STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 166 SS=D	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 observations, resident interview, staff interviews and record review, the facility failed to respond to repeated verbal grievances for 1 of 3 (Residents #151) sampled residents who reported concerns about getting assistance with his computer and cell phone. Findings included: Resident #151 was readmitted to the facility on 6/2/10. The resident's cumulative diagnoses include seizure disorder, spasticity, chronic pain and depression. The quarterly Minimum Data Set (MDS) dated 3/17/11, indicated the resident had no short term memory or long term memory problems or decision making problems. The MDS indicated that resident #151 required total assistance with all activities of daily living. He had impaired range of motion on both sides of upper and lower extremities. During an interview and observation on 5/9/11 at 12:20PM, Resident #151 was lying in bed with oxygen tube in place. A laptop computer was on night stand with headset attached. He stated that he spoke with the unit manager and Social Workers (SW) about getting assistance with dialing numbers on the cell phone. Resident #151	F 166	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. F-166 1. Resident # 151 was interviewed on 05/31/11 by the Administrator and 2nd Floor Unit Coordinator to identify and address any outstanding concerns. 2. The Social Service Director conducted a 100% audit on 5/25/2011 of resident concerns that had been logged for the previous 30 days to ensure that they all have been resolved. A 100% audit of all facility residents was conducted on 6/3/2011 by the Director of Nursing, Unit Coordinators, Dietary Director, Social Service Director, and Social Workers to ensure there are any undocumented or unresolved concerns are resolved. 3. An inservice for all licensed nurses and certified nursing assistants and employees of the Social Services Department, Dietary Department, Therapy Department, Maintenance and Housekeeping Department, Activities Department and administrative office staff was conducted on 05/23/11 through 05/31/11 by the Director of Nursing, Social Services Director and Staff Development Coordinator regarding the concern/comment process and policy.	6/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Raymond Cooper	Administrator	6/9/11

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 166	Continued From page 1 stated that he had an ear piece for the phone. The staff was only allowed to put the head piece on and start the computer. If the computer freezes he needed assistance with restarting the computer. He was told that activity director could assist with the computer. He indicated that he uses his computer any time of the day when he feels like. In order to get staff assistance to use the computer he has to use the call bell to get staff assistance. The voice activation is set up at 4 hours at a time before it goes to energy saving mode. He stated that he would like to start using it in the morning. Sometimes during the 4 hour period the computer will shut down and needs to restart. A scheduled time was established with activity director (1:1 visit) at one point when he needed to make a phone call but it has not been consistent. During an observation on 5/9/11 at 12:54 PM, Resident #151's cell phone rang four staff (2 nurse Aides and 2 administrative staff #1 and #2) were outside of the room passing out lunch. The four staff were observed standing in front of resident's room as the phone rang, no staff entered the room to answer the call. The call light was attached to the top of bed in which it was out of reach for the resident to roll head to activate. Computer equipment was pushed away out of reach on a side table. The cell phone was being charged on top of the light and the ear piece was dangling on the floor. Resident#151 indicated that he has to constantly tell the DON and administrator about his concerns with the phone and the computer, but " they do nothing to help me use it by myself. I wouldn't bother them if I could do it myself. "	F 166	4. The Social Services Director will conduct audits of all concerns and comments received to ensure they are responded to and addressed. These audits will be conducted daily, five days per week for four weeks, twice weekly for four weeks then two times a month for two months and/or 100% compliance. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Social Services Director and will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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F 166	Continued From page 2 During an interview on 5/9/11 at 1:12PM, the community support agency indicated that she felt the computer and cell phone issue was resolved because he did receive the cell phone and the computer. The concern with the cell phone was that he wanted to call his daughter after 8:00pm. Activities staff would assist during the day when he rang the call light to let them know he needed to make a call. The community support staff indicated the facility had established a schedule and did an in-service with staff. She also indicated that she thought the facility had been monitoring and assisting the resident with the cell phone access. She added that the resident had recently received the computer and that he needed assistance with applying the headset and turning on the computer. During an interview on 5/11/11 at 12:15PM, the primary SW for Resident #151 indicated that Resident #151 had complained to her several times regarding not getting assistance with his computer or his cell phone. She indicated that when Resident #151 reported these concerns to her regarding the cell pone and the computer she completed a grievance form and submitted the information to her immediate supervisor, Administrator, Unit Manager (UM) and the Director of Nurses (DON). She further stated that it was discussed during the standup meeting, but she did not know whether there was any follow-up or monitoring occurring once she submitted the grievance to the appropriate department head. She indicated that the action plan was that activity staff would assist the resident and in the absence of the activity staff the nursing staff would assist Resident #151 when he used the call light. In addition, when nursing staff was unable to assist,	F 166		

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F 166	Continued From page 3 the social workers (SW) were responsible for assisting. However, she was uncertain how this was being monitored or tracked. She added that she was also uncertain whether the concern following the grievance process was resolved for Resident #151. She stated that she only fills out the grievance. The facility concern reports (grievance) dated 10/28/10 were reviewed. Concerns were documented as not receiving assistance with cell phone. Response was the resident was able to use phone as needed with assistance from social worker or activities according to plan, on 11/19/10, documented the concern as: turning and reposition and assistance with cell phone. The response was that resident dials phone to call director of nursing or social worker, but cannot dial when he needs to, so the Activities staff had a program set-up for phone use with resident. Review of correspondence between the facility and the community support staff dated 2/16/11 and 2/22/11, revealed a continuation of concerns with getting assistance from nursing assistants to use the cell phone from staff and staff reporting to resident that they were told by administrator that they could not assist the resident with the use of the cell phone. The response from the facility was the nursing assistants would assist with calls when their time permitted and it did not interfere with the care of others. A scheduled in-service would be provided to all nursing assistants to understand and acknowledge the information. On 3/14/11, the documented concern was staff would not dial a phone number on cell phone. The response was the resident was assisted with the use of the cell phone on 5 different times and did not use the	F 166		

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F 166	Continued From page 4 phone between 8-9PM. Review of the in-service records dated 2/21/11, titled provide care and assistance with cell phone only had 14 staff on sign in sheet. There were no other in-services presented regarding the resident's assistance with cell phone. The last noted in-service was dated 12/20/10 on abuse and neglect. Review of the MAR from January 2011-March 2011, was inconsistent with phone logs. The phone logs revealed a variation of calls throughout the day. The log does not reveal whether calls were answered. The MAR was the location nursing staff documented when they assisted Resident #151 with phone calls. During an interview on 5/11/11 at 1:49PM, the unit manager(UM) indicated that a journal was kept on the unit for Resident #151 in which staff was responsible for documenting anytime a service was provided for him. The journal would include any nursing care and assistance with using the phone or computer. She added that the nursing notes would also include this information. She further stated that she was the only person who had access to Resident #151 cell phone password/account and a telephone log was kept of the calls he received. She added that the phone was set up for voice activation, however he would need assistance to dial and answer the phone. An ear piece was available for the phone use and a head set was available for the computer. She further stated that all Resident #151 had to do was use his modifed call light to let staff know that he needed assistance with making calls. She indicated that on the	F 166		

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F 166	Continued From page 5 medication administration record(MAR) the nursing staff should be documenting between 8-9pm of when they assist Resident #151 with using the cell phone. She also indicated that the call light should be in reach, headset should be placed on resident's head daily and the computer should also be within reach for access. She further stated that several discussions had been held with Resident #151 social workers, community support staff, DON, nursing staff and administrator on how to handle Resident #151 concerns of not having access/assistance with the phone or computer and how to resolve the issue to Resident #151's satifaction. She indicated that the process included that activity staff would assist Resident #151 during the 1:1 visits and upon request for use the phone, in the absence of the activity staff, the nursing staff would also assist the resident and department was third back up. She was uncertain of what the monitoring process for ensuring that whether all parties were following up on the assistance with the phone or computer access. She added that when she reviewed the phone log Resident #151 averaged 4-5 calls per day with assistance from staff. She further stated that once the voice activation was set up it was agreed with Resident #151 that all he had to do was to use the call light and let staff know he wanted to make a call, however, if the nursing assistants/nursing staff was assisting other residents during meals, shift change, etc., then activities or SW would assist. She also indicated that she was unware that he was not receiving assistance with the computer. . During an interview on 5/11/11 at 3:45PM, the DON indicated that a journal was kept where the nursing staff was expected to document all the	F 166		

