STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____ AUG 02 2011	C 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to post a sign in the resident care area that directed residents and/or the general public to the location of the last survey results. Findings include: During an interview with Resident # 27 on 07/13/11 at 9:30 AM, he stated he did not know the results of the last survey and he did not know where the results of the last survey were kept. Resident # 27 acted as the Resident Council President. He stated the results or location of the last survey had not been discussed in Resident Council meetings. Review of the resident council minutes indicated a resident right was reviewed monthly but there was no indication the results or location of the survey results had been reviewed. An interview was held with the Activity Director (AD) on 7/13/11 at 3:47 PM. The AD identified	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peggy W. Bullock RN/CNHA		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 167	Continued From page 1 herself as responsible for organizing resident council meetings. The AD stated she had not reviewed where the survey results were kept and had not reviewed the results of the last survey with residents She added she was not sure if a sign giving location of results was posted. On 07/13/11 during rounds of the facility, the survey results were found in a binder across the hall from the Administrator's office. A small label was placed on the spine of the binder indicating the binder contained survey results. The spine of the binder was on top, pointing toward the ceiling, and not visible unless a person could stand and look down at the spine. The AD stated a resident would not be able to recognize the binder as the survey results. The AD stated most residents were from the era that would interpret the binder as a phonebook. No sign was found in the resident care area that indicated where survey results were located. An interview was held with Resident # 57 on 07/13/11 at 4:11 PM. The resident stated she did not know where the survey results were kept and did not know the results of the last survey. On 07/14/11 at 9:27 AM, the AD reported she had spoken to Resident # 27 about the survey results location. The AD stated Resident # 27 reaffirmed he was unaware of the location or the results of the last state survey. The AD stated a resident council meeting had been scheduled that day to review the last survey results and that a larger sign had been posted to alert residents and the general public to the location of the survey results.	F 167		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 2 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to implement their abuse policy protocol by investigating and/or reporting an alleged incident of abuse for 1 of 2 sampled residents (Resident # 17) whose family member had reported rough handling during the delivery of personal care. Findings include: Resident # 17 was admitted on 01/13/09 with cumulative diagnoses of Alzheimer's dementia, failure to thrive and osteoarthrosis . A Minimum Data Set (MDS), coded as a quarterly and dated 05/02/11, indicated Resident # 17 had unclear speech, was rarely understood and rarely was able to understand others. She was coded as having short and long term impairment and severely impaired cognitive skills for daily decision making. The facility Grievance log, dated 06/13/11, indicated Resident # 17's Responsible Party (RP) had filed a grievance by phone related to nursing care and dietary food concerns. The log indicated the issue had been resolved on 06/13/11. Review of the Social Services section of the resident's record indicated there were no notes	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* **F226** **Corrective Action - Affected resident (s)** For Resident # 17 whose family member had reported rough handling during the delivery of personal care, a 24 hour report was sent on July 14, 2011 for a complaint of rough handling and 5 day investigation followed on July 19, 2011. **Corrective Action - potential resident (s)** All interviewable residents where interviewed to ask if they had been treated roughly or if anyone has yelled at them or been rude to them. This was completed on 7/14/11. **Systemic Changes to prevent recurrence** An in-service was conducted on July 14, 2011 by the staff development coordinator. Those who attended included all staff in all departments. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included 7 types of abuse, responsibility of employees to the law, and recognizing/reporting abuse. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	08/11/11

