STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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=B	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and record review, the facility failed to follow up on grievances made by a family member on behalf of two (2) of two (2) residents regarding staff treatment and call bell response. (Resident #1 and Resident #4). The findings are: 1. Resident #1 was admitted to the facility with diagnoses which included dementia. The most recent Minimum Data Set (MDS), a quarterly assessment dated 06/02/2011, indicagted the resident has severely impaired cognition and requires extensive assistance with activities of daily living. A review of the medical record of Resident #1 revealed a nurses progress note dated 06/13/2011 8:00 p.m. which stated: "Family upset said Res. had had her light on a long time." An interview with the family of Resident #1 on 06/30/2011 at 3:25 p.m. revealed they filed a verbal complaint with the Social Worker on 06/14/2011 about the incident on 06/13/2011. The family stated they were upset because two nursing assistants and a licensed nurse came	F 166	**F 166 483.10 (f) (2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES SS= B** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A careplan meeting was held on 7/22/11 with family of resident #1. The Executive Director and Regional Director of clinical services was in attending. A weekly call from careplan team and /or ED to daughter (responsible party) will be made on Thursdays to ensure there are no grievances that have not been addressed. Resident # 4 Was discharged on 07/12/11. Prior to planned discharge resident had 2 grievances that were resolved within the same day. Social Worker stated that family verbalized satisfaction with care given. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. The DON was re-educated by ED and Regional Consultant on 06/30/11 on following-up on grievances promptly. **All residents were asked if they had any complaints/issues that had not been addressed. No residents verbalized having any grievances that have been un- resolved. Audit completed on 07/28/11 by Social worker and ED, IDON.** RECEIVED JUL 29 2011 BY: DEN	7/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Morrow | TITLE: Executive Director | (X6) DATE: 7/29/11

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 into their mother's room, over a period of approximately twenty minutes, in response to their mother's call bell but none of them attended to their mother's needs. The resident needed repositioned in bed and her gown changed because it was damp with perspiration. Resident #1's family stated they were told by the Social Worker that the Director of Nursing (DON) would be notified and would follow up with them. They stated they had not been contacted by the DON as of 06/30/2011. An interview with the Social Worker on 06/30/2011 at 4:00 p.m. revealed she had spoken to Resident #1's family on 06/14/2011 and had relayed the family's concerns to the DON on 06/14/2011. An interview with the DON on 06/30/2011 at 4:14 p.m. revealed she had spoken to one of the nursing assistants named in the complaint but had not yet talked to the other nursing assistant or the licensed nurse named in the complaint. When asked about the usual time it takes to follow up on grievances, she stated she usually tries to follow up with family members within three (3) days. When asked about the lack of response to Resident #1's family, she stated she just got busy with other things and forgot. 2. Resident #4 was admitted to the facility with diagnoses which included left pelvic fracture, fracture of left humerus, hypertension and hypokalemia. Review of the 5/31/11 Minimum Data Set (MDS) revealed Resident #4 was assessed as alert and oriented. The facility also identified Resident #4 as being interviewable. During an interview with Resident #4 on 6/28/11	F 166	**What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** The Social Worker will fill out comment and concern card on all grievances. The Social Worker will make a copy of comment and concern and give the original to appropriate Dept. Manager. The Social Worker will follow-up with Dept. Manager if grievance card is not returned within 5 days. Beginning on 06/30/11 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The Social Worker will present data to the Monthly Quality Assurance Meeting for the next 3 months. The Data will include how many grievances per month and how many were followed up in a timely manner. Beginning with the August 17th, 2011 Q A meeting.	