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F 166	Continued From page 6 care/treatment that was provided to the resident. Nursing was also expected to document during the evening on the MAR of when assistance was provided for phone calls. She added that an in-service was done with nursing to address the telephone concerns and how to administer care to the resident. Review of the in-service record dated 2/21/11, revealed 5 nursing staff and 9 NA were in-serviced. She added that staff did rotate floors. She indicated that the activity staff was expected to assist with the calls during the day. She was uncertain whether activity staff was consistently performing this process. In addition, she added that the unit supervisor was responsible for ensuring nursing was assisting the resident at night. DON added that the care plan should reflect what was expected of the staff in meeting the needs of the resident. After review of the call pattern and the care plan and grievance log, the DON indicated some monitoring and changes should have occurred to ensure the resident was getting the assistance needed. During an interview on 5/11/11 at 4:15PM, the Administrator indicated that he expected the staff to assist the resident with using the telephone and the computer. The telephone and computer should be accessible for the resident and staff should be following the established plan. He also indicated after review of care plan that the care plan should be specific to his needs and designated staff would be assigned to monitor and check status and meet the resolution process of the grievance procedures.	F 166		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		

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

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F 246	Continued From page 7 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interview, the facility failed to provide assistance and modify 1 of 1 sampled resident's personal equipment(cell phone and computer) to assist with maintaining his level of independence for a physically challenged individual. (Resident #151). Resident #151 was readmitted to the facility on 6/2/10. The resident's cumulative diagnoses include quadriplegic, seizure disorder, spasticity, chronic pain and depression. The quarterly Minimum Data Set (MDS) dated 3/17/11, indicated the resident had no short term memory or long term memory problems or decision making problems. The MDS indicated that resident #151 required total assistance with all activities of daily living. He had impaired range of motion on both sides of upper and lower extremities. The MDS also indicated that Resident #151 also needed assistance with socialization. Reviewed care plan dated 3/25/11, read in part: 1. Resident is at risk for decreased socialization due to being bed bound. Resident requires in-room visits with 1:1 interaction to maintain socialization and mental awareness. The goal	F 246	F 246 1. The Certified Nursing Assistants and the Licensed Nurses assigned to resident #151 were immediately inserviced on 5/11/11 by the Director of Nursing on ensuring that resident #151 was assisted with utilizing his personal equipment. 2. A 100% audit was conducted by the Activities Director on 05/16/11 to identify all residents that utilize personal equipment and to determine if any of these residents required staff assistance in utilizing their personal equipment. No other residents were found to be affected 3. An inservice was conducted by the Director of Nursing and the Staff Development Coordinator on 05/27/11 through 05/31/11 for all licensed nursing staff and certified nursing assistants regarding the procedure of assisting residents who have been identified or have requested assistance with using personal equipment. 4. An audit of all residents that require assistance with utilizing personal equipment to ensure that they have assistance when requested will be conducted by the Director of Nursing and Social Service Director daily, five times per week for two weeks, then three times weekly for two weeks, then weekly for two months and/or 100% compliance. The results will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	6/3/11

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F 246	Continued From page 8 was the resident will actively participate with in-room visits and socialization at least once weekly through next review. The approaches include offer visits to resident being mindful of treatment ties, activity of daily living, meals and rest periods, offer magazines, music, word games, trivia sheets, and/other activities for residents' choice, involve reside resident in discussion of current events as tolerated, offer refreshments from activities within dietary restrictions, offer a copy of and to read the resident council minutes to the resident, offer to review and read resident's mail as desired, offer other activities of choice, on 9/21/10: staff will assist resident in using cell phone s time allow not to interfere with direct resident care of daily duties. If resident request assistance with laptop act still will be available to assist during weekly in room visits, other staff may also assist upon request if time permits not to interfere with daily work task. During an observation on 5/9/11 the cell phone ring at 12:54PM 4 staff(2 NA and 2 administrative staff#1 and#2) outside of room passing lunch. The 4 staff were observed standing in front of resident's room as the phone rang, no staff entered the room to answer the call. The call light was attached to the top of bed in which it was out of reach for the resident to roll head to activate. Computer equipment was pushed away out of reach on side table. The cell phone was being charged on top of the light and the ear piece was dangling on the floor. Resident#151 indicated that he has to constantly tell the DON and administrator about his concerns with the phone and the computer but they do nothing to help me use it by myself. I	F 246		

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F 246	Continued From page 9 wouldn't bother them if I could do it myself. During observation on 5/10/11 at 9:00AM, the cell phone was on the charger on top of the light fixture. The head set to the computer was hanging on side of bed and computer was on night stand across the room, the ear piece to telephone was under the resident's body. The phone rang and there were two nursing assistants and two nursing staff in the hall. No-one entered the room. All were standing in from of Resident #151 room. The call light was position above Resident #151's head out of turn reach During an observation on 5/10/11 at 3:40PM, the resident's call light was positioned above head, computer with head set on night stand at foot of resident 's bed. The cell phone was on top of light fixture. During an observation 5/11/11 at 11:21AM, the cell phone was on top of light fixture, ear piece on floor, computer at foot of bed and call light fixed to bed at shoulder level. During an interview on 5/11/11 at 12:15PM, primary SW for Resident #151 indicated that Resident #151 had complained to her several times regarding not getting assistance with his computer or his cell phone. She indicated that when Resident #151 reported these concerns to her regarding the cell pone and the computer she completed a grievance form and submitted the information to her immediate supervisor, Administrator, Unit Manager(UM) and Director of Nurses(DON). She further stated that it was discussed during the standup meeting but she did	F 246		

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F 246	Continued From page 10 not know whether there was any follow-up or monitoring occurring once she submitted the grievance to appropriate department head. She indicated that the action plan was that activity staff would assist the resident and in the absence of the activity staff the nursing staff would assist Resident #151 when he used the call light. In addition, when nursing staff was unable to assist the social workers(SW) were responsible for assisting. However, she was uncertain how this was being monitored or tracked. She added that she was also uncertain whether the concern following the grievance process was resolved for Resident #151. She stated that she only fills out the grievance. During an interview on 5/11/11 at 1:49PM, the unit manager(UM) indicated that a journal was kept on the unit for Resident #151 in which staff was responsible for documenting anytime a service was provided for him. The journal would include any nursing care and assistance with using the phone or computer. She added that the nursing notes would also include this information. She further stated that she was the only person who had access to Resident #151 cell phone password/account and a telephone log was kept of the calls he received. She added that the phone was set up for voice activation, however he would need assistance to dial and answer the phone. An ear piece was available for the phone use and a head set was available for the computer. She further stated that all Resident #151 had to do was use his modifed call light to let staff know that he needed assistance with making calls. She indicated that on the medication administration record(MAR) the nursing staff should be documenting between	F 246		

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F 246	Continued From page 11 8-9pm of when they assist Resident #151 with using the cell phone. She also indicated that the call light should be in reach, headset should be placed on resident's head daily and the computer should also be within reach for access. She further stated that several discussions had been held with Resident #151 social workers, community support staff, DON, nursing staff and administrator on how to handle Resident #151 concerns of not having access/assistance with the phone or computer and how to resolve the issue to Resident #151's satifaction. She indicated that the process included that activity staff would assist Resident #151 during the 1:1 visits and upon request for use the phone, in the absence of the activity staff, the nursing staff would also assist the resident and department was third back up. She was uncertain of what the monitoring process for ensuring that whether all parties were following up on the assistance with the phone or computer access. She added that when she reviewed the phone log Resident #151 averaged 4-5 calls per day with assistance from staff. She further stated that once the voice activation was set up it was agreed with Resident #151 that all he had to do was to use the call light and let staff know he wanted to make a call, however, if the nursing assistants/nursing staff was assisting other residents during meals, shift change, etc., then activities or SW would assist. She also indicated that she was unware that he was not receiving assistance with the computer. During an interview on 5/11/11 at 2:20PM, the SW director indicated that the recurrent concerns were getting assistance using the cell phone. The process for resolving the issue was that activity staff would assist him during the day and nursing	F 246		

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	345092	A. BUILDING _____ B. WING _____	C 05/12/2011

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F 246	Continued From page 12 staff would assist him during the evening hours and SW was the back-up. She added that the resident continuously submits grievance concerning his computer or the cell phone, however she was uncertain how to resolve the issue for him. She was also uncertain who was monitoring whether the resident was actually receiving assistance. When asked who was responsible for follow-up with resident regarding his satisfaction or completion of the grievance she had no response. During an interview on 5/11/11 at 2:20PM, the activity director indicated that she was scheduled to visit with the resident 1x a week to do 1:1 activities. The activities included assisting with phone calls, and activities of resident's choice. Review of the 1:1 participation record for Feb, March and April reveal that 1:1 activities were occurring. She added that she would also assist the resident with phone calls upon request. She added that she documented these calls in the general notes. Review of the activity notes revealed that May 1 call was made, April=2, March =1 Feb=4, Jan=5. Review of the telephone log revealed at the time indicated assistance was provided by activities did not match the presented call log. During a follow-up interview on 5/11/11 at 2:20PM, the unit manager indicated that the call pattern was established on the MAR for 8-9pm, because that was the time frame in which the resident stated that he wanted to call his family, therefore the nursing staff was instructed to assist him upon request during this hour. She indicated that the expectation was that nursing staff document on the MAR of when this assistance was provided. Review of the MAR and the	F 246		

