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
	346421	A. BUILDING _____ B. WING _____	C 06/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(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 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to forward expired resident ' s funds to the Executor of the Estate or Clerk of Courts for 4 of 5 fund accounts reviewed. (Residents # 28, # 29, # 30, and # 31). Findings include: 1. Review of facility records revealed resident # 29 expired on 12/15/10. The resident ' s account was closed and a check for $ 45.29 was written to the estate of resident # 29. During an interview on 6/1/11 at 3:05 pm, the Business Office Manager stated the check was made out to the estate of resident # 29. The responsible party on record had moved and left no forwarding address. The responsible party came by the facility and picked up the check from the Business Office Manager on 3/15/11. During an interview on 6/2/11 at 4:30 pm the Administrator stated they were told by the clerk of courts to send the checks to the responsible party.	F 160	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is June 24th, 2011. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. **F 160 Conveyance of Personal Funds Upon Death:** Resident #'s 28, 29, 30, and 31's responsible parties have been contacted to determine if they have been able to cash the check written "To the Estate Of". No further issues were found.	6-24-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6-21-11

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 160	Continued From page 1 During and interview on 6/3/11 at 11:30 am the Accounting and Payroll Manager stated she was told by the clerk of courts to send the checks to the responsible party. During a telephone interview on 6/15/11 at 1:16 pm, the Business Office Manager failed to confirm that the responsible party to whom the check had been given was the Executor of the Estate for resident # 29. 2. Review of facility records revealed resident # 31 expired on 2-17-11. The resident ' s account was closed and a check for $420.07 was written to the estate of resident # 31. During an interview on 6/1/11 at 3:05 pm, the Business Office Manager stated the check was made out to the estate of resident # 31, and then mailed to the responsible party on record for resident # 31 on 3/15/11. The Business Office Manager stated she was told by her predecessor, the current Accounting and Payroll Manager, that according to the clerk of courts, the checks were to be mailed to the responsible party. During an interview on 6/2/11 at 4:30 pm the Administrator stated they were told by the clerk of courts to send the checks to the responsible party. During and interview on 6/3/11 at 11:30 am the Accounting and Payroll Manager stated she was told by the clerk of courts to send the checks to the responsible party. During a telephone interview on 6/15/11 at 1:16 pm, the Business Office Manager failed to	F 160	The Business Office Manager will receive additional education by the Administrator or Regional Business Office Manager relating to conveyance of personal funds upon death to the appropriate legal representative. The Business Office Manager will review the accounts receivable of expired residents for the last (6) six months to ensure any personal funds have been returned to the appropriate legal representative. Variances will be corrected as identified. Upon the death of a resident, the Business Office Manager (BOM) will prepare final accounting. If a refund is due, the BOM will call the responsible party to determine if an executor of the estate has been determined and filed. Any refund that is due will be made by check "To the Estate Of". Upon receipt of the appropriate legal documentation, the BOM will release the funds. If there is no	

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F 160	Continued From page 2 confirm that the responsible party to whom the check had been mailed was the Executor of the Estate for resident # 31. 3. Review of facility records revealed resident # 30 expired on 2/22/11. The resident ' s account was closed and a check for 329.42 was written to the estate of resident # 30. During an interview on 6/1/11 at 3:05 pm, the Business Office Manager stated the check was made out to the estate of resident # 30, and then mailed to the responsible party on record for resident # 30 on 3/15/11. The Business Office Manager stated she was told by her predecessor, the current Accounting and Payroll Manager, that according to the clerk of courts, the checks were to be mailed to the responsible party. During an interview on 6/2/11 at 4:30 pm the Administrator stated they were told by the clerk of courts to send the checks to the responsible party. During and interview on 6/3/11 at 11:30 am the Accounting and Payroll Manager stated she was told by the clerk of courts to send the checks to the responsible party. During a telephone interview on 6/15/11 at 1:16 pm, the Business Office Manager failed to confirm that the responsible party to whom the check had been mailed was the Executor of the Estate for resident # 30. 4. Review of facility records revealed resident # 28 expired on 3-1-11. The resident ' s account	F 160	executor, the check will be sent to the clerk of court in the county of residence. A QA Monitoring tool will be utilized by the Administrator/designee weekly x 4 weeks, then monthly times 2 months then randomly thereafter to ensure compliance with the regulation. Variances will be corrected as identified. Concerns will be reported to the quality assurance committee for further recommendations. Continued compliance will be monitored through routine review of accounts and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 160	Continued From page 3 was closed and a check for $30.01 was written to the estate of resident # 28. During an interview on 6/1/11 at 3:05 pm, the Business Office Manager stated the check was made out to the estate of resident # 28, and then mailed to the responsible party on record for resident # 28 on 3/15/11. The Business Office Manager stated she was told by her predecessor, the current Accounting and Payroll Manager, that according to the clerk of courts, the checks were to be mailed to the responsible party. During an interview on 6/2/11 at 4:30 pm the Administrator stated they were told by the clerk of courts to send the checks to the responsible party. During and interview on 6/3/11 at 11:30 am the Accounting and Payroll Manager stated she was told by the clerk of courts to send the checks to the responsible party. During a telephone interview on 6/15/11 at 1:16 pm, the Business Office Manager failed to confirm that the responsible party to whom the check had been mailed was the Executor of the Estate for resident # 28.	F 160	**F 161 Surety Bond-Security of Personal Funds** The Surety Bond was increased at the time of the survey to $50,000.00. The surety bond is adequate to cover all current residents' funds. The Business Office Manager will be provided additional education by the Administrator relating to monitoring the total amount of funds in the residents' funds, ensuring the surety bond covers all funds and notifying the Administrator when the funds are approaching the surety bond limit. The Administrator, while reviewing the monthly reconciliation of residents' trusts funds will review the total in the account and secure additional funds when indicated. Concerns will be reported to the quality assurance committee during the monthly meeting.	6-24-11
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced	F 161		

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F 161	Continued From page 4 by: Based on record review and staff interviews, the facility failed to ensure the amount of the surety bond was adequate to cover the balances of the residents ' trust funds for 104 of 123 residents at the facility. Findings include: On 6/1/11 at 3:00 pm the facility Business Office Manager provided a copy of the facility surety bond for review. Review of the surety bond, dated 11/4/10 and effective to 1/10/12 revealed the liability limit was $25,000. Review of the residents ' trust fund balances for January, February and March of 2011 revealed the residents ' trust fund balances were over $25,000 each month. The January 2011 balance was $29,000; the February 2011 balance was $31,000, and the March 2011 balance was $34,678.76. During an interview on 6/1/11 at 3:00 pm the Business Office Manager stated the existing surety bond did not cover the residents ' trust fund balances. During an interview on 6/2/11 at 4:30 pm the Administrator stated he expected the surety bond would cover the balances in the residents ' trust fund.	F 161	Continued compliance will be monitored through monthly review of resident trust and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. **F 176 Resident Self-Administer Drugs if Deemed Safe** Resident #1: The identified medication was removed at the time of survey. No negative outcome resulted from this observation. All current residents' rooms were checked to ensure no other medications were left at bedside without a physician's order. No other variances were identified.	6-24-11
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	All licensed nurses have been re-educated to not leave medication at bedside unless an assessment	

