STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345179	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/25/2011
NAME OF PROVIDER OR SUPPLIER **BRIAN CENTER HEALTH AND RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **752 E CENTER AVE MOORESVILLE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, family interview and staff interviews, the facility failed to notify a family of a resident's room change for one (1) of three (3) sampled residents reviewed for notifications of room changes. (Resident # 87)

The findings are:

Resident # 87 was admitted to the facility on 02/12/07 with an admitting diagnosis of Alzheimer's dementia. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 02/20/11 revealed Resident # 87 had short and long-term memory problems and had moderately impaired decision-making skills.

A review of social services progress notes dated 09/05/10 and 12/03/10 revealed no documentation of a room change.

A review of the facility's 'Resident Status Report' provided by the Administrator revealed Resident # 87 had a room change on 11/15/10 to her current room.

An interview with Resident # 87's family on 03/22/11 at 11:56AM revealed she visited Resident # 87 one day before the winter holidays and the next time she visited the resident again, after two weeks, Resident # 87 was in another room. The family reported Resident # 87's former roommate explained to her that Resident # 87 was moved to another room. The family stated the facility did not call her to notify her about the room

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	Continued From Page 1

change. The family further revealed the facility notified her in the past regarding room changes, but not the last room change. The family reported she would have been fine if they called her about it.

An interview with the Administrator on 03/24/11 at 11:51AM revealed Resident # 87's room change was not documented in the resident's medical record and the facility's room change form was not completed. The Administrator reported at the time of the room change, the facility had no social services director. The Administrator stated the former social services assistant was available at the time of Resident # 87's room change and the assistant explained to him that she did not document the notification of the room change, but stated she spoke with the family regarding the room change.

An interview with the former Social Services Assistant (SSA) on 03/24/11 at 4:27PM revealed she could not remember if she left a message for Resident #87's family or spoke to family in person about the room change. The SSA could not recall why Resident # 87 moved rooms. The SSA reported she would not document every time regarding room changes, but would fill out the room change form if she spoke with the family in person and would have the family sign the form.

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F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156	F 156 1. Corrective action has been accomplished for the alleged deficient practice in regards to posting Medicare, Medicaid, and State agency contact information by providing the contact information in a central location within the facility. 2. Facility residents have the potential to be affected by the same alleged deficient practice. The information has been replaced and is available for review. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator or Social Services Director will conduct inservice education for the Interdisciplinary Team regarding the requirement for information posting in central areas of the facility. The Administrator or Social Services Director will monitor placement of the State contact information at least weekly during facility rounds to ensure continued compliance. 4. The Administrator or Social Services Director will review data "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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

✓ [signature] ✓ Administrator ✓ 4.18.11

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.

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F 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and	F 156	obtained during facility rounds, analyze the data and report patterns/trends to the QA&A committee monthly for three months. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 156	Continued From page 2 applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations of the facility and staff interviews, the facility failed to post information about Medicare, Medicaid and the State complaint contact information. The findings are: A family interview during the survey on 03/22/11 at 12:05PM revealed she had not noticed the State Complaint Line contact information posted in the facility. The family interview further revealed she would use the posted information as a resource if she had any concerns that were not being resolved by the facility. Observations of the facility on 03/22/1 at 12:20 PM revealed no postings of information about the Medicare and Medicaid programs, and the State Complaint Line contact information. An observation of the facility's lobby and initial hallway with the Business Office Manager and	F 156	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 156	Continued From page 3 Admissions Director on 03/22/11 at 12:27 PM revealed no postings of the information about the Medicare and Medicaid programs, and the State Complaint Line contact information. An interview with the Administrator on 03/22/11 at 12:38PM revealed the information about Medicare and Medicaid, and the State Complaint Line contact information was not posted in the lobby or the first hallway into the facility. The Administrator reported the postings must have been misplaced when the facility's own corporate complaint line information was posted on the hallway. The Administrator further revealed the information should be posted and would be posted on paper format in the hallway and on electronic format on the facility's monitors.	F 156	F 166 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #83 and #87 by following up on his/her concerns and providing replacement or reimbursement for clothing items. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Administrator or Social Services Director has completed an audit of the past 90 days of recorded concerns to identify timely resolution. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator, Director of Nursing or Staff Development Coordinator will conduct inservice education for facility staff regarding the concerns "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11
F 166 SS=B	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to follow up with residents' grievances about missing items for 2 of 3 sampled residents who voiced concerns of missing items. (Resident # 87 and 83) The findings are: 1. Resident # 87 was admitted to the facility on 02/12/07 with an admitting diagnosis of Alzheimer's dementia. A review of the most	F 166		