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F 166	Continued From page 2 at 12:00 PM, she stated staff had spoken rudely to her while her family was visiting. She could not recall the date or the exact words spoken but stated the "tone of voice was harsh and rude." Resident #4 stated that her family member reported the incident to staff. During a telephone interview on 6/29/11 at 5:30 p.m. and again on 7/15/11 at 8:50 a.m., Resident #4's family stated while visiting Resident #4 on 6/7/11 she overheard a staff member speak rudely to her family. The family member stated she reported the staff member's rudeness the following day 6/8/11 during a scheduled care plan meeting. The family member also stated she was unaware of the facility's follow-up. Resident # 4's family further stated on another occasion (she could not recall the date) while talking on the phone with her mother, she overheard a staff member say "there is only one of me," when her mother asked for help. The family member specified she reported this immediately following the incident to the Director of Nurses (DON). She stated the DON reported she would address the incident but was never notified of follow-up to the incident. The Director of Nurses (DON) stated during an interview on 6/29/11 at 5:45 PM Resident # 4's family had reported staff member speaking rudely to her mother. The DON stated she spoke with the staff member but had not followed up with the family member.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 3 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, the facility staff failed to treat residents in a dignified and respectful manor for two (2) of ten (10) sampled residents reviewed for treat residents with dignigty and respect (Resident #1 and Resident #4). The findings are: 1. Resident #1 was admitted to the facility with diagnoses which included dementia. The most recent Minimum Data Set (MDS), a quarterly assessment dated 06/02/2011, indicagted the resident has severely impaired cognition and requires extensive assistance with activities of daily living. A review of the medical record of Resident #1 revealed a nurses progress note dated 06/13/2011 8:00 p.m. which stated: "Family upset said Res. had had her light on a long time." An interview with the family of Resident #1 on 06/30/2011 at 3:25 p.m. revealed they filed a verbal complaint with the Social Worker on 06/14/2011 about the incident on 06/13/2011. The family stated they were upset because two nursing assistants and a licensed nurse came into their mother's room, over a period of approximately twenty minutes, in response to their mother's call bell but none of them attended to their mother's needs. The resident needed	F 241	**F241 483.15 (a) DIGNITY AND RESPECT OF INDIVIDUALITY SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A careplan meeting was held on 7/22/11 with family of resident #1. The Executive Director and Regional Director of clinical services was in attending. A weekly call from careplan team and /or ED to daughter (responsible party) will be made weekly to ensure there are no grievances that have not been addressed. Resident # 4 Was discharged on 07/12/11. Prior to planned discharge resident had 2 grievances that were resolved within the same day. Social Worker stated that family verbalized satisfaction with care given. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. **All Staff are being educated on how to address residents in a respectful manner, answer residents request promptly and to report any grievance a resident has immediately to supervisor. Staff are also being educated on filling out comment and concern cards and returning to Social Worker immediately when a complaint /issue is brought to their attention. Education is being done by IDON, ED, SDC and will be completed by July 28trh** **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?**	7/28/11

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F 241	Continued From page 4 repositioned in bed and her gown changed because it was damp with perspiration. Resident #1's family stated they were told by the Social Worker that the Director of Nursing (DON) would be notified and would follow up with them. They stated they had not been contacted by the DON as of 06/30/2011. An interview with the Social Worker on 06/30/2011 at 4:00 p.m. revealed she had spoken to Resident #1's family on 06/14/2011 and had relayed the family's concerns to the DON on 06/14/2011. 2. Resident #4 was admitted to the facility with diagnoses which included left pelvic fracture, fracture of left humerus, hypertension and hypokalemia. Review of the 5/31/11 Minimum Data Set (MDS) revealed Resident #4 was assessed as alert and oriented. The facility also identified Resident #4 as being interviewable. During an interview with Resident #4 on 6/28/11 at 12:00 PM, she stated staff had spoken rudely to her while her family was visiting. She could not recall the date or the exact words spoken but stated the "tone of voice was harsh and rude." Resident #4 stated that her family who witnessed the incident reported the incident to staff. During a telephone interview on 6/29/11 at 5:30 p.m. and again on 7/15/11 at 8:50 a.m., Resident #4's family stated while visiting Resident #4 on 6/7/11 she overheard a staff member speak rudely to her family. The family member stated she reported the staff member's rudeness the following day on 6/8/11 during a scheduled care	F 241	**All new staff will be educated on dignity, and responding to resident in a respectful manner, responding to call light quickly. All current employees will be re-educated on dignity and respect every three months. The education will be done by DON, ED, Social Services and/or SDC.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** **The Social Worker will interview 10 residents per week to ensure they are being treated with dignity i.e. call lights are being answered timely, spoken to in a respectful manner . The audits will begin on 07/28/11 and will be taken to the PI meetings for the next 3 months by the Social Services Director. Beginning with the PI meeting set for August 17th, 2011**	