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F 176	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to determine the ability to self-administer a breathing medication for one (1) of one (1) sampled residents (Resident #1). Facility Policy titled Self-Administration of Medications and dated 03/05 reads in part "Guests who wish to self-administer medications will need to be evaluated for safety and cognitive ability by the interdisciplinary team .... This evaluation will include the Mini-Mental State Examination. Guests must score 23 or above on the Mini-Mental in order to be considered for self-administration of medications. A physician's order will be obtained which specifies each medication which the guest may self-administer, as well as whether or not the medication(s) will be stored in the guest's room." Resident #1 was originally admitted to the facility 09/16/2009 and readmitted to the facility 11/02/2010. Cumulative diagnoses included: Chronic Obstructive Pulmonary Disease (COPD). Quarterly Minimum Data Set dated 04/25/2011 indicated Resident #1 was moderately impaired in memory and cognition. On 05/31/2011, facility indicated Resident #1 was alert and oriented and interviewable. Record review of physician's orders dated 05/01/2011-05/31/2011 did not reveal a written	F 176	has been completed and a physician's order obtained. Additionally, education relating to self administration of medications has been added to the new nurse orientation information. Random observations of residents' rooms will be performed by the DON/ and/or her designee (3) three times a week for (2) two weeks then weekly times (2) weeks then randomly for (2) months. Variances will be corrected at the time of observation. Observation results will be reported to the Director of Nurses weekly for the next (2) two months and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine facility room round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 176	Continued From page 6 order that Resident #1 could self-administer any medication. Medical record review for Resident #1 did not reveal a self administration assessment form indicating Resident #1 was able to self-administer any medications. A physician's order dated 05/20/2011 stated Advair Diskus 250/50 one inhalation twice daily (BID) for COPD. On 06/01/2011 at 9:15 AM., observation revealed an Advair Diskus 250-50 with dispensing date 05/30/2011 in a medication bag on Resident #1's overbed table beside her breakfast tray. On 06/01/2011 at 9:15 AM., Resident #1 stated the nurse gave the Advair Diskus to her that morning and she had used it at 5:00 AM. When asked how often she took the medication, Resident #1 stated she used it every four hours. Resident #1 picked up the medication bag, read the instructions and stated she took the medication twice a day. On 06/01/2011 at 9:20 AM., the Director of Nursing (DON) stated before a resident self-administered any medication, the resident would perform a return demonstration of self-administration, be evaluated by the interdisciplinary team for evaluation of ability to perform self-administration and have a physician's order on the chart in order to self-administer. She reviewed Resident #1's chart and stated a self-administration sheet was not on the chart. The DON looked at Resident #1's medication administration record and stated	F 176		

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F 176	Continued From page 7 the Advair Diskus was ordered to be given at 6:00 AM. and 6:00 PM. and would have been given by the night nurse. She stated she did not know why the nurse left the medication at the bedside. On 06/01/2011 at 9:35 AM., the Quality Assurance manager went to Resident #1's room, observed the Advair Diskus in the plastic bag on the resident ' s overbed table and removed the medication from the room. On 06/01/2011 at 9:35 AM., the Director of Nursing stated, since there was not a physician's order or self-administration sheet on Resident #1's chart, she would not expect the medication to be left at the bedside.	F 176	**F 281 Services Provided Meet Professional Standards** A physician's order and supporting diagnosis has been obtained for the use of oxygen for Resident #1 and a physician's order and supporting diagnosis has been obtained for utilization of the indwelling urinary catheters for Residents #'s 3, #4 and #14. The charts of current residents utilizing oxygen and/or an indwelling urinary catheter have been reviewed by the Unit Managers to ensure physicians' orders and supporting diagnoses are in place for the treatments. No other variances were identified. The Licensed Nursing staff has been re-educated relating to the obtainment of physicians' orders and supporting diagnoses for the use of oxygen and indwelling urinary catheters by the Director of Nursing/designee.	6.24.11 6.22.11
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to obtain a physician ' s order for a indwelling urinary catheter for 3 of 7 sampled resident ' s (resident #3, #4, and #14), and failed to obtain a physician ' s order for oxygen for 1 of 2 sampled residents (resident #1). Findings include: 1. Resident #4 was admitted to the facility on 12/09/2010 with cumulative diagnosis of Neurogenic Bladder, Paraplegia, and Chronic Urinary Tract Infections. The Minimum Data Set (MDS) dated 03/02/2011 indicated the Resident	F 281		

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F 281	Continued From page 8 #4 was cognitively intact, and had a catheter in use with a diagnosis of a Neurogenic Bladder. The Care Plan (CP) most recently updated on 05/17/2011 indicated the resident was at risk for dehydration/fluid imbalance/ urinary tract infections due to a suprapubic catheter. On 05/31/2011 at 11:00 am Resident #4 had a supra pubic catheter and received morning care by nursing assistant (NA) # 1. At that time, NA #1 indicated the resident had a catheter since his admission. Review of the physician ' s orders only mentioned the catheter on 04/27/2011 with an order to change the indwelling catheter. There was no physician ' s order for the reason for the catheter. On 06/02/2011 at 2:25 pm, the Director of Nursing stated she expected a physician ' s order to be written for an indwelling urinary catheter with a supporting diagnosis, the size for the indwelling catheter and balloon, change catheter as needed and an order for catheter care. 2. Resident # 14 was admitted to the facility on 5/16/11 with a diagnosis of an unstageable sacral pressure sore. The Minimum Data Set (MDS) dated 5/23/11 indicated the resident was cognitively intact and had an indwelling catheter. Review of the physician ' s orders dated 5/16/ indicated catheter care and catheter to be changed every month and the medical history and physical examination record of 5/17/11 indicated an existing catheter. There was no physician ' s order supporting a reason for use of the	F 281	The Unit Managers will review all new admissions, new orders and the 24 hr nursing report during the morning clinical meeting to ensure orders and diagnoses are obtained and transcribed correctly upon admission and new orders for oxygen and indwelling urinary catheters have a supporting diagnosis. A QA Monitoring tool will be utilized by the Director of Nurses and/or her designees weekly times 4 weeks, then monthly times 3 months. Variances will be corrected as identified. The facility QA committee will review findings during the monthly QA committee meeting x 3 months to monitor for on going compliance with additional education being provided if indicated. Continued compliance will be monitored through routine chart reviews, review of new admissions, new orders, the 24 hr	

