STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____ APR 29 2011	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 SS=D	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 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 record review and staff interview, the facility failed to review and revise the care plan for falls and nutrition for 3 (Resident # 31, #12 & #44) of 14 sampled residents. The findings include: 1. Resident # 31 was admitted to the facility on 12/22/09 and was re-admitted on 11/05/10 with multiple diagnoses including Alzheimer's disease, Left scaphoid fracture and left hip femoral neck fracture (10/31/10), status post Open Reduction and Internal Fixation (ORIF). The quarterly Minimum Data Set (MDS)	F 280	The Center provided the following Plan of Correction (POC) without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and executed solely because it is required by provisions of the Federal and State Law. The facility reserves all rights to contest findings through dispute, resolution, final appeal proceeding and any administrator or legal proceeding.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 280	Continued From page 1 assessment dated 01/31/11 indicated that the resident had severe cognitive impairment. The assessment also indicated that the resident needed extensive assist with transfer, independent with ambulation in room and limited assist with ambulation in corridor. The assessment further indicated that the resident was not steady with walking. The care plan for falls initiated on 11/05/10 was reviewed. The problem was " Resident is at risk for falls, impaired mobility, cognitive loss, lack of safety awareness " . The goal was " Resident will have no falls with injury x 90 days " . The approaches were low bed with mats on the floor (03/16/10), provide verbal cues for safety and sequencing when needed (01/02/10), place call light within reach at all times (01/02/10), maintain clutter free environment in the resident's room and consistent furniture arrangement (01/02/10), when resident in bed, place all necessary personal items within reach (01/02/10), monitor for and assist toileting needs (01/02/10), fall risk assessment per protocol (01/02/10) and bed alarm to bed to alert staff members of resident's need to ambulate (01/02/10). The incident reports and the nurse's notes were reviewed. The reports and the notes revealed that Resident #31 had 12 incidents of falls from September 01, 2010 to April 05, 2011. The reports and the care plan did not indicate that new interventions were put in place to prevent further falls for Resident #31. On 04/07/11 at 10:15 AM, the MDS Nurse #1 was interviewed. She stated that after an incident of fall, the IDT (interdisciplinary team) members	F 280	F 280 1. Residents # 31, #12 and #44 have all care plans and interventions current and revised to include falls and nutrition. Resident # 31 has a new intervention added to fall care plan to remove straight chair in room in addition to low bed with mats, verbal cues for safety, call light in reach, clutter free environment, place personal items in reach, assist toileting needs and bed alarm to bed. Resident # 12 has bed alarm, physical therapy 5 times a week, intervention for psychotropic drug use to taper Ativan. House supplement as ordered-removed from care plan. Resident #14 has a nutritional assessment complete with nutritional care plan current and specific. 2. Resident's will have current care plans to include resident specific approaches and interventions that will be followed according to accepted standard of practice.	5/5/2011 5/5/2011

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F 280	Continued From page 2 meet and discuss the incident, decide what new intervention to put in place to prevent further falls and update the care plan. She further stated after reviewing the IDT minutes, that there was no new intervention put in place except the low bed with mat on the floor (03/16/10). On 04/07/11 at 10:17 AM, Administrative Nurse #1 was interviewed. Administrative Nurse #1 stated that he was a member of the IDT team and was helping with the MDS and care plans. After reviewing the care plan, he stated that there was no update to the care plan to prevent further falls except the low bed with mat on the floor (03/16/10). 2. (a) Resident #12 was admitted to the facility on 11/26/07. Cumulative diagnoses included a history of falls. The quarterly minimum data set dated 3/15/11 revealed that Resident #12 was cognitively intact. Resident #12's care plan dated 3/30/11 included a problem of potential for falls with a goal of no falls with injury. Interventions included a bed alarm and physical therapy 5 times per week. No bed alarm was observed on Resident #12's bed on 4/5/11 at 10:00AM or 4/7/11 at 9:30 AM. During an interview on 4/7/11 ay 9:30 AM, Resident #12 indicated that she did not have an alarm on her bed, and had completed therapy months ago. During an interview on 4/7/11 at 10:55AM, administrative nurse #1 acknowledged that Resident #12 had completed therapy in October	F 280	3. Interdisciplines will be inserviced on care plan process to insure specific goals, interventions and updates are completed- Focus placed on nutrition and falls. 4. Care plan will be reviewed, revised and updated daily. Monitor weekly at IDT meeting findings reviewed monthly x3 then quarterly thru QI committee for continuous quarterly improvement.	5/5/2011 5/5/2011