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F 246	Continued From page 13 telephone log did not match what was reported as assistance by nursing during this hour. She added that she was uncertain who was monitoring to ensure whether the resident was receiving assistance. Reviewed the care plan and she indicated that assistance would be provided as long as it didn't interfere with the care of other residents. She further stated the care plan should be more specific to the resident's call pattern requests and follow-up should be done to ensure assistance was being provided. During an interview on 5/11/11 at 3:25PM, Nurse #4, Nurse#5 and Nurse#6. Nurse#6 indicated that nursing staff was expected to document on the MAR when they assisted the resident with making phone calls. Nursing also should document in the journal all other services/treatment that was provided. The headset should be kept on the resident or on the pillow or in the computer for easier access. The call light should be positioned so that the resident could turn his head to access. The cell phone was voice activated but he did need assistance to dial and answer the phone. She indicated that she had assisted him in making calls when he told her who he wanted to call. She indicated that she did not know how to operate the computer and the only thing she did was ensure the computer was close and the headset was in place. Nurse#4 indicated that she knew that nursing was to document on the MAR when they provided assistance with phone calls. She added that she had not assisted the resident with phone or computer. Nurse#5 indicated that she had assisted the resident with the use of the phone and making sure the headset for the computer and phone were in place. The resident was able	F 246		

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F 246	Continued From page 14 to use the call light without difficult to let staff know his needs. Staff was expected to ensure that the ear piece and headset and computer were close enough for the resident to access. Calls were documented on the MAR and care in the journal. During a follow-up interview with Resident #151 on 5/11/11 at 3:30PM, Nurse#7 was present. Resident #151 indicated that Nurse #7 had assisted him with using his cell phone and ensuring that his headset was in place and the computer was on. Resident #151 acknowledged that Nurse #7 was one of few that did assist him in this area. Resident #151 indicated that all he wanted for was staff to ensure that he made his phone calls when he needed and the head piece for the phone/computer was within reach. He indicated that many times the phone would ring and he would push the call light to get staff to come in and answer the phone but no-one would come, so he had to wait until someone came by to recall the number because he could not answer the phone. Resident #151 stated that because his family was on a different time zone he needed assistance between 7-9pm to make these calls and it does not always happen even when he uses the call light. Staff tended to ignore the call light. During the day when he needs to make his local calls activities was busy and nursing assistance would not assist because they were told that only the nurse's could do it. "It just gets me real upset and angry that the nursing doesn't assist me when I need them to all I want was for them to dial the number. Same thing with my computer, all they have to do was turn it on and make sure I have my headset on. Sometimes my headset is across the room. Everybody keeps	F 246		

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F 246	Continued From page 15 telling me they don't know how to operate the computer, they could be trained on how to turn it on and unfreeze the screen when I need it." He added that nurse #7 was the only one who was consistent with helping with the computer. During a follow-up interview on 5/12/11 at 8:00AM, the DON presented an action plan to changes in Resident#151 access and assistance to use the cell phone and computer. She indicated that she would be contacting outside sources to assist with obtaining assistive devices for resident to use a hands free device for computer and staff would be assigned to assist resident with computer and cell phone usage.	F 246		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, family interviews and record review the facility failed to maintain an environment free from lingering odors on 3 of 5 floors (2nd, 3rd and 4th floors). Findings include: A strong lingering (to remain existent) odor of urine was noted on the 4th floor (long hall) on 5/9/11 at 12:15PM. The lunch meal was being	F 252	F 252 1. An audit was conducted on 5/11/11 and 05/12/11 by the Housekeeping Manager Administrator, and Director of Nursing to ensure there were no odors on 2nd, 3rd, and 4th floors. 2. An audit was conducted by the Housekeeping Manager on 05/12/11 to ensure there were no odors in the facility. No residents were found to be affected. 3. The Staff Development Coordinator conducted an inservice on 05/12/11 through 05/31/11 for all licensed nurses and certified nursing assistants on identifying and removing the source of odors. An In-Service was conducted for facility housekeepers by the Housekeeping Director on 05/14/11 to ensure that sources of odors are identified and removed timely. 4. A daily audit for odors on all floors and elevators will be conducted by the Housekeeping Manager three times daily, five days per week for four weeks, then	6/3/11

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F 252	Continued From page 16 served at the time. A lingering stool odor was noted on 5/9/11 at 3:10PM on the 3rd floor (short hall). On 5/9/11 at 4:55PM, a strong foul odor was noted down the length of the long hall on the 4th floor. During an interview on 5/10/11, at 9:06AM, resident #234 indicated there were times when a lingering odor of stool was noted on the 4th floor. A family member of resident #123 was interviewed on 5/10/11 at 8:45AM. The family member indicated they visited a couple of times a week and noticed the 4th floor smelled like "sickness" when they visited. The family member described the smell as being like "pus from a boil." On 5/10/11 at 2:53PM, a strong lingering stool odor was noted on the 3rd floor (short hall). A lingering strong stool smell was noted on the 2nd floor (long hall) during a continuous observation from 10AM to 11:20AM on 5/11/11. An interview was conducted on 5/12/11 at 8:23AM with housekeeper (HK) #1. The HK indicated her daily routine started with wiping the dayroom tables. She then begins sweeping, moping and emptying the trash. While the breakfast trays are on the hall, HK #1 cleans the employee restroom, the kitchen (snack) area. Once the trays for breakfast were removed from the floor, she would then proceed into resident rooms. The HK stated she would clean surfaces	F 252	daily for two months and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Administrator. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director .	

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F 252	Continued From page 17 such as windowsills, the air conditioner unit, and sweep and mop each room. She stated the facility usually deep cleaned one to two rooms during the week. HK #1 stated she did notice odors in the facility. When asked what type of measures the facility used to combat odors HK #1 stated her supervisor informed the HK staff not to use air fresheners due to some of the residents not being able to tolerate them. She did indicate they used a disinfectant to cut down on the odors. HK #1 stated the nursing assistants would sometimes spray air freshener in the hallways but she did not know where they got it. During an interview on 5/12/11 at 9:41AM, the HK supervisor indicated the facility used a "foul odor digester" to combat odors in the facility. He stated the foul odor enzymatic was what the HK staff had been using this week. The HK supervisor indicated the gray and yellow bins (for soiled linens and soiled incontinent products) on the hallway were to be emptied every two to three hours. The lids on the bins should be closed. The HK supervisor stated he was not aware of any concerns the resident or family members might have in regards to lingering odors. On 5/12/11 at 11:20AM, a strong lingering odor of urine and stool was noted on the 3rd floor (short hall). On 5/12/11 at 1:07PM, an odor of urine was noted on the 3rd floor by the elevators and down the short hallway on the 3rd floor. An interview was conducted with the director of nursing (DON) on 5/12/11 at 2:19PM. The DON indicated she expected the facility to be free from	F 252		