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F 281	Continued From page 9 indwelling catheter. On 5/31/11 at 3:30 pm the resident was observed to have an indwelling catheter. Nurse #8 was interviewed on 6/1/11 at 12:00 pm. While reviewing the physician ' s orders, Nurse # 8 indicated there was no physician order supporting a reason for use of an indwelling catheter. Nurse # 8 instructed Nurse # 7 to telephone the physician to obtain an order. On 6/2/11 at 2:55 pm the Director Of Nursing (DON) stated she expected a physician ' s order to be written for an indwelling catheter with supporting diagnosis, the size for the indwelling catheter and balloon, change catheter as needed and an order for catheter care. #3 Resident #3 was readmitted to the facility 05/27/2011 following a hospitalization for septic shock with altered mental status. Cumulative diagnoses also included: Cerebrovascular Accident (CVA), renal insufficiency and urinary retention. The latest Quarterly Minimum Data Set (MDS) dated 04/14/2011 indicated Resident #3 was moderately impaired in memory and cognition. Resident #3 was independent with eating and toileting. Extensive assistance was required with dressing, personal hygiene and bathing. Resident #3 was continent of bladder and bowel. Indwelling urinary catheter was not checked. Discharge Summary from (name) hospital dated 05/26/2011 with an addendum dated 05/27/2011 stated Resident #3 had complained on inability to	F 281	nursing report and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 281	Continued From page 10 void. Bladder scans were performed with greater than 600 milliliters (ml) noted. An indwelling catheter was placed prior to hospital discharge and a urology appointment had been scheduled. A review of the medical record and physician's orders for Resident #3 revealed no physician order for an indwelling catheter. On 5/31/2011 at 10:30 AM., Resident #3 was observed to have an indwelling urinary catheter. On 06/01/2011 at 11:20 AM., Nurse #7 stated an order had been written on 06/01/2011 to discontinue the indwelling urinary catheter because there was not a diagnosis to support the use of the catheter. Nurse #7 reviewed Resident #3's readmission orders and stated an order should have been written for the indwelling catheter on the readmission orders 05/27/2011. On 06/02/2011 at 2:25 PM., the Director of Nursing stated she expected a physician's order to be written for an indwelling urinary catheter with a supporting diagnosis, the size of the indwelling catheter and balloon, change catheter as needed and an order for catheter care. #4 Resident #1 was admitted to the facility 09/16/2009 and readmitted to the facility 11/02/2010 following a hospitalization. Cumulative diagnoses included: Chronic Obstructive Pulmonary Disease (COPD). The latest Quarterly Minimum Data Set (MDS) dated 04/25/2011 indicated Resident #1 received oxygen therapy. Oxygen therapy was also indicated on the quarterly assessments dated	F 281		

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F 281	Continued From page 11 3/18/2011 and 10/15/2010. A review of the medical record and physician's orders dated 11/02/2010 through May 2011 for Resident #1 revealed no physician's order for oxygen therapy. On 5/31/2011 at 8:50 AM., Resident #1 was observed receiving oxygen at two (2) liters per minute via nasal cannula. On 5/31/2011 at 4:45 PM., Nurse #6 stated residents who received oxygen therapy would have a physician's order for oxygen. Oxygen therapy would also be noted on the resident's Medication Administration Record (MAR). On 05/31/2011 at 4:45 PM., the Director of Nursing (DON) stated she expected a physician's order to be written when a resident received oxygen therapy. On 5/31/2011 at 4:55 PM., Nurse #6 checked Resident #1's MAR and stated oxygen was not noted on the MAR. Nurse #6 checked Resident #1's physician's orders from 11/02/2010 through May 2011 and stated there was no order for oxygen therapy. Nurse #6 said Resident #1 had been in the facility and on oxygen for a long time and the order must have not been added when the resident returned from the hospital on 11/02/2010.	F 281	**F 315 No Catheter, Prevent UTI, Restore Bladder** Leg straps have been placed for residents' #'s 4, 5, and 14. All residents with catheters were reviewed by the DON at the time of the survey. No other resident was found to be without a leg strap. The Nursing staff has been re-educated regarding the use of the proper leg strap when a catheter is in use. New nursing staff will be oriented to the catheter policy and procedure during the orientation process. A QA Monitoring tool will be utilized to check for proper anchoring of catheters by the Director of Nurses and/or her designees weekly times 4 weeks, then randomly thereafter. Variances will be corrected at the time of observation.	24 6-22-11
F 315 SS=E	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	F 315		

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	345421	A. BUILDING _____ B. WING _____	C 06/03/2011

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F 315	Continued From page 12 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to secure a urinary catheter to prevent excessive tension on the catheter for 3 of 7 sampled residents (residents # 4, 5, and 14). Findings include: 1. Resident #4 was admitted to the facility on 12/09/2010 with cumulative diagnosis of Neurogenic Bladder, Paraplegia, and Chronic Urinary Tract Infections.The Minimum Data Set (MDS) on 03/02/2011 indicated the resident (#4) was cognitively intact, and had a catheter in use with diagnosis of a Neurogenic Bladder. Record review of the facility inservice on 01/18/2011 instructed staff on proper perineal and catheter care. Inservice on 04/01/2011 instructed staff on perineal-care review. The facility Catheter Care Policy dated 03/2005 indicated an indwelling catheter was to be anchored to prevent pulling. . On 05/31/2011 at 11:00 am, nursing assistant (NA) #1), provided assistance to Resident #4 for morning care. NA #1 indicated the resident had a	F 315	Observation results will be reported to the Director of Nurses weekly and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine daily round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 315	Continued From page 13 catheter since his admission. There was no anchor in place and NA #1 did not anchor the catheter when the care was completed. On 06/02/2011 at 2:25 pm the Director of Nursing (DON) indicated newly hired nursing assistants and nurses had been educated during general orientation and with a preceptor when first on assignments. The DON indicated nursing assistants and nurses were taught to secure the catheters. The DON indicated she expected nursing assistants and nursing staff to secure catheter tubing to the leg with a leg bands or tape. On 06/02/2011 at 3:45 pm an interview with NA #10 indicated indwelling catheters should have been anchored to the leg with a leg band or clamps, she indicated she never used tape to anchor. On 06/02/2011 at 4:00 pm an interview with NA #11 indicated indwelling catheters should have been anchored with leg bands or clamps. NA #11 indicated she had informed the nurse when the anchors needed replacement. On 06/03/2011 at 10:15 am an interview with the Nurse #6 indicated staff training for indwelling catheter was done annually, by herself and Nurse #8. Nurse #6 said her expectation was that indwelling catheters were anchored to the residents to prevent pulling on the catheter. 2. Resident #5 was admitted to the facility on 08/31/2010 with cumulative diagnosis of Paraplegia, Neurogenic Bladder, and Frequent Urinary Tract Infections.The most recent	F 315		

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F 315	Continued From page 14 Minimum Data Set on 05/02/2011 indicated resident #5 was cognitively intact, had a suprapubic catheter in place due to a Neurogenic Bladder. Record review of the facility inservice on 01/18/2011 instructed staff on proper perineal and catheter care. Inservice on 04/01/2011 instructed staff on perineal-care review. The facility Catheter Care Policy dated 03/2005 indicated an indwelling catheter was to be anchored to prevent pulling. On 05/31/2011 at 5:00 pm with NA #3 perineal and catheter care was provided. NA #3 did not place an anchor to the indwelling catheter after completing care. On 05/31/2011 at 5:30 pm Resident #5 indicated the indwelling catheter was usually taped to her leg. Resident #5 indicated the indwelling catheter tubing still had not been secured in place. On 06/02/2011 at 2:25 pm the Director of Nursing (DON) indicated newly hired nursing assistants and nurses had been educated during general orientation and with a preceptor when first on assignments. The DON indicated nursing assistants and nurses were taught to secure the catheters. The DON indicated she expected nursing assistants and nursing staff to secure catheter tubing to the leg with a leg bands or tape. On 06/02/2011 at 3:45 pm an interview with NA #10 indicated indwelling catheters should have	F 315		