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F 280	Continued From page 3 2010 and that the care plan should have been updated. Administrative nurse #1 added that he did not know if Resident #12 had a bed alarm. 2 (b) Resident #12 was admitted to the facility on 11/26/07. Cumulative diagnoses included anxiety and dementia. The quarterly minimum data set dated 3/15/11 revealed that Resident #12 was cognitively intact. Physician orders for March and April 2011 revealed an order for Ativan (an anti-anxiety drug) 0.25 milligrams every evening. Resident #12's care plan dated 3/30/11 included a problem of psychotropic drug use with the goal: "resident will have the smallest, most effective dose without side effects". Interventions included, "Titrate Ativan every week starting at 0.75 mg (milligrams), then 0.5 mg, then 0.25 mg, then discontinue." During an interview on 4/7/11 at 10:55AM, administrative nurse #1 indicated that the attempted Ativan taper for Resident #12 occurred in 2007 and the care plan had not been updated. 2 (c) Resident #12 was admitted to the facility on 11/26/07. Cumulative diagnoses included gradual weight loss. The quarterly minimum data set dated 3/15/11 revealed that Resident #12 was cognitively intact. Resident #12's care plan dated 3/30/11 included a problem of nutritional risk related to gradual weight loss and goal of maintaining a stabilized weight. Interventions included, "house	F 280		

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F 280	Continued From page 4 supplement as ordered". Review of physician orders for March and April 2011 revealed no order for a nutritional supplement. During an interview on 4/7/11 at 11:08 AM, the dietician acknowledged that Resident #12 was not on a nutritional supplement and the care plan needed to be updated. 3. Resident #44 was admitted to the facility on 2/18/11 with diagnoses that included acute vascular insufficiency of intestine and chronic kidney disease. He had been admitted post a small bowel resection. Review of the admission Minimum Data Set (MDS) dated 2/24/11 revealed the resident had moderately impaired cognition and unclear speech but was usually understood. It further indicated that the resident required limited assistance with eating had impairment on one side of his body and was on a mechanically altered diet. Review of the Care Areas Assessment for the Admission MDS dated 2/24/11 revealed the nutrition triggered as a Care Area but there was a determination not to proceed to Care Plan at that time. Review of the Care Plan dated 2/24/11 and updated on 3/9/11 revealed there was no care plan for nutrition. A review of the Medical Record revealed a comprehensive Nutrition Assessment has not been conducted for the resident from the time of admission through the date of the review, 4/6/11.	F 280		

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F 280	Continued From page 5 Review of Resident #44's weight record indicated the resident had the following weights: 211.8 pounds on admission (2/18/11) and 174 pounds on 3/8/11. Review of the " Weight Loss Notification Form dated 3/16/11 revealed a hand written note that read " (decrease) 5 % x (times) 30 days. Appetite poor acute episode of bowel resection and wound hematoma. Evacuation of wound done by MD (medical Doctor) and wound vac applied. " Under the Intervention section the words " Dietary Consult, Currently on Megace (an appetite stimulant) were written. " The form also indicated that the resident's weight was 174 pounds and that the family was notified and would bring food from home. Further review of the Medical Record revealed there was no Nutrition Consult available on the chart. Interview with Consultant Registered Dietician (RD) on 4/6/11 at 1:30 PM revealed that an initial comprehensive assessment and the Dietary Consult had not been done for this resident. She did not know how the resident " fell through the cracks " but speculated that it had something to do with changes to the Care Tracker system. She stated that although the resident did not initially have nutrition issues that would necessitate care planning that at some point as he lost weight, updating the care plan to address nutrition would have been appropriate. She also indicated that the Assistant Dietary Director attends the Interdisciplinary Team (IDT) Meetings and should have passed on the information to the Consultant RD to trigger assessment and care	F 280		