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F 166	Continued From page 4 recent quarterly Minimum Data Set (MDS) assessment dated 02/20/11 revealed Resident # 87 had short and long-term memory problems and had moderately impaired decision-making skills. A review of Resident # 87's social services progress notes revealed no documentation of concerns from the family regarding missing items. A review of the facility's grievance log revealed no indication of concerns from Resident # 87's family regarding missing items until the concern was brought to the Administrator's attention. An interview with Resident # 87's family on 03/22/11 at 12:00PM revealed when the resident had her last room change, the family discovered Resident # 87 was missing a skirt, three bras, a comforter for her bed, a burgundy blanket, and a black blanket. The family assumed the items were washed and the items were not returned to the resident, even though the family was responsible for washing Resident # 87's clothes and items. The family stated the missing items were reported to the floor nursing staff and a staff member in administration, and facility had not followed up with her regarding the status of the missing items. The family further revealed the items had been missing since November 2010. A review of the facility's concern form dated 03/23/11 revealed surveyor alerted the Administrator regarding missing items that was shared by Resident # 87's family. The Administrator contacted Resident # 87's family on 03/24/11 and confirmed the missing items. The concern form further revealed there was no staff member identified, but Resident # 87's family	F 166	process, specifically related to the right to prompt efforts by the facility to resolve concerns the resident may have, including those with respect to the behavior of other residents; Resident Council minutes will be reviewed monthly by the Administrator with regard to timely resolution of concerns; the Interdisciplinary Team will conduct rounds on a weekly basis to include questions regarding concerns resolution and how concerns are handled and resolutions communicated; Concerns will be reviewed Monday through Friday, as received, by the Interdisciplinary Team during the morning meeting and distributed to the appropriately designated team member; and, the Administrator or Social Services Director will be responsible to follow up daily during morning meeting until resolution is accomplished to ensure continued compliance. 4. The Administrator or Social Services Director will review data obtained during rounds, Resident Council minutes, and Concerns reviews, analyze the data and "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 166	Continued From page 5 stated she had reported the missing items to staff. The actions taken on the concern form revealed some missing items were located and other items would be replaced by family and the facility would reimburse the family member. An interview with the Administrator on 03/24/11 at 3:54PM revealed he was not aware of Resident # 87's missing items and spoke with her family. The Administrator contacted Resident # 87's family and she informed him that she told her concern of the missing items to a nursing staff, but could not recall nurse's name. The Administrator reported he apologized to Resident # 87's family and the facility would write up a grievance form now. The Administrator stated he explained to the family member that the missing items would be searched for, found and/or replaced. Another interview with the Administrator on 03/24/11 at 4:16PM revealed writing up grievance forms were reviewed with staff members in orientation and staff meetings. The Administrator reported the facility was going through changes with their administrative staff. The facility did not currently have a staff development coordinator and recently hired a social services director. The Administrator reported the grievance log may not be complete with the transition of the administrative staff. The Administrator stated any staff member could complete a grievance form or assist a resident or family member with filing a grievance. The Administrator further revealed the staff members were trained to hand off the grievances to the Director of Nursing or the Administrator. The Administrator reported the grievances should be investigated and followed up with the residents or family members with the resolution.	F 166	report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 166	Continued From page 6 2. Resident # 83 was readmitted to the facility on 11/26/10 with an admitting diagnosis of spina bifida. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 12/26/10 revealed Resident # 83's cognition was intact. A review of Resident # 83's social services progress notes revealed no documentation of concerns from the resident regarding missing items. A review of the facility's grievance log revealed no indication of concerns from Resident # 83 regarding missing items until the concern was brought to the Administrator's attention. An interview with Resident # 83 on 03/22/11 at 10:53AM revealed she had missing items that included long pairs of socks and bras that went missing in recent months. Resident # 83 stated she reported to the housekeeping or laundry staff that the items were missing and no staff had followed up with her regarding the missing items. Resident # 83 reported she no longer sent her socks to the laundry to be cleaned because she did not want to lose the socks she still had in her possession. A review of the facility's concern form dated 03/23/11 revealed Resident # 83 reported to a surveyor about missing items. The concern form further revealed Resident # 83 previously voiced the concern to a staff member which she identified as being the housekeeping staff. The actions taken on the concern form dated 03/24/11 revealed the missing items were searched for and could not be located. The Administrator replaced	F 166	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 166	Continued From page 7 the items with Resident # 83's approval and satisfaction. An interview with the Administrator on 03/24/11 at 11:51AM revealed he spoke with Resident # 83 and she explained to him that she told housekeeping of the missing items. The Administrator reported he was not aware of the missing items. The Administrator stated the grievance log may not be complete with the changes and the transition of the administrative staff. The facility did not currently have a staff development coordinator and recently hired a social services director. Another interview with the Administrator on 03/24/11 at 4:16PM revealed writing up grievance forms were reviewed with staff members in orientation and staff meetings. The Administrator stated any staff member could complete a grievance form or assist a resident or family member with filing a grievance. The Administrator further revealed the staff members were trained to hand off the grievances to the Director of Nursing or the Administrator. The Administrator reported the grievances should be investigated and followed up with the residents or family members with the resolution.	