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F 315	Continued From page 15 been anchored to the leg with a leg band or clamps, she indicated she never used tape to anchor. On 06/02/2011 at 4:00 pm an interview with NA #11 indicated indwelling catheters should have been anchored with leg bands or clamps. NA #11 indicated she had informed the nurse when the anchors needed replacement. On 06/03/2011 at 10:15 am an interview with the Nurse #6 indicated staff training for indwelling catheter was done annually, by herself and Nurse #8. Nurse #6 her said her expectation was that indwelling catheters were anchored to the residents to prevent pulling on the catheter. 3. Resident # 14 was admitted to the facility on 5/16/11 with a diagnosis of unstageable sacral pressure sore. The Minimum Data Set (MDS) dated 5/23/11 indicated the resident was cognitively intact and had an indwelling catheter. Review of the facility Female/Male Catheterization Policy indicated the staff had been instructed to tape the indwelling catheter to the resident ' s thigh or use a leg band with Velcro. Observation on 5/31/11 at 3:30 pm revealed the resident had and indwelling catheter connected to a collection bag which was attached to the side of the bed. The catheter tube was not anchored to the resident ' s thigh or leg. When asked if the catheter was anchored, Nurse # 8, who was present during the observation, responded it was not.	F 315		

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F 315	Continued From page 16 On 6/2/11, at 2:25 pm the Director of Nursing (DON) indicated the nursing assistants and nurses had been educated during general orientation and preceptor ship when first on assignments. The DON indicated nursing assistants and nurses were taught how to secure catheters. The DON indicated she expected nursing assistants and nursing staff to secure catheter tubing to the let with a leg band or hypofix/mefix (tape).	F 315	**F 318 Increase /Prevent Decrease In Range of Motion** Resident #10 is receiving range of motion as ordered. Current residents identified to need Restorative Nursing programs have been reviewed by the Restorative Nurse to ensure treatment is being delivered as ordered and documented. The Restorative aides have been re-educated regarding range of motion orders, scheduling and documentation of services provided. The Nursing staff has been re-educated in both active and passive range of motion. The Director of Nursing has reviewed current staffing patterns and will ensure restorative programs are delivered as ordered. A QA Monitoring tool will be utilized by the Director of Nurses and/or her designees weekly times	14 6-22-11 JPS
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to provide range of motion consistently 6 to 7 days per week as care planned in 1 of 21 sampled residents at risk for decline (Resident #10). The findings include: The facility ' s manual for Restorative Nursing Programs revised February 2005 stated the following: " Daily documentation is required for verification that the program was executed. "	F 318		

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F 318	Continued From page 17 " Program will be provided six to seven days a week. " " Episodic documentation to explain why the guest did not participate in the program will be recorded on the back of the form when necessary. " The facility ' s Restorative Program Therapy to Nursing Communication form revised April 2005 indicated the signatures of the restorative aides having received instruction in interventions and when instruction was received. Resident #10 was readmitted 09/05/10 with diagnoses, in part, spinal cord injury and quadriplegic. The Minimum Data Set (MDS) dated 12/22/10 indicated the resident had intact cognition. The MDS indicated the resident had functional limitation in range of motion with impairment on both sides of the upper and lower extremities. The Restorative Passive Range of Motion Program Daily Record indicated Resident #10 was supposed to have had range of motion. For January, February and March 2011, under problem/need, the Record indicated the resident was unable to perform passive range of motion, unable to raise arms above head, unable to raise arms straight out from shoulders, unable to touch top of head, unable to rotate feet in and out, unable to move feet up and down and unable to rotate legs inward and outward. The Record indicated the problem/need was related to functional impairment and muscle weakness. The Record indicated the goals, in part, were to improve passive range of motion. The Record indicated interventions for left and right hands,	F 318	4 weeks, then monthly times 3 months to ensure residents are receiving treatment as ordered and documented per policy. Variances will be corrected as identified. Monitoring results will be reported to the Director of Nursing weekly times (4) four weeks and concerns will be reported to the quality assurance committee for further recommendations during the monthly meeting. Continued compliance will be monitored by the Restorative Nurse through routine review of restorative documentation, observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 318	Continued From page 18 fingers, elbows, shoulders, knees, legs and feet. The Record indicated frequency as once a day and 6 - 7 days per week with a met date of April 2011. In January 2011, there was no documentation of restorative services rendered to Resident #10 on 11 of 31 days (1/1/11, 1/2/11, 1/8/11, 1/10/11, 1/11/11, 1/15/11, 1/20/11, 1/21/11, 1/22/11, 1/23/11and 1/28/11). There was no documentation to explain why the resident did not participate in the program on those days. In February 2011, there was no documentation of restorative services rendered to Resident #10 on 13 of 28 days (2/2/11, 2/4/11, 2/5/11, 2/6/11, 2/11/11, 2/15/11, 2/16/11, 2/17/11, 2/18/11, 2/19/11, 2/20/11, 2/22/11, 2/25/11 and 2/28/11). There was no documentation to explain why the resident did not participate in the program on those days. In March 2011, there was no documentation of restorative services rendered to Resident #10 on 18 of 31 days (3/1/11, 3/3/11, 3/5/11, 3/6/11, 3/7/11, 3/8/11, 3/10/11, 3/11/11, 3/13/11, 3/14/11, 3/15/11, 3/17/11, 3/18/11, 3/19/11, 3/20/11, 3/21/11, 3/25/11and 3/28/11). There was no documentation to explain why the resident did not participate in the program on those days. The Restorative Passive Range of Motion Program Daily Record for April, May and June 2011, under problem/need, indicated the Resident #10 was unable to perform passive range of motion, unable to raise arms above head, unable to raise arms straight out from shoulders and unable to touch top of head. The	F 318		

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F 318	Continued From page 19 Record indicated the problem/need was related to functional impairment and muscle weakness. The Record indicated the goals, in part, were to improve passive range of motion. The Record indicated interventions for left and right hands, fingers, elbows, shoulders, knees, legs and feet. The Record indicated the Tier was functional. The Record indicated frequency as once a day and 6 - 7 days per week with a met date of July 2011. In April 2011, there was no documentation of restorative services rendered to Resident #10 on 18 of 30 days (4/2/11, 4/3/11, 4/8/11, 4/11/11, 4/13/11, 4/16/11, 4/17/11, 4/21/11, 4/22/11, 4/23/11, 4/24/11, 4/25/11, 4/27/11, 4/28/11, 4/29/11and 4/30/11). There was no documentation to explain why the resident did not participate in the program on those days. In May 2011, there was no documentation of restorative services rendered to Resident #10 on 12 of 31 days (5/1/11, 5/2/11, 5/6/11, 5/9/11, 5/15/11, 5/20/11, 5/21/11, 5/22/11, 5/23/11, 5/28/11, 5/29/11 and 5/31/11). There was no documentation to explain why the resident did not participate in the program on those days. On 05/31/11 at 12:16 PM, RA #1 stated Resident #10 was assigned to RA #2. RA #1 stated she had not done restorative therapy on Resident #10 for months. On 05/31/11 at 3:14 PM, RA #2 was observed providing range of motion to the right upper and right lower extremities of Resident #10. This included the right shoulder, elbow, hand, fingers, leg, knee and foot. RA #2 stated it was active	F 318		