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F 280	Continued From page 6 planning. Interview with the Assistant Dietary Director on 4/6/11 at 1:55 PM revealed that he attends the weekly INR meetings and that the Nursing Supervisors, wound nurse and social worker usually also attend.. He stated that the resident's weight loss was discussed at the 3/16/11 meeting and he went to talk to the resident about his food preferences but did not write a progress note. He stated that the care plan was not updated and there was no further nutrition assessment. Interview with the Clinical Reimbursement Coordinator on 4/7/11 at 9 AM revealed that the weekly IDT meeting is where " they discuss the care plans and patients care and make any changes. " She also indicated that Dietary initiates the nutrition care plans. Interview with the Director of Nursing (DON) on 4/7/11 at 11 AM revealed that it was unusual for this resident not to have a care plan. She indicated that there had been reasons for the Resident # 44's weight loss such as abdominal ascites on admission, due to his surgery, and subsequent fluid loss and also that his normal weight was 185 pounds. This had not been documented in the Medical Record. She revealed that the resident had been followed in the weekly IDR meeting and interventions were in place but had not been updated in the care plan as would be expected.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 7 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to put new interventions in place to prevent further falls for 1 (Resident #31)of 3 sampled residents with accidents. The findings include: Resident # 31 was admitted to the facility on 12/22/09 and was re-admitted on 11/05/10 with multiple diagnoses including Alzheimer ' s disease, Left scaphoid fracture and left hip femoral neck fracture (10/31/10), status post Open Reduction and Internal Fixation (ORIF). The quarterly Minimum Data Set (MDS) assessment dated 01/31/11 indicated that the resident had severe cognitive impairment. The assessment also indicated that the resident needed extensive assist with transfer, independent with ambulation in room and limited assist with ambulation in corridor. The assessment further indicated that the resident was not steady with walking. The care plan for falls initiated on 11/05/10 was reviewed. The problem was " Resident is at risk for falls, impaired mobility, cognitive loss, lack of safety awareness " . The goal was " Resident will have no falls with injury x 90 days " . The approaches were low bed with mats on the floor (03/16/10); provide verbal cues for safety and	F 323	F 323 1. Resident #31 has new interventions in place to prevent further falls to ensure the resident environment remains as free of accidents as possible with adequate supervision and assist devices to prevent accidents and new intervention added to care plan to remove straight chair from room. 2. Resident at high risk for falls will have individualized interventions in place with new interventions added to prevent further falls and ensure a safe environment. 3. Inservice provided to nurses and interdiscipline team on falls. Management to ensure those residents to be at risk will receive appropriate and further interventions to insure resident environment remains safe and free of accidents.	5/5/2011 5/5/2011 5/5/2011

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F 323	Continued From page 8 sequencing when needed (01/02/10), place call light within reach at all times (01/02/10), maintain clutter free environment in the resident ' s room and consistent furniture arrangement (01/02/10), when resident in bed, place all necessary personal items within reach (01/02/10), monitor for and assist toileting needs (01/02/10), fall risk assessment per protocol (01/02/10) and bed alarm to bed to alert staff members of resident ' s need to ambulate (01/02/10). The records revealed that the resident was on the PT (physical therapy) caseload from 11/08/10 - 01/04/11 and on OT (Occupational therapy) caseload from 11/08/10 - 01/10/11. From 01/05/11 - 03/06/11, the resident was on restorative ambulation program. The nurse ' s notes and the incident reports were reviewed. The following were the dates and description of falls: 09/01/10 at 4:45 AM - " pt (patient) up with walker all night ambulating around her room with socks on and pajamas that go under pt. feet while she ' s up walking. Pt slipped and fell. " The report indicated that the resident had abrasion to left lower back. There was no new interventions/preventative measures added to care plan documented on the report. .There was no new intervention added to the care plan after the fall. 09/19/10 at 11:15 AM - " pt. noted on floor face down with head against bottom of bedside table " . The report indicated that the resident sustained laceration on her left eyebrow, bruise on end of nose, skin tear x (times) 2 on left shoulder and on left elbow and small laceration on inside of top lip.	F 323	4. Falls will be investigated, contributing factors addressed, new interventions and preventive measures added to care plan. Interdiscipline team will review within 72 hours and follow up completed within one week to ensure appropriate actions were taken. Falls will be monitored weekly by Unit Managers/Staff Development Coordinator. Findings brought to QI committee monthly x3, then quarterly for continuous quality improvement.	5/5/2011

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F 323	Continued From page 9 The report also indicated that the resident was disoriented and with poor safety awareness. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 10/21/10 at 7:00 AM - " pt. on floor in room with shoulder against w/c (wheelchair). " No injury noted. The report also indicated that the resident had a balance problem. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 10/31/10 at 10:15 AM - " pt. up walking in room and fell to floor sitting on butt, was on way to get her walker " . The report indicated that the resident had complained of right leg and knee pain. There was no new interventions/preventative measures added to the care plan documented on the report. The nurse ' s notes indicated that the resident was admitted to the hospital with fracture leg and was re-admitted to the facility on 11/05/10. There was no new intervention added to the care plan after the resident was re-admitted. 01/05/11 at 2:00 PM - " pt was up in recliner and used controller to raise chair to assist with stand position and slip out of recliner " . There was no injury noted. The report indicated that the resident was alert and oriented with confusion and has poor safety awareness. The report also revealed that the resident was independent with transfer and ambulation. Under new interventions/preventative measures added to care plan was documented N/A (not applicable).	F 323		

