmonary hypertension, atrial fibrillation and fluid retention. The most recent Minimum Data Set dated 11/30/10 indicated no impairment of memory and cognition and the resident required assistance by staff for personal care.</p> <p>Dependent Resident #2 was observed in the main dining room on 01/18/11 at 5:36 p.m. reclined in a Geri chair with her meal tray in front of her unopened. Resident #2 was observed to be watching other resident's eating their meals from 5:36 p.m. until 5:53 p.m., before being assisted by staff to eat her food.</p> <p>During an interview on 01/20/11 at 9:00 a.m., the Director of Nurses stated, "I agree there is a dignity issue going on in the dining room at meal times. There is only one feeding in the dining room. Staff say if they don't bring the dependent residents in Geri chairs in first, they can't get them into the dining room, after all the other residents come into room. There is nothing for the residents to do except wait for their meals."</p> <p>6. Resident #5 was admitted to the facility on 01/31/04 with diagnoses of diabetes mellitus type II, hypertension, gastroesophageal reflux disease, and depression. The most recent Minimum Data Set dated 10/04/10 indicated that the resident had problems with short and long term memory and was totally dependent on staff for care.</p> <p>Dependent resident #5 was observed in the main</p>	F241	<p><i>Any deficiencies will be corrected immediately and reported to the DON or designee daily. The DON will monitor for patterns of deficiencies. When patterns are identified the meal time process will be reviewed and revised to facilitate improvement.</i></p> <p><i>The Registered Dietitian and the Certified Dietary Manger will randomly visit the dining room during meal times, surveying residents about the food they are receiving and whether it is warm enough when it arrives. Any deficiencies they find will be reported to the DON and addressed immediately.</i></p> <p><i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON.</i></p>	2/16/2011	

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F 241	Continued From page 6 dining room on 01/18/11 at 5:36 p.m. reclined in a Geri chair with her meal tray in front of her unopened. Resident #5 was observed to be watching other resident's eating their meals from 5:36 p.m. until 5:53 p.m., before being assisted by staff to eat her food.  On 01/20/11 at 10:10 a.m., Resident #5 was transported from the shower room in her Geri chair to the dining room and positioned along a back wall at the window with her back to other resident's who were involved in activities. Resident #5 was observed in the dining room at the following times sitting alone in her Geri chair: 10:35 a.m., 10:50 a.m., 11:05 a.m., 11:15 a.m., 11:30 a.m., 11:45 a.m., and 12:00 p.m. At 12:20 p.m., Resident #5 was observed being fed by a staff member.  During an interview with Nursing Assistant #3 on 01/20/11 at 10:15 a.m. she stated that "we clean and dry the resident and take them to the dining room so that they will be ready for their meals."  During an interview with the Director of Nurses on 01/20/11 at 09:00 a.m., it was stated, "I agree there is a dignity issue going on in the dining room at meal times. Staff say that if they don't bring the dependent residents in Geri chairs in first, they can't get them in the room after all of the other residents come into the room. There is no activity provided and nothing for the resident's to do but wait for their meals."	F 241			
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F280	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>Resident #7, #9, and #10 Will be notified of date, time and location of all scheduled "Resident Care Plan Meetings", by the Social Worker.</i>  <i>Resident #7, #9, and #10 Were invited to and participated in a review of their current care plan.</i>  2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	1/28/2011  2/1/2011	

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F 280	Continued From page 7 participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and medical record review, the facility failed to invite three (3) of twelve (12) sampled residents to their Care Plan Meetings. (Residents #7, #9 and 10).  The findings are:  1. Resident #7 was admitted to the facility on 12/31/09. Resident #7's quarterly Minimum Data Set dated 10/06/10 assessed her as being alert and oriented. Review of the Care Plan meeting attendance in the medical record for Resident #7 revealed no documentation where she had attended her quarterly Care Plan meeting dated 10/11/10. Further review of the medical record for Resident #7 revealed no documentation of the care plan having been discussed with her. During an interview on 1/19/11 at 1:30 pm	F 280      F280    F280	There was a report made to the Resident Council Meeting by the DON regarding the results of the survey. During that meeting the DON reviewed the Care Plan Process. Each resident / their family / legal representative will be invited to their care plan meeting and are encouraged to attend and participate in these meetings.  Two residents from the MDS schedule will be reviewed for participation in their care plan process by the DON or designee each week. Any resident / family / legal representative who were not given the opportunity to participate in their care plan process, will have a new care plan meeting scheduled and they will be given the opportunity to participate in this meeting. There will be weekly follow-up by the DON or designee to assure that these residents do receive the opportunity to participate in their care plan meeting.  All residents / their families / legal representatives will be receiving a letter from our Social Worker outlining the care plan process and notifying them that they will be invited to and are encouraged to participate in their future care plan meetings.  3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:	1/28/2011   02/16/2011   2/16/2011



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F 280	<p>Continued From page 8</p> <p>Resident # 7 stated she "had not been invited" to her care plan meetings with staff. During an interview with the Director of Nurses on 1/20/11 at 9:00 am, it was stated, "the Social Worker mails care plan notices to the families. No one is discussing the care plans with the residents that I know of. I attend the care plan meetings and do not see residents attending." During a telephone interview on 1/20/11 at 9:20 am, the Social Worker stated, "I mail notices of care plan meetings to the families. I do not document verbal invitations to residents. Sometimes residents are told what happened in care plan meetings. I can't say that I do it every time."</p> <p>2. Resident #9 was admitted to the facility on 9/07/09. Resident #9's quarterly Minimum Data Set dated 10/04/10 assessed her as being independent in Cognitive Functioning and Decision Making abilities. Review of the Care Plan attendance, in the medical record for sampled Resident #9, revealed no documentation that she had attended her quarterly Care Plan meeting dated 10/11/10. Further review of the medical record for Resident #9 revealed no documentation of the care plan having been discussed with her.</p> <p>During an interview on 1/19/11 at 1:30 pm Resident # 9 stated she "had not been invited" to her care plan meetings with staff. During an interview with the Director of Nurses on 01/20/11 at 9:00 a.m., it was stated, "the Social Worker mails care plan notices to the families. No one is discussing the care plans with the residents that I know of. I attend the care plan meetings and do not see residents attending." "During a telephone interview on 01/20/11 at 9:20 a.m., the Social Worker stated, "I mail notices of care plan meetings to the families. I do not</p>	F280	<p><i>The Social Worker will add a notice to the resident admission packet which outlines the "Resident Care Plan" process. It will include information about how invitations to participate in the meetings will occur and will encourage their attendance. During the admission process and as appropriate the Social Worker will discuss tentative dates and times for scheduled care plan meetings with the resident / their family / legal representative.</i></p> <p><i>The Social Worker will advise the Care Plan Team of upcoming "Resident Care Plan" meetings at the weekly Medicare meeting.</i></p> <p><i>The Social Worker will extend a written and verbal invitation to each resident requesting their attendance at their care plan meeting. This invitation will be documented in the resident's medical record. The resident's family / legal representative will also receive a written invitation to attend the care plan meeting.</i></p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p> <p><i>Two residents from the MDS schedule will be reviewed for participation in their care plan</i></p>	2/16/2011	