F 166		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record reviews, and policy review, facility staff	F 281	F 281 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #14 by completing gastrostomy tube verification prior to flushes and/or medication administration. Resident #223 has been discharged from the facility, therefore, no additional corrective action could be provided in regards to wound treatment orders. An order for treatment was obtained from the physician on 3/22/11 as noted in the Statement of Deficiencies. The facility obtained a physician's order for laboratory tests for Resident #61 on 3/25/11 and these results were reported to the attending MD. Resident #44 has the left heel boot and non-skid socks applied daily as ordered. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 8 failed to verify gastrostomy tube placement prior to medication administration for one (1) of two (2) sampled residents with gastrostomy tube observed during medication pass (Resident #14); failed to obtain physician order for wound care treatment for one (1) of four (4) sampled residents with wound care treatment (Resident #223); failed to follow physician orders and draw laboratory (lab) tests (Valproic Acid, Complete Blood Count and Lipid Panel) for one (1) of ten (10) sampled residents reviewed for unnecessary medications (Resident # 61); and failed to follow physician orders for non skid socks and a left heel protector boot for one (1) of four (4) sampled residents (Resident # 44). The findings are: 1. A facility policy entitled Enteral Nutrition revised March 2008 read in part: Guidelines 6. The nurse checks nasogatric, gastrostomy and jejunostomy tube placement · Prior to flushes and/or medication administration Resident # 14 was admitted to the facility 2/8/2000 with diagnoses including cardiovascular accident, dysphagia, and use of a gastrostomy tube. Record review indicated the gastrostomy tube was placed for nutritional support and medication administration. On 03/23/11 at 9:52 a.m. Licensed Nurse (LN) # 1 was observed as she prepared to administer scheduled medications through Resident # 14's gastrostomy tube. LN #1 did not auscultate air bolus or aspirate residual to verify tube placement	F 281	2. Facility Residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing or Unit Coordinators has completed an audit of physician's orders to validate laboratory tests and wound care treatments are completed per order; audited current resident population to identify residents who require the use of gastrostomy tubes; audited medical records to identify residents who use adaptive equipment such as heel boots or non-skid socks and validated the accuracy of the Care Grids based on physicians' orders and/or care plan interventions. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Director of Nursing or Unit Coordinators will provide inservice education for licensed nursing staff and Resident Care Specialists (as applicable to scope of practice) regarding professional standards of practice, specifically - wound treatment orders are to be obtained from the physician at the time of wound "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 9 prior to medication administration through the gastrostomy tube. Interview with LN #1 on 03/23/11 at 10:00 a.m. revealed that she would normally auscultate and aspirate to verify tube placement prior to medication administration. LN #1 stated that she forgot to check for placement. Interview with the Director of Nursing (DON) on 03/24/11 at 3:45 p.m. revealed she expected licensed staff to verify gastrostomy tube placement prior to all medication administration. 2. A faciltiy policy entitled Physician Orders revised June 2007 read in part: Purpose: Physician orders are obtained to provide a clear direction in the care of the resident. Resident #223 was admitted to the facility 03/18/11 with a pressure ulcer to the sacrum. The admission skin assessment dated 3/18/11 assessed the area as 2cm x 2.5cm x unstageable due to slough. Record review of care plan dated 3/22/11 indicated Resident #223 was care planned for pressure ulcers. Interventions included to provide pressure ulcer treatment as ordered. Record review revealed Physician order dated 3/22/11 for wound care treatment. Santyl dressing was ordered daily and as needed. Record review dated 3/22/11 revealed no change in wound assessment. Resident #223's dressing change was observed	F 281	identification and documented accordingly; following physician's orders for adaptive equipment such as heel boots and how to read the facility's Care Grids to identify resident-specific interventions; gastrostomy tube care, including placement verification and use; and the importance of assuring laboratory values are obtained per the physician's order. The Staff Development Coordinator, Director of Nursing, or Unit Manager will conduct skills validations for licensed nurses to assess competency in gastrostomy placement verification prior to flushes and/or medication administration. At least 5 skills validations will be conducted per week until current nurses have been observed. Newly hired nurses will have a skills validation completed during their orientation period and included as an annual skills validation thereafter. The Director of Nursing or Unit Coordinator will review new orders daily, Monday through Friday, during morning "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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	345179	A. BUILDING _____ B. WING _____	C 03/25/2011