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F 323	Continued From page 10 There was no new intervention added to the care plan after the fall. 02/06/11 at 7:40 AM - " resident in recliner messing with her shoe and slid to floor " . There was no injury noted. The report indicated that the resident was alert/disoriented. Under new interventions/preventative measures added to care plan was documented none and pt. is non compliant most of the time. There was no new intervention added to the care plan after the fall. 03/22/11 at 3:00 AM - " during rounds CNA (certified nursing assistant) found pt. lying on floor beside her straight chair. She stated she slid out of chair " . There was no injury noted. The report also revealed that the resident was alert and oriented with confusion and poor safety awareness. The report also indicated that the resident was independent with ambulation with walker. There was no new intervention added to the care plan after the fall. 03/27/11 at 11:15 AM - " pt was walking down hall return from exercises and simply fell on the floor in hall " . There was no injury noted. The report indicated that the resident was confused and memory impaired. The report also indicated that the resident was independent with ambulation. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 03/29/11 at 5:15 AM - " down hall during med (medication) pass, this nurse heard a noise from	F 323		

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F 323	Continued From page 11 pt. room and noticed pt. on floor beside straight chair which was turned over " . There was no injury noted. The report indicated that the resident was alert with confusion and poor safety awareness. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 03/30/11 at 3:55 AM - " pt was sleeping in recliner, staff at nurse ' s station and heard a noise. Pt. sitting on floor by the door with walker on the side " . The report indicated that the resident was confused with memory impaired and with poor safety awareness. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 04/01/11 at 5:45 AM - " pt was attempting to sit in lounge chair and slid down to floor. Pt. did not call for assist " . There was no injury noted. The report indicated that the resident was independent with transfer and ambulation, with poor safety awareness and balance problems. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. 04/05/11 at 6:15 AM - " pt yelling ' help I can ' t get up ' . This nurse in hall doing med pass hears pt. and finds her sitting in floor in front of lounge chair, walker beside of her. " The resident had a	F 323		

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F 323	Continued From page 12 skin on left forearm. There was no new interventions/preventative measures added to care plan documented on the report. There was no new intervention added to the care plan after the fall. On 04/06/11 at 9:12 AM, the resident was observed sitting in a regular chair in her room. She was trying to go to the bathroom to wash her hands. The resident was observed to be unsteady during transfer. She asked for help from a staff member in getting up from the chair. A staff member was observed to help her get up. On 04/06/11 at 2:50 PM, Nurse #2 was interviewed. The nurse stated that the resident was alert but with poor safety awareness. He was aware that the resident had multiple falls and most of her falls were related to her unsafe practices, transferring and ambulating without using the walker, or the walker was away from her and she tried to walk without it. He also stated that the resident was on low bed with mat on the floor. He further stated that the falls were from the recliner/chair and not from the bed. On 04/06/11 at 2:56 PM, NA #1 (nursing assistant) was interviewed. NA #1 stated that the resident was confused and was independent with transfer and ambulation using the walker. She indicated that she was not aware that the resident had been falling. On 04/07/11 at 9:25 AM, the resident was observed in her room. She was trying to go to the dining room for breakfast. She was observed trying to walk with her walker but she was	F 323		

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	345286	A. BUILDING _____ B. WING _____	04/07/2011

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F 323	Continued From page 13 unsteady. She asked a staff member to get her a wheelchair and to take her to the dining room. On 04/07/11 at 10:15 AM, the MDS Nurse #1 was interviewed. She stated that after an incident of fall, the IDT (interdisciplinary team) members meet and discuss the incident, decide what new intervention to put in place to prevent further falls and update the care plan. She further stated after reviewing the IDT minutes, that there was no new intervention put in place except the low bed with mat on the floor (03/16/10). On 04/07/11 at 10:17 AM, Administrative Nurse #1 was interviewed. Administrative Nurse #1 stated that he was a member of the IDT team and was helping with the MDS and care plans. After reviewing the care plan, he stated that there was no new intervention added to prevent further falls except the low bed with mat on the floor (03/16/10).	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of the facility policy, the facility failed to maintain the medication error rate of 5% or below by not following doctor's order and the manufacturers' specification. There were 3 errors (Residents # 12, #78 and #148) of 51 opportunities for error observed	F 332	F 332 1. Residents # 12, #78 and #146 have doctor's orders followed and administered according to manufacture specifications. Resident #148 had a mouth rinse and spot after Advair Diskus according to manufacture specifications and it will be noted for nurses and Med-aide on MAR. Resident #12 has Nevanac eye drops administered to right eye twice a day as ordered by physician. Resident #78 receives Allegra 180mg daily at 9am as ordered by physician.	5/5/2011