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F 252	Continued From page 18 lingering foul odors.	F 252	F 253	6/3/11
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that heating and air units in the resident's rooms were clean for 50 of 123 resident rooms. Resident rooms that were directly observed with large volumes of dust/food debris were as follows: 200, 201, 203, 205,213,214,221,218,208,227,226,230,209,300,305,306,301,302,304,312,311,313,326,329,314,315,400,407,412,424,425,417,409,410,418,411,413,426,412,429,520,522,524,530,529,528,521,513,505,515. During initial tour on 5/9/11 at 10:35AM to 11:00AM, the following resident rooms, 200, 201,203,205,213,214,221,218,208,227,226,230,209,300,305,306,301,302,304,312,311313,326,329,314,315,400,407,412,424,425,417,409,410,418,411,413,426,412,429,520,522,524,530,529,528,521,513,505,515. The heating and air systems were observed with dirty grey build up, food particles inside and outside of the heating system. During a follow-up observation on 5/10//11 at 10:54 AM to 11:45AM, of the identified rooms 200, 201, 203, 205, 213, 214, 221, 218, 208, 227, 226, 230, 209, 300, 305, 306, 301,302,304,312,311,313,326,329,314,315,400,4	F 253	1. The heating and air units in rooms 200, 201, 203, 205, 213, 214, 221, 218, 208, 227, 226, 230, 209, 300, 305, 306, 301, 302, 304, 312, 311, 313, 326, 329, 314, 315, 400, 407, 412, 424, 425, 417, 409, 410, 418, 411, 413, 426, 412, 429, 520, 522, 524, 530, 529, 528, 521, 513, 505, 515 were cleaned on 05/12/11 by the Housekeeping Director. 2. A 100% audit of all facility heating and air units was conducted by the Housekeeping Manager on 05/11/11 and 05/12/11 to ensure all facility heating and air units were clean. 3. The Housekeeping Manager conducted an inservice for all housekeeping staff on 05/18/11 on cleaning techniques and the schedule for cleaning heating and air units within the building. 4. A weekly audit of twenty-five heating and air units on all floors and will be conducted by the Housekeeping Manager to ensure that the units are clean. This audit will be conducted weekly times four weeks, then monthly for four months and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by Administrator. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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F 253	Continued From page 19 07,412,424,425,417,409,410,418,,411,413,426,412,429,520,522,524,530,529,528,521,513,505,515. The heating and air units had large volumes of dust/food debris. During observations on 5/11/11 at 10:50AM-11:22AM, tour of the facility with maintenance were done in the following resident rooms 200, 201, 203, 205,213, 214, 221, 218, 208, 227, 226, 230, 209,300,305,306,301,302,304,312,311,313,326, 329,314,315,400,407, 412,424,425,417,409,410,418,411,413,426,412,, 429,520,522,524,530,529,528,521,513,505,515. During the tour the heating and air systems were also checked and the systems had large heavy volume of grey dust build up and food particles inside and outside of the system. The maintenance director wiped hands across the outside of systems and checked inside the units and stated that maintenance was responsible for cleaning the vents inside and housekeeping should be cleaning and wiping down the outside on a daily basis. He further stated there was a consistent pattern that the units were no being done on a regular basis. During the observation several housekeeping staff were observed cleaning resident rooms, however, none of the heating systems were cleaned of wiped down. During an interview on 5/11/11 at 11:15AM, the housekeeping director indicated that he expected the housekeeping staff to do routine cleaning which included empty trash, dust resident dressers, clean bathrooms, wipe down heating systems daily, sweep/mop. Maintenance was responsible for cleaning out the vents in the heating systems. Maintenance director pointed out to housekeeping director the many heating	F 253		

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F 253	Continued From page 20 systems had large volumes of grey matter and food particles on the inside and outside of the system. Maintenance stated to housekeeping director during the tour that on all the floors the heating systems had not been thoroughly been cleaned. During an interview on 5/11/11 at 11:50AM, housekeeper(HK#2) indicated that she was responsible for sweeping/mopping, dusting resident rooms, furniture. She indicated that she was also responsible for cleaning the front and outside of heating system once a week. She was asked whether she had cleaned the heating system, where she was working she stated no and after observation stated it needed a good cleaning. During an interview on 5/11/11 at 12:00PM, HK#1 indicated that there was 1-2 HK's per floor sometimes just one and the hall assignment was split. She added that the only time the heating systems were cleaned was when the room was scheduled for a deep cleaning. She added then the fronts of the heating systems would be wiped down by the housekeeping. She indicated after observations of her assigned rooms that she had not cleaned the heating system. During an interview on 5/12/11 at 7:20AM, HK#3 indicated she was responsible for cleaning window sills, bed frames, light fixtures, sweep/mop,clean the front of the heating system. She indicated that she did not always clean them. During an interview on 5/12/11 at 8:25AM, HK#4 indicated that she was expected to empty trash wipe down window sills, and heating system. She	F 253		

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F 253	Continued From page 21 indicated that she had not been doing them prior to in-service. Maintenance was responsible.	F 253	F 280	
F 280 SS=G	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 staff interviews and record review the facility failed to update the care plan for 1 of 1 resident with urethral erosion. (Resident #277) Findings include: Resident #277 was re-admitted to the facility on 4/18/11. His diagnoses included but were not limited to; hypertension, aphasia, right	F 280	1. The Director of Nursing assessed resident # 277 on 05/11/11. The catheter for resident # 277 was securely anchored by the licensed nurse on 05/11/11. The family was notified by the Wound Care Nurse on 05/12/11. The physician was notified of the on 05/12/11 by the Wound Care Nurse. The care plan for Resident #277 was updated on 05/12/11 by the Minimum Data Set Coordinator to reflect the resident's current plan of care. The Director of Nursing inserviced the MDS #1 and MDS #2 on updating care plans with changes in resident status, diagnosis, or orders. 2. A 100% audit of all residents who have indwelling catheters was conducted by the Wound Care Nurse on 05/13/11 to ensure that the catheters were securely anchored, assessed, and treatments as ordered. No other residents were found to be affected. A 100% audit of all resident care plans was conducted by the Minimum Data Set Coordinators on 05/27/011 for the previous thirty days to ensure that all new orders and diagnosis were updated on resident care plans. 3. An in-service was conducted by the Director of Nursing on 05/31/11 for all the facility Minimum Data Set Coordinators on the process of updating a resident's to reflect the resident's current plan of care. A facility directed inservice for all licensed nurses and certified nursing assistants regarding Urinary Catheter Use in Long-term Care was conducted on 06/03/11 by a state approved education agency. All licensed nurses and certified nursing assistants are required to attend prior to resuming their work schedule.	6/3/11

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F 280	Continued From page 22 hemiparesis, seizure disorder, aspiration pneumonia, pressure ulcer, diabetes and history of urinary tract infection. Review of the resident's care area assessment (CAA) summary, dated 1/27/11, revealed a CAA for "Urinary Incontinence and Indwelling Catheter." The indwelling catheter was in place on admission due to unstageable pressure ulcers on his sacrum and left hip. The CAA read in part, "Resident does have a catheter in place. He has several pressure ulcers to sacrum, hip, and lower extremities." He is at increased risk for pressure ulcers due to his impaired mobility, impaired cognition, incontinence, and existing pressure ulcers." Will proceed to care plan to help manage skin integrity and provide ADLs (activities of daily living). The CAA summary for pressure ulcer was dated 1/27/11. It was noted, "Resident was admitted to facility with several pressure ulcers to bilateral lower extremities, left hip, and sacrum." The most recent minimum data set (MDS), dated 4/28/11 revealed the resident had severe cognitive impairment. He was totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating, toilet use and bathing. He required extensive assistance for personal hygiene. Resident #277 had no noted behaviors on the MDS. The resident was incontinent of bowel and had an indwelling urinary catheter. Resident #277's care plan included a care plan, dated 5/6/11, for "Potential for infection related to use of indwelling catheter." The goal was for the resident not to experience any adverse effects related to the use of the indwelling catheter through the next review. The interventions	F 280	4. An audit will be conducted of all resident care plans to ensure resident's with new orders or new or updated diagnosis will be conducted daily, five days per week, for four weeks, then twice weekly for four weeks, then weekly for four weeks and/or 100% compliance. An audit of all residents with foley catheters to ensure securement of indwelling catheters will be conducted by the Director of Nursing and/or Unit Coordinators, Wound Care Nurse, and Nursing Supervisors every shift for fourteen days, then daily for fourteen days, then three times weekly for four weeks, then weekly for four weeks and/or 100% compliance. The results of these audits will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Committee Performance Improvement as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director	

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F 280	Continued From page 23	F 280		

included; catheter care every shift and as needed, maintain a closed drainage bag below level of bladder. Monitor for signs and symptoms of urinary tract infection: fever, and change in color, consistency, and odor of urine. The staff was to report any unusual findings immediately to the physician. A care plan titled "Potential for impaired skin integrity related to decreased mobility, contractures, pressure sore left hip, sacral wound and pressure ulcers to bilateral feet", dated 5/6/11, noted the goal was for the resident to not experience any adverse effects from any skin integrity issues through the next review. The interventions included; staff to report to nurse any red or open areas, ensure appropriate pressure relieving devices in place during repositioning. Monitor skin daily during care for any changes. Report any abnormal observations to the physician.

During an interview, on 5/12/11 at 1:37PM, MDS nurse #1 indicated if a resident had a wound (penile erosion) it should be noted on their care plan. MDS nurse #1 was not sure why the wound to the penis was not mentioned on the care plan.

An interview was conducted on 5/12/11 at 2:06PM with MDS nurse #3. She stated the care plans should be revised and updated at least quarterly and annually. MDS nurse #3 indicated if a resident had a wound, it should be noted on their care plan with interventions in place. The nurse was not sure why the penile erosion wound was not care planned.