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F 241	Continued From page 5 plan meeting. Resident # 4's family further stated on another occasion (she could not recall the date) while talking on the phone with her mother, she overheard a staff member in a rude tone say "there is only one of me," when her mother asked for help. The family member specified she reported this immediately following the incident to the Director of Nurses (DON).	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to transcribe and administer medications as ordered by the physician for two (2) of of fifteen (15) sampled residents. (Resident #12 and #19) The findings are: 1. Resident #12 was admitted to the facility on 6/15/2011. The resident's admitting diagnoses included Spinal Stenosis, pain and status post Lumbar Laminectomy. A review of the admitting physician orders dated 6/15/11 included an order for Glucosamine/Chondrollin one capsule by mouth daily at 8:00 AM for generalized joint pain. Further review of the hand written Medication Administration Record (MAR) for the month of June 2011 revealed that	F 281	**F281 483.20 (k) (3) (i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #12 MARS were corrected on 06/30/11, MD was notified of missed doses and Medication error was filled out. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** **All residents having been admitted prior to May 2011 MAR checks have a potential to be affected.** On 06/30/11 Omincare Pharmacy Director Jackie Knight was notified by phone by the Regional Director of Clinical Services that facility will use hand written MARS on new admits until the next months MARS are printed out for review. New admissions for the month of June were checked for medication errors. No further transcription errors were found. Audit was completed by Medical Records Director and was completed on July 28th, 2011.	7/28/11

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F 281	Continued From page 6 Glucosamine/Chondroitin was administered from 6/15/2011 to 6/19/2011. The hand written MAR was then replaced with a printed MAR sent by the pharmacy on 6/20/2011. Review of the computerized MAR dated 6/20/11 revealed the order for Glucosamine/Chondroitin was not transcribed and Resident #12 did not get this medication from 6/20/11 to 6/30/11. An observation revealed that Glucosamine/Chondroitin capsule was one of the stocked over the counter medication items in the facility. An interview with Licensed Nurse #1 (LN #1) on 6/30/2011 at 9:55 AM revealed that she did not administer the medication and was not sure why it was not transcribed on the computer printed MAR. The interview revealed that two nurses were assigned to check for accuracy of all physician orders when printed MARs were received from the pharmacy. An interview with Licensed Nurse #3 (LN #3) on 6/30/2011 at 10:02 AM revealed that she was one of the nurses who checked the entries in the newly printed MAR on 6/20/2011 and she had not notice the omitted Glucosamine/Chondroitin order. LN #3 stated that the second nurse who signed off on the entries also missed the error resulting in Resident #12 not getting the medication as ordered by the physician. An interview with the Director of Nursing (DON) on 6/30/2011 at 11:30 AM confirmed that two nurses were responsible for checking the accuracy of all physician orders. The DON stated that it was her expectation that all entries had to be double verified and signed off by two licensed	F 281	**What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Nursing staff will be educated to use handwritten MARS until MARS are printed out for the next month. They have also been educated on the systematic change of not using the printed MARS until they have been the monthly check of two nurses verifying accuracy has been completed. Education will begin on 7/25/11 and will be completed on 07/28/11. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Medical Records will audit all new admission to ensure that a hand written MAR is used until the end of the month when MARS are printed and printed MARS are used only after two nurses have signed that they have checked. The information will be taken by Medical Records to the Monthly Quality Assurance meeting for the next three months beginning with the August 17th 2011.	