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F 332	Continued From page 14 resulting to 5.8 % error rate. The findings included: 1. A facility policy dated 4/1/07 entitled, "Medication Administration: Diskus Inhaler" read in part, "Have patient rinse mouth with water if using a corticosteroid inhaler." Manufacturer specifications for Advair Diskus (a corticosteroid medication) include, "After inhalation, the patient should rinse the mouth with water without swallowing." On 4/6/11 at 8:53 AM, Nurse #1 was observed administering Advair Diskus to Resident #148 for a diagnosis of reactive airway disease. The resident did not rinse and spit following the inhalation, nor did Nurse #1 instruct the resident to do so. Nurse #1 said she was unaware that rinse and spit was required after inhalation of Advair Diskus. 2. April 2011 physician orders for Resident #12 included Nevanac (a nonsteroidal anti-inflammatory eye drop) one drop to the right eye twice a day as postoperative treatment for recent cataract surgery on the right eye. On 4/6/11 at 9:35 AM, Med (Medication) Aide#1 was observed administering Nevanac one drop into each eye. During an interview on 4/6/11 at 9:45 AM, Med Aide #1 stated that she included a drop into the left eye because Resident #12 usually asked her to do so. Nurse #2 added that she had contacted the ophthalmologist's office to ask for an order for the left eye but had not received a response.	F 332	2. Current residents have medications administered according to physician's orders and manufacturer specifications. 3. Inservice provided by Staff Development Coordinator on Medication Administration in Long Term Care setting to ensure Professional Standards of Practice for License nurses and medication aides. 4. Unit Managers/Staff Development Coordinator will observe skills and medication administration techniques for nurses and med. aides on a weekly basis, findings brought to QI committee monthly x3 for continuous quality improvement to ensure facility is free of medication error rates of 5% or greater.	5/5/2011 5/5/2011 5/5/2011

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F 332	Continued From page 15 3. April 2011 physician orders for Resident #78 included Allegra 180 milligrams daily at 9:00 AM for seasonal allergies. On 4/6/11 at 9:40 AM, Med Aide #1 was observed administering Resident #78's scheduled medications expect for the Allegra. During an interview on 4/6/11 at 3:00 PM, Med Aide #1 said she missed the order for Allegra on the Medication Administration Record (MAR) because it was the only scheduled drug listed on the last page.	F 332		
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 observation, staff interview and facility document review, the facility failed to keep stored milk products off the floor, refrigerate milk at a temperature of 41 degrees Fahrenheit or below, discard leftover pureed fruit more than 3 days old and opened juice more than 10 days old) and to label and date food items stored in the walk in refrigerator. The findings include: Review of the facility policy titled " 5.7	F 371	F 371 1. Four cartons of milk and ice cream observed on the floor during initial tour 4/4/2011. These were discarded immediately by the Dietary Manager. Items identified as safe were dated immediately and outdated items such as puree fruit were immediately discarded. 2. Procurement of individual serve cans to be discareded after use has been implemented. Policy on food storage 5.7 Refrigerated/Frozen storage reviewed and staff education implemented.	5/5/2011 5/5/2011

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F 371	Continued From page 16 Refrigerated/Frozen Storage " dated as revised on 6/15/05 read in part " 1.6 Fluid milk is stored on lower shelves or on separate racks " and " 1.9 Refrigeration units are kept clean and organized. " The policy also read in part " 1.4 All foods are labeled with the name of the product and the date received, opened or prepared. " On 4/4/11 at 11:20 AM during the initial tour 4 cartons of milk and 6 containers of ice cream were found on the freezer floor. The cartons of milk were frozen solid. On 4/4/11 at 11:21 AM, the Dietary Manager indicated that these items were not to be on the floor. He stated that the milk and ice cream must have tipped over and staff had not picked all of them up. He also said that sometimes staff put the cartons of milk in the freezer to get them cold faster. On 4/4/11 at 11:22 AM, the Dietary Manager was observed to discard the frozen milk and ice cream that was on the floor. On 4/4/11 at 11:25 AM, unlabeled and undated Swiss cheese was observed on the top shelf of the walk-in refrigerator. There was also a pan dated 3/23/11 on the next top shelf. There was also an undated pan of vegetables on the second from the top shelf. On 4/4/11 at 11:27 AM, the Dietary Manager stated that the Swiss cheese had been opened on 4/1/11 for sandwiches. He then dated it 4/01/11. He also stated that the pan dated 3/23/11 contained pureed fruit and indicated that it should have been discarded after 3 days. The dietary Manager then asked a Dietary Aide why	F 371	3. Dietary staff inserviced on Refrigerated/Frozen storage in addition to proper storage covered, labeled and dated to ensure standards are met and dietary staff understands guidelines. Items properly covered, labeled and dated. 4. FSD to monitor daily to ensure items are covered, labeled and dated and safety standards are met by sanitation checklist and food storage audit. Findings brought to QI committee monthly x3 and then quarterly for continuous quality improvement	5/5/2011 5/5/2011