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NAME OF PROVIDER OR SUPPLIER  AMH SEGRAVES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL AVE JEFFERSON, NC 28640	
(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 280	Continued From page 9 document verbal invitations to residents. Sometimes residents are told what happened in care plan meetings. I can't say that I do it every time."  3. Resident #10 was admitted to the facility on 05/14/09 with diagnoses of diabetes mellitus type II, vitamin B12 deficiency, arthritis and chronic obstructive pulmonary disease. The most recent Minimum Data Set dated 11/23/10 indicated no cognitive impairment and resident required assistance by staff for personal care.  During an interview with the Director of Nurses (DON) on 01/20/11 at 09:00 a.m., it was stated "the Social Worker mails care plan notices to the families. No one is discussing care plans with the residents' that I know of. I attend the care plan meetings and do not see residents' attending."  During a telephone interview on 01/20/11 at 9:20 a.m., the hospital Social Worker stated, "I mail notices of care plan meetings to the families. I do not document verbal invitations to residents. Sometimes residents are told what happened in the care plan meetings. I can't say that I do it every time."  During an interview with Resident #10 on 01/20/11 at 10:15 a.m., the resident stated that she has never participated in meetings where her care or activities are discussed. She further stated that she does not remember being told about care planning meetings since she has been in this facility.	F 280	<i>process by the DON or designee each week. Any resident / family / legal representative who were not given the opportunity to participate in their care plan process, will have a new care plan meeting scheduled and they will be given the opportunity to participate in this meeting. There will be weekly follow-up by the DON or designee to assure that any resident, whose process is found to be deficient does receive the opportunity to participate in their care plan meeting. The DON will report Quarterly to the QA committee on these deficiencies and their resolution.</i>	2/14/2011
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility	F281	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>Resident #2's physician was contacted and notified of the resident's need for Oxygen administration. The physician ordered Oxygen administration for the resident.</i>  <i>A medication occurrence report was completed per protocol.</i>	1/20/2011  1/21/2011

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F 281	<p>Continued From page 10 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to implement interventions to obtain a physician's order for oxygen for one (1) of three (3) residents (Resident #2).</p> <p>The findings are:</p> <p>Resident #2 was re-admitted to the facility on 10/29/10 with diagnoses of Congestive Heart Failure, Aortic Stenosis, Pulmonary Hypertension, Atrial Fibrillation and Fluid Retention. The most recent Minimum Data Set dated 11/30/10 indicated no memory impairment or cognitive deficit. The resident required assistance by staff for personal care. It also indicated the resident received oxygen therapy.</p> <p>A review of the physician's orders from October 2010 to January 2011 revealed that there were no physician orders for oxygen therapy for the resident.</p> <p>A review of the nurse's notes from October 2010 to January 2011 revealed that there was no documentation regarding notification to the physician that the resident was getting oxygen.</p> <p>On 01/18/11 at 5:36 p.m., Resident #2 was observed sitting in the main dining room with a nasal cannula in place. The oxygen machine was turned on and set at three (3) liters per minute.</p> <p>On 01/19/11 at 07:40 a.m., Resident #2 was</p>	F 281	<p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p><i>A review of the medical records of all residents currently receiving Oxygen administration was conducted to assure that the proper orders were in place.</i></p> <p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p> <p><i>Nurses were re-educated on the necessity of obtaining an order for Oxygen administration when a resident requires oxygen.</i></p> <p><i>Nurses were reminded that when utilizing the Standing Order form to implement oxygen administration for a resident they must still contact the physician for follow-up approval and any further assessment or orders.</i></p> <p><i>All residents will be assessed at admission for any ongoing needs for oxygen administration. An order will be obtained from the physician at admission as applicable.</i></p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p>	1/24/2011          2/10/2011

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F 281	Continued From page 11 observed in her room in bed with a nasal cannula in place. The oxygen machine was turned on and set at three (3) liters per minute.  On 01/19/11 at 10:00 a.m., the Assistant Director of Nurses was interviewed. She verified that the resident was re-admitted to the facility from a hospital with oxygen in place. She also verified that standing orders for the facility dated October 18, 2010 stated to notify the physician when oxygen was started to obtain orders for liter flow but the nurses did not call the physician for oxygen orders.		<i>The Nurse assigned to perform the weekly Oxygen Maintenance rounds will concurrently observe all the residents and identify anyone receiving Oxygen Administration who is not on the Oxygen Maintenance list. The nurse will review the chart of any resident noted to be receiving oxygen administration, to update the Oxygen Maintenance list and to assure there is an appropriate order in place for the oxygen. The nurse will follow up on obtaining an order if one is not found to be in place. The nurse will report any deficiencies noted to the DON who will monitor for any patterns and re-educate staff as necessary.</i>	2/10/2011
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public	F281          F356	<i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON</i>  1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>The facility name, current date, total number and hours worked by category of staff by shift: RN, LPN, &amp; CNA, were posted on the dry erase board in the hall across from the nurses station. These totals also included the current resident census.</i>	2/16/2011          1/20/2011

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F 356	<p>Continued From page 12 for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to include the facility name and information regarding the total number of Registered Nurses, Licensed Practical Nurses, and Nurse Aides directly responsible for resident care and the actual hours worked per shift on the daily staff posting for three (3) of three (3) survey days.</p> <p>The findings are:</p> <p>During initial tour of the facility on 01/18/2011 at 1:05 p.m., facility daily staffing information was observed posted on a board in the main hall adjacent to the nurses' station. The posting included the name and assignment of Registered Nurse (RN), Licensed Practical Nurse (LPN), and Nurse Aide (NA) staff along with the current date and resident census. The total number of RN, LPN, and NA staff on duty and actual hours worked per shift along with the facility name were omitted from the posted daily staffing information. Additional observations of the daily staff posting on 01/18/2011 at 4:10 p.m., 01/19/2011 at 10:30 a.m. and 12:05 p.m., and 01/20/2011 at 8:10 a.m. and 12:00 p.m., revealed the facility name as well as the total number of staff and actual hours worked per shift were omitted from this posting.</p>	F 356	<p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p><i>The facility name, current date, total number of staff and hours worked by category of staff by shift: RN, LPN, &amp; CNA, as well as a cumulative 24 hour total, were posted on the dry erase board in the hall across from the nurses station. These totals also included the current resident census. This information is posted daily in a clear legible manner available for the review of all residents, staff and visitors</i></p> <p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p> <p><i>The nursing staff have been in-serviced on the importance of this data being posted and updated on a daily basis as outlined in the "Daily Staffing Post, SCC" policy. A laminated example of the appropriate format for the posting has been placed in the assignment book at the nurses station where it is available for review.</i></p> <p><i>The DON and all Nurses will observe the board daily to assure it has been updated as appropriate. Any nurse finding the board has not been updated for the day will immediately correct the board or notify the DON so the correction may be facilitated.</i></p>	1/20/2011	2/10/2011

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F 356	Continued From page 13 During an interview on 01/20/2011 at 2:00 p.m., the facility Director of Nursing (DON) stated she was unaware the facility name was required on the posted daily staffing information along with the total number of RNs, LPNs, and NAs and actual hours worked per shift.	F356	<p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p> <p><i>The DON will observe for compliance with the daily posting. Deficiencies will be corrected immediately and assigned staff will be reminded of the importance of remaining in compliance with this posting. The DON will monitor for any patterns in failure to post or update this data as applicable.</i></p> <p><i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON</i></p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Resident#7, #9 &amp; #10 Were in attendance at the Resident Council Meeting where the findings from the survey were reviewed with everyone by the DON. At that time the DON notified everyone in</i></p>			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.	F356			1/24/2011	
	When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  This REQUIREMENT is not met as evidenced by: Based on group interview with members of the Residents Council, individual resident interviews, and staff interview, the facility failed to offer four (4) of twelve (12) sampled residents snacks at bedtime. (Residents #7, #9, #10, and #20).  The findings are:  1. Review of Resident #20's admission	F368			2/16/2011	