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F 318	Continued From page 20 range of motion. On 05/31/11 at 3:14 PM, RA #2 stated when there were too many residents referred to restorative services, there was a work overload. RA #2 stated Resident #10 really needed therapy consistently because he got stiff and was at risk for more resistance with range of motion. While providing therapy, RA #2 stated Resident #10 was resistant to range of motion in his right arm. RA #2 stated Resident #10 was not like this when he got therapy consistently. On 05/31/11 in continued interview, RA #2 stated she had been pulled from the restorative program and been reassigned to work as a nursing assistant on the floor when there has been a staffing shortage. RA #2 stated restorative services were not provided to residents when the RAs were reassigned to work as a nursing assistant. RA #2 stated there are 2 RAs in the restorative nursing program. RA #2 stated each RA was scheduled to work every other alternate weekend. On 05/31/11 at 3:25 PM, Resident #10 stated he wanted restorative therapy consistently because he got real stiff. Resident #10 stated he was not receiving restorative therapy like he ' s supposed to. Resident #10 stated there were many days in a row when he didn ' t get therapy. Resident #10 stated RA #1 hadn ' t done his range of motion every other weekend for months. On 06/01/11 at 3:04 PM, the Restorative Coordinator Nurse (RCN) stated Resident #10 had not received consistent range of motion as scheduled. The RCN stated the 2 RAs are very	F 318		

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F 318	Continued From page 21 good. The RCN stated if there were blanks in the documentation then services were not provided. The RNC was observed reviewing the chart for Resident #10. The RCN stated there was no medical indication to not do range of motion for Resident #10. The RCN stated the facility should have a better system. The RCN stated 3 reasons why the restorative services were not consistently provided. The RCN stated the RAs had been pulled from the restorative program and been reassigned to work as nursing assistants when there had been a staffing shortage on the floor; when the RAs had been on vacation; and when the RAs had a scheduled day off. On 06/02/11 at 2:52 PM, the Director of Nursing (DON) stated there had been staffing shortages on the floor. The DON stated she expected the RAs and the RCN to follow the policies and procedures for the restorative nursing program.	F 318	**F 323 Free of Accident Hazards/Supervision/Devices** Residents # 1's, 26, and 27's slings have been replaced. All lift pads were inspected by the Administrator and DON during the survey. Any frayed, or damaged slings were disposed of and new slings were put into service. The Housekeeping/Laundry employees have been re-educated in proper laundering of slings, to include not using bleach, inspecting for damage and to discard if found to be damaged or frayed. The Nursing staff has been re-educated in the proper use of the lift sling which included inspection of the sling prior to use and discarding and replacement of the sling if any damage is found. Lift use, sling inspection and replacement will continue to be included in new nursing assistant	24 6.22.11
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure total lift slings were maintained and used according to the manufacturer ' s instructions for	F 323		

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F 323	Continued From page 22 3 of 4 sampled residents transferred with a total lift sling (residents # 1, # 26, and # 27). The Manufacturer ' s Operator and Maintenance Manual for Electric Portable Patient Lifts provided by the Director of Nursing (DON) on 6/2/11 at 4:00 pm revealed the following warnings for transferring the patient: When the sling is elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If attachments are NOT properly in place, lower the patient back on the stationary surface and correct this problem-otherwise injury or damage may occur. (page 32). Be sure to check the sling attachments each time the sling is removed and replaced to ensure that it is properly attached before the patient is removed from the bed or chair (page 33). The Manufacturer ' s Sling Guide provided by the Director of Nursing (DON) on 6/2/11 at 4:00 pm revealed the following warnings on the second page: Before using the Patient Sling and Patient Lift, read and understand the Owner ' s Manual for proper operation and safety procedures. Before lifting, check all sling straps for secure points of attachment on lift device. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately. Findings include: 1. Resident # 27 was admitted to the facility on 1/23/06. A Minimum Data Set (MDS) dated 4/13/11 indicated the resident was cognitively impaired and totally dependent on staff for	F 323	orientation and reviewed periodically through the nursing assistant in-service education calendar process. A QA Monitoring tool will be utilized by the Director of Nurses and/or her designees weekly times 4 weeks, then monthly times 3 months to ensure slings are in proper condition. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine lift observations, through routine review of sling inventory and through the facility's quality assurance program. Additional	

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F 323	Continued From page 23 transfers. The resident transferred with a total mechanical lift and sling. On 6/2/11 at 4:10 pm Laundry Worker # 1 indicated the slings used for the mechanical lifts were washed in the machines and that bleach was added automatically to the wash cycle. Laundry Worker # 1 said slings were inspected and the ones that were frayed or had loose stitching were supposed to be given to the laundry supervisor. On 6/2/11 at 4:12 pm the Environmental Services Director stated laundry staff were taught to inspect slings for tearing and fraying and if found in this condition, slings were brought to the attention of this supervisor who threw the sling away and ordered a replacement. On 6/2/11 at 4:15 pm resident # 27 was observed prior to transfer with the total mechanical lift. The resident was lying in bed with a fabric full body style sling in place. This sling had two web straps on the top of the sling and two web straps on the bottom of the sling. Each strap in turn had four loops or connection points for a total of sixteen. NA # 3 and NA # 4 brought the total mechanical lift to the bedside and started to hook up the sling to the lift. One loop was completely torn through and a second loop was half torn through and the stitching was loose. The sling was faded in color. After NA # 4 observed one loop was completely torn through and a second loop was half torn through, another sling was selected for transfer. On 6/2/11 at 4:20 pm NA # 4 stated she thought the straps were ok and had not looked at the straps prior to placing the sling on the resident.	F 323		

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F 323	Continued From page 24 NA # 4 stated lift training was completed during orientation about one year ago and included checking the sling. On 6/2/11 at 4:25 pm a label on the back top of the sling was noted to read in part: Warning: Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately. Do not bleach. On 6/3/11 at 11:08 am the facility ' s Staff Development Coordinator (SDC) stated lift training was completed on the floor during orientation by another NA or Restorative Aide. The SDC stated she expected the trainer to discuss safe sling use. 2. Resident # 1 was readmitted to the facility on 11/2/10. A Minimum Data Set (MDS) dated 4/25/11 indicated the resident was cognitively intact and totally dependent on staff for transfers. The resident transferred with a total mechanical lift and sling. On 6/3/11 at 10:55 am, the QA Manager stated resident # 1 was transferred back to bed to replace the sling in use because it had a broken loop. On 6/3/11 at 10:56 am resident # 1 was observed in transfer from the wheelchair to the bed with a total mechanical lift and sling. NA# 13 and the SDC performed the transfer. The resident was up in the air beside the bed and was then pushed over to the bed and lowered onto the bed with the total mechanical lift. The sling used was a fabric divided leg style sling with six straps-two near the	F 323		