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F 281	Continued From page 10 3/24/11 at 10:22 a.m. Observation of dressing change identified no concerns and revealed no change in wound assessment. Interview on 3/23/11 at 1:30 p.m. with Treatment Nurse revealed that he completed Resident #223 skin assessment on admission. Treatment Nurse reported that he contacted Physician on 3/18/11 for wound treatment orders. Treatment Nurse confirmed after chart review that no wound treatment orders were written on 3/18/11. Interview on 3/23/11 at 1:55 p.m. with LN #2 revealed that she completed dressing change for Resident #223 on 3/19/11. Interview with LN #2 revealed that she applied santyl dressing without an order for treatment. LN #2 stated that she had worked with Treatment Nurse and she felt knowledgeable about the appropriate type of dressing to apply. LN #2 reported that Resident #223 repeatedly removed the dressing to the sacral ulcer so she applied topical ointment to the area. Interview with LN #2 confirmed she was not wound care certified. Interview on 3/24/11 at 2:50 p.m. with Director of Nursing (DON) revealed that she would expect nursing staff to contact the Physician for clarification of wound care treatment if no treatment orders were on Resident #223's chart. Interview on 3/25/11 at 1:00 p.m. with Physician revealed the facility did not have standard wound care guidelines in place for wound treatments and that he would expect the nursing staff to contact him for treatment orders. The Physician stated that a dry dressing to cover Resident #223 sacral pressure sore would have been appropriate until he or the Treatment Nurse could complete their	F 281	meeting to identify laboratory needs, adaptive equipment orders, and new treatment orders to assure appropriate follow up is provided. New admission medical records will be reviewed by the Interdisciplinary Team to verify accuracy of transcribed orders based on the resident assessment. On a monthly basis, the Director of Nursing and/or Unit Coordinators will audit physician's orders for labs to assure those orders have been completed and reported to the physician for follow up as needed. Nursing Administration (Director of Nursing, Unit Coordinators, Unit Manager, Weekend Supervisor, and/or Staff Development Coordinator) will conduct care rounds daily for 14 days then at least 3 times per week thereafter to monitor for placement of adaptive equipment, gastrostomy tube care, and treatments completed as ordered to ensure continued compliance. 4. The Director of Nursing or Unit Coordinator will review data obtained during Lab audits, skills validations, and care rounds. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 11 assessment and write treatment orders. 3. Resident # 61 was admitted to the facility on 03/30/09 with admitting diagnoses that included chronic kidney disease, anemia, psychiatric disorders and hyperlipidemia. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 03/20/11 revealed Resident # 61 had short-term memory problems and had moderately impaired decision-making skills. A review of Resident # 61's physician's orders recap for March 2011 revealed an order for Depakote 350 milligrams to be given three times a day for psychiatric disorders (originally ordered on 03/30/09). The physician's orders further revealed lab tests to be drawn for Complete Blood Count (CBC) every six months (originally ordered on 07/25/10) and Fasting Lipid Panel every six months in February and August (originally ordered on 02/01/10). A review of Resident # 61's lab tests revealed the following. Lab results for Valproic Acid for Depakote dated 05/28/10 and no lab results completed in November 2010. Lab results for CBC dated 07/16/10 and no lab results completed in January 2011. Lab results for Lipid Panel dated 08/10/10 and no lab results completed in February 2011. The facility obtained a physician's order on 03/25/11 for the Valproic Acid, CBC and Lipid Panel and the lab tests were completed. A review of Resident # 61's pharmacy notes revealed no documentation of lab tests being missed or to be completed.	F 281	They will analyze the data and report patterns/trends to the QA&A committee monthly for 6 months. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 12 An interview with the Director of Nursing (DON) on 03/25/11 at 12:43PM revealed there were no recent labs completed for Resident # 61 and should have been completed as ordered. The DON reported the facility's consulting pharmacist did not bring the lab tests to the facility's attention. The DON stated the lab tests were usually completed every six months unless otherwise ordered. The DON further revealed the physician was made aware and a physician's order for the lab tests was obtained on 03/25/11. An interview with the Consulting Pharmacist on 03/25/11 at 1:00PM revealed he reviewed his notes and requested a Valproic acid lab test in June 2010 and a CBC lab test in August 2010. The Consulting Pharmacist reported he was aware the lab tests were ordered by the physician for every six months, but he did not recommend any further lab tests because Resident # 61's lab values were within normal range and there was no need to draw the lab tests. There was no formal recommendation completed by the Consulting Pharmacist. Another interview with the DON on 03/25/11 at 2:48PM revealed the expectation would be to draw the lab tests as ordered or for the consulting pharmacist to make recommendations to change the order of when lab tests should be drawn. The DON reported she would expect the nursing staff to also review Resident # 61's physician orders and lab tests, and the nursing staff should have caught that the lab tests were not completed in six months. The DON further revealed the facility's unit coordinators conducted lab audits and should have also caught Resident # 61 incomplete lab tests.	