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F 371	Continued From page 17 the pan of vegetables had not been dated this morning. Her response was that she had been busy and had forgotten. The Dietary Manager labeled and dated the pan of vegetables 4/04/11. On 4/4/11 at 11:35 AM, a pitcher of prune juice dated 3/21/11 was observed in the reach in refrigerator. It was in a plastic jug with a plastic wrap cover. On 4/4/11 at 11:36 AM, the Dietary Manager indicated that opened juice is to be discarded after 10 days. The Dietary Manager discarded the juice On 4/4/11 at 11:37 AM, the Consulting Registered Dietician stated that opened juice should be discarded after one week. On 4/5/11 at 8:30 AM, the Dietary Manager indicated that he was surprised by the undated food items yesterday and that he had just held inservices with staff about labeling and dating food. He then provided a checklist showing that the AM and PM shift cooks are responsible for ensuring foods are labeled, dated and stored. Review of the AM and PM Cook checklists revealed the cooks are responsible for ensuring all foods are properly stored, labeled and dated at the beginning and end of their shifts. Interview with Cooks Helper #1 on 4/7/11 at 3:03 PM revealed that leftover foods that are stored are to be covered, labeled and dated. She also said that leftover food items must be used within 2 days or discarded. She further stated that the Cooks Helpers are normally responsible for labeling and dating leftovers. Cooks Helper #1	F 371		

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F 371	Continued From page 18 also revealed that the AM and PM cooks have a checklist that they must complete but that each staff member does part of it. She said that as the Cooks Helper she checks the walk in and reach in refrigerators for unlabeled and undated foods and for leftover food items that need to be discarded. She did not know how long opened prune juice could be kept before it needed to be discarded. She further indicated that unlabeled and undated leftovers could be missed if they were stored on the wrong shelf or behind other items. Interview with the Administrator on 4/7/11 at 2:55 PM revealed that her expectation was for leftovers to be discarded timely and both the pureed fruit and prune juice had not been. She also stated that milk should not be frozen or left on the floor.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F 441 1. Resident # 92, #73 and #44 have Glucometers disinfected before first use of the day, between patients and before placing in storage. Resident #95 expired. Resident #172 and #194 have signs posted for CONTACT ISOLATION.	5/5/2011

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F 441	Continued From page 19 (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, manufacturer specifications and facility policy, the facility failed to disinfect a glucometer between residents for 1 of 2 sampled residents (Resident #92), failed to follow manufacturer specifications for effective use of germicidal wipes used in disinfecting glucometers for 1 of 3 sampled residents (Residents #73 and #244), and failed to post contact isolation signs for 3 of 3 sampled residents (Resident #95, #172 and #194) on contact precautions. The findings included: 1. A facility policy revised 10/1/10 entitled, "Fingerstick Glucose Measurement", read in part, "Glucometers will be disinfected before first use of the day, between patients, and before placing in storage."	F 441	2. Current Residents will have a safe, sanitary and comfortable environment. Facility has an Infection Control Program to help prevent the development and transmission of disease and infection. Glucometers are disinfected with germicidal wipes before first use of the day, between patients and before placing in storage and surface will air dry for 5 minutes. Isolation signs will be posted according to physicians orders and to the type of isolation precaution required as in CONTACT ISOLATION. Signs-'See Nurse before entering' have been removed. 3. Inservice provided to nurses and Glucometer disinfecting protocol and review of requirements of isolation signs with residents in contact isolation.	5/5/2011 5/5/2011