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F 281	Continued From page 7 nurses. 2. Resident #19 was admitted to the facility on 12/04/2010. Resident #19 had admitting diagnoses including history of Urinary Tract Infection. Resident #19 had a physician order dated 12/06/2010 for: Nitrofuantoin 50 mg capsule Take 1 Cap (capsule) by mouth every day as preventive treatment for a history of urinary tract infection. Review of the monthly computerized physician orders for April and May 2011 revealed the resident continued to receive the Nitrofurantoin as ordered. Further review of Resident #19's medical record revealed the order for the Nitrofurantoin was not written on the computerized physician orders for June 2011. Review of the Medication Administration Record for June 2011 revealed the resident continued to receive the Nitrofurantoin 50 mg once a day. An interview with Administrative Nurse #1 on 6/28/2011 at 11:59 AM revealed that two nurses always checked the accuracy of all physician orders at the beginning of the month. The nurse stated it was the responsibility of those two assigned nurses to check all new and previous physician orders for accuracy and completeness. An interview with the Director of Nursing (DON) on 6/30/2011 at 11:30 AM confirmed that two nurses were responsible for checking the accuracy of all physician orders. The DON stated that it was her expectation that all entries should	F 281		

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F 281	Continued From page 8 be verified and signed off by two licensed nurses.	F 281		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide treatment and interventions as ordered by the physician for two (2) of six (6) sampled residents with pressure ulcers. Resident #s 7 and 10. The findings are: 1. Resident #7 was admitted to the facility on 10/6/10 with diagnoses that included dementia, anxiety and diabetes mellitus among others. The most recent Minimum Data Set (MDS) dated 6/2/11 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) that included bed mobility and had no pressure ulcers.	F 314	**F 314 TREATMENT AND SERVICES TO PREVENT/HEAL PRESSURE SORES. SS=E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 TARS are being reviewed daily to ensure there are no omission of treatments. Resident #7 Heel booties wereadded to care guides on June 30/11 is being monitored by MDS Coordinator daily to ensure heel booties are on. Resident # 3 Lift booties added to care guide on 6/30/11. TARS are being monitored daily by the MDS Coordinator to ensure there are no omission on treatment. Monitoring began on 07/25/11 **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All resident with pressure ulcers or preventive measure in place have a potential to be affected. **All resident with pressure ulcers and preventive measure were audited on 06/30/11 to see if treatments were being carried out as per ordered and preventative devices were in place as per orders. All preventive devices were found to be on residents as per orders. Licensed nursing staff were re-educated on the need to give treatment and sign TAR off when treatment given and they are responsible for checking their own TARS prior to end of shift to ensure all TARS are completed. Nursing staff was**	7/28/11

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F 314	Continued From page 9 Resident #7's medical record was reviewed and revealed a document titled, "Braden Scale for Predicting Pressure Sore Risk" dated 10/6/10 that specified the resident was at risk for developing a pressure ulcer secondary to decreased bed/chair mobility, urinary or bowel incontinence and diagnosis of diabetes. The document also specified weekly skin assessments would be initiated. Resident #7's care plan updated 4/20/10 revealed the resident was at risk for skin breakdown and specified interventions to maintain skin integrity included: -skin prep to right inner ankle, sock and heel bootie to right foot a. Resident #7's medical record revealed a Physician's order dated 4/20/11 that specified, "skin prep to right inner ankle (daily), sock and heel bootie to right foot at all times." The resident's Treatment Administration Records (TARs) for the months of 4/11, 5/11 and 6/11 specified the resident was ordered to have daily dressing changes to the unstageable deep tissue injury on her right heel. The TARs also revealed the resident had missed nineteen (19) of sixty-nine (69) dressing changes with no documentation why the treatment had not been administered. The 5/11 TAR specified at one point the resident went from 4/30/11 to 5/13/11 without a dressing change to her unstageable deep tissue injury on her right heel. On 6/27/11 at 7:00 p.m. the treatment nurse was interviewed and stated that Resident #7 had a facility acquired unstageable deep tissue injury on	F 314	educated on ensuring that Lift booties are in place on resident that have orders for them. The Education is being done by the SDC and will be completed by 07/28/11 **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Daily audits of the treatment records are being performed by the MDS Coordinator and Weekend on –call nurse to check for omissions. **The hall nurses are responsible for check TARS prior to the end of shift to ensure any treatment they have rendered has been signed off.** Licensed Nursing staff will be asked to come back in if omissions are found so DON can investigate. Daily audits were begun on 07/25/11 Daily audits of the heel booties will be performed by MDS Coordinator and designated Week-end nurse will check to ensure Heel booties are on. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Findings of the audits for TARS and heel booties will be taken to the QA committee by the MDS Coordinator.for the next 3 months beginning with the August 17th QA meeting.	