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F 226	Continued From page 3 indicating any concerns had been voiced by Resident # 17's RP. Review of Allegations of Abuse did not reveal any allegations involving Resident # 17 had been investigated. During an interview with Resident # 17's RP, she identified Nursing Assistant (NA) # 1 as working second shift. The RP stated NA # 1 was rough with Resident #17 and all the residents. The RP added she had reported her concerns to a nurse that no longer worked at the facility. She added there had been no resolution. An interview was held with NA # 2 on 07/13/11 at 11:00 AM. NA # 2 worked with Resident # 17 on the 7:00 AM to 3:00 PM shift. She was able to name the types of abuse, and stated she had never had to report abuse,but if she did, she would report it to the nurse on the hall. NA # 2 stated Resident # 17's RP had not mentioned anything about staff being rough with Resident #17. An interview was held with Nurse # 2 on 07/14/11 at 9:30 AM. The nurse stated mental, physical, verbal, seclusion, misappropriation of funds were types of abuse. The nurse stated she had never reported abuse. Nurse # 2 added if she had to report abuse, she would report the abuse to the Director of Nursing (DON). Nurse # 2 stated a while back, the RP for Resident # 17 reported a NA on second shift handled the resident roughly, but could not remember the NA's name. The nurse stated she had reported this allegation to the DON at the time. Nurse # 2 stated she thought the matter had been investigated.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Quality Assurance** The Director of Nursing or Staff Development Coordinator will monitor this issue by using the "Survey QA Tool for Recognizing and Reporting Abuse". The monitoring will include asking staff specific questions on the details of recognizing and reporting abuse. This will be done daily Monday thru Friday for four weeks on alternating shifts and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 226	Continued From page 4 An interview was held with NA # 3 on 07/14/11 at 10:05 AM. She stated the resident's RP had reported that an NA on second shift handled the resident roughly. The NA stated she had not reported this to anyone. The NA identified rough handling as physical abuse. As a reason for not reporting, NA # 3 stated the RP told "everyone" about the NA. The NA stated the second shift NA had worked this week with the resident. She acknowledged she was expected to report abuse and should have reported this allegation to the DON. An interview was held with the Administrator on 07/14/11 at 11:15 AM. She stated there were 2 parts to the 06/13/11 grievance filed by Resident # 17's RP. The first part dealt with the RP's belief the hall nurses were not giving the resident her medication or giving the medications on time. This allegation was investigated by the Administrator. The allegation was resolved the same day. Part two of the grievance involved Resident # 17 receiving her meal tray timely. This too was investigated by the Administrator and resolution achieved. The Administrator stated that any allegation of abuse or neglect was investigated immediately, normally by the DON. The resident's safety was maintained. The suspected staff member was suspended pending the outcome of the investigation. Rough handling during the provision of care would be considered physical abuse. The Administrator stated the expectation was that any staff member receiving an allegation of abuse would report it immediately to their supervisor. The Administrator stated she had not received any reports of rough handling for Resident # 17.	F 226		

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F 226	Continued From page 5 An interview was held with the Regional Directions of Operations (RDO) on 07/14/11 at 2:41 PM. The RDO stated she was surprised the RP had not reported the rough treatment to her. The RDO stated the RP had her phone number and had called to report other concerns. The RDO stated it was her expectation for staff to report any allegations of abuse as facility policy directed. An interview was held with NA # 1 on 07/14/11 at 3:02 PM. NA # 1 worked 3:00 PM to 11:00 PM and was the NA identified by the resident's RP. The NA stated different types of abuse would include mental, physical and sexual abuse. NA # 1 stated she had never had to report abuse, but if she had to, she would report the abuse to the supervisor. NA # 1 stated she had never had a family member come to her about the care she provided to a resident. The NA identified Resident # 17 as having special needs requested by the RP such as raising her feet, raising the head of the bed and raising the bed to the highest position. The NA stated she told the RP she could not raise the bed to the highest position as the facility's policy indicated the bed was supposed to be in the lowest position. The NA stated the RP told her that "everyone else did it" and she (the NA) was the only one that the RP had problems with. The NA stated the RP was here during the 3:00 PM to 11:00 PM shift almost daily for at least a few minutes. The NA stated Resident # 17's RP had never stopped care or told the NA she was being too rough. The NA stated that no one had ever complained of her being rough during care. NA # 2 was unable to identify rough handling as physical abuse.	F 226		