F 281	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 13 4. Resident # 44 was admitted to the facility on 04/16/03 with admitting diagnoses that included Alzheimer's dementia, joint contracture of left leg and osteoarthritis. A review of the most recent annual Minimum Data Set (MDS) assessment dated 01/02/11 revealed Resident # 44 had short and long-term memory problems and had severely impaired decision-making skills. The MDS further revealed Resident # 44 required extensive assistance with activities of daily living and supervision with locomotion on and off the unit. A review of Resident # 44's physician's orders dated 12/04/09 revealed a heel boot to resident's left foot at all times, and to remove only for skin checks and personal hygiene. The physician orders further revealed to apply non-skid socks. A review of Resident # 44's care plan update on 03/21/11 revealed Resident # 44 required extensive to total staff assistance and intervention for the completion of activities of daily. The care further revealed interventions that included the application of a left foot heel boot and non skid socks for Resident # 44 to be able to propel self in her wheelchair. A review of Resident # 44's 'Care Grid' printed daily for the nursing assistants from 03/22/11 to 3/25/11 revealed to apply heel boot to left foot at all times and non skid socks. Observations of Resident # 44 in the hallways, in front of her room door and lying in bed on 03/22/11 at 10:30AM, on 03/23/11 at 10:05AM and 4:35PM, on 03/24/11 at 3:14PM, and on 03/25/11 at 9:00AM revealed no left foot boot applied. There were also no observations of the	F 281	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 281	Continued From page 14 non skid socks applied on Resident # 44's feet. An interview with Nursing Assistant (NA) # 2 on 03/25/11 at 9:02AM revealed she was not aware that Resident # 44 had to have a left foot boot and non skid socks applied. NA # 2 reported she observed Resident # 44's 'Care Grid' and she did not notice before the applications on her care grid. NA # 2 stated she noted no left heel boot or the non skid socks applied on Resident # 44's feet. NA # 2 searched for the items in Resident # 44's room and neither item could be located and were not available for the resident. NA # 2 further revealed she usually worked in restorative, but the left foot heel and the non skid socks should have been applied. NA # 2 could not explain why they were not applied, but obtained the items from laundry and placed both the non-skid socks and the left foot heel boot on Resident # 44. An interview with Licensed Nurse (LN) # 3 on 03/25/11 at 9:08AM revealed Resident # 44 should have had her left foot boot on at all times except for showers and hygiene, and her non skid socks should have been on. LN # 1 reported she did not notice and she was not aware that Resident # 44 did not have her left heel boot and non skid socks applied. An interview with the Director of Nursing (DON) on 03/25/11 at 9:17AM revealed the 'Care Grid' was printed out every morning for the nursing assistants, and that was how they knew how to care for the residents. The DON reported if Resident # 44's left foot heel boot and non skid socks were ordered, and/or documented on the care plan and on the 'Care Grid,' the items should have been applied on Resident # 44's feet.	F 281	F 312 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 120 by providing incontinence care, as needed, prior to meal delivery. 2. Facility residents who have incontinence have the potential to be affected by the same alleged deficient practice and have been identified by the Director of Nursing via an audit of most recent MDS assessment data related to incontinence. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 15 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record reviews, the facility failed to provide incontinence care to a resident (Resident #120) prior to a breakfast meal, for 1 (one)of 2 (two) sampled residents observed for incontinence care. The findings are: The facility's policy "Routine Resident Care" revised June 2008, recorded in part: "Incontinence care is provided timely according to each resident's needs." Resident #120 was admitted to the facility on 1/8/11. Diagnoses included atrial fibrillation, hyperlipidemia, Alzheimer's dementia, congestive heart failure (CHF), hypertension and adult failure to thrive. The 1/17/11 care plan for Resident #120, identified a problem with incontinence related to his diagnosis of CHF, the use of diuretics and impaired cognition. Approaches included to provide peri care daily and as needed and to observe for incontinence episodes at regular and frequent intervals and as needed.	F 312	3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Staff Development Coordinator, Director of Nursing, or Unit Coordinators will conduct inservice education for Resident Care Specialists regarding Care of Dependent Residents, specifically, residents should be monitored for incontinence and provided personal hygiene care prior to serving meals. Nursing Administration (Director of Nursing, Unit Coordinators, Unit Manager, Staff Development Coordinator, and/or Weekend Supervisor) will conduct care rounds daily for 14 days then at least three (3) times per week during randomly chosen meal time. Facility Ambassadors will conduct rounds at least three (3) times per week to include questions related to provision of incontinence care prior to meals. The Administrator of Social Services Director will review concerns monthly to identify trends related to provision of incontinence care. Resident Council meetings will include "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 312	Continued From page 16 The minimum data set (MDS) dated 1/28/11 assessed Resident #120 as having impaired short-term memory and intact long-term memory with moderately impaired daily