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her right heel that was considered to be pressure ulcer. He reported the facility had a nurse aide who was responsible for administering treatments. He added he did not routinely perform dressing and treatment changes but stated that he measured all pressure ulcers weekly.

On 6/30/11 at 8:30 a.m. the treatment nurse aide was interviewed. She reviewed Resident #7's TARs for 4/11, 5/11 and 6/11 and stated the treatments had not been performed as ordered. She stated she was responsible for completing daily dressing changes Monday through Thursday but was often pulled to fill assignments for nurse aides who had called off. She specified that when this occurred the assigned licensed nurses were responsible for completing scheduled dressing changes and treatments. She added that she had observed scheduled dressing changes and treatments were not completed on days when she was pulled from providing treatments and had reported this to the treatment nurse.

On 6/30/11 at 9:20 a.m. the treatment nurse was interviewed. He reviewed Resident #7's TARs for the months of 4/11, 5/11 and 6/11 and stated he was unaware of treatments not being done as ordered. He revealed he did not monitor TARs to ensure residents were receiving the services as ordered by the Physician. He confirmed he would expect all dressing and treatment changes to be done as ordered.

On 6/30/11 at 4:35 p.m. the Director of Nursing (DON), Regional Nurse and Administrator were interviewed. The DON reported she did not

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F 314	Continued From page 11 monitor TARs to ensure dressings changes were performed as ordered. The DON confirmed when the treatment nurse aide was pulled from her assignment the licensed nurses were to assume responsibility of providing treatments as ordered when this occurred. She was unable to specify how often this occurred. She confirmed there was no system to ensure the licensed nurses provided the treatments on days when the treatment nurse aide was pulled from her assignment. The DON stated she would expect all treatments to be done as ordered and offered no explanation why Resident #7 missed 19 of 69 treatments to her unstageable deep tissue injury on her right heel. On 6/30/11 at 11:00 a.m. observations made of Resident #7's pressure ulcer revealed the wound appeared clean and healing. Wound measurements were consistent with the wound assessment completed 6/27/11. b. Resident #7's care guide, a document that specifies the individual needs of each resident used by the nurse aides, (not dated) was reviewed and did not specify the resident was to have a heel bootie to her right foot. Observations made of Resident #7 revealed the following: - On 6/27/11 at 7:15 p.m. the resident was in the activity room with her socked feet resting against the foot rest of her wheelchair. - On 6/28/11 at 10:00 a.m. the resident was in the activity room with her socked feet positioned against the foot rest of her wheelchair. - On 6/28/11 at 3:30 p.m. the resident was in	F 314		