During an interview, on 5/12/11 at 2:06PM, the director of nursing (DON) indicated she expected the care plans to be updated quarterly, annually

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F 280	Continued From page 24 and if a resident had a history of a wound or a new or worsening wound.	F 280	F 282 1. The Minimum Data Set Coordinators updated the ADL care guide for resident #151 on 05/11/11. On 05/11/11 the staff assigned to resident #151 was immediately inserviced by the Director of Nursing on ensuring that resident #151 was assisted with utilizing his personal equipment. 2. An audit of all resident care plans was conducted on 05/27/11 to ensure that the care planned needs of the resident were communicated to the care staff on the ADL care guide. 3. An inservice was conducted on 05/31/11 by the Director of Nursing and the Staff Development Coordinator for the facility Minimum Data Set Coordinators on communicating the care needs identified in the care plan to the care staff. 4. Audits of the care plans and the ADL care guide will take place daily, five times per week for four weeks, then twice weekly for four weeks, then weekly for four weeks. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	6/3/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to implement the care plan to assist a resident with using the cell phone and computer as documented in the plan of care for 1 of 1 sampled resident (Resident #151). . Resident #151 was readmitted to the facility on 6/2/10. The resident's cumulative diagnoses include seizure disorder, spasticity, chronic pain and depression. The quarterly Minimum Data Set (MDS) dated 3/17/11, indicated the resident had no short term memory or long term memory problems or decision making problems. The MDS indicated that resident #151 required total assistance with all activities of daily living. He had impaired range of motion on both sides of upper and lower extremities. Review of care plan dated 3/25/11, read in part: 1. Resident is at risk for decreased socialization due to being bed bound. Resident requires in-room visits with 1:1 interaction to maintain socialization and mental awareness. The goal was the resident will actively participate with	F 282		

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F 282	Continued From page 25 in-room visits and socialization at least once weekly through next review. The approaches included the staff would assist the resident with using the cell phone when time allowed and not to interfere with direct resident care of daily duties. If the resident requested assistance with the laptop activities staff would be available to assist during the weekly in room visits, other stay may also assist upon request if time permits not to interfere with daily work task. During an observation on 5/9/11 the cell phone ring at 12:54PM 4 staff outside of room passing lunch. The 4 staff were observed standing in front of resident's room as the phone rang, no staff entered the room to answer the call. The call light was attached to the top of bed in which it was out of reach for the resident to roll head to activate. Computer equipment was pushed away out of reach on side table. The cell phone was being charged on top of the light and the ear piece was dangling on the floor. Resident #151 indicated that he has to constantly tell the DON and administrator about his concerns with the phone and the computer but they do nothing to help me use it by myself. I wouldn't bother them if I could do it myself. During observation on 5/10/11 at 9:00AM, the cell phone was on the charger on top of the light fixture. The head set to the computer was hanging on side of bed and computer was on night stand across the room, the ear piece to telephone was under Resident #151 body. The phone rang and there were two nursing assistants and two nursing staff in the hall. No-one entered the room. All were standing in from of Resident #151's room. The call light was	F 282		

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F 282	Continued From page 26 position above Resident #151 head out of turn reach. During an observation on 5/10/11 at 3:40PM, Resident #151 call light was positioned above head, computer with head set on night stand at foot of resident s bed. Cell phone on top of light fixture. During an observation 5/11/11 at 11:21AM, cell phone on top of light fixture, ear piece on floor, computer at foot of bed and call light fixed to bed at shoulder level. During an interview on 5/11/11 at 2:06PM the MDS coordinator #3 indicated that the care plan should be revised annual, quarterly and during significant changes. The expectation would be that when the care plan was established staff should follow the plan. The care plan should be revised when there is a change in condition or concern. During an interview on 5/11/11 at 3:45PM, the DON indicated the care plan should reflect what was expected of the staff in meeting the needs of the resident. After review of the call pattern and the care plan and grievance log, the DON indicated some monitoring and changes should have occurred to ensure the resident was getting the assistance needed. During an interview on 5/11/11 at 4:15PM, the Administrator indicated that he expected the staff to assist the resident with using the telephone and the computer. The telephone and computer should be accessible for the resident and staff should be following the established plan. He also	F 282		

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F 282	Continued From page 27 Indicated after review of care plan that the care plan should be specific to his needs and designated staff would be assigned to monitor and check status and meet the resolution process of the grievance procedures.	F 282		6/3/11
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review the facility failed to provide fingernail care to 2 of 2 sampled residents who required assistance with activities of daily living. (Resident # 191, Resident # 302) Findings include: The undated policy titled, "Fingernails/Toenails, Care of" revealed the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. Some of the guidelines read in part, "Nail care includes daily cleaning and regular trimming." The staff should report to the nurse supervisor if there was evidence of ingrown nails, infections, pain, or if nails were too hard or too thick to cut with ease. 1. Resident #191 was admitted to the facility on 10/11/10. The resident's diagnoses included but	F 312	F 312 1. Resident # 191nails were cleaned and trimmed by the Treatment Nurse 05/13/11. No adverse outcomes noted. Resident #302 nails were cleaned and trimmed on 05/11/11 by the Certified Nursing Assistant. No adverse outcomes noted. The Director of Nursing inserviced the treatment nurses on 05/13/11 regarding the expectations of trimming of fingernails and toenails and referring residents to podiatry as need. 2. A 100% audit was conducted by the Unit Coordinators and the Treatment Nurses on 05/11/11 for all facility residents to determine if any residents needed nails trimmed and cleaned or added to the podiatry list. 3. An in-service was conducted by the Staff Development Coordinator 05/20/11 through 06/02/11 for all licensed nurses and Certified Nursing Assistants in regards to nail care for toenails and fingernail trimming and cleaning.	

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F 312	Continued From page 28 were not limited to, congestive heart failure, hypertension, diabetes and renal failure (receiving dialysis). The most recent minimum data set (MDS), dated 2/18/11 revealed the resident was cognitively intact. He required extensive assistance from one to two staff members for the following activities of daily living: bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. He had a functional impairment (decreased range of motion) on one side of his upper and lower extremities. He had no noted behaviors during the look back period. His most recent care plan was dated 2/21/11 noted he had a self-deficit and required extensive assistance with activities of daily living (ADLs). The goal was for the resident to have his ADL needs met. Some of the interventions included; staff will provide or assist with nail care as needed. An observation of resident #191 on 5/9/11 at 3:56PM noted both hands had long thick fingernails with dark matter underneath the fingernails. The resident stated he did what he could to keep his nails clean but he needed help from the staff to do a good job. On 5/11/11 at 9AM, the resident was observed in his room. His fingernails were long with dark matter underneath the nails. The resident stated he would try to clean under the nails but could not do much without assistance from staff members.	F 312	4. Audits will be conducted by the Unit Coordinators and Director of Nursing for all facility residents to ensure that nails are trimmed, cleaned and/or added to the podiatry list. This audit will be conducted weekly for four weeks, then monthly for two months and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	6/3/11

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F 312	Continued From page 29 During an observation and interview with the resident on 5/12/11 8:20AM, he stated the dark matter underneath his nails "bothered" him and he wanted them cleaned and trimmed on a regular basis. His nails remained long with dark matter underneath (both hands). He indicated the staff was supposed to trim his nails today. He stated he needed extensive assistance to complete his activities of daily living. He thought it had been around 2 months since his nails were trimmed and cleaned. An interview was conducted with nurse #2 and nurse #3 on 5/12/11 at 9:25AM. Nurse #2 and nurse #3 (both on treatment team) indicated the treatment nurses checked the residents' toenails and fingernails weekly. If a resident were to refuse to have, their nails trimmed (fingernails or toenails) it would be noted on the "Resident Weekly Skin Check Sheet." The treatment nurses would trim the nails (toes and fingernails) as needed. During an interview on 5/12/11 at 2:06PM, the director of nursing (DON) indicated she expected the staff to be trimming and cleaning the residents fingernails if they were noted to be long or have matter underneath the nail. Resident #302 was admitted to the facility on 4/25/11. The resident ' s cumulative diagnoses included cancer, end stage renal disease, seizure disorder and chronic obstruction pulmonary disease. The Minimum Data Set (MDS) dated 5/14/11, revealed that resident needed	F 312		

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F 312	Continued From page 30 assistance with activities of daily living. Review of the care plan dated 5/4/1, documented 1: resident requires assistant with and/or provision for ADLs. The goals included, resident will experience cleanliness and comfort each day and assistance as needed for ADLs each day through next review. The approaches included assist resident with am,/PM care and record completion at evening, bath/shower every Tues, Thursday and sat on evening. During observation on 5/9/11 at 2:206 PM, Resident #302 was sitting in his room with his finger nails long dirty with brown matter underneath nine of ten fingernails. During an observation on 5/10/11 at 12:15PM, Resident #302 was eating lunch with long dirty finger nails During an observation on 5/10/11 at 5:25PM, Resident #302 was eating dinner with long dirty nails on 9 of 10 fingers. During an observation on 5/11/11 at 8:44AM, Resident #302 fingernails was eating breakfast. The nails had large volume brown matter and food in 9 of the finger nails. During an interview on 5/11/11 at 5:05PM, NA#3 indicated that nursing was responsible for cutting the diabetic residents finger/toenails and nursing assistants all other residents. He stated that nails/toenails should be checked during am/pm care bathing. He added that he was unaware that Resident #302 nails need to be cut. He observed the nails and indicated that he would take care of them during bathing.	F 312		