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F 226	Continued From page 6 An interview was held with Nurse # 3 on 07/14/11 at 3:15 PM. Nurse # 3 normally works the 3 to 11 shift on Resident # 17's hall. The nurse stated the types of abuse included physical, emotional, misappropriation of property, verbal and neglect/seclusion. She added she had never had to report abuse, but if she needed to report abuse, she would report to the DON. The nurse stated the RP for Resident # 17 was in the facility on a nightly basis and stayed from 30 minutes to an hour. The nurse stated the RP had been in the room during care and had not reported rough treatment and had not requested any NA not care for Resident # 17. An interview was held with the Social Worker (SW) on 07/14/11 at 3:47 PM. The SW stated she had not be involved in any of the issues the Resident # 17's RP had voiced. The SW stated the RP always went straight to the Administrator.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F242** **Corrective Action - Affected resident (s)** For Resident # 17 lactose intolerance was added to her care plan and dietary likes and dislikes were added to her tray card on July 13, 2011. **Corrective Action - potential resident (s)** All resident's have the potential to be affected by the alleged deficient practice. All residents who have specific food allergies or intolerances have been noted in the individual's care plan. Specific food choices along with food allergies or intolerances will be noted on meal tray cards and a reference list will be maintained in the dietary department. Completed July 14, 2011. Dietary Manager will reinstitute the use of tray cards when dietary staff preparing meal trays. Tray cards will include, prescribed diet by MD along with likes and dislikes of the resident (s) and food allergies and intolerances. DON, MDS and SDC to perform 100% chart audit and update care plans to include resident (s) dietary food allergies and intolerances using the tray cards provided by the dietary staff. They will also check the tray cards to make sure the likes and dislikes are listed on the tray cards. **Systemic Changes to prevent recurrence** Dietary Manager in-serviced dietary staff on proper usage of the dietary tray cards and their distribution on July 27, 2011. Those in attendance include all dietary staff. SDC in-serviced the staff on July 25, 2011 on	08/11/11
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to have a system in place for direct care staff to identify and honor	F 242		

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F 242	Continued From page 7 resident food preferences for 1 of 1 sampled residents (Resident # 17) whose Responsible Party (RP) had identified food preferences. Findings include: Resident # 17 was admitted on 01/13/09 with cumulative diagnoses of Alzheimer's dementia, gastroesophageal reflux disease, colitis, hypertension, dyslipidemia, chronic renal insufficiency, anemia, failure to thrive, and Vitamin B deficiency. Review of the resident's chart indicated the Responsible Party (RP) was the Power of Attorney for Resident # 17 and was able to make decisions regarding personal relationships and affairs. This included all acts necessary to maintain the customary standard of living for Resident # 17. A Minimum Data Set (MDS), coded as a quarterly and dated 05/02/11, indicated Resident # 17 had unclear speech, was rarely understood and rarely was able to understand others. She was coded as having short and long term impairment and severely impaired cognitive skills for daily decision making. The MDS indicated the resident required extensive to total assistance for all ADL's. Review of Resident # 17's care plan, last updated on 05/04/11, did not indicate the resident's lactose intolerance or specific dietary requests. The facility Grievance Log, dated 06/13/11, indicated the RP had filed a grievance by phone with nursing care and dietary food concerns. The log indicated the issues had been resolved on	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* dietary cards placed on residents meal trays. Those who attended include RNs, LPNs, C.N.A.'s, Med-tech's, FT, PT, PRN and administrative nursing staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** DON, DM or cook (s) will monitor the meal trays to ensure the resident (s) likes and dislikes and food allergies and intolerances are being followed using the "Survey QA Tool Meal Trays". Three random meal trays will be selected from each meal served, breakfast, lunch and supper. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 242	Continued From page 8 06/13/11. An interview was conducted with Resident # 17's RP on 07/11/11 at 12:16 PM. She stated Resident # 17's food preferences were not honored. She stated the resident continued to receive leafy green vegetables on her plate frequently and also received milk. An interview was held with Nursing Assistant (NA) # 2 on 07/13/11 at 11:01 AM. NA # 2 cared for Resident # 17 on the 7 to 3 shift. The NA stated she thought food likes and dislikes were listed on the care plan. Likes and dislikes were also listed in the ADL flow book. The NA identified Resident # 17 as lactose intolerant and allergic to tomatoes. The NA stated the RP told her this. The NA stated the resident did not receive greens of any kind, adding she thought she was allergic to them. An observation was made of Resident # 17 having lunch,on 07/13/11 at 12:33 PM. NA # 4 was feeding the resident. The NA stated allergies, likes and dislikes, if any, were listed on the tray card. The NA stated there was no other place for this information to be listed that was accessible to the NA's. The resident's tray card was reviewed. The area for likes and dislikes was blank. When asked if the resident had any food allergies or intolerance's, the NA stated that looking at the information on the tray card, she could not answer that. An interview was held with Nurse # 2 on 07/14/11 at 9:10 AM. The nurse stated the Dietary Manager was responsible for interviewing resident's/families about dietary preferences.	F 242		