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F 368	<p>Continued From page 14</p> <p>assessment dated 12/26/10 assessed the resident as having no memory problems. Resident #20 was also identified on a list of interviewable residents provided by the facility. Review of Resident #20's medical record reveals she has a diagnosis of diabetes.</p> <p>During an interview with the Registered Dietician on 01/20/11 at 2:52 p.m., she explained that residents receive a bedtime snack if they are on a defined calorie diet or if the Dietician assigns them to receive a snack. She stated that, "sometimes diabetics get a snack and sometimes they don't." She explained that snacks are prepared in the Dietary Department, dated the day they are prepared and labeled with the resident's name. These snacks are delivered to the refrigerator in the nourishment room behind the nurse's station the day after they are prepared and the nursing assistants distribute them to the residents.</p> <p>During individual interview on 01/20/11 at 4 p.m., Resident #20 stated she "was a diabetic" and staff "did not offer her a snack at night."</p> <p>2. Resident #7 was admitted to the facility on 12/31/09 with diagnoses which includes: pelvic fracture, pneumonia, osteoarthritis, hypertension and coronary artery disease. The Quarterly Minimum Data Set for Resident #7 dated 10/06/10 coded her as having no difficulty with cognition and decision making. Resident #7 was also identified as being interviewable on a list of interviewable residents provided by the facility.</p> <p>In an interview on 01/20/11 at 11:00 a.m., Resident #7 stated, "I am not offered a snack at night. I might want one if it was offered. I have a</p>	<p>F368</p> <p>F368</p>	<p><i>attendance that all residents will be offered a bedtime snack each night.</i></p> <p><i>Resident #20 was notified that she would be offered a bedtime snack daily</i></p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p><i>The DON requested that the Dietitian and the Certified Dietary Manger identify nutritious snacks which would be appropriate for the residents on a daily basis.</i></p> <p><i>As reviewed by the DON in the "Resident Council Meeting" all residents will be offered a bedtime snack each night.</i></p> <p><i>The diabetic residents will be offered the snacks which are prepared for them by the dietary department in compliance with their diabetic diet. All other residents will be offered the opportunity to choose from 5 prepackaged nutritious snack options identified by the dietitian and certified dietary manager.</i></p> <p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p> <p><i>The diabetic resident's snacks will be individually prepared by the dietary department in compliance with the resident's diabetic diet labeled for the applicable resident and brought to the resident diet kitchen at the nurses station daily.</i></p> <p><i>The CNA's will distribute the diabetic resident's snacks to them while concurrently offering all other residents a bedtime snack. The CNA will</i></p>	<p>1/28/2011</p> <p>1/28/2011</p> <p>1/21/2011</p> <p>Diabetic previous practice / others 2/10/2011</p> <p>Diabetic previous practice / others 2/10/2011</p>
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F 368	Continued From page 15 few things brought from home, that's all."  During an interview with the Registered Dietician on 01/20/11 at 2:52 p.m., she explained that residents receive a bedtime snack if they are on a defined calorie diet or if the Dietician assigns them to receive a snack. She stated that, "sometimes diabetics get a snack and sometimes they don't." She explained that snacks are prepared in the Dietary Department, dated the day they are prepared and labeled with the resident's name. These snacks are delivered to the refrigerator in the nourishment room behind the nurse's station the day after they are prepared and the nursing assistants distribute them to the residents.  3. Resident #9 was admitted to the facility on 9/07/10 with diagnoses which includes: cardiac arrhythmia, chronic bronchitis, congestive heart failure, and hypertension. Resident #9's quarterly Minimum Data Set dated 10/04/10 assessed her as being independent in Cognitive Functioning and Decision Making abilities.  In an interview on 01/20/11 at 11:30 a.m., Resident # 9 stated I am "not offered a snack at night."  During an interview with the Registered Dietician on 01/20/11 at 2:52 p.m., she explained that residents receive a bedtime snack if they are on a defined calorie diet or if the Dietician assigns them to receive a snack. She stated that, "sometimes diabetics get a snack and sometimes they don't." She explained that snacks are prepared in the Dietary Department, dated the day they are prepared and labeled with the resident's name. These snacks are delivered to	F 368	<i>document the PO intake or refusal of the snack in the CareTracker system.</i>  <i>The direct care nurse on shift at night will monitor whether each resident is being offered a snack. The nurse will correct any deficiency found immediately by offering a snack to that resident. The direct care nurse will notify the DON of any deficiencies she has had to correct.</i>  4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.  <i>The DON or designee will review the CareTracker documentation on at least 4 days a week to assure that the bedtime snacks are being documented appropriately.</i>  <i>The direct care nurse on shift will make nightly surveys of bedtime snacks being offered, and report findings to the DON.</i>  <i>The DON will monitor deficiencies reported by the direct care nurse for patterns and re-educate staff as necessary.</i>  <i>The Dietitian and Certified Dietary Manager will monitor intake or refusal of bedtime snacks. Any recommendations based on monitoring of these action plans will be reported to the Quality Improvement Committee.</i>  <i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON</i>	02/10/2011	2/16/2011
		F368			2/16/2011



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F 368	Continued From page 16 the refrigerator in the nourishment room behind the nurse's station the day after they are prepared and the nursing assistants distribute them to the residents.  4. Resident #10 was admitted to the facility on 05/14/09 with diagnoses of diabetes mellitus type II, vitamin B12 deficiency, arthritis and chronic obstructive pulmonary disease. The most recent Minimum Data Set dated 11/23/10 indicated no cognitive impairment and resident required assistance by staff for personal care.  During an interview with Resident #10 on 01/20/11 at 10:15 a.m., the resident stated that she does not receive a bedtime snack. She stated that when she first came to the facility they brought her a snack "a time or two but it's been awhile."  During an interview with the Registered Dietician on 01/20/11 at 02:52 p.m., she explained that residents receive a bedtime snack if they are on a defined calorie diet or if the Dietician assigns them to receive a snack. She stated that, "sometimes diabetics get a snack and sometimes they don't." She explained that snacks are prepared in the Dietary Department, dated the day they are prepared and labeled with the resident's name. These snacks are delivered to the refrigerator in the nourishment room behind the nurse's station the day after they are prepared and the nursing assistants distribute them to the residents.	F 368		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or	F371	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>All food items found to be expired were immediately discarded.</i>  2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:  <i>The food items in the Resident Diet Kitchen refrigerator and cabinets were reviewed for expiration dates. There were no other out of dates to be discarded.</i>	1/20/2011  1/20/2011