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F 323	Continued From page 25 top of the sling, two near the middle of the sling and one on each leg piece at the bottom of the sling. The total mechanical lift provided hook up points for all six straps but only five of the six sling straps were hooked to the total mechanical lift during transfer. The top left sling strap near the resident ' s head was not hooked to the lift. One of twenty-two sling loops was broken. On 6/3/11 at 10:57 am, the SDC stated she had not noticed during the transfer that one sling strap was not hooked to the lift and NA # 13 stated the resident must have unhooked the strap prior to or during the transfer. On 6/3/11 at 11:08 am the facility ' s Staff Development Coordinator (SDC) stated lift training was completed on the floor during orientation by another NA or Restorative Aide. The SDC stated she expected the trainer to discuss safe sling use. 3. Resident # 26 was admitted to the facility on 5/31/11. The Nursing Admission Assessment dated 5/31/11 indicated the resident was a bilateral amputee and totally dependent on staff for transfers. The resident transferred with a total mechanical lift and sling. On 6/1/11 at 5:25 pm resident # 26 was observed sitting on a total lift sling in a wheelchair. On 6/1/11 at 5:28 pm, after the resident was back in bed, the sling was examined. Upon examination, the sling was a full body mesh style sling used with the total mechanical lift. The sling had four straps made of webbing-two straps on the top of the sling and two straps on the bottom	F 323		

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F 323	Continued From page 26 of the sling. Each webbed strap in turn was made with four loops or connection points for a total of sixteen loops or connection points that could be used to hook the sling to the total mechanical lift during transfer and lifting or lowering the resident. Twelve of the sixteen loops were frayed and had started to wear through. The lining of the sling was torn, the binding was missing and reinforcement stitching on the bottom corner of the sling was loose. The sling was faded and smelled like bleach. On 6/2/11 at 9:00 am the QA Manager indicated the sling belonged to the facility. On 6/2/11 at 9:48 am NA # 16 stated the sling was used on 6/1/11 to transfer the resident out of bed. NA #16 indicated that the sling looked worn but said, " It was the only one back there. " On 6/2/11 at 4:10 pm Laundry Worker # 1 indicated the slings used for the mechanical lifts were washed in the machines and that bleach was added automatically to the wash cycle. Laundry Worker # 1 said slings were inspected and the ones that were frayed or had loose stitching were supposed to be given to the laundry supervisor. On 6/2/11 at 4:12 pm the Environmental Services Director stated laundry staff were taught to inspect slings for tearing and fraying and if found in this condition, slings were brought to the attention of this supervisor who threw the sling away and ordered a replacement. On 6/3/11 at 11:08 am the facility ' s Staff Development Coordinator (SDC) stated lift	F 323		

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F 323	Continued From page 27 training was completed on the floor during orientation by another NA or Restorative Aide. The SDC stated she expected the trainer to discuss safe sling use.	F 323		
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, medical record review and staff interview, the facility failed to change the oxygen tubing weekly and failed to provide humidified water for one of two sampled residents who received oxygen (Resident #1). Findings include: Facility policy titled Bubble Humidifiers and dated 12/02 stated, in part,"Prefilled humidifiers are changed when empty, at least every seven days by nursing." Facility policy titled Nasal Cannula and dated 12/02 stated, in part,"Nasal cannulas are to be changed one time per week and prn (as needed) by nursing."	F 328	**F 328 Treatment/Care for Special Needs** The humidifier water container and oxygen tubing for resident #1 was changed at the time of survey. No negative outcome resulted from this observation. All current residents utilizing oxygen were checked to ensure the humidifiers were properly filled with water, and equipment had been changed within the last (7) seven days and dated. No other variances were identified. The Nursing staff and Central Supply Clerk have been re-educated to properly change and date oxygen tubing and water bottles. A QA Monitoring tool will be utilized by the Director of Nurses	24 6-22-11 jpg

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F 328	Continued From page 28 Resident #1 was admitted to the facility 09/16/2009 and readmitted to the facility 11/02/2010 following a hospitalization. Cumulative diagnoses included: Chronic Obstructive Pulmonary Disease (COPD). During the initial tour on 05/31/2011 at 8:50 AM., Resident #1 was observed wearing an oxygen nasal cannula. The water bottle attached to the oxygen concentrator that supplied humidified oxygen to Resident #1 was empty. The oxygen tubing was dated 05/12/2011. The water bottle was not dated. On 05/31/2011 at 2:55 PM., Resident #1 stated the oxygen tubing and the water bottle are changed once a week. Resident #1 stated the oxygen felt more comfortable when there was water in the bottle. Resident #1 said she told the nursing staff last night (5/30/2011) that the water bottle was empty. Another observation on 05/31/2011 at 4:35 PM. revealed the oxygen tubing that Resident #1 was wearing was dated 05/12/2011 and the water bottle used to humidify the oxygen was empty. On 05/31/2011 at 4:35 PM., Nurse #6 stated nursing staff on night shift changed the oxygen tubing weekly. The water bottles were also changed at that time. The date that the tubing and water bottle was changed was documented on the oxygen tubing. Nurse #6 went to Resident #1's room and observed the oxygen tubing was dated 5/12/2011 and the water bottle that contained the humidified water was empty.	F 328	and/or her designees weekly times (4) weeks, then monthly times 3 months to ensure oxygen equipment is changed per policy. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks then monthly for the next (3) three months. Concerns will reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through routine daily round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 328	Continued From page 29 Nurse #6 stated the oxygen tubing should have been changed last week and the water bottle should not have been empty. On 5/31/2011 at 4:45 PM., the Director of Nursing stated night shift nursing staff no longer changed the oxygen tubing. The Central supply clerk changed the oxygen tubing every seven days. The water bottle would be changed at that time or more frequently if necessary. She expected the oxygen tubing and the water bottle to be dated and changed per facility policy. The water bottle should not be empty.	F 328	**F 371 Food Procure, Store/Prepare/Serve-Sanitary** The drinks in the walk in refrigerator were discarded at the time of observation. The items unlabeled and open in the walk in freezer and the parmesan cheese were discarded at the time of observation.	24 6.22-11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and staff interviews the facility failed to store foods under sanitary conditions, label and date opened food products, clean and sanitize kitchen equipment, maintain refrigerator temperatures below 41 degrees fahrenheit and prevent possible cross contamination while preparing food. Findings Include:	F 371	The table can opener has been cleaned. The items in the reach in refrigerator were discarded. The circuit breaker for the refrigerator has been replaced. The temperature log was replaced on the refrigerator and temperatures are being monitored per policy. The cook has been re-educated in proper hand washing policy and procedure. The kitchen refrigerator and freezers were inspected by the Dietary Manager at the time of	