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F 314	Continued From page 12 her room seated in her wheelchair wearing socks and shoes. - On 6/29/11 at 12:05 p.m. the resident ate lunch and was not observed to wear a heel bootie to her right foot. On 6/29/11 at 12:05 p.m. the treatment nurse was present for the observation and confirmed the resident did not have a heel bootie in place. Later that day at 3:10 p.m. the treatment nurse was interviewed and nurse aides were responsible for following the care plan and putting heel booties on residents. He added that heel booties were available through central supply and the nurse aides were notified of residents who required heel booties via the care guide. He stated the Staff Development Coordinator (SDC) was responsible for reviewing Physician orders and updating the care guides with changes. On 6/30/11 at 9:40 a.m. nurse aide #1 (NA) assigned to care for Resident #7 was interviewed and reported she relied on the resident care guide to know how to care for the individual needs of residents. She reported that Resident #7 was to have a heel bootie on her right foot at all times and stated she was recently told this by a licensed nurse. NA #1 reported that Resident #7 did not have her heel bootie in place on 6/27/11, 6/28/11 or 6/29/11. She stated she thought the heel bootie was in the laundry and offered no other explanation why it had not been in place for three days of observations. On 6/30/11 at 9:50 a.m. the SDC was interviewed and reported she was responsible for updating the resident care guides. She specified that she reviewed Physician Orders daily for changes in	F 314		

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F 314	Continued From page 13 residents' care that would include wearing heel booties. She reviewed Resident #7's care guide and confirmed that it failed to include that the resident was to wear a heel bootie at all times on her right foot. She stated it was an oversight and offered no explanation why the resident was observed three days to be without her heel bootie but confirmed that it should have been in place. 2. Resident #3 was admitted to the facility 5/26/11 with diagnoses including Infection of Hip Prosthesis and Diabetes. The most recent Minimum Data Set (MDS) dated 6/1/11 indicated the resident had no cognitive deficit and required extensive assistance with activities of daily living including bed mobility. The MDS assessed one (1) Stage II pressure ulcer on admisssion. The current care plan updated 5/26/11 addressed the risk for skin breakdown with interventions including: -turn and reposition every 2-3 hours and as needed -keep clean and dry -treatments as ordered -heel booties while in bed	F 314		

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F 314	Continued From page 14 Reviw of the physician's orders revealed orders dated 6/14/11 for "Skin prep to bilateral heels bid (twice daily)" and "Heel booties to both heels while in bed." The resident's Treatment Administration Record (TAR) for the month June 2011 specified the resident was ordered to have skin prep applied to both heels twice daily. The TAR revealed the resident had missed nine (9) of twenty-eight (28) treatments. The June 2011 TAR indicated a treatment was initiated 6/18/11 to a new open area on the left heel. On 6/27/11 at 7:00 p.m. the treatment nurse was interviewed and reported Resident #3 had a facility acquired pressure area to the heel. He reported the facility had a nurse aide who was responsible for administering treatments. He added he did not routinely perform dressing and treatment changes but stated that he measured all pressure ulcers weekly. On 6/29/11 at 9:30 a.m., the resident was observed in bed. The heel boots were in a chair at the bedside. At 10:45 a.m., the resident remained in bed without heel boots in place. Interview with the resident revealed staff applied the protective boots "sometimes." Follow-up interview with the treatment nurse on 6/29/11 at 3:00 p.m. revealed the resident wore the heel boots "some but not regularly." On 6/29/11 at 2:45 p.m., the treatment nurse stated the resident entered the facility with the wound to the plantar surface, and the wound on the heel developed in-house 6/18/11. He stated the wounds were improving. The treatments to the the pressure areas on the left foot and heel were observed, and the wounds appeared clean	F 314		

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and healing. Wound measurements were consistent with the wound assessment completed 6/27/11.

On 6/30/11 at 8:30 a.m. the treatment nurse aide was interviewed. She reviewed Resident #3's TARs for June 2011 and stated the treatments had not been performed as ordered. She stated she was responsible for completing daily dressing changes Monday through Thursday but was often pulled to fill assignments for nurse aides who had called off. She specified that when this occurred the assigned licensed nurses were responsible for completing scheduled dressing changes and treatments. She added that she had observed scheduled dressing changes and treatments were not completed on days when she was pulled from providing treatments and had reported this to the treatment nurse.

On 6/30/11 at 9:20 a.m. the treatment nurse was interviewed. He reviewed Resident #3's TARs for the month of June 2011 and stated he did not monitor TARs to ensure residents were receiving the treatments as ordered by the physician. The treatment nurse stated he would expect all dressing and treatment changes to be done as ordered.