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NAME OF PROVIDER OR SUPPLIER  AMH SEGRAVES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL AVE JEFFERSON, NC 28640		
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F 371	<p>Continued From page 17 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired and left over foods more than three days old in the kitchen's dry storage, walk-in refrigerator, and reach-in refrigerator and failed to discard expired foods in the Resident Refreshment Room refrigerator and cabinet.</p> <p>The findings are:</p> <p>1. Observations of the kitchen's food storage areas on 01/18/2011 from 12:20 p.m. to 1:10 p.m., revealed the following concerns:</p> <p>a. In dry storage and available for residents' use: Eleven (11) ready to serve-seven and one fourth (7 ¼) ounce cans of Cream of Mushroom Soup stamped "Dec 11 2010 XP" by the manufacturer were observed. An interview was conducted with the Dietary Manager (DM), present during the observation and the stamped date was confirmed to be the manufacturer's product expiration date. The DM stated expiration dates were checked when individual items were reordered and when delivered items were being stocked. The DM reported that when deliveries come in, older stock with the earliest expiration dates were moved forward and new stock with the latest expiration</p>	F 371	<p>3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:</p> <p><i>F-371 Expired produce -- When groceries are delivered by Sysco, dietary staff will be responsible for checking the produce expiration dates and refusing any food items that have an en expiration date of 3 days or less. Checklist for expiration dates of produce was developed.</i></p> <p><i>F371 Left over food greater than 3 days - Supervisors and cooks will be responsible for checking the cook's refrigerator on Sunday, Tuesday and Thursday for all food items that are dated greater than 3 days. Checklist for monitoring food items was developed.</i></p> <p><i>Checklists have been developed to track expired canned goods, produce, left over foods greater than 3 days.</i></p> <p>****</p> <p><i>A daily review of expiration dates process has been established for the Resident Diet Kitchen behind the nurses station. The nurse assigned to gray hall will be responsible for checking the refrigerator and cabinets each shift for expired items. There will be a daily check off shift for documenting this review. Any expired items found during this review will be discarded immediately.</i></p>	2/10/2011	

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F 371	<p>Continued From page 18</p> <p>dates were placed in the back to ensure foods were used prior to expiring. In addition, DM stated that weekly random "spot checks" were conducted on stored food stock. The DM reported that Cream of Mushroom Soup was not used or reordered often and during spot checks of the dry storage area the soups dated "Dec 11 2010" were overlooked. The interview further revealed all dietary staff were responsible for checking expiration dates and discarding expired products. During the interview the DM confirmed the expired Cream of Mushroom Soup was stocked and available for resident's use.</p> <p>b. Stored in the walk-in refrigerator: Three (3) and one half (1/2) five (5) pound bags of commercially packaged chopped raw cabbage were observed as follows: Two (2) and a half (1/2) bags with a "Use Thru 01 05" manufacturer stamp. One (1) bag was stamped "Use" and bore no discernable date. During and interview at the time of the observation, the Dietary Manager (DM) confirmed the manufacturers stamp and confirmed that the current date was beyond the date stamped on the commercially packed cabbage. The DM stated she would need to confirm the dates with the manufacturer since the cabbage was received on 01/14/2011, which was beyond the stamped date. On 01/19/2011 at 11:25 a.m., a follow-up interview was conducted with the DM. During the interview the DM stated she had spoken with the manufacture and confirmed the "Use Thru 01 05" stamp was the expiration of the raw cabbage. The DM stated the cabbage was expired when received and should have been refused and returned. The DM stated all dietary staff were responsible for checking expiration dates at the time of delivery and refusing expired products. During the</p>	F 371	<p><i>Par levels have been reviewed and changes made where appropriate to limit the number of infrequently used items in this area. This will assist in limiting the opportunity for items to expire before they are utilized.</i></p> <p><i>For staff reference instructions for proper identification of expiration dates on the items we typically stock have been posted in this area. This posting is to assist staff with identifying the correct date on items that do not have a clear expiration date noted on them.</i></p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p> <p><i>The DON or designee will randomly check the Resident Diet Kitchen refrigerator and cabinets at least 3 times a week to ensure there are not expired items. The DON or here designee will review the check off sheet to assure the reviews are being completed each shift.</i></p> <p><i>The Certified Dietary Manager will monitor the Dietary expired food checklists.</i></p> <p><i>The DON, Dietitian and the Certified Dietary Manager will monitor their action plans, reporting to the Quality Assurance committee on a quarterly basis and making recommendations as necessary.</i></p>	2/16/2011  2/10/2011    2/16/2011
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F 371	<p>Continued From page 19</p> <p>interview the DM confirmed the cabbage was for use in residents' meals. On 01/19/2011 at 11:45 a.m., an interview was conducted with Dietary Staff (DS) #1 assigned to put up stock on 01/14/2011. DS #1 stated, when checking in and putting up stock, she checked the expiration date on the delivery box and did not always check the contents for expiration dates. DS #1 stated she did not recall but probably would not have checked the expiration dates on individual bags of cabbage received in the box. DS #1 stated she was not aware the individual bags of cabbage were stamped with expiration dates.</p> <p>c. In the cook's reach-in refrigerator: One (1) and a half to two (2) cups of brown gravy dated 01/11/2011 and approximately two (2) cups of pureed fish dated 01/14/2011 were observed stored and available for use. Interview with the Dietary Manager (DM), present at the time of the observation, revealed prepared foods should be discarded after three days. The DM confirmed the dates and stated the gravy and pureed fish were more than three days old and should have been discarded. The DM stated dietary cooks were responsible for cleaning and checking the refrigerator daily and for discarding left over foods more than three days old. The interview further revealed that foods stored in the refrigerator were for use in residents' meals. On 01/19/2011 at 11:50 a.m., an interview was conducted with Dietary Cook #1. During the interview Dietary Cook #1 stated on 01/18/2011, she had not completed her daily cleaning and checks when the gravy dated 01/11/2011 and pureed fish dated 01/14/2011 were observed. The interview further revealed left over foods more than three days old should be discarded. On 01/19/2011 at 11:55 a.m., the assigned weekend cook on 01/17/2011,</p>	F 371		
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F 371	<p>Continued From page 20</p> <p>Dietary Cook #2, was interviewed. Dietary Cook #2 stated he cleaned and checked the refrigerator on 01/17/2011 and was not aware the gravy and pureed fish were more than three days old. Dietary Cook #2 stated left over foods should be discarded after three days.</p> <p>2. A facility cleaning assignment document, provided by the facility, read in part: "Staff assigned are to clean the area each shift and initial the signature sheet." "Gray Hall Staff ----- Resident Refreshment Room." "The assignment includes at least the following items: Resident Refreshment Room - No out-dated food in refrigerator or cabinets."</p> <p>On 01/18/2011 at 4:30 p.m., the following expired foods were observed in the Resident Refreshment Room located at the nurse's station:</p> <p>a. In the Resident Refreshment Room cabinet - Four (4) expired, ready to serve, seven and one fourth (7 ¼) cans of Cream of Mushroom Soup were observed with manufacturer stamped expiration dates as follows: Three (3) cans stamped "Jul 18 2010 XP." One (1) can stamped "Dec 11 2010 XP."</p> <p>b. In the Resident Refreshment Room refrigerator designated for residents' food - One (1) prepackaged individual serving of gelatin with fruit stamped "Best used by May 05" by the manufacturer.</p> <p>During an interview on 01/18/2011 at 4:45 p.m., Licensed Nurse (LN) #3, assigned to the Gray Hall, confirmed and acknowledged the expiration</p>	F 371		