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F 371	Continued From page 30 1. On 5/31/11 at 8:55am an initial kitchen tour was conducted. At 8:57am, a rolling rack containing cups filled with liquid beverages was pushed under the bottom shelf in the walk-in refrigerator. The shelf directly above the rolling rack of beverages had a pan of thawing ground beef on it. An interview with the Dietary Manager on 6/2/11 at 2:38pm revealed he would not expect to store prepared beverages under thawing meat. 2. On 5/31/11 at 8:55am an initial kitchen tour was conducted. There were unlabeled opened food products found in the walk-in freezer. The food products were pork cutlets, hot dogs, ground beef patties, and cookie dough. Also an unlabeled package of parmesan cheese was located in the reach in refrigerator next to the pot sink. An interview with the Dietary Manager on 6/2/11 at 2:38pm revealed he would expect for opened food items to be labeled and dated. 3. On 5/31/11 at 8:55am an initial kitchen tour was conducted. At 9:05am, a table can opener located at the end of a preparation table had a buildup of a black sticky substance. This buildup was located around all the edges on the table can opener. Also the puncture area had some additional black sticky substance on it. An interview with the Dietary Manager on 6/2/11 at 2:38pm revealed he had the table can opener on a cleaning schedule. He would not have expected to have a black sticky substance	F 371	the survey. No other items were identified as unlabeled or open. The dietary staff have been re-educated in proper cleaning techniques, proper hand washing, and proper storage, labeling, and dating of refrigerated items, and monitoring temperatures of the freezers and refrigerators . A QA Monitoring tool will be utilized by the Dietary Manager twice daily times two weeks, and two times weekly times three months to ensure compliance. Variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator weekly for the next (3) three months and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored by the Dietary Manager through daily sanitation	

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F 371	Continued From page 31 buildup on the can opener. This was not acceptable. 4. On 5/31/11 at 8:55am an initial kitchen tour was conducted. The tray line was completed for breakfast. At 9:15am, the refrigerator next to serving line external temperature reading was 65 degrees fahrenheit. The internal thermometer reading was 55 degrees fahrenheit. There were milk, juices, nutritional shakes and thickened beverages inside the refrigerator. An interview with Dietary Aide #1 on 5/31/11 at 9:18am indicated this refrigerator was used for the tray line. Dietary Aide #1 indicated the breaker had tripped for the refrigerator. He was not sure when this had happened. An interview with the Cook on 5/31/11 at 9:20am revealed that there was no temperature logs documented for the reach-in refrigerator next to the tray line. An interview with the Dietary Manager on 6/2/11 at 2:38pm revealed he would not expect the refrigerator temperature to be at 55 degrees fahrenheit. 5. An observation on 5/31/11 at 11:36am revealed the Cook washing a utensil in the pot sink. Afterwards the Cook began to use the utensil in a pot on the stove. The Cook did not wash his hands after cleaning the utensil. An interview with the Dietary Manager on 6/2/11 at 2:38pm revealed he would expect staff to wash their hands after washing dishes and returning to food preparation.	F 371	observations, through the monthly sanitation review and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain the temperature range between 36 degrees Fahrenheit (F) to 46 degrees F in 2 of 2 medication room refrigerators (Station 1, Station 2). The findings include: According to the standard set by US Pharmacopeia revised June 1994, " a refrigerator is a cold place in which the	F 425	**F 425 Pharmaceutical svc- Accurate Procedures, RPH** The temperature log has been updated to include the 36 to 46 degree range for medication refrigerators. The refrigerator on station 2 has been replaced. The temperatures have been adjusted to within acceptable range. No negative outcome resulted from this observation. All medication refrigerators were checked for proper temps and all logs have been updated to include the acceptable range. The temperatures are being monitored by the charge nurses and variances corrected when indicated. The Licensed Nurses have been re-educated regarding the proper temperature range, the updated temperature log sheet, and proper medication storage.	24 6-22-11 JPS

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F 425	Continued From page 33 temperature is maintained thermostatically between 2 degrees Celsius and 8 degrees Celsius (36 degrees F to 46 degrees F). " The facility ' s Refrigerator / Freezer Temperature Record identified the temperature range for the refrigerator between 33 degrees F to 41 degrees F. On 6/01/11 at 9:20 AM, the Maintenance Director stated he did not know the temperature range for medication refrigerators. On 06/01/11 at 10:05 AM, the labeled Refrigerator / Freezer Temperature Record for June 2011 was observed taped to the door of the Station 1 medication room refrigerator. The Record included separate columns for date, initials, time (AM or PM) and temperature. Refrigerator temperatures were notated under the reach-in refrigerator column of the Record. The Station 1 medication room Refrigerator / Freezer Temperature Record for May 1, 2011 to June 1, 2011 indicated all temperatures were recorded in AM. The May 1, 2011 to June 1, 2001 Record indicated two days were recorded within the acceptable temperature range set by US Pharmacopeia (5/28/11 at 36 degrees F and 5/29/11 at 38 degrees F). The May 1, 2011 to June 1, 2011 Record indicated one day at 30 degrees F (5/31/11) and 7 days at 34 degrees F (5/2/11, 5/7/11, 5/11/11, 5/17/11, 5/20/11, 5/27/11 and 5/30/11). The Station 1 Record indicated the following documentation:	F 425	A QA Monitoring tool will be utilized by the Director of Nurses and/or her designees weekly times 4 weeks, then monthly times 3 months to ensure proper temperatures in the medication refrigerators. Variances will be corrected as identified. Monitoring results will be reported to the Director of Nurses weekly and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through routine review of the temperature logs and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 425		F 425		

Continued From page 34

date	time	temperature (F)
5/1/11	AM	33
5/3/11	AM	33
5/4/11	AM	33
5/5/11	AM	33
5/6/11	AM	33
5/8/11	AM	33
5/9/11	AM	33
5/10/11	AM	33
5/12/11	AM	33
5/13/11	AM	33
5/14/11	AM	33
5/15/11	AM	33
5/16/11	AM	33
5/18/11	AM	33
5/19/11	AM	33
5/21/11	AM	33
5/22/11	AM	33
5/23/11	AM	33
5/24/11	AM	33
5/25/11	AM	33
5/26/11	AM	33
6/1/11	AM	33

The Station 1 medication room Refrigerator / Freezer Temperature Record for May 31, 2011 indicated a new thermometer had registered a temperature of 40 degrees F. On 06/01/11 the Record indicated the Station 1 medication room refrigerator registered 33 degrees F.

On 06/01/11 at 12:24 PM, the facility ' s contracted pharmacist (FCP) was observed referencing pharmaceutical guidelines on the medications stored in the Station 1 medication refrigerator. The FCP stated the reason the medication refrigerator temperature range needs

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F 425	Continued From page 35	F 425		

to be 36 degrees F to 46 degrees F is because that is what the reference pharmaceutical guidelines state for medication storage. The FCP stated Phenadoz, Humalog, Lantus, Novolin R, Novolog, Novolin, Phenergan Suppository, Aplisol and Hepatitis B vaccine were stored in the Station 1 medication refrigerator.