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F 242	Continued From page 9 She added the diet card comes out on the meal tray with the preferences listed. If the information was not on the tray card, there was no other place the information was located. The NA would have to go to the dietary department to find out resident food preferences. The RP for this resident had relayed information verbally to the staff about Resident # 17's likes and dislikes. The nurse stated Resident # 17 was not to receive sweet potatoes, carrots, can receive some milk, but a lot of milk gave her gas. The nurse stated that was the entire list of likes and dislikes for Resident # 17. The RP reported to the nurse this week that carrots had been placed on the resident's tray. Another tray was retrieved from the kitchen for the resident. An interview was held with NA # 3 on 07/14/11 at 10:05 AM. Food preferences, she added were not listed on the tray card. NA # 3 added the only way she would know what Resident # 17's food preferences were would be to ask the nurse. The NA identified Resident # 17 as not liking leafy greens, sweet potatoes, carrots and rice. The NA added that anytime greens or rice were served for a meal, the greens and rice ended up on Resident # 17's plate as well. NA # 3 stated because she knew the resident did not like these items, she would get something else for the resident to eat. The NA stated a new NA that had not worked with the resident would not know the resident's preferences.. An interview was held with the Dietary Manager (DM) on 07/14/11 at 10:39 AM. Residents are visited within the first 5 days after admission and the interview included food preferences. The DM added food preferences were reviewed quarterly.	F 242		

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F 242	Continued From page 10 The DM stated food preferences are not recorded on any form that became a part of the resident's permanent record. Food preferences were put on sticky notes and on the plastic diet cards that were kept in the dietary department. The dietary staff use the sticky notes and the diet cards to determine what to put on a resident's tray. An observation was made of the system the DM used in tracking food preferences. Sticky notes were observed posted on the ice machine. One sticky note included dislikes for Resident # 17. Sweet potatoes, carrots, rice, and green leafy vegetables were among the dislikes seen on the sticky notes. The DM stated there were times when the items listed as disliked by Resident # 17 were received on meal trays. She stated Resident # 17 received both carrots and sweet potatoes this past Tuesday. The DM reviewed a tray card for Resident # 17's food preferences. Handwritten on the card were words which indicated staff were to refer to the sticky notes on the ice machine to review the food preferences for Resident # 17. The DM stated at the present time she had no system in place whereby the nursing staff would be able to identify food preferences. The food preferences were only available to dietary staff, adding a new employee may not be aware of Resident # 17's food preferences. An interview was held with the Administrator on 07/14/11 at 11:15 AM. Part two of the allegation involved getting Resident # 17 receiving meal trays timely. Resolution was reached the same day the grievance was filed.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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

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F 280	Continued From page 11 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and record review the facility failed to invite the family of 1 of 22 sampled residents (Resident #73) to care plan meetings, and failed to update the care plan for 1 of 3 sampled residents (Resident #9) with indwelling urinary catheters. Findings include: 1. Resident #9 was admitted to the facility on 09/24/10 and readmitted to the facility on 01/26/11 and 04/19/11. The resident's documented diagnoses included urinary retention, acute seizures, hypertension, and transient ischemic attacks.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F280 **Corrective Action - Affected resident (s)** The facility failed to invite the family of 1 of 22 sampled residents (resident 73) to care plan meetings. Resident #73 family was invited to a clan planning meeting on July 29, 2011 by invitation and the meeting is scheduled for August 4, 2011. **Corrective Action - potential resident (s)** MDS Coordinator and or DON will generate the monthly calendar according to assessments due. Social Services Director will prepare the care plan invitations according to the assessment calendar. S. W. will mail the care plan invitation 2 weeks prior to the scheduled meeting to the P. O. A., and or responsible party. S.W. will give a copy of the invitation to the resident with date and time of notice written on the copy. S.W. will keep a copy for facility records. **Systemic Changes to prevent recurrence** The DON in-serviced the MDS, SDC, and SW on July 26, 2011.The in-service included the process for developing the MDS calendar, when to mail the invitations to the P.O.A., and or responsible family member, and when to invite the resident to the care planning meeting.This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	08/11/11

Quality Assurance

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

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	345309	A. BUILDING _____ B. WING _____	C 07/14/2011