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F 371	Continued From page 21 dates on the four (4) cans of Cream of Mushroom Soup and the prepackaged gelatin with fruit. LN #3 stated all staff were responsible for keeping the refrigerator clean and discarding expired products and foods more than three days old. LN #3 stated she had no knowledge regarding who specifically was responsible for checking the cabinet for expired foods.  During an interview on 01/20/2011 at 2:40 p.m., the Director of Nursing (DON) provided a daily cleaning assignment sheet and stated staff on each hall were assigned specific areas to clean each shift. The DON referred to the cleaning assignment sheet and reported that "Gray Hall" staff were responsible for cleaning and removing out-dated foods from the refrigerator and cabinets in the Resident Refreshment Room. The DON stated staff were expected to clean their assigned area each shift but were not required to sign that the task was completed. The DON stated the expired soup and gelatin should have been discarded when expired.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F425	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>For resident # 1 a medication error report was completed and submitted to the Pharmacy and quality assurance committee per facility policy. The physician caring for resident #1 was notified of the medication errors. Orders for completion of the medication administration were received and followed for resident #1.</i>  2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	1/20/2011

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F 425	Continued From page 22  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to acquire medications in a timely manner for one (1) of eight (8) sampled residents. (Resident #1).  The findings are:  Resident #1 was admitted to the facility on 05/20/1999. On 01/03/2011 a Physician's Order was written to administer Resident #1 Guaifenesin 400 milligram (mg) by mouth every four (4) hours while awake for ten (10) days. The Physician's Order was noted by Licensed Nursing (LN) #3 at 5:30 p.m., and transcribed to the January 2011 Medication Administration Record (MAR) of Resident #1.  Resident #1's MAR for January 10, 2011 reflected the 01/03/2011 Physician's Order for Guaifenesin 400 mg to be administered by mouth every 4 hours while awake for 10 days. The medication was to be started on 01/04/2011 and administered at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. through 01/13/2011. Documentation on the MAR for 01/04/2011 and 01/05/2011 revealed circled nurses' initials to indicate the medication was not administered throughout the day. The documentation on the	F 425	<i>Nurses were inserviced on the proper procedure for noting and following up on medications which are unavailable for administration when ordered.</i>  <i>The nurse will contact the resident's pharmacy to obtain the medication or treatment. If they are unable to provide the medication or treatment as ordered, the AMH pharmacy will be contacted to fill the order. In the event that neither pharmacy is able to supply the medication or treatment in a timely manner the nurse will contact the ordering physician and ask for alternative orders or if holding administration is appropriate for the resident until the medication or treatment is available from their pharmacy. The physician's revised order will be noted in the resident's record.</i>	2/10/2011	
		F425	3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:  <i>The nurses were in-serviced that it is unacceptable to circle a medication as unavailable on the MAR without following up on the order.</i>	2/10/2011	
		F425	<i>All medications or treatments will be administered as ordered unless otherwise noted and the physician notified.</i>		

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F 425	<p>Continued From page 23</p> <p>01/04/2011 and 01/05/2011 "NURSE'S MEDICATION NOTES" on the MAR read "not available" for the 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. administration of Resident #1's Guaifenesin. Resident #1's medication was available and administered on 01/06/2011 and through the duration of the Physician's Order.</p> <p>Review of a fax "Communication Result Report" dated 01/3/11 at 5:29 p.m., provided by the Director of Nursing (DON), revealed Resident #1's 01/03/2011 Physician's Order for Guaifenesin 400 mg was successfully faxed to the pharmacy at 5:28 p.m.</p> <p>During an interview on 01/20/2011 at 11:00 a.m., the DON confirmed Resident #1's Guaifenesin 400 mg was not available or administered on 01/04/2011 and 01/05/2011 as ordered. The DON stated after noting and transcribing Resident #1's 01/03/2011 Physician's Order for Guaifenesin, LN #3 should have faxed the order to the hospital pharmacy. The interview revealed Physician's Orders faxed to the pharmacy after 5:00 p.m., were received the morning of the following day. The DON stated Guaifenesin 400 mg should have been dispensed and available from the hospital pharmacy on 01/04/2011.</p> <p>During a telephone interview on 01/20/2011 at 2:35 p.m., LN #3 stated she noted Resident #1's Physician's Order for Guaifenesin 400 mg and faxed the order to the pharmacy on 01/03/2011. LN #3 stated the order was faxed after 5:00 p.m. and the medication should have been available from the pharmacy on 01/04/2011.</p> <p>During a telephone interview on 01/20/2011 at 3:25 p.m., the hospital Pharmacist stated just</p>	F 425	<p><i>These nurses were in-serviced as to the definition of "as noted". When "as noted" is utilized it should be in reference to placing a medication order on the "MAR", placing labs on the Lab Sheet, or entering orders into the Meditech system for initiation. They were also reminded of the importance of faxing all orders to the appropriate pharmacy.</i></p> <p><i>The DON or designee will review the Medication Administration Sheets weekly for any medications circled as unavailable. The DON or designee will review the resident's record to assure that proper procedure was followed in either filling the order or contacting the physician for a revised order. The DON or designee will immediately resolve any ongoing deficiencies identified.</i></p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p> <p><i>The DON will follow up any deficiencies noted in the weekly review, observing for patterns or repeated barriers to the timely administration of medications or treatment. Any patterns will be reported to the QA committee and an action plan implemented to resolve any patterns noted.</i></p>		



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F 425	Continued From page 24 prior to the interview he reviewed the 01/03/2011 fax "Communication Results Report" and confirmed that Resident #1's Physician's Order for Guaifenesin was successfully faxed to the pharmacy at 5:28 p.m. on 01/03/2011. The interview revealed that Physician's Orders faxed after 5:00 p.m., were processed and available the following morning. The Pharmacist reported Resident #1's Guaifenesin was filled and dispensed on 01/06/2011 and that the pharmacy had no record regarding the date and time the order was received via fax. The Pharmacist stated the 01/03/2011 Physician's Order should have been dispensed and available for Resident #1 on 01/04/2011.	F 425	<i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON</i>	
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 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.	F431	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <i>Licensed Nurse #1 was counseled as to the proper retrieval, storage and security of medications for residents #1 and #16.</i>	2/16/2011
		F431	2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:  <i>Nurses were in-serviced on the proper security of resident medications. Resident medications are to be secured at all times. The nurses were encouraged to assess the location of the resident prior to retrieving their medications from the secured medication cart drawers.</i>	1/21/2011
		F431	3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:	2/10/2011