According to the Drug Information Handbook for Nursing dated 2011, storage for Phenadoz, Humalog, Lantus, Novolin R, Novolog, Novolin and Phenergan Suppository should be between 36 degrees F to 46 degrees F. According to the packet insert for Aplisol, storage should be between 36 degrees F to 46 degrees F. According to the internet drug index for Hepatitis B vaccine, storage should be between 36 degrees F to 46 degrees F.

The Station 2 medication room Refrigerator / Freezer Temperature Record indicated all temperatures were recorded in AM. The Station 2 medication room Refrigerator / Freezer Temperature Record for May 2011 indicated three days recorded not within the acceptable temperature range set by US Pharmacopeia.

The Station 2 Record indicated the following documentation:

date	time	temperature (F)
5/27/11	AM	34
5/28/11	AM	33
5/29/11	AM	33

On 06/01/11 at 10:05 AM with continued tour of

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 06/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(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) COMPLETIO DATE
F 425	Continued From page 36 the medication storage area, the Station 2 medication room refrigerator was observed to have 1.5 inches of ice on the base of the freezer. The thermostatic knob for the dial to regulate the temperature of the Station 2 medication room refrigerator was missing. The thermometer in the Station 2 medication room was observed to register 48 degrees F. On 06/01/11 at 12:04 PM, with the FCP present, the thermometer in the Station 2 medication room was observed to register 50 degrees F. On 06/01/11 at 12:04 PM, the FCP stated the thermostatic knob for the dial to regulate the temperature of the Station 2 medication room refrigerator was broken. The FCP stated the Station 2 Unit Coordinator had adjusted the temperature earlier that day but must have turned, what was left of the dial, the wrong way. On 06/01/11 at 12:12 PM, with the FCP present, the Administrator stated the medication refrigerators should be 36 degrees F to 46 degrees F.	F 425	**F 441 Infection Control, Prevent Spread, Linens** Resident #5's catheter bag has been replaced with a leg bag when up to ensure no tubing touches the floor. An audit of residents with catheters was done by the DON and nurse managers during the survey. No other residents were found to be without catheter bags or with tubing touching the floor. The nursing staff has been re-educated in proper use of dignity bags and keeping tubing off of the floor. A QA Monitoring tool will be utilized by the Director of Nurses and/or her designees weekly times 4 weeks, then monthly times 3 months to ensure proper placement of dignity bags and that tubing is kept off of the floor. Variances will be corrected at the time of observation.	6-24-11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 37 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to keep an indwelling urinary catheter bag and tubing off the floor for 1 of 7 sampled residents, (resident #5). Findings include: Resident #5 was admitted to the facility on 08/31/2010 with cumulative diagnosis of Paraplegia, Neurogenic Bladder, and Frequent Urinary Tract Infections. The most recent	F 441	Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks then monthly for (3) three months. Concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine daily round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 441	Continued From page 38 Minimum Data Set on 05/02/2011 indicated resident #5 was cognitively intact, had a suprapubic catheter in place due to a Neurogenic Bladder. Chart review on 05/31/2011 of the Care Plan indicated the resident was at risk for dehydration/fluid volume alteration due to the indwelling catheter Record review of the facility inservice to staff on 01/02/2011 instructed staff on urinary tract infection prevention. Inservice on 01/13/2011 instructed staff on infection control policy and procedures. Inservice on 01/18/2011 instructed staff on proper perineal and catheter care. . On 05/31/2011 at 9:00 am and 10:00 am Resident #5 indwelling catheter bag and tubing was found to be on the floor next to her bed. On 05/31/2011 at 12:00 noon Resident #5 was out of bed to wheel chair with indwelling catheter bag in a privacy bag attached to the wheel chair. On 05/31/2011 at 5:00 pm Nursing Assistant (NA) #3 provided perineal and catheter care for Resident #5. NA #3 provided care per facility policies. NA #3 hung the indwelling catheter to bed frame with no part of it or tubing touching the floor. On 06/02/2011 at 2:25 pm the Director of Nursing (DON) indicated she expected staff to replace the indwelling catheter bag if it was found on the floor. On 06/02/2011 at 3:35 pm Nurse #3 indicated if she found an indwelling catheter bag on the floor she would have used a sanitizer to clean it off	F 441		

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F 441	Continued From page 39 with gloves on and hooked it back on the bed.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345421	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/3/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based upon record review and staff interviews the facility failed to develop a comprehensive care plan for 1 of 21 Sampled Residents (Resident #7) for mood and psychosocial well being.

Finding Include:

Resident #7 was admitted to the facility on 4/12/11 with cumulative diagnoses of right femur fracture, anxiety, depression, weight loss and stage II lung cancer. The Minimum Data Set (MDS) dated 4/19/11 indicated Resident #7 was without significant cognitive impairment. The mood state section indicated Resident #7 was feeling down/depressed or hopeless and feeling tired or having little energy for the past 12 to 14 days.

A record review of the Social Services evaluation dated 4/19/11 revealed Resident #7 spouse recently passed. The psychosocial section indicated Resident #7 felt down, depressed or hopeless and was tired with little energy.

A record review of the physician progress notes dated 4/15/11 revealed Resident #7 to have severe pain and was depressed. Resident #7 was crying and desired company. The physician progress note dated 5/5/11 Resident #7 husband died 4 months ago and was grieving. The physician progress note for 5/17/11 revealed Resident #7 was needy with severe anxiety and depression manifesting. A psychiatric consult was ordered on 5/26/11 for counsel of depression and anxiety.

An interview with the Social Worker (SW) on 6/1/11 at 9:18am revealed Resident was very depressed when admitted due to the loss of her husband and a new diagnosis of lung cancer. She had improved since being admitted. The Psychiatric Nurse visited Resident #7 close to her admission and indicated Resident #7 had improved. Resident #7 however does get anxious at times due to working out issues with her insurance company and medications. The SW looked through Resident #7 chart and could not find the resident care planned for mood state and psychosocial well being. The SW indicated that behavioral management would

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345421	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/3/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 1

be done soon. The behavioral management was done on anyone on antipsychotic medications, recent falls or behavior issues. It was typically done once a week. The minimum to be done was once a month. Resident #7 has had anxiety since the end of April.

An interview with the MDS Nurse on 6/1/11 at 10:28am revealed she does not attend care plan meetings. The SW fills out the psychosocial and mood section of the MDS. The MDS Nurse indicated she was unaware of Resident #7 psychosocial and mood issues. She created a care plan for mood this morning, after the SW notified her of the missing care plan.

An interview with the Director of Nursing (DON) on 6/2/11 at 2:51pm revealed that an initial care plan was to be created in a 3 day time period upon admission. The care plan meetings were arranged by the SW and MDS Nurse. The DON indicated you can complete a care plan for a resident who does not trigger on the MDS. The DON indicated she had completed care plans for residents that did not trigger on the MDS in the past. Resident #7 psychological condition was discussed at her initial care plan meeting and a psychotropic medication was ordered at the end of April. The DON indicated she would have expected for a care plan to be completed for Resident #7 mood state and psychosocial well being.