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F 280	Continued From page 12 A 04/19/11 hospital Discharge Summary documented Resident #9 was hospitalized from 04/12/11 until 04/19/11 for seizures and a UTI (urinary tract infection). It also documented the resident was being discharged back to the facility with an indwelling urinary catheter secondary to urinary retention. Record review revealed Resident #9 was still catheterized until present. A Care Plan Review Signature Sheet documented Resident #9's care plan was reviewed and updated on 06/24/11. The documented staff in attendance at the review were the Minimum Data Set (MDS) nurse, the social worker, the activity director, and the dietary manager. After review and update of the care plan on 06/24/11, no changes were made to the problem of "I have history of recurrent UTI (urinary tract infection). D/C (discontinue) Foley." (problem originally identified on 09/24/10) At 10:53 AM on 07/14/11 the MDS Nurse stated it was an over site that she did not realize Resident #9 returned to the facility on 04/19/11 with an indwelling catheter. The nurse reported the last she knew Resident #9 returned from the hospital in January 2011 without the catheter she previously had in the facility. The MDS Nurse commented it was possible Resident #9's indwelling catheter was not discussed at the 06/24/11 care plan review meeting because a direct care nursing representative was not in attendance at the meeting.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Administrator and or Director of Nursing will monitor using the "Survey QA Tool for CARE PLAN MEETINGS INVITATION". The monitoring will include verifying that the invitations and notifications of P.O.A.'s and or family members are notified and the residents. All residents with care plan meetings will be reviewed. This will be done weekly, four months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. **Corrective Action – affected resident (s)** The care plan was updated for Resident #9 for indwelling urinary catheter on July 14, 2011. **Corrective Action – potential resident (s)** DON, MDS, and or SDC will perform 100% care plan chart audit of residents with urinary catheters to ensure all care plans are updated as required. **Systemic Changes to prevent recurrence** MDS and SDC were in-serviced on the risk assessments, care area assessments and diagnosis list July 27, 2011. **Evaluation of Plan/Monitoring** DNS and or designee will monitor this process using the Survey QA Tool for indwelling Catheters Care Plans". This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA Committee and corrective action initiated as appropriate.	

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F 280	Continued From page 13	F 280		

2. Resident # 73 was initially admitted on 03/07/11 with cumulative diagnoses of progressive supranuclear palsy, major depressive disorder, anxiety, psychosis, dementia, hypertension and dysphagia requiring feeding tube placement.

The Quarterly Minimum Data Set (MDS), dated 06/12/11, indicated Resident # 73 was moderately cognitively impaired. The resident was assessed as having unclear speech, usually understood and able to understand others.

An interview was held with Resident # 73's Responsible Party (RP) on 07/11/11 at 12:30 PM. He stated since admission to the skilled unit, he had not been invited to a care planning conference.

An interview was held with the Social Worker (SW) on 07/13/11 at 2:39 PM. The SW stated she was responsible for care plan conference notification. Notification was done face to face or by phone. The SW stated there was no documentation of resident and/or RP notification. The SW stated when a resident and/or RP attended a care conference they signed a signature sheet that was kept in front of the care plan book.

Review of the CARE PLAN REVIEW SIGNATURE SHEET for Resident # 73, indicated care plan review had occurred on 03/09/11,

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F 280	Continued From page 14 03/29/11 and 06/21/11. Review of the signatures did not indicate the Responsible Party (RP) had attended. An interview was held with the SW on 07/14/11 at 3:47 PM. The SW stated Resident # 73's RP had been invited to a care plan conference prior to her admission to the skilled unit, but probably was accurate when he stated he had not been invited since her admission to the skilled unit.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide the removal of facial hair from 1 of 1 sampled residents (Resident # 41) that expressed a desire for the facial hair to be removed. Findings include: The facility's General AM (Morning) Care Policy, with an effective date of 10/01/01, indicated in part the purpose of morning care was to refresh the resident, provide cleanliness, comfort and neatness and to assess the resident's needs. Under PROCEDURE, Paragraph 2, the policy indicated staff should make a note of special problems or special care needed by each resident. The policy also indicated resident care	F 312	**F312** **Corrective Action - Affected resident (s)** Resident #41 that expressed a desire for the facial hair to be removed was shaved on July 13, 2011. **Corrective Action - potential resident (s)** All residents who are unable to carry out ADL care will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. An audit for the presence of facial hair on men and women was done on July 25, 2011. Facial hair was removed for the residents that desired it. Those who preferred facial hair was noted on their care plans. **Systemic Changes to prevent recurrence** Staff Development Coordinator in-serviced the staff on or before July 29, 2011 on ADL care. Those who attended include RNs, LPNs, C.N.A.'s Med-tech's, FT, PT, PRN and administrative nursing staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** Director of Nursing and or designee will monitor using the "Survey QA Tool for ADL" The monitoring will include random selection of 5	08/11/11