decision-making skills. The MDS also assessed Resident #120 as independent with eating after tray set up, frequent incontinence of bowel/bladder and participating in a bowel/bladder retraining program. On 3/24/11 Resident #120 received his breakfast meal at 7:55 AM from nursing assistant #1 (NA #1). The lights were off in the Resident's room and the Resident was observed sleeping. There was a strong odor of urine smelled from the doorway of the Resident's room. NA #1 turned on the lights, entered the Residents room, greeted the Resident and advised him that his breakfast was available. The Resident awoke and was assisted to sit up in the bed by NA #1. The NA set up his breakfast tray, informed the Resident what he had for breakfast and encouraged the Resident to feed himself breakfast and left his room. The odor of urine was strong coming from the Resident. NA #1 was not observed to ask the Resident if he needed anything else, offer toileting assistance or to check the Resident for an incontinent episode before leaving his room. The Resident fed himself breakfast until 8:15 AM with a strong odor of urine still present. At 8:20 AM, NA #1 encouraged Resident #120 to eat more of his breakfast, the Resident refused and NA #1 removed his breakfast tray from his room. The NA was not observed to offer any assistance with toileting or to check the Resident for an incontinent episode before leaving his room. 3/23/11 at 9:44 AM, NA #1 entered the room for Resident #120 with a wash basis and assisted the Resident with morning care and incontinence	F 312	questions regarding provision of incontinence care prior to meals for the next six (6) months to identify concerns and ensure continued compliance. 4. The Administrator or Director of Nursing will review data obtained during care rounds, Ambassador rounds, Concerns reviews, and Resident Council minutes, analyze the data and report patterns/trends to the QA&A committee monthly for 6 months. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 312	Continued From page 17 care. The Resident was still in bed and his brief was observed dry, but his bed clothes and sheet were visibly saturated with urine. The strong odor of urine was still present. During an interview with NA #1 on 3/23/11 at 10:14 AM, she stated that she completed routine checks of her assigned residents at the beginning of her shift. She checked residents to see if any one was wet during her rounds. She provided incontinence care as needed during her routine checks. Then she would pass breakfast trays to residents once the trays were delivered to the floor. NA #1 stated that she briefly checked Resident #120 that morning for incontinence care before his breakfast was served. She briefly looked and saw that the brief for Resident #120 was dry. She did not notice that his clothes and sheet were wet when she served Resident #120 his breakfast. She further stated that when she was performing care for Resident #120 at 9:44 AM, she observed his brief dry and his clothes and sheet wet. NA #1 also stated that Resident #120 had a habit of urinating with his brief on and would urinate around the brief, leaving his brief dry but his clothes and sheets wet. An interview with unit manager #1 on 3/25/11 at 3:30 PM revealed that if incontinence care was needed and the breakfast tray had already been delivered, she expected nursing assistants to allow a resident to eat breakfast and to give incontinence care after breakfast. Unit manager #1 further stated that other residents would need to be assisted with feeding and since Resident #120 could feed himself, the nursing assistant should set up his tray, assist other residents who required feeding assistance and then come back to provide incontinence care. Unit manager #1	F 312	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 312	Continued From page 18 also stated "I would not want to eat with wet pants, but residents have a right to have a hot breakfast." She stated that all staff were assisting with meals at that time so the nursing assistant would have to go back and provide the incontinence care after all residents had been assisted with their breakfast. The director of nursing (DON) stated in an interview on 3/25/11 at 3:45 PM that she expected residents to be made comfortable and to allow residents to direct their care. The DON stated that if a resident was wet, or the bed sheets were wet, she would expect the nursing assistant to change the resident's clothes/sheets before giving the resident breakfast and come back after breakfast to provide the incontinence care. The DON stated that she expected that the resident would be asked if there was anything that could have been done to make him comfortable.	F 312		4.22.11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, the facility failed to 1) serve grilled cheese sandwiches at or above 135	F 371	F 371 1. Corrective action has been accomplished for the alleged deficient practice in regards to sanitary food preparation and storage by serving grilled cheese sandwiches at or above 135 degrees Fahrenheit; cleaning the condiment cart containers; and assuring that staffs are utilizing hair nets appropriately. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 371	Continued From page 19 degrees Fahrenheit, 2) maintain the condiment cart clean, and 3) monitor dietary staff for the use of hair nets during meal preparation/service. The findings are: 1. An observation of the dinner meal occurred on 3/23/11 at 4:45 PM. Two grilled cheese sandwiches were stored on the cook's prep table and observed on small plates, covered with plastic wrap. At 5:25 PM, the evening cook plated the grilled cheese sandwiches for service to residents and confirmed that he had not monitored the temperature of the sandwiches prior to service. The dietary manager conducted temperature monitoring of the sandwiches at 5:29 PM and obtained a temperature of 88.3 degrees Fahrenheit. The dietary manager stated that since the cheese was processed and was being served within two hours of preparation, the sandwiches were okay to serve. The sandwiches were placed on resident's meal trays for service. The packaging for the cheese recorded the first two ingredients as "cultured milk and skim milk". At 5:38 PM the dietary manager stated that hot foods should be served from the tray line at 140 degrees Fahrenheit. He then stated that he should not serve the grilled cheese sandwiches since the temperature was less than 140 degrees Fahrenheit. He was observed to obtain one of the two grilled cheese sandwiches from a resident before the sandwich was eaten. The second grilled cheese sandwich was eaten by the resident. The resident who ate her sandwich stated at 5:43 PM that her sandwich was warm, not hot and that she gets a grilled cheese sandwich twice daily. Dietary Aide #2 stated in an interview on 3/23/11	F 371	2. Facility residents have the potential to be affected by the same alleged deficient practice. The Dietary Manager or Assistant Manager will audit residents' tray card system to identify residents requesting Grilled Cheese Sandwiches and audit food temperature logs to identify discrepancies in appropriate temperature ranges for the serving line. 3. Additional measures put into place to ensure that the alleged deficient practice does not recur include: the Dietary Manager or Assistant Dietary Manager will conduct inservice education for Dietary staffs on proper use of hair nets, adherence to the cleaning schedules to include condiment carts, and serving food at appropriate temperatures, including such items as grilled cheese sandwiches, at or above 135 degrees Farhenheit. The Dietary Manager or Assistant Manager will conduct Sanitation Rounds at least 3 times weekly for 4 week and weekly thereafter to ensure proper use of hair nets and cleanliness of condiment "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 371	Continued From page 20 at 5:45 PM that she prepared the grilled cheese sandwiches that day for the dinner meal to help out. She prepared the sandwiches at 4:30 PM and had been trained to leave the sandwiches on the stove to keep warm. She confirmed that she had not monitored the temperature of the sandwiches. No answer was given as to why the sandwiches were left on the cook's prep table instead of being kept hot. 2. An observation of the dinner meal occurred on 3/23/11 at 4:45 PM. The condiment cart was observed at 4:49 PM available for use on the dinner tray line. Further observation of the condiment cart revealed that each of the nine storage containers had multiple dried food particles in the bottom of the containers. One of the containers had flat ware wrapped in napkins and in the bottom of this container, a small black dead insect was observed. The condiment cart was used for the dinner tray line on 3/23/11 which started at 5:02 PM in the condition described. Dietary Aide #2 was observed on 3/23/11 at 5:02 PM placing items from the condiment cart on resident's dinner trays. She was interviewed on 3/23/11 at 5:45 PM and stated that the condiment cart was already prepped for dinner when she came to work. She had not noticed the food debris or the small black insect. The condiment cart was observed on 3/23/11 at 5:50 PM with the dietary manager. He stated the condiment cart needed to be cleaned more thoroughly. He observed the small black insect in the container with the rolled flat ware and stated this should have been cleaned. The dietary manager further stated that he expected the condiment cart to be cleaned weekly and as	F 371	carts. Food temperatures will be taken and recorded by the Cook at the serving line prior to each meal service, including grilled cheese sandwiches prepared prior to serving, to ensure appropriate food temperatures are maintained. The facility's Registered Dietician (RD) will conduct sanitation rounds, including monitoring of food temperatures, during monthly visits and report findings to the Administrator for follow up as needed to ensure continued compliance. 4. The Dietary Manager or Assistant Dietary Manager will review data obtained during Sanitation rounds, food temperature log reviews, and RD visits; analyze the data and report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 371	Continued From page 21 needed. He reviewed the posted daily cleaning schedule and said the condiment cart was not listed, but it would be added to the cleaning schedule. An interview with the kitchen manager on 3/24/11 11:00 AM revealed that she wiped down the condiment cart after lunch on 3/23/11 and set it up for dinner, but she did not clean out each bin. The kitchen manager stated that she did not notice the small black insect. She confirmed that the condiment cart was to be cleaned thoroughly each week and wiped down as needed. 3. An observation of the dinner meal occurred on 3/23/11 at 4:45 PM. Dietary Aide #1 (DA #1), DA #2 and DA #3 were all observed wearing hair nets that did not completely cover their hair. DA #1 was observed on 3/23/11 at 5:00 PM wearing a hair net that exposed her hair on the right side while pouring tea into iced cups for the dinner tray line. The dinner tray line started at 5:02 PM. DA #2 and DA #3 were both observed on the dinner tray line wearing hair nets that did not cover their hair. DA #2 had hair exposed on both sides near her ears and in the back at her neck line. DA #3 also had hair exposed on both sides nears her ears. DA #2 stated on 3/23/11 at 5:45 PM that she prepared the grilled cheese sandwiches for the dinner meal that day (3/23/11) at the beginning of her shift. Interview with the dietary manager on 3/23/11 at 5:48 PM confirmed that dietary staff should wear hair nets to cover all of their hair. He further stated that the kitchen manager was responsible for