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F 441	Continued From page 20 On 4/5/11 at 4:45 PM, Nurse #3 was observed obtaining Resident #55's blood sugar. At 4:52 PM, Nurse #3 entered Resident #92's room to check her blood sugar with the same glucometer. The glucometer had not been cleaned after use on Resident #55. Nurse #3 was asked to step into the hall at this time. Nurse #3 was interviewed on 4/5/11 at 4:52 PM, prior to obtaining the blood sample from Resident #55. Nurse #3 indicated that there was one glucometer on the medication cart. Nurse #3 indicated that she was unaware that the glucometer needed to be cleaned and disinfected between residents. Nurse #3 indicated that she would speak with the Staff Development Coordinator (SDC) for further instructions before obtaining any more blood samples. During an interview on 4/4/11 at 5:10 PM, the SDC stated that glucometer was to be cleaned between residents using germicidal wipes that came with the glucometer. 2. Review of the directions on the germicidal wipe package read in part, "A 5 minute contact is required for effectiveness." "Allow surface to air dry." On 4/7/11 at 11:33 AM, Nurse #2 was observed obtaining Resident #92's blood sugar. Upon completion at 11:34 AM, Nurse #2 wiped off the glucometer using a germicidal wipe. At 11:37 AM, Nurse #2 obtained a blood sugar from Resident #73 using the same glucometer. Upon completion at 11:38 AM, Nurse #2 wiped off the glucometer using a germicidal wipe. At 11:40 AM, Nurse #2 approached Resident #244 with the same	F 441	4. Staff Development Coordinator/Unit Managers will observe skills technique for nurses doing glucometer disinfecting. Infection Control surveillance will be completed to ensure appropriate isolation signs are posted and according to precautions of Infection Control Program. The skills observation of glucometer disinfection and Infection Control Surveillance will be monitored weekly. Findings reviewed monthly x3 thru QI Committee.	5/5/2011

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F 441	Continued From page 21 glucometer to obtain a blood sugar. Nurse #2 was interviewed on 4/7/11 at 11:40 AM, prior to obtaining the blood sample from Resident #244. Nurse #2 indicated that she was inserviced the previous day on cleaning and disinfecting the glucometer between residents, but did not recall having to wait 5 minutes and allowing the surface to dry. The facility's Infection Control Policy and Procedure on Multi Drug Resistant Organisms (MDROs) dated 02/01/10 was reviewed. The policy and procedure did not mention what isolation sign to use for residents on contact isolation. 3. Resident #172 was admitted to the facility on 05/08/10 with multiple diagnoses including Cellulitis and Abscess of the leg. Review of the resident's records revealed a doctor's order dated 04/01/11 for " Contact isolation for MRSA (Mithicillin Resistant Staphylococcus Aureus) on the leg ". On 04/05/11 at 4:40 PM and 04/06/11 at 9:45 AM, a sign on the door was observed. The sign read " Please see Nurse before entering ". On 04/06/11 at 9:46 AM, Nurse #1 was interviewed. She stated that the sign on the door was to alert the family that the resident was on isolation and to see the nurse before entering the room. She further stated that the sign " Please see nurse before entering " indicated that the resident was on isolation. She indicated that Resident #172 was on contact isolation for MRSA on her leg.	F 441		

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F 441	Continued From page 22 On 04/06/11 at 3:50 PM, the infection control nurse was interviewed. She stated that the facility uses the sign " Please see Nurse before entering " if the resident was on isolation. She identified three residents (Residents # 172, #95 & # 194) with MRSA and they were on contact isolation. 4. Resident # 95 was admitted to the facility on 09/17/10 with multiple diagnoses including Cellulitis and Abscess of the leg " . Review of the resident's records revealed that on 02/02/11, there was a doctor's order for " contact isolation for MRSA in wounds " . On 04/05/11 at 4:40 PM and 04/06/11 at 9:45 AM, a sign on the door was observed. The sign read " Please see Nurse before entering " . On 04/06/11 at 9:46 AM, Nurse #1 was interviewed. She stated that the sign on the door was to alert the family that the resident was on isolation and to see the nurse before entering the room. She further stated that the sign " Please see nurse before entering " indicated that the resident was on isolation. She indicated that Resident #95 was on contact isolation for MRSA on her leg. On 04/06/11 at 3:50 PM, the infection control nurse was interviewed. She stated that the facility uses the sign " Please see Nurse before entering " if the resident was on isolation. She identified three residents (Residents # 172, #95 & # 194) with MRSA and they were on contact isolation. 5. Resident #194 was admitted to the facility on	F 441		

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F 441	Continued From page 23 11/04/10 with multiple diagnoses including Staph (staphylococcus) on R (right) ear. On 04/05/11 at 4:40 PM and 04/06/11 at 9:45 AM, a sign on the door was observed. The sign read " Please see Nurse before entering " . On 04/06/11 at 9:46 AM, Nurse #1 was interviewed. She stated that the sign on the door was to alert the family that the resident was on isolation and to see the nurse before entering the room. She further stated that the sign " Please see nurse before entering " indicated that the resident was on isolation. On 04/06/11 at 3:50 PM, the infection control nurse was interviewed. She stated that the facility uses the sign " Please see Nurse before entering " if the resident was on isolation. She identified three residents (Residents # 172, #95 & # 194) with MRSA and they were on contact isolation.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to maintain a clean sanitary nourishment refrigerator for 1 of 2 nourishment rooms. The finding includes: Review of the Policy titled " 5.7 Refrigerated/Frozen Storage " and dated as	F 465	F 465 1. Refrigerators in both nourishment rooms are clean and sanitary. 2. Nourishment rooms will be clean and sanitary. Refrigerator and freezer will be cleaned daily by assigned housekeeper. 3. Environmental service staff will be inserviced on policy and procedure. 5.7 Refrigerator/frozen storage. Environmental staff will be aware of assigned duties.	5/5/2011 5/5/2011 5/5/2011