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F 312	Continued From page 15 plans were individualized and gave specific instructions on care. The policy did not speak specifically to shaving residents. Resident #41 was admitted on 11/09/09 with cumulative diagnoses of blindness, osteoarthritis, diabetes, hypertension and muscle weakness. The resident's Quarterly Minimum Data Set (MDS), dated 04/19/11, indicated Resident # 41 was moderately cognitively impaired. She was able to be understood and was coded as understanding others. The MDS indicated the resident was dependent on staff for personal hygiene. The resident was not coded as refusing care. Resident # 41's care plan, last reviewed and updated on 05/18/11, indicated the resident required assistance with activities of daily living and was at risk for complications related to the dependence. Approaches to ensure the resident participated in care included encouragement, task segmentation, allowing choices about clothing, setting up supplies, assisting as needed with oral care. There was no mention of the resident's desire to be shaved. An observation was made on 07/11/11 at 10:30 AM. Resident # 41 had facial hair on her chin, under her chin and on her upper lip that was noticeable. Resident # 41 stated it was very embarrassing to have facial hair. The resident added her 9 year old great grandson had pointed out her facial hair during a recent visit and had offered to shave her. Resident # 41 added the grandson had stated the resident had a lot of facial hair. The resident stated for her facial hair	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* males and 5 females for observation of their ADL care. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 312	Continued From page 16 to be pointed out by a child was humiliating. The resident stated she had to ask over and over to get shaved. Resident # 41 stated she had received her bath earlier. At 12:30 PM on 07/11/11, the resident was eating lunch. The resident had obvious chin hair and a moustache. On 07/12/11 at 9:00 AM, the resident was lying in bed. The chin hair and moustache were clearly visible. An observation on 7/13/11 at 8:00 AM indicated dark stubble was apparent on her chin. An interview was held with Nursing Assistant (NA) # 2 on 07/13/11 at 11:10 AM. In addition to the bath, NA # 2 stated she lotioned the residents, applied deodorant, provided hair care, mouth care, and shaved residents, both male and female, as needed. She stated she did not shave Resident # 41 when the morning bath was provided. The NA stated she asked Resident # 41 if she wanted to be shaved and the resident told the NA she wanted to wait. An observation was made on 07/14/11 at 8:26 AM. The resident was clean shaven. An interview was held with Nurse # 2 on 07/14/11 at 9:33 AM. The nurse stated residents should have their hair combed, be given mouth care, and generally be well groomed including shaving if needed. This included both men and women. The nurse stated Resident # 41 had mentioned to her that she needed to be shaved. The nurse added Resident # 41 liked to be neat. Nurse # 2	F 312		