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F 312	Continued From page 31 During an interview on 5/11/11 at 5:10PM, nurse #8 indicated that NA was responsible for cutting residents fingernails and toenails during am/pm care and bath/shower. He added that nursing was responsible for cutting residents nails/toenails that were diabetic. Nurse #8 went into Resident #302 room and observed fingernails and indicated they should be cut. Resident #302 stated he was happy that they were getting cut. During an interview on 5/12/11 at 4:00PM, the director of nursing indicated that she expected nursing assistance to provide nail care during baths and report to charge nurse any resident that needed special nail care. She added that all residents finger nails and toenails should be kept cleaned and trimmed.	F 312		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, nurse practitioner interviews and record review the facility failed to securely anchor the tubing of an indwelling catheter to prevent pulling or reduce	F 315	F 315 1. The Director of Nursing assessed resident # 277 on 05/11/11. The catheter for resident # 277 was securely anchored by the licensed nurse on 05/11/11. The family was notified by the Wound Care Nurse on 05/12/11. The physician was notified of the on 05/12/11 by the Wound Care Nurse. The care plan for Resident #277 was updated on 05/12/11 by the Minimum Data Set Coordinator to reflect the resident's current plan of care. The Director of Nursing inserviced the MDS #1 and MDS #2 on updating care plans with changes in resident status, diagnosis, or orders. 2. A 100% audit of all residents who have indwelling catheters was conducted by the Wound Care Nurse on 05/13/11 to ensure that the catheters were securely anchored, assessed, and treatments as ordered. No other residents were found to be affected. A 100% audit of all resident care plans was conducted by the Minimum Data Set Coordinators on 05/27/011 for the previous thirty days to ensure that all new orders and diagnosis were updated on resident care plans.	6/3/11

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F 315	Continued From page 32 trauma on the catheter tubing for 1 of 1 sampled residents with indwelling catheters. (Resident #277) Findings include: Resident #277 was re-admitted to the facility on 4/18/11. His diagnoses included but were not limited to; hypertension, aphasia, right hemiparesis, seizure disorder, aspiration pneumonia, multiple pressure ulcer (stage 4 to the sacrum and left hip), diabetes and history of urinary tract infection. Review of the resident's Care Area Assessment (CAA) summary, dated 1/27/11, revealed a CAA for "Urinary Incontinence and Indwelling Catheter." The CAA read in part, "Resident does have a catheter in place. He has several pressure ulcers to sacrum, hip, and lower extremities." He is at increased risk for pressure ulcers due to his impaired mobility, impaired cognition, incontinence, and existing pressure ulcers." Will proceed to care plan to help manage skin integrity and provide ADLs (activities of daily living). Review of the nurse's notes revealed a re-admission note dated, 4/18/11 completed by MDS nurse #1. The nurse noted the resident had open areas to his left and right ankle, left hip, sacrum, behind his left ear and also a healing area to left outer ear. A non-blanchable area was noted to the right hip. No mention was made of an assessment being completed to the penis area. No mention was made of the resident having any type of healed penile erosion.	F 315	3. An in-service was conducted by the Director of Nursing on 05/31/11 for all the facility Minimum Data Set Coordinators on the process of updating a resident's to reflect the resident's current plan of care. A facility directed inservice for all licensed nurses and certified nursing assistants regarding Urinary Catheter Use in Long-term Care was conducted on 06/03/11 by a state approved education agency. All licensed nurses and certified nursing assistants are required to attend prior to resuming their work schedule. 4. An audit will be conducted of all resident care plans to ensure resident's with new orders or new or updated diagnosis will be conducted daily, five days per week, for four weeks, then twice weekly for four weeks, then weekly for four weeks and/or 100% compliance. An audit of all residents with foley catheters to ensure securement of indwelling catheters will be conducted by the Director of Nursing and/or Unit Coordinators, Wound Care Nurse, and Nursing Supervisors every shift for fourteen days, then daily for fourteen days, then three times weekly for four weeks, then weekly for four weeks and/or 100% compliance. The results of these audits will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Committee Performance Improvement as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director	

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F 315	Continued From page 33 The wound care notes dated 4/19/11 noted the TN (treatment nurse) had assessed and measured the residents wounds. The TN noted the following wounds; left hip stage 4, sacral wound stage 4, left inner malleolus stage 3, left heel unstageable, right outer malleolus stage 3, right ischium possible deep tissue injury. No mention was made in regards to the assessment of the penis area. No mention was made of a healed wound to the penis. Review of the "Resident Weekly Skin Check Sheet", dated 4/19/11 found no mention of any wound to the penis. A nurse's note, dated 4/25/11 read in part, "cna (nursing assistant) reported residents penis swollen. This nurse assessed, small amount of edema noted at head of penis. No drainage noted at this time (name of physician) notified orders received to change cath (catheter)." A new indwelling catheter was inserted without difficulty, yellow urine noted with some mucus and small pus like area at the meatus (opening of the urinary tract). A culture was obtained from the drainage along with a urinalysis and culture and sensitivity. On 4/26/11 a nurse's note revealed the resident was started on antibiotics after the urinalysis results were back. The catheter was draining yellow urine with mucous noted and a small amount of drainage noted from around the meatus. Review of the "Resident Weekly Skin Check Sheet", dated 4/26/11 found no mention of any wound to the penis.	F 315		

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F 315	Continued From page 34 The next treatment note (done by the TN) was dated 4/28/11. There was no mention of a wound to the penis (open or healed). The culture results for the penis were reported on 4/28/11. The results noted "Normal Genital Tract Flora." The most recent minimum data set (MDS), dated 4/28/11 revealed the resident had severe cognitive impairment. He was totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating, toilet use and bathing. He required extensive assistance for personal hygiene. Resident #277 had no noted behaviors on the MDS. The resident was incontinent of bowel and had an indwelling urinary catheter. The MDS revealed the resident had multiple unstageable pressure ulcers during the look back period. The treatment note dated 5/4/11 did not make mention of any wounds to the penis. Resident #277's plan of care, dated 5/6/11, included "Potential for infection related to use of indwelling catheter." The goal was for the resident not to experience any adverse effects related to the use of the indwelling catheter through the next review. The interventions included; catheter care every shift and as needed, maintain a closed drainage bag below level of bladder. Monitor for signs and symptoms of urinary tract infection: fever, and change in color, consistency, and odor of urine. The staff was to report any unusual findings immediately to the physician. A care plan titled "Potential for impaired skin integrity related	F 315		

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to decreased mobility, contractures, pressure sore left hip, sacral wound and pressure ulcers to bilateral feet", dated 5/6/11, noted the goal was for the resident to not experience any adverse effects from any skin integrity issues through the next review. The interventions included; staff to report to nurse any red or open areas, ensure appropriate pressure relieving devices in place during repositioning. Monitor skin daily during care for any changes. Report any abnormal observations to the physician.

Review of the "Resident Weekly Skin Check Sheet", dated 5/6/11 found no mention of any wound to the penis.

A verbal order, dated 5/9/11 and obtained by the TN read in part, "Tx (treatment) penile erosion (with) 1. clean (with) wound cleanser 2. cover (with) Xeroform gauze 3. (change) q (every) day & PRN (as needed)- keep (catheter) attached to leg to limit movement."

On 5/10/11 the treatment note did not mention any wounds to the penis and no measurements could be found.

A wound care observation and interview was conducted on 5/11/11 at 9:32AM with the treatment nurse (TN). The resident had an indwelling urinary catheter. The TN cleansed the open area around the tip of the penis. The open area resembled a widened track. The area was red with a small amount of mucus type drainage noted. He referred to the area as"penile erosion" and stated the resident came back from the hospital (4/18/11) with the erosion. The resident did not have a leg strap on at the time. His

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catheter tubing was tangled in between his legs (which were contracted). Resident #277 displayed facial expressions of discomfort when the penile erosion was cleaned and when the catheter tubing was adjusted. The TN stated the resident might have removed the catheter strap. The TN then placed a new anchorage system on the resident's thigh to prevent tension or pulling on the indwelling catheter. The TN indicated he had measured the penis wound and that information could be found in "Integumentary/Skin Concerns" notes for the resident. The TN could not provide a reason as to why no treatment was initiated to the penile erosion until 5/9/11.

During an interview on 5/11/11 at 4:27PM, nurse practitioner (NP) #1 stated she had viewed the penile wound since the resident had been re-admitted. She stated it was a little swollen and red. She acknowledged not seeing the wound since shortly after re-admission but stated the wound care staff was very good about informing her of new areas and keeping her updated. The NP indicated she was not sure if anchoring the catheter tubing would help prevent any skin breakdown to the penis area.