On 6/30/11 at 4:35 p.m. the Director of Nursing (DON), Regional Nurse Consultant, and Administrator were interviewed. The DON reported she did not monitor TARs to ensure dressings changes were performed as ordered. The DON confirmed when the treatment nurse alde was pulled from her assignment the licensed nurses were to assume responsibility of providing treatments as ordered when this occurred. She

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F 314	Continued From page 16 was unable to specify how often this occurred. She confirmed there was no system to ensure the licensed nurses provided the treatments on days when the treatment nurse aide was pulled from her assignment. The DON stated she would expect all treatments to be done as ordered and offered no explanation why Resident #3 missed preventative treatments to his heels.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record review, the facility failed to ensure physician ordered gerisleeves were applied to one (1) of two (2) residents (Resident #15). The findings are: Resident #15 was admitted to the facility on 06/13/11 with a diagnosis of a fractured hip. The latest Minimum Data Set dated 05/11/11 revealed the resident had moderate cognitive impairment and required extensive assistance with most activities of daily living. The medical record for Resident #15 was reviewed on 06/30/11 and revealed that he had a	F 323	**F323 483.25 (h) FREE OF ACCIDENT AND HAZARDS/SUPERVISON/DEVICES SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #15 Geri-sleeves were placed on resident on 06/30/11 when it was noted that they were not on. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents with preventative measure in place have a potential to be affected .**All residents with orders for were audited to ensure geri-sleeves were being worn and that it was on careguide for CNA. No further residents were found to have deficient practice.** Licensed Nursing staff are being educated on the need to ensure geri-sleeves are placed on residents as per orders.	7/28/11

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F 323	Continued From page 17 history of skin tears on his arms. Further review revealed a physician order dated 06/21/11 for the resident to wear gerisleeves on both arms to protect against skin tears. The Treatment Administration Record (TAR) revealed a note dated 06/21/11 informing the nurse that the resident wore gerisleeves on bilateral arms. Further review of the TAR revealed that the resident had skin tears on his right hand and right elbow which were being treated with dressing changes every three days. Resident #15's care plan, dated 06/13/11, revealed the resident had fragile skin and was at risk for skin problems. The care plan did not contain an intervention for the use of gerisleeves. On 06/30/11 at 10:50 a.m. Resident #15 was interviewed. The resident was dressed and in his wheelchair but was not wearing gerisleeves on his arms during the interview. The resident stated that he could not remember anyone who had offered to put gerisleeves on his arms in the past week. On 06/30/11 at 2:07 p.m. Nursing Assistant (NA) #6 was interviewed. She stated she usually worked with Resident #15 but had not been putting gerisleeves on the resident because she was not aware he wore them. She reviewed the Daily Care Guide (DCG) which she stated she used to know what care a resident needed and she noted that "bilateral gerisleeves to upper extremities" was on the guide for Resident #15. She stated it had not been on the guide before today and she had not seen it when she got the resident up for the day. She stated that usually NAs were informed by the nurse if there was a new order for gerisleeves for a resident and that	F 323	Education is being given by the SDC. Education will be completed by 07/28/11 **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Daily audits are being performed to ensure the geri-sleeves are being worn per MD orders. The audits will be performed by MDS coordinator and week-end on call nurse. Audits will begin on 07/25/11 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The findings of the audits for geri-sleeves will be taken to the Monthly QA committee meeting for the next 3 months by the MDS coordinator. Beginning with the meeting set for August 17th 2011.	