monitoring hair nets, but she left early that day (3/23/11) at 2:30 PM and he had not noticed that some of the staff were wearing hair nets that did	F 371	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 371	Continued From page 22 not cover their hair. DA #3 was interviewed on 3/24/11 at 7:45 AM and confirmed that the dietary staff were trained to wear a hair net that covered all of the hair. She had not noticed that her hair was not covered during the dinner meal on 3/23/11. The kitchen manager stated in an interview on 3/24/11 at 11:00 AM that she normally worked from 6 AM - 2:30 PM during the week and on weekends and was responsible for monitoring dietary staff on the first shift. The kitchen manager stated that she often had to remind day shift dietary staff to completely cover their hair with a hair net and that she had also recently reminded DA #2. The kitchen manager stated that DA #1 came to work on 3/23/11 before the kitchen manager left, but the kitchen manager did not notice her hair net.	F 371		4.22.11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F 441 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #120 by providing personal care by using appropriate infection prevention practices including use of gloves, changing of gloves when soiled, and disposing of soiled linen in the appropriate containers. NA#1 "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 441	Continued From page 23 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review facility staff failed to change disposable gloves between dirty and clean tasks of resident care and failed to handle and dispose of soiled linen in a manner to prevent the spread of infection. (Resident #120) The findings are: Resident #120 was admitted to the facility on 1/8/11. Diagnoses included atrial fibrillation, hyperlipidemia, Alzheimer's dementia, congestive heart failure (CHF), hypertension and adult failure to thrive. Admission Minimum Data Set (MDS) dated 1/15/11 assessed the resident with short term and long term memory problems with	F 441	has received one-on-one education regarding infection prevention practices for personal protective equipment and linen handling. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing or Staff Development Coordinator has initiated skills validations for resident care specialists related to use of gloves during personal care and soiled linen handling. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Staff Development Coordinator, Director of Nursing, or Unit Coordinators will conduct inservice education for nursing staff regarding Infection Prevention Practices, specifically, the use of gloves, when to change gloves during care, and proper linen handling. The Staff Development Coordinator, Director of Nursing, Unit Coordinators, and/or Weekend Supervisor will conduct five (5) skills validations per week "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 441	Continued From page 24 moderately impaired decision making skills. The MDS assessed the resident as requiring extensive assistance with personal hygiene care and frequently incontinent of bowel and bladder. On 3/23/11 at 9:44 a.m. NA #1 was observed providing incontinent care to Resident #120. NA #1 donned disposable gloves and proceeded to remove the resident's night clothes and bed linen which were all visibly saturated with urine. NA #1 placed the soiled items in a pile on the floor. NA #1 continued with the resident's bath, provided incontinent care and shaved the resident wearing the same pair of disposable gloves. NA #1 obtained clean clothes from Resident #120's closet and helped him get dressed as she continued to wear the same pair of disposable gloves. After completing care for Resident #120, NA #1 removed the disposable gloves, washed her hands, and left the room. NA #1 returned to the resident's room with a soiled linen bin. NA #1 donned disposable gloves, removed the soiled linen from the floor and placed the items in the bin. NA #1 returned the soiled linen bin to the storage closet. NA #1 was interviewed following this observation. NA #1 stated that she would change gloves while providing resident care if her gloves were visibly soiled with urine or feces. NA #1 stated that she handled the soiled items carefully so her gloves would not get soiled. NA #1 stated that she was aware the soiled linen should not be placed on the floor. NA #1 stated that she had a large amount of soiled linen that would not fit in the plastic bags available in resident #120's room so she placed the soiled items on the floor until she could get a larger container to hold all the linen.	F 441	regarding use of gloves and linen handling until current staff have been observed. Newly hired nursing staff will complete these skills validations during their orientation period and annually thereafter. The Director of Nursing, Unit Coordinators, Staff Development Coordinator, and/or Weekend Supervisor will conduct care rounds daily for 14 days then at least three (3) times per week thereafter to monitor infection prevention practices, including use of gloves and linen handling to ensure continued compliance. 4. The Staff Development Coordinator or Director of Nursing will review data obtained during care rounds and skills validations, analyze the data and report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4.22.11

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F 441	Continued From page 25 Interview on 3/24/11 at 2:50 p.m. with the Director of Nursing (DON) revealed that staff had been recently inserviced on infection control practices. The DON stated she expected staff to adhere to infection control practices, including to ensure gloves were changed with appropriate hand hygiene after providing incontinent care and to handle and dispose of soiled linen appropriately.	F 441	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	4-22-11