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F 465	Continued From page 24 revised on 6/15/05 revealed " 1.9 Refrigeration units are kept clean and organized. Cleaning is routinely scheduled and completed. " On 4/7/11 at 2 PM, the nourishment refrigerator on B unit was observed to have dried brown, beige, pink and white matter as well as beige crumbs on all the clear plastic in door shelves. The inside bottom shelf had an approximately 4 inch by 2 inch area of dried yellow matter and both interior clear plastic shelves had a hazy film and there were random smudges and apparent spill marks on the overall interior. The food stored in the refrigerator included 1 bowl pudding, 3 individual milk cartons, 4 individual yogurt containers, 1 boost drink and 5 salad dressing packets. The freezer was noted to have dried rusty brown matter covering approximately one quarter of the bottom of the freezer and the frost on the top of the freezer ranged from 1 - 3 inches thick. There was no food stored in the freezer. On 4/7/11 at 2:21 PM, LPN (License Practical Nurse)#1 stated that housekeeping was responsible for cleaning the nourishment refrigerator. On 4/7/1 at 2:23 PM, Housekeeping Aide #1 stated that the Housekeeping Aide who is assigned to hall 500 was responsible for cleaning the nourishment refrigerator. On 4/7/11 at 2:25 PM, Housekeeping Aide #2 stated she just took over 500 Hall on Monday 4/4/11 and did not know if she was responsible for cleaning the nourishment refrigerator. She asked Housekeeping Aide #3 who was also present. Housekeeping Aide #3 indicated that as	F 465	4. Refrigerator/freezers to be monitored for clean, functional and sanitary environment. Environmental rounds and sanitation checks will be done weekly x3 months. Findings brought to QI for quality improvement.	5/5/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 25 the Housekeeping Aide for 500 Hall Housekeeping Aide #2 was responsible for cleaning the nourishment refrigerator. Housekeeping Aide #3 stated that she had been responsible for cleaning the other nourishment refrigerator on A unit up until their assignments changed on 4/4/11. Both Housekeeping Aides noted that their assignments rotated every 3 months. Housekeeping Aide #3 indicated that the nourishment refrigerator should be checked every day to ensure it is clean and cleaned as needed. Housekeeping Aide #2 stated that when they rotate assignments it often takes a couple of weeks to learn the requirements of the new area. Interview with the Administrator on 4/7/11 at 3:17 PM revealed her expectation is that the nourishment refrigerators are cleaned regularly. Telephone Interview with the Environmental Service Director on 4/18/11 at 2:15 PM revealed that the assignments were different for the Housekeeping Aids on each hall and the job responsibilities for each assignment were posted on the Laundry Room bulletin board. She further stated that the Housekeeping Aid on 500 Hall was responsible for keeping the nourishment refrigerator on B unit clean.	F 465		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors; such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 8:00am onward, there is non-passage hardware on exit access door from mechanical room adjacent to electrical room - located near room 601. The hardware required special knowledge for releasing locking mechanism from inside the room.	K 018	A. A handle was ordered on 5-18-11. Maintenance staff installed handle On 5-19-11. 5-20-11 B. All mechanical rooms have been Inspected to ensure proper latching Hardware. C. Maintenance Dept. will inspect all All doors as outlined in the preventive Maintenance manual monthly. D. The maintenance director will report Any problems to the Administrator.	
K 147 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

RECEIVED
JUN 10 2011
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deangelea Moore BSNHA — TITLE — (X6) DATE: 6-6-11

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 8:00am onward, there is a relocatable power tap used in resident room 319. Extension cords and relocatable multioutlet extension cords are not permitted in patient care areas of health care facilities. 42 CFR 483.70(a)	K 147	A.Maintenance Dept. removed extension cord On 5-18-11. and inspected room for other cords. B. All Customer rooms have been inspected For extension cords. 5-20-11 C.Maintenance Dept. will inspect customer rooms Monthly as outlined in the Preventive Maintenance Manual. D.The Maintenance director will report any findings To Administrator. .	