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F 431	Continued From page 25  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 and staff interviews, one (1) of four (4) Licensed Nursing staff failed to properly secure medications during medication pass.  The findings are:  Observations on 01/19/11 at 7:52 a.m., revealed a bottle of Liquid Tears sitting on top of the medication cart. At this time LN #1 prepared the following medications intended for Resident #16 and poured them into a small plastic medication cup: micardis/hydrochlorothiazide 40/125 mg (milligrams) for high blood pressure; acetaminophen 650 mg, an analgesic; docusate sodium 100 mg, a stool softener; calcium carbonate 500 mg, an antacid; potassium chloride 10 milliequivalents, a potassium supplement and Metamucil 5.85 grams for constipation, mixed in 8 ounces of water.  Upon entering the resident's room at 7:55 a.m., LN #1 noted Resident #16 was in the bathroom. LN #1 came back out into the hallway, sat the	F431	<i>Nurses have been in-serviced on proper medication security policies and practices which are in place. Nurses have been directed to either administer the medication to the resident after it has been removed from the secured drawer and prepared or discard it and prepare a new dose when the resident is available for administration.</i>  <i>The AMH pharmacy staff will implement a plan to complete monthly medication passes with the nurses to observe for deficiencies. Any deficient practice will be noted and corrected immediately. Any deficiencies observed will be reported to the DON.</i>  <i>The DON or designee will monitor for deficient practices during daily rounds and correct any deficiencies noted immediately.</i>	2/16/2011
		F431	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.  <i>The AMH pharmacy staff will implement a plan to complete monthly medication passes with the nurses to observe for deficiencies. Any deficient practice will be noted and corrected immediately. Any deficiencies observed will be reported to the DON.</i>	2/1/2011  2/16/2011  2/1/2011

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F 431	<p>Continued From page 26</p> <p>medications on top of the medication cart beside the Liquid Tears bottle and prepared medications for Resident #17 who shared a room with Resident #16. After LN #1 had prepared Resident #17's medications, she locked the medication cart and re-entered the residents' room, however left the medications, which had been prepared for Resident #16, sitting on top of the cart in the hallway. Several staff members, residents and visitors were observed in the hallway at this time.</p> <p>Once LN #1 had finished administering Resident #17's medications, she came back out into the hallway, retrieved Resident #16's medications from the top of the cart, returned to the residents' room and administered Resident #16's medications at 8:05 a.m.</p> <p>During an interview on 01/19/11 at 8:07 a.m., LN #1 stated the Liquid Tears were intended for Resident #15 and had been left out on the cart as a reminder for the LN to give them later that morning. LN #1 further stated she knew she was not supposed to leave medications on top of the cart unattended, but thought they might spill if placed back into medication cart's drawer.</p>	F431	<p><i>The DON or designee will monitor for deficient practices during daily rounds and correct any deficiencies noted immediately</i></p> <p><i>The DON will monitor any reported deficiencies for patterns. If any patterns of deficient behavior are identified they will be addressed.</i></p> <p><i>The results of the monitoring activity will be reported to the quality assurance committee on a quarterly basis by the DON</i></p>	
F 441 SS=J	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a</p>	F441	<p>I. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>All licensed nurses will be educated on the manufacturers' recommended practice for cleaning and sanitation of the glucometer equipment. In addition, all licensed staff will be educated on facility cleaning and disinfection procedures as well as sharps disposal and proper hand washing prior to caring for residents. Physicians caring for Residents #18 and #19 have been notified of the deficient practice.</i></p>	3/31/2011

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F 441	Continued From page 27 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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 reviews the facility staff failed to clean or	F441  F441  F441	2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:  <i>All licensed nurses will be educated on the manufacturers' recommended practice for cleaning and sanitation of the glucometer equipment. In addition, all licensed staff will be educated on facility cleaning and disinfection procedures as well as sharps disposal and proper hand washing prior to caring for residents.</i>  3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:  <i>All licensed nurses will be trained on the manufacturers' recommended practice for cleaning and sanitation of the glucometer equipment prior to performing procedures on residents and annually during the annual skills fair. The annual training will be conducted by members of the laboratory staff or the Infection Control Nurse or the Education Coordinator or a member of Nursing Administration.</i>  4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.	3/31/2011   3/31/2011
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F 441	<p>Continued From page 28</p> <p>disinfect the blood glucose meter (used to monitor sugar levels) for two (2) of four (4) residents that required blood glucose monitoring (Residents #18 and 19), failed to properly dispose used lancets (used to puncture the skin to obtain a blood sample) and perform hand hygiene before and after checking the blood sugars for three (3) of four (4) residents (Resident # 17, 18 and 19). The facility staff failed to do hand hygiene before drawing up insulin in a syringe for one (1) of three (3) residents (Resident #17).</p> <p>Immediate Jeopardy began on 01/18/11 when Licensed Nurse (LN) #2 failed to clean and disinfect the blood glucose meter (glucometer) and failed to wash her hands before or after using the glucometer or using single use lancets to obtain fresh blood samples to monitor the blood sugar levels of Residents #18 and #19. Immediate jeopardy was removed on 03/08/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems which were put into place and the completion of employee training.</p> <p>The findings are:</p> <p>A facility policy dated July 7, 2010 and entitled "Exposure Plan: Program Administration" specified, in part that "the infection control/employee health nurse is responsible for implementing the exposure control plan. Those employees who are determined to have occupational exposure to blood or other potentially infectious materials must comply with</p>	<p>F 441</p> <p>F441</p> <p>F441</p>	<p><i>The Infection Control Nurse or a member of Nursing Management will randomly monitor the nurses performing blood glucose checks at least 3 times a week. Random checks will be rotated by day of week, shift and testing frequency so as to observe as many different Licensed Nurses as possible, with the goal being to observe each Licensed Nurse at least once per quarter. For Licensed Nurse #2, specific monitoring will occur at least weekly for one quarter, then at least monthly for one quarter then at least quarterly there after. (please note that Licensed Nurse #2 is currently on a leave of absence, upon this employees return to work the monitoring plan outlined in the PoC will be implemented.) The monitoring for all Licensed Nurses will focus on facility policy as well as manufacturer and CDC recommendations for device use and cleaning, hand washing, and sharps disposal. Any deficient practices noted will be addressed immediately with the Nurse and reported to the DON.</i></p>	<p>3/31/2011</p>
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F 441	<p>Continued From page 29</p> <p>the procedures and work practices outlined in the exposure control plan. Employees are responsible for using personal protective equipment appropriately."</p> <p>A facility policy dated August 5, 2010 and entitled "Standard Precautions" specified, "Clean/disinfect reusable patient equipment between each patient use with the facility approved disinfectant. Discard single use items appropriately after use."</p> <p>A facility policy dated August 5, 2010 and entitled "Hand Washing and Hand Hygiene" specified the following; "Decontaminate/Cleanse hands before preparing or administering medications and before applying and after removing gloves."</p> <p>An Infection Prevention and Control Plan dated August 5, 2010 read in part, "Direct referrals from nursing staff are also utilized to identify potential concerns. Employees' compliance with standard precautions, hand hygiene, and transmission based precautions can impact the transmission of disease and infection. Compliance is strongly encouraged and reviewed."</p> <p>A facility policy dated August 31, 2010 and entitled "Blood Glucose: Accu-Check Inform System" specified the following; "Wipe down the meter between each patient using a sani-cloth."</p> <p>An e-mail dated November 30, 2010 sent from the infection control nurse to all users revealed instructions to staff to "clean glucometers with alcohol between residents."</p> <p>Review of a facility staff roster of facility nurses provided on 03/07/11 specified that there were a</p>	F 441	<p><i>The results of the random monitoring will be recorded on the Glucose Monitoring Process Observations Log. Deviations from established practice will result in immediate in-service education training by the Infection Control Nurse or a member of Nursing Management before a resident is exposed to improperly cleaned or disinfected equipment. The DON will monitor reports from the Infection Control Nurse and educate staff as applicable. Reports of the random monitoring will be presented to the facility's quality assurance committee on a quarterly basis by the DON.</i></p>	3/31/2011
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F 441	<p>Continued From page 30</p> <p>total of fourteen (14) licensed nurses employed to work in the facility full-time or as needed.</p> <p>1. On 01/18/11 Licensed Nurse (LN) #2 was continuously observed from 4:40 p.m. to 5:02 p.m. The following observations were made during this continuous observation:</p> <p>On 01/18/11 at 4:40 p.m., LN #2 was observed placing a medication cart at the facility's nurse's station. While at the nurse's station LN #2 was not observed to perform any hand hygiene and picked up a box containing a blood glucose meter (glucometer). LN #2 was observed to carry the box into Resident #17's room. After entering the resident's room LN #2 placed the box on the resident's overbed table, put on gloves, removed the glucometer from the box, used a single use lancet to prick the skin on one of Resident #17's fingers to obtain a blood sample, placed the blood sample in the glucometer to check the resident's blood sugar level and placed the used lancet into her pocket. LN #2 then placed the glucometer back into the box, removed her gloves and exited the resident's room without washing her hands or cleaning and disinfecting the glucometer. Continued observations of LN #2 revealed she did not perform any hand hygiene in between leaving Resident #17's room and proceeding to assist Resident #18 in her room.</p> <p>On 01/18/11 at 4:46 p.m., LN #2 was observed to enter Resident #18's room carrying the box that contained the same glucometer that she used to monitor Resident #17's blood sugar level. After entering Resident #18's room LN #2 placed the box on the resident's overbed table, put on gloves, removed the glucometer from the box, used a new single use lancet to prick the skin on</p>	F 441		
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F 441	<p>Continued From page 31</p> <p>one of Resident #18's fingers to obtain a blood sample, placed the blood sample in the glucometer to check the resident's blood sugar level and placed the used lancet into her pocket. LN #2 then placed the glucometer back into the box, removed her gloves and exited the resident's room without cleaning and disinfecting the glucometer or washing her hands. Continued observations of LN #2 revealed she did not perform any hand hygiene in between leaving Resident #18's room and proceeding to assist Resident #19.</p> <p>On 01/18/11 at 4:52 p.m., LN #2 was observed to assist Resident #19 from the facility's main dining room to her room. After entering Resident #19's room LN #2 placed the box containing the glucometer on the resident's overbed table, put on gloves, removed the glucometer from the box, used a single use lancet to prick the skin on one of Resident #19's fingers to obtain a blood sample, placed the blood sample in the glucometer to check the resident's blood sugar level and placed the used lancet into her pocket. LN #2 then placed the glucometer back into the box, removed her gloves and exited the resident's room without cleaning and disinfecting the glucometer or washing her hands.</p> <p>On 01/18/11 at 5:02 p.m., LN #2 was observed to carry the blood glucose meter to the nurse's station, take the used lancets out of her pocket and placed them in a sharps box located on a medication cart. During this continuous twenty-two (22) minute observation of LN #2 she was not observed to wash or sanitize her hands and failed to clean or disinfect the glucometer that she utilized to monitor the blood sugar levels of Residents #17, #18 and #19.</p>	F 441			