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F 323	Continued From page 18 the nurse would have to obtain the gerisleeves for the NAs. On 06/30/11 at 2:25 p.m. a family member of Resident #15 was interviewed. At that time the resident was observed to have gerisleeves on both arms. The family member stated that she had visited her husband every day since his admission and this was the first time she had seen him wearing gerisleeves. On 06/30/11 at 2:32 p.m. Licensed Nurse (LN) #7 was interviewed. She stated she had not worked on the resident's hall since last week and at that time there was no mention of gerisleeves on the TAR or on the DCG. She stated that when the 06/21/11 physician order was noted by the nurse, she should have put it on the TAR, called to obtain the gerisleeves from the supply room, and made sure the NAs were informed and the DCG was updated. LN #7 stated she had done all the above today when she discovered the 06/21/11 physician order. She also stated she had just put gerisleeves on the resident. On 06/30/11 at 3:12 p.m. the Director of Nursing was interviewed. She stated she would expect the nurse who noted the 06/21/11 physician order for gerisleeves to revise the TAR, the DCG, and the care plan, obtain the gerisleeves for the NAs, inform the NAs of the new order, and ensure the resident was wearing the gerisleeves.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to administer seven doses of Cozaar (a medication given to reduce high blood pressure) for one (1) of seven (7) sampled residents observed during the medication pass. (Resident #18) The findings include: Resident #18 was readmitted to the facility on 6/25/2011 following a hospitalization for diagnoses including Hypertension, Coronary Artery disease status post Cardiac Pacemaker and history of Myocardial Infraction. Observation on 6/28/11 at 8:55 AM revealed Licensed Nurse (LN) #2 administering the following medications to Resident #18: · Flexeril 5 mg one tablet · Colace 100 mg one capsule · Lexapro 20 mg one tablet · Metoprolol Tartrate 25 mg one tablet · Omeprazole 20 mg one capsule · Miralax 17 G (1 capful) in 8 oz water · Fentanyl Patch 12.5mcg (microgram) with 25mcg patch (total dose 37.5 mcg) A review of the physician orders dated 6/25/2011 included an order for: 'Cozaar 50 mg (milligram) by mouth BID (two times daily)'. Review of the Medication Administration Record (MAR) for the month of June 2011 it revealed that the physician ordered Cozaar 50 mg had not	F 333	**F 333 483.25 (m) (2) RESIDENT FREE OF SIGNIFICANT MED ERRORS** **SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #18 MD was notified of Med Error. Med error report filled out. Cozar was added to MAR on 06/28/11 **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** **All residents having been admitted in the month of June after May month end MAR checks have a potential to be affected. An audit of all June admissions was conducted by Medical Records Director and was completed on June 30th , 2011.** Licensed Nursing Staff are being educated to have a second nurse check MARS for transcription accuracy and 2nd nurse will place a check mark beside medication The education is being done by the SDC and will be completed on July 28th **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Hand written orders will be checked by 2nd nurse and he/she will place a check beside each medication on the hand written MAR to ensure it has be checked by second nurses against new orders. The Medical Records manager will audit all new admissions to ensure medications were transcribed correctly. The audits will begin on July 25th	7/28/11

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F 333	Continued From page 20 been transcribed to the MAR. The review further revealed that Resident #18 had not received Cozaar 50 mg two times daily as ordered by the physician from 6/25/2011 through 6/28/11, resulting with Resident #18 missing a total of seven (7) doses of Cozaar 50 mg. LN #2 was interviewed on 6/28/2011 at 11:30 AM. The interview revealed that LN #2 confirmed she had not administered Cozaar to Resident #18 during the morning medication pass. LN #2 stated she had transcribed the physician orders to the MAR and by oversight she had omitted the Cozaar 50 mg orders. The interview also revealed that the second nurse who checked for the transcription accuracy had also missed the error resulting in Resident #18 not getting the medication. An interview with the Director of Nursing on 6/30/2011 at 11:30 AM confirmed that two nurses were assigned to check for the accuracy of all new orders. The DON stated that she had completed the medication error report after the error was brought to her attention identified by the surveyor and the physician had been made aware of the situation and Resident #18's blood pressure was being monitored.	F 333	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Findings of the new admission audits for new admission transcriptions will be taken to QA committee by Medical Records Manager for the next 3 month beginning with the meeting set for August 17th, 2011.	