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F 312	Continued From page 17 stated she knew it bothered Resident # 41 when she had facial hair. The nurse added the resident should not have to ask to be shaven. The nurse stated she had not noticed the resident needed a shave Monday, Tuesday or Wednesday. An interview was held with Resident # 41 on 07/14/11 at 4:40 PM. She stated NA # 2 had cared for her yesterday. The resident stated she could not remember if NA # 2 had offered a shave. Resident # 41 stated had never refused to be shaven. The resident stated NA # 3 had shaved her today. An interview was held with the Director of Nursing on 07/14/11 at 4:51 PM. She stated activity of daily living care included anything the resident wanted. If the resident expressed a desire to be shaven, she expected that to be done.	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F315** **Corrective Action - Affected resident (s)** Resident # 9 was reassessed the continued need for an indwelling urinary catheterized during the hospital stay secondary to urinary retention. A Catheter Justification Worksheet was done and Primary MD order received not to remove foley on 7/19/11. **Corrective Action - potential resident (s)**	08/11/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to reassess the continued	F 315	DON will notify MD of resident (s) with urinary catheters and request removal of catheter unless contraindications. Contraindications would include, urinary retention, BPH, Stages III or IV wounds or per MD orders. Phone calls would be followed by written notification to each MD. This was completed on July 28, 2011. **Systemic Changes to prevent recurrence** Staff Development Coordinator in-serviced the staff on or before July 29, 2011 on Urinary Catheters, Notification to MD's and contraindications for usage. Those who attended include RNs, LPNs, FT, PT, PRN and administrative nursing staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 315	Continued From page 18 need for an indwelling urinary catheter for 1 of 1 sampled residents (Resident #9) discharged from the hospital, catheterized during the hospital stay secondary to urinary retention. Findings include: Resident #9 was admitted to the facility on 09/24/10 and readmitted to the facility on 01/26/11 and 04/19/11. The resident's documented diagnoses included urinary retention, acute seizures, hypertension, and transient ischemic attacks. Record review revealed Resident #9 had an indwelling urinary catheter prior to hospitalization on 01/20/11. A 01/26/11 hospital Discharge Summary documented Resident #9 was hospitalized from 01/20/11 until 01/26/11 for suspected seizure activity and an urinary tract infection (UTI). A 01/26/11 2:30 PM Nurse's Note documented, "Resident with (symbol used) hx (history) of urinary retention, but arrived with no (symbols used) catheter...." Nurse's Notes documented Resident #9 experienced no bladder distention between 01/26/11 and 01/31/11. On 01/31/11 Resident #9's primary physician ordered a post void in and out catheterization to check for residual urine and a consult appointment to be scheduled with an urologist. A 02/01/11 Nurse's Note documented Resident #9's primary physician was notified of the post void residual, but deferred to the urologist to	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Quality Assurance** DON, MDS or SDC, will monitor resident (s) having urinary catheters using the "Catheterization justification worksheet and Catheterization review schedule". This will be done quarterly times three quarters or until resolved by QOL/QA committee. Reports will be given to the quarterly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 315	Continued From page 19 make a decision regarding placement of an indwelling urinary catheter based on the upcoming 02/02/11 urology consult. 02/02/11 Nurse's Notes documented the urologist did not recommend catheterization for Resident #9, but initiated Flomax 0.4 milligrams (mg) daily for the resident. A 04/05/11 progress note generated by Resident #9's follow-up urology appointment documented there was no need to catheterize the resident. Record review revealed Resident #9 remained in the facility without an indwelling urinary catheter until being hospitalized on 04/12/11. A 04/19/11 hospital Discharge Summary documented Resident #9 was hospitalized from 04/12/11 until 04/19/11 for seizures and a UTI (urinary tract infection). It also documented the resident was being discharged back to the facility with an indwelling urinary catheter secondary to urinary retention. Record review revealed no documentation of catheter removal and voiding trials completed for Resident #9 after being readmitted to the facility on 04/19/11. In addition, there was no documentation of any correspondence with Resident #9's primary physician or urologist after the resident's 04/19/11 readmission, regarding the continued need to catheterize the resident. At 11:12 AM on 07/11/11 Resident #9 was in her room. The resident's indwelling catheter bag was contained in a privacy bag.	F 315		

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F 315	Continued From page 20 At 8:47 AM on 07/14/11 Nurse #1 stated the facility periodically removed catheters and conducted voiding trials to determine post void residuals for those residents with indwelling catheters which were justified by the diagnosis of urinary retention. She explained the amount of post void residual was important in determining whether there was a continued need to keep residents catheterized. According to Nurse #1, the catheter was not removed and no voiding trials were conducted for Resident #9 since the resident's 04/19/11 readmission. She commented no trials were completed in the facility because she thought she overheard comments that the resident "failed" a voiding trial when the residents catheter was removed while hospitalized between 04/12/11 and 04/19/11. Nurse #1 reported Resident #9's primary physician realized the resident still had an indwelling urinary catheter because he was signing the resident's monthly orders which included an order for this catheter. However, Nurse #1 remarked she was unsure whether Resident #9's urologist was aware the resident was catheterized between 04/19/11 and present. At 9:23 AM on 07/14/11 Nurse #1 stated she contacted Resident #9's urologist by phone, and the urologist stated he preferred that resident's catheter be removed. However, the urologist reported the facility staff needed to remove the catheter and conduct a voiding trial to determine if the post void residual justified permanent catheter removal. At 10:08 AM on 07/14/11 the Director of Nursing (DON) commented it was only her seventh day as the facility's DON so therefore she was unsure	F 315		