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F 441	<p>Continued From page 32</p> <p>On 01/18/11 at 5:08 p.m. LN #2 was interviewed. LN #2 stated that she was "so nervous" and didn't realize she did not clean or disinfect the blood glucose meter or wash her hands. LN #2 also stated that she placed the lancets in her pocket because, "they did not have sharps containers in the resident's rooms." Further interview with LN #2 on 03/08/11 at 1:45 p.m. revealed she had received training on how to properly use and clean glucometer prior to 01/18/11. LN #2 confirmed that on 01/18/11 she did not properly clean or disinfect the glucometer or wash her hands when she used a glucometer to check the blood sugars for Residents #17, #18 and #19. LN #2 stated that after this incident she was instructed that alcohol was not sufficient to disinfect the glucometer and that she must use a sanicloth to disinfect the glucometer.</p> <p>An interview on 01/18/11 at 5:15 p.m., with the Chief Nursing Officer (CNO) revealed it was her expectation that the nurses should clean and disinfect the blood glucose meter between each resident. She stated that it was also her expectation that the nurses should wash their hands before putting on gloves and after taking them off. She further stated that they should have a mechanism in place to dispose of the lancets and they should not put them in their pockets.</p> <p>An interview on 01/18/11 at 5:25 p.m. with a medication nurse revealed that Residents #17, #18 and #19 had diagnoses which included diabetes, but did not have any diagnoses which involved blood borne pathogens.</p> <p>An interview on 01/19/11 at 11:15 a.m. with the Director of Nurses (DON) revealed it was her</p>	F 441		
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F 441	<p>Continued From page 33</p> <p>expectation that the nurses should clean and disinfect the glucometers between residents and they should dispose of the lancets in the sharps container located on the medication cart. The DON specified that staff were to disinfect the glucometer by using a sanicloth-wipe. She stated that nurses should also wash their hands before putting on gloves and after taking them off.</p> <p>On 03/07/11 at 12:30 p.m. an interview was conducted with the facility's infection control nurse. The infection control nurse stated that on 01/18/11 LN #2 should have used a sani-cloth to clean and disinfect the glucometer between each resident and should have placed the used lancets in the sharps box and not in her pocket. She stated that before 01/18/11 the laboratory staff instructed the nurses on using the glucometer, but the importance of cleaning and disinfecting the glucometer was not stressed at the level it was now. She explained that since 01/18/11 she provided infection control information (including glucometer cleaning and disinfecting) to the nursing staff in the form of handouts and e-mails as she received information from various sources. She stated that the facility's policy entitled "Blood Glucose: Accu-Chek Inform System" was revised on 01/19/11 and now included additional information about cleaning and disinfecting the glucometer. The facility's revised policy now specified for staff the products, which were listed in the glucometer's manufacturer information, as being approved for effectively disinfecting the glucometer, with the "sani-cloth" being one of the approved disinfecting products. The infection control nurse specified that this issue and policy change was also added to the employee annual inservice training. The infection control nurse stated that on</p>	F 441		