A follow up interview was conducted with the TN on 5/12/11 at 9:06AM. The TN indicated he thought he charted about applying the leg anchoring device but "clearly he did not." He reviewed the TN notes and could not find any notes in regards to the assessment and measurement of the penile erosion. He stated he thought he measured the wound but "has no excuse" for why the information was not there. The TN stated it was everyone's responsibility to

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F 315	Continued From page 37 maintain the urinary catheter. He stated the catheter tubing should be anchored to the resident's leg to prevent tension and pulling. During an interview on 5/12/11 at 9:25AM, nurse #2 stated the resident has had the open area to the penis since his last hospital admission. She did not think it had changed. Only the TN does the measurements. Nurse #3 stated there was not much treatment they could have done for the penis wound. During a follow up wound care observation on 5/12/11 at 9:47AM measurements of the penile erosion were obtained by the TN. The penile erosion measured 1.3 centimeters (cm) by 1cm, with a depth of 0.2cm. Nurse #2 stated there was no change to the wound since the resident had been re-admitted. Neither the TN nor nurse #2 could provide a clear answer as to why the wound had no treatment until the verbal order was obtained on 5/9/11. The resident's catheter tubing was secured to his thigh. On 5/12/11 at 1:48PM NP #1 provided some information on "Securing the Indwelling Catheter." The information was from "Lippincott's Nursing Center.Com." The article read in part, "Optimal management of an indwelling catheter includes securing the catheter to the thigh or abdomen in a way that prevents the catheter or its retention balloon from exerting excessive force on the bladder neck or urethra." During an interview on 5/12/11 at 2:19PM the director of nursing stated the catheter tubing should be secured on the leg of residents who had indwelling catheters.	F 315		

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F 315	Continued From page 38 An interview was conducted on 5/12/11 at 3:18PM with MDS nurse #1. The nurse stated she thought the resident might have had a healed erosion to the penis before going to the hospital. When he returned from the hospital, she did his initial skin assessment. She thought there was "like a slit or erosion (to the penis), the skin was intact like someone had a scar but not as bad as that." MDS nurse #1 stated she did not think the resident was at increased risk for open areas to the penis if he had a history of healed erosion	F 315	F 328 1. The toenails for Resident #293 were trimmed on 05/11/11 by the Certified Nursing Assistant. The physician was notified on 05/12/11 by the charge nurse and an order was obtained by the Unit Coordinator on 05/12/11 to refer Resident # 277 to the podiatrist. Resident#277 was seen by the podiatrist on 05/18/11. 2. A 100% audit was conducted by the Unit Coordinators and the Treatment Nurses on 05/13/11 for all facility residents who requiring toenails trim and cleaned or added to the podiatry list.	6/3/11
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and. Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide 2 of 2 sampled residents with diabetes toenail care by the contracted podiatry services. (Resident #293 and #277) Findings include: 1.Resident#293 was admitted to facility on	F 328	3. An in-service was conducted by the Staff Development Coordinator 05/20/11 through 06/02/11 for all licensed nurses and Certified Nursing Assistants in regards to nail care for toenails and fingernail trimming and cleaning. 4. Audits will be conducted by the Unit Coordinators and Treatment Nurse's for all facility residents to ensure that nails are trimmed, cleaned and/or added to the podiatry list. This audit will be conducted weekly for four weeks, then monthly for two months and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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F 328	Continued From page 39 2/25/11. The resident's cumulative diagnoses included hypertension, diabetes, acute renal failure, cerebral vascular accident. The annual Minimum Data Set(MDS) dated 3/4/11 revealed Resident#293 required total to extensive assistance with activities of daily. Review of care plan dated 2/25/11 documented 1: resident requires assistant with and/or provision for activities of daily living. The goals included resident will experience cleanliness and comfort each day, by next review, will receive assistance as needed for activities of daily living each day and bath/shower every Tues, Thursday and sat on evening, Review of the facility's podiatry list from 1/2011 to present (1/4/11, 2/1/11, 3/7/11 and 4/4/11) revealed resident #293 was not on any of the list. The podiatry clinics lists dated 1/11/11 and 3/28/11, revealed no entries for the resident. During an observation on 5/10/11 at 9:20AM, Resident #293 was lying in bed and his toe nails were long 1 inch on both ft and thick at nail bed on all of the toes. .During an observation on 5/10/11 at 5:21PM, Resident #293 lying in room in low bed and toenails was long and thick on both feet and all toes. During an observation on 5/11/11 at 8:40AM, Resident #293 sleeping in low bed.The toenails remain long and thick on both feet and all toes. During an interview on 5/11/11 at 10:10AM, NA#2 indicated that nursing assistants was expected to cut nails/toenails during bath/shower, nursing cut diabetic residents nails/toenails. She observed	F 328		

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F 328	Continued From page 40 toenails and stated that nursing would be resposnible for cutting toenails and NA was responsible for reporting when the nails/toenails should be cut. She indicated that she did not report the condition of Resident #293 toe nails. During an observation on 5/11/11 at 11:18AM, Resident #293 was lying in bed and his toenails remained long and uncut. During an interview on 5/11/11 at 12:08PM, unit manager (UM) #1 stated if the staff noticed/observed residents in need of toenail care, those residents were added to the podiatry list. The diabetic residents were "automatically" on the podiatry list. During an interview/observation on 5/11/11 at 5:15PM, nurse#5 indicated that nursing was responsible for cut/trimming diabetic resident toe nails and NA all other times. NA should report to nursing when resident nails/toenails need to be cut/trimmed. She indicated that once a week a person was assigned to cut/trim resident nails/toenails. She observed resident's toenails and stated that they should have been cut sometime ago. During an interview on 5/11/11 at 5:20 PM, NA#4 indicated that she noticed the toenails last night during bath, but she did not report to nursing During an interview on 5/12/11 at 4:00PM, the director of nursing indicated that she expected nursing assistant to provide nail care during baths and report to charge nurse any resident that needed special nail care. She added that all residents finger nails and toenails should be kept cleaned and trimmed.	F 328		

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F 328	Continued From page 41 The undated policy titled, "Fingernails/Toenails, Care of" revealed the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. Some of the guidelines read in part, "Nail care includes daily cleaning and regular trimming." The staff should report to the nurse supervisor if there was evidence of ingrown nails, infections, pain, or if nails were too hard or too thick to cut with ease. 2. Resident #277 was re-admitted to the facility on 4/18/11. His diagnoses included but were not limited to; hypertension, alcohol encephalopathy, aphasia, right hemiparesis, seizure disorder, aspiration pneumonia, pressure ulcer, diabetes and history of urinary tract infection. The most recent minimum data set (MDS), dated 4/28/11 revealed the resident had severe cognitive impairment. He was totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating, toilet use and bathing. He required extensive assistance for personal hygiene. Resident #277 had no noted behaviors on the MDS. A care plan, dated 5/6/11 revealed the resident had a self-care deficit and required assistance with activities of daily living. The goal was for the resident to have his ADL needs addressed as evidenced by remaining neat, clean, and without odors through the next review. One of the interventions was for the staff to provide or assist with nail care as needed. Review of the "Resident Weekly Skin Check	F 328		

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F 328	Continued From page 42 Sheet" revealed: For 2/1/11, the resident's finger and toenails were trimmed. On 2/9/11, the resident's finger and toenails were noted as "OK." On 2/15/11, no boxes were checked to indicate the resident's nails had been assessed. For the 3/1/11 and for the 3/8/11 weekly check, there were no check marks in any boxes to indicate whether the nails were ok or trimmed or if the resident refused. The dates of 3/16/11 and 3/22/11 found the residents nails to both be "OK." On 4/19/11, the toenails and the fingernails were noted as "trimmed." The finger and toenails were noted as "OK" on the 4/26/11 assessment. The next assessment was done on 5/6/11. The resident's nails (both) were noted as "OK." Review of the facility's podiatry list from 1/2011 to present (1/4/11, 2/1/11, 3/7/11 and 4/4/11) revealed resident #277 was not on any of the list. The podiatry clinics lists dated 1/11/11 and 3/28/11, revealed no entries for the resident. A review of resident #277's admission and discharges to date revealed, he was admitted to the facility on 1/20/11. The only hospitalization listed was from 4/2/11 to 4/18/11.	F 328		