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F 315	Continued From page 21 about the company policy concerning justification for continued indwelling catheter use for residents with a diagnosis of urinary retention. The DON reported, in general, her expectation was the staff document follow-up correspondence with primary physicians once catheters were put in place because of urinary retention. She commented physicians usually reassessed the continued need for indwelling catheters under these circumstances, and determining post void residuals was a frequently used tool in making such decisions. The DON remarked Resident #9 had some type of urinary problem since she was diagnosed with urinary tract infections during two different hospitalizations.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F329 **Corrective Action - Affected resident (s)** Resident # 50 for procrit administration, a med error form was filled out and the MD was notified. The administration instructions for Procit will be underlined on the MAR with red ink. The procrit order for administration will be rewritten on the MAR to include a designation for results of the CBC drawn monthly. **Corrective Action - potential resident (s)** All residents who have medications that have meds ordered other than with a time administration q day will be reviewed by Pharmacy Consultants on 7/14/11 to assure that they are getting their meds according within the order guidelines provided by the MD. This was completed on 7/14/11. **Systemic Changes to prevent recurrence** All residents who have medications that have meds ordered other than with a time administration q day will be reviewed by Pharmacy Consultants on 7/14/11 to assure that they are getting their meds according within the order guidelines provided by the MD. This	08/11/11
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	C 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 22 drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure residents were free from excessive dosage of medication for 1 of 10 sampled residents whose medications were reviewed (Resident #50). Findings include: Resident #50 was admitted to the facility on 12/22/11 and readmitted on 03/01/11 with diagnoses of anemia, mild renal failure, hypothyroidism, coronary artery disease, congestive heart failure, and hypothyroidism. Resident #50 had a physician's order, dated 03/01/11 for Procrit (medication used to treat anemia) 40,000 Units injection subcutaneously (just under the skin) monthly if hgb (Hemoglobin) was under 11 (normal range for female is 12.3-15.3). The physician ordered a CBC (complete blood count) laboratory test to be drawn monthly on Resident #50. The manufacturer's product information stated in part; "Using ESAs (drugs used to treat anemia by stimulating red blood cell production) to target a hemoglobin level of greater than 11g/dL (grams per deciliters) increases the risk of serious adverse cardiovascular reactions and has not shown to provide additional benefits." Review of Resident #50's medical record	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* was completed on 7/14/11. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing or Staff Development Coordinator will monitor this issue using the "Survey QA Tool for Meds Given Other Than Daily". The monitoring will include auditing resident MARS on Hall 1 and Hall 2 to ensure that medications other than daily are being given correctly. See attached monitoring tool. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 329	Continued From page 23 revealed a CBC had been drawn on 05/31/11 and the hgb (hemoglobin) was 10.4. A review of Resident #50's Medication Administration Record (MAR) for June 2011 listed Procrit 40,000 UNITS/ML (milliliter) vial inject 1 ML (40,000) subq (subcutaneously) monthly if hgb < or = 11 at 9:00 AM. There were initials under the columns for 06/06/11, 06/13/11, 06/20/11, and 06/27/11. Another CBC drawn on 06/27/11 on Resident #50 indicated her hgb level was 12.1. In an interview with Nurse #1 on 07/14/11 at 9:50 AM, she said the facility procedure was to draw the blood sample prior and give the Procrit after the results of the blood test were received. Nurse #1 said the results of the blood test were only written on the MAR when the Procrit was not given to justify why it had not been given. After review of Resident #50's June 2011 MAR, Nurse #1 said it looked like Resident #50 had received the Procit on four occasions instead of once monthly as ordered by the physician. In an interview with the Consultant Pharmacist on 07/14/11 at 10:25 AM she said her expectation was to draw the laboratory test the week prior to a monthly scheduled dose so the results would be back and the medication obtained from the pharmacy. The Consultant Pharmacist said the effects of an increased dosage of Procrit would elevate the hemoglobin and increase the risk for cardiovascular events. After review of Resident #50's June 2011 MAR, the Consultant Pharmacist said it looked like Resident #50 had received three additional doses of Procrit on	F 329		

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F 329	Continued From page 24 06/13/11, 06/20/11, and 06/27/11 which could account for her hemoglobin being 12.1 on 06/27/11. The Director of Nurses (DON) said in an interview on 07/14/11 at 10:50 AM, it was her expectation lab testing be done and medications be given per the physician's orders. After review of Resident #50's June 2011, the DON said there were initials in four slots by Resident #50's Procrit order which would mean the Procrit had been given four times in June 2011 rather than once monthly as ordered by the physician.	F 329		