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F 441	<p>Continued From page 34</p> <p>01/24/11 she had a one on one inservice with LN #2 regarding cleaning and disinfecting of glucometers by using a sani-cloth and had discussed this issue with other nurses after that time. She explained that LN #2 was required to create a presentation on glucometer cleaning and disinfecting and to provide an inservice on this topic to the other nurses on 02/10/11. The infection control nurse verified that prior to 01/18/11 there was no monitoring of glucometer cleaning or disinfecting, but she started monitoring this process after 01/20/11. The infection control nurse explained that she was now monitoring how the nurses utilize, clean and disinfect the glucometer three days per week by either performing direct observations or by having staff explain how they performed this procedure. She specified that a monitoring log sheet was created to record her observations, but this log had not been implemented.</p> <p>On 03/07/11 at 12:45 p.m. an interview with the Chief Nursing Officer verified that only six (6) licensed nurses out of a total of fourteen (14), employed by the facility, had been inserviced on glucometer cleaning and disinfecting as of March 7, 2011.</p> <p>The Administrator was notified of the immediate Jeopardy on 3/07/11 at 12:00 p.m. The facility provided a credible allegation of compliance on 3/08/11 at 1:00 p.m. The following interventions were put into place by the facility to remove the Immediate Jeopardy:</p> <p>On January 18, 2011 Licensed Nurse #2 was observed to be deficient in processes relating to the proper cleaning and disinfecting of a glucometer for residents #18 and #19. These</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345424	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/08/2011
NAME OF PROVIDER OR SUPPLIER  AMH SEGRAVES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL AVE JEFFERSON, NC 28640		
(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 441	<p>Continued From page 35</p> <p>observations occurred between 4:40pm and 4:52pm. The Chief Nursing Officer was informed of this deficient practice at 5:15pm and immediately counseled Licensed Nurse #2 on facility policy as well as manufacturer and the Center's for Disease Control (CDC) recommendations for device use, cleaning and disinfecting, hand washing, and sharps disposal.</p> <p>During the time of the survey there were 10 residents who were receiving routine finger stick blood glucose measurements per physician order. Following the exit conference for the survey on January 20, 2011 the facility's Medical Director was notified of the potential citations. No orders were received at that time to perform additional testing of the residents.</p> <p>On January 19, 2011 the Director of Nursing and the Clinical Supervisor met with Licensed Nurse #2 at 2:50pm prior to the beginning of her shift to reinforce the education provided on facility policy as well as manufacturer and CDC recommendations for glucometer use, cleaning and disinfecting, hand washing, and sharps disposal.</p> <p>On January 19, 2011 the facility wide policy on use of glucometers was revised to include manufacturer and CDC recommendations for glucometer use and cleaning. This revised policy will be used to train all employees who utilize glucometers to perform finger stick blood sugar testing during routine annual competency training at the employee's skills fair which will be offered in May 2011. AMH Segraves utilizes Licensed Nurses exclusively to perform finger stick blood glucose testing. New employees who will have responsibility to provide finger stick blood sugar</p>	F 441			

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F 441	<p>Continued From page 36</p> <p>testing with glucometers will be trained on the revised glucometer process as they complete their orientation.</p> <p>On January 20, 2011 The Director of Nursing composed and sent an e-mail to all licensed staff detailing the steps each employee must follow when utilizing the glucometer.</p> <p>On January 24, 2011 Licensed Nurse #2 was provided one on one education by the facility Infection Control Nurse. This education covered glucometer cleaning and disinfecting and appropriate handling and disposal of used single use lancets. To reinforce the recent training Licensed Nurse #2 prepared an in-service program explaining the facility's policy as well as manufacturer and CDC recommendations for device use, cleaning and disinfecting, hand washing, and single use lancet disposal. This in-service training was presented on February 10, 2011.</p> <p>On January 26, 2011 the CDC recommendations for infection-control and safe injection practices were provided, via handout, to all licensed staff at Ashe Memorial Hospital and Segraves Care Center by the Infection Control Nurse.</p> <p>On February 2, 2011 the Education Coordinator and the Infection Control Nurse met with the Licensed Nurse #2 to review the in-service education program which had been developed to train licensed staff on the proper cleaning techniques for glucometer cleaning and disinfecting and appropriate handling and disposal of used single use lancets. During this meeting the information to be provided was reviewed as well as handouts that would be</p>	F 441		

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F 441	<p>Continued From page 37 provided to the licensed staff.</p> <p>On February 10, 2011 the in-service program was presented to six members of the licensed staff. This training program was monitored by the Director of Nursing. In addition to the glucometer and hand washing in-service additional information on Facility policy for disposal of single use lancets and safely syringes was provided. During the in-service training program Licensed Nurse #2 demonstrated the cleaning and sanitation of the glucometer utilizing facility policy as well as manufacturer and CDC recommendations. On March 7, 2011 three of the remaining six licensed staff, were in-serviced on the cleaning and disinfecting of glucometers. This training was conducted one on one with staff who were working or were scheduled to work that day by the Chief Nursing Officer and/or the Director of Nursing. The remaining four staff members will be in-serviced one on one with return demonstration, prior to their next working shift by the Director of Nursing or the Clinical Supervisor.</p> <p>On February 11, 2011 to assist the staff in maintaining the appropriate supplies needed, a cart will be provided for the nursing staff to utilize for all resident glucometer checks. The cart includes space for the glucometer, gloves, hand sanitizer equipment cleaning supplies, and a sharps disposal container. The glucometer cart will be stored, when not in use, in the Medication room.</p> <p>Effective February 23, 2011 the Infection Control Nurse began randomly monitoring the nurses performing blood glucose checks at least 3 times a week. Random checks will be rotated by day of</p>	F 441		
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F 441	<p>Continued From page 38</p> <p>week, shift and testing frequency so as to observe as many different Licensed Nurses as possible, with the goal being to observe each Licensed Nurse at least once per quarter. For Licensed Nurse #2, specific monitoring will occur at least weekly for one quarter, then at least monthly for one quarter then at least quarterly there after. The monitoring for all Licensed Nurses will focus on facility policy as well as manufacturer and CDC recommendations for device use and cleaning, hand washing, and sharps disposal. Any deficient practices noted will be addressed immediately with the Nurse and reported to the DON.</p> <p>Effective March 8, 2011 the Infection Control Nurse's monitoring will be recorded on the Glucose Monitoring Process Observations Log. Deviations from established practice will result in immediate in-service education training by the Infection Control Nurse before a resident is exposed to improperly cleaned or disinfected equipment. The DON will monitor reports from the Infection Control Nurse and educate staff as applicable.</p> <p>Immediate Jeopardy was removed on 03/08/11 at 5:30 p.m. A review of the facility's policy revealed that it had been revised on 01/19/11 to reflect additional information regarding cleaning and disinfecting glucometers and specifically to "wipe down the analyzer between each patient using sani-cloth." Review of the glucometer's manufacturer information revealed that the "sani-cloth", which was approved by the Environmental Protection Agency (EPA), met the manufacturer's criteria as being an approved product to disinfect the glucometer. A review of in-service attendance records and education</p>	F 441		
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F 441	<p>Continued From page 39</p> <p>records verified that nurses were trained on cleaning and disinfecting glucometers. Interviews with Licensed nursing staff, who worked on the day, evening and night shifts confirmed that they had received recent training on how to correctly utilize, clean and disinfect a glucometer to prevent the spread of infections and correctly explained how to disinfect glucometers by using a sani cloth. Observations of licensed nurses, using a glucometer to monitor blood sugar levels, revealed that the glucometer was correctly used, cleaned and disinfected with a sani cloth to prevent the spread of infections.</p> <p>2. During observation of medication pass for Resident #17 on 01/18/11 at 5:05 p.m., LN #2 removed a vial of insulin from the medication refrigerator. She verified the resident's name on the vial, cleaned the top of it with an alcohol swab and drew up two (2) units of insulin. She put the vial back in the refrigerator, took the syringe to the resident's room and gave the injection to the resident. Prior to the procedure LN #2 did not wash her hands before drawing up the insulin in the syringe.</p> <p>An interview on 01/18/11 at 5:08 p.m., LN #2 stated that she was "so nervous" and didn't realize that she had not washed her hands.</p> <p>An interview on 01/18/11 at 5:15 p.m., with the Chief Nursing Officer (CNO) revealed it was her expectation that the nurses should wash their hands before putting on gloves and after taking them off.</p> <p>An interview on 01/19/11 at 11:15 a.m., with the Director of Nurses (DON) revealed it was her expectation that the nurses should wash their</p>	F 441		



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F 441	Continued From page 40 hands or use hand sanitizer before putting on gloves and after taking them off.	F 441			