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F 328	Continued From page 43 During an interview on 5/11/11 at 12:08PM, unit manager (UM) #1 stated if the staff noticed/observed residents in need of toenail care, those residents were added to the podiatry list. The diabetic residents were "automatically" on the podiatry list. An interview was conducted with nurse #2 and nurse #3 on 5/12/11 at 9:25AM. Nurse #2 and nurse #3 (both on treatment team) indicated the treatment nurses checked the residents' toenails and fingernails weekly. If a resident were to refuse to have, their nails trimmed (fingernails or toenails) it would be noted on the "Resident Weekly Skin Check Sheet." The treatment nurses would trim the nails (toes and fingernails) as needed. Nurse #2 indicated "all" diabetics were seen by the podiatrist. Nurse #2 stated she could cut resident #277's toenails except for his great toes and the podiatrist needed to trim those. Nurse #2 stated the resident had missed the podiatrist visits due to multiple hospitalizations since his admission on 1/20/11. Both nurses indicated when a resident goes out to the hospital and comes back they should remain on the podiatry list to be seen at the next visit. In the absence of the podiatrist, if the residents needed to have their toenails trimmed they should be referred to an out of facility podiatrist. A wound care observation was done on 5/11/11 at 9:32AM with the TN. Resident #277 was alert and awake in bed. During the course of the wound care it was noted the resident had very long thickened toenails. The TN stated his team (nurse #2, nurse #3) were responsible for trimming toenails on the residents. The TN indicated if the nurses were unable to trim the	F 328		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 44 nails then the resident would be added to the podiatry list. During an interview on 5/12/11 at 2:06PM, the director of nursing (DON) indicated she expected the staff to be putting the diabetic residents and whoever else needed to see the podiatrist on his list unless the family wanted a private podiatrist and then they could arrange transportation.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the facility had delayed egress locks on all exit door (stair-wells and exterior doors). a. 5th floor long hall irreversible process stopped in code was entered during 15 sec. delay b.4th floor stair-well door near room 417 would relock automatically if code was entered during 15 sec. delay c.4th floor Stair-well door at Day Room would not release under pressure on release device d. 3rd. floor delayed egress lock on the short hall requires more the 15 sec. to release e 1st floor the locks on the front and rear exit doors did not sound an alarm when pressure was applied to the release device.	K 038	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. 1. (A) The facility maintenance director serviced and replaced the key pad on the fifth floor long hall on 06/24/11 and currently does not stop when the code is entered during the 15 second delay. (B) The keypad at the fourth floor stairwell door near room 417 was upgraded by the Maintenance Director on 07/08/11 and now remains unlocked if the code is entered during the 15 second delay. (C) The the Mag Lock was adjusted to the proper pressure by the Maintenance Director on 06/24/11 at the fourth floor stairwell door near the Day Room. (D). The Mag Lock at the third floor delayed egress on the short hall was repaired by the Maintenance Director on 06/25/11 and currently releases within 15 seconds. (E). The first floor locks on the front and rear exit doors sound when pressure is applied. The key pads were inspected and repaired by the Maintenance Director on 06/24/11. 2. All doors were inspected for release pressure and delay times by the Maintenance Director on 06/24/11. No other doors were found to be affected.	7/8/11
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper — TITLE: Administrator — (X6) DATE: 7/8/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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
K 051	Continued From page 1 tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 there was no audible nor visual signal when the phone line was disconnected from the fire alarm panel. 42 CFR 483.70 (a)	K 051	3. All doors will be inspected once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The results will be noted and reviewed in the monthly Quality Assurance Performance Improvement Committee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 051	7/8/11
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	1. The fire alarm system test was conducted by the Maintenance Director on 07/06/11 and its' components were found to be functioning properly. There is an audible and visual signal when the phone line is disconnected from the fire alarm panel. 2. The practice had the potential to impact all facility residents, however none were found to be affected. 3. The fire alarm panel will be inspected by the Maintenance Director once weekly for three weeks and then monthly for three months to ensure that it is working properly.	

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 056	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the 8 inch sprinkler main is in a wood structure out side and there is no heat provided for protection from freezing. 42 CFR 483.70 (a)	K 056	4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 056 1. The certified technician installed thermostatic baseboard heaters on 06/29/11 per manufacturers' recommendations in the wood structure outside to prevent freezing. 2. This practice has the potential to impact all facility residents, however none were found to be affected. 3. All outside areas will be inspected weekly times three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development	7/8/11
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the clean linen door on the 2nd and 3rd floors between the nurses station and the stair-well exit door opens into the corridor reduces the width (the doors do not have closers) .	K 072		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the med. refrigerator on 2nd, 3rd, and 4th floor were not plugged into a emergency receptacle. 42 CFR 483.70 (a)	K 147		

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
	345092	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/24/2011

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GRACE HEALTHCARE OF WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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			Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 072 1. The door closures for the second and third floor clean linen rooms were installed on 06/29/11 by the Maintenance Director. 2. All facility door closures were inspected by the Maintenance Director on 06/29/11. 3. All door closures will be inspected once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	7/8/11

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

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			147 1. All dedicated medication refrigerators in the second, third, and fourth floor medication rooms were plugged into the emergency outlet receptacles and labeled on 06/24/11 by the Maintenance Director 2. All medication room refrigerators on all floors were inspected and verified to be plugged into the emergency receptacles and labeled on 06/24/11 by the Maintenance Director. 3. All medication room refrigerators will be inspected to ensure that they are plugged into the emergency outlet and labeled. This inspection will be conducted once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	7/8/11

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 RECEIVED JUL 12 2011 CONSTRUCTION SECTION This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the facility had delayed egress locks on all exit door (stair-wells and exterior doors). a. 5th floor long hall irreversible process stopped in code was entered during 15 sec. delay b.4th floor stair-well door near room 417 would relock automatically if code was entered during 15 sec. delay c.4th floor Stair-well door at Day Room would not release under pressure on release device d. 3rd. floor delayed egress lock on the short hall requires more the 15 sec. to release e 1st floor the locks on the front and rear exit doors did not sound an alarm when pressure was applied to the release device.	K 038	**This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** 1. (A) The facility maintenance director serviced and replaced the key pad on the fifth floor long hall on 06/24/11 and currently does not stop when the code is entered during the 15 second delay. (B) The keypad at the fourth floor stairwell door near room 417 was upgraded by the Maintenance Director on 07/08/11 and now remains unlocked if the code is entered during the 15 second delay. (C) The the Mag Lock was adjusted to the proper pressure by the Maintenance Director on 06/24/11 at the fourth floor stairwell door near the Day Room. (D). The Mag Lock at the third floor delayed egress on the short hall was repaired by the Maintenance Director on 06/25/11 and currently releases within 15 seconds. (E). The first floor locks on the front and rear exit doors sound when pressure is applied. The key pads were inspected and repaired by the Maintenance Director on 06/24/11. 2. All doors were inspected for release pressure and delay times by the Maintenance Director on 06/24/11. No other doors were found to be affected.	7/8/11
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper | TITLE: Administrator | (X6) DATE: 7/8/11

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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K 051	Continued From page 1 tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	3. All doors will be inspected once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The results will be noted and reviewed in the monthly Quality Assurance Performance Improvement Committee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 051 1. The fire alarm system test was conducted by the Maintenance Director on 07/06/11 and its' components were found to be functioning properly. There is an audible and visual signal when the phone line is disconnected from the fire alarm panel. 2. The practice had the potential to impact all facility residents, however none were found to be affected. 3. The fire alarm panel will be inspected by the Maintenance Director once weekly for three weeks and then monthly for three months to ensure that it is working properly.	7/8/11
	This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 there was no audible nor visual signal when the phone line was disconnected from the fire alarm panel. 42 CFR 483.70 (a)			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		

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K 056	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the 8 inch sprinkler main is in a wood structure out side and there is no heat provided for protection from freezing. 42 CFR 483.70 (a)	K 056	4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 056 1. The certified technician installed thermostatic baseboard heaters on 06/29/11 per manufacturers' recommendations in the wood structure outside to prevent freezing. 2. This practice has the potential to impact all facility residents, however none were found to be affected. 3. All outside areas will be inspected weekly times three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development	7/8/11
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the clean linen door on the 2nd and 3rd floors between the nurses station and the stair-well exit door opens into the corridor reduces the width (the doors do not have closers) .	K 072		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 06/24/2011 the med. refrigerator on 2nd, 3rd, and 4th floor were not plugged into a emergency receptacle. 42 CFR 483.70 (a)	K 147		

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			Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. 072 1. The door closures for the second and third floor clean linen rooms were installed on 06/29/11 by the Maintenance Director. 2. All facility door closures were inspected by the Maintenance Director on 06/29/11. 3. All door closures will be inspected once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	7/8/11

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			147 1. All dedicated medication refrigerators in the second, third, and fourth floor medication rooms were plugged into the emergency outlet receptacles and labeled on 06/24/11 by the Maintenance Director 2. All medication room refrigerators on all floors were inspected and verified to be plugged into the emergency receptacles and labeled on 06/24/11 by the Maintenance Director. 3. All medication room refrigerators will be inspected to ensure that they are plugged into the emergency outlet and labeled. This inspection will be conducted once weekly for three weeks and then monthly for three months by the Maintenance Director. 4. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	7/8/11