

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

PRINTED: 10/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/22/2011
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360		
(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 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>(1) A. Upon becoming aware during the survey of the missing posted notice, the administrator immediately had the social worker post the notice of rights and rules in the location it had previously been posted. The facility social worker posted the notice of rights and rules providing residents and applicants for admission information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>B. At the time of admission and at least annually, the facility social worker will inform and/or remind each current resident about the location of the posted information. Shift by shift in-services will be held beginning October 21, 2011 informing all staff to report any removed items from the information board to their supervisor. Completion date October 31st.</p> <p>C. The social worker and administrator will monitor weekly x 4 then monthly to ensure the notice of rights and rules remains posted in a visible location and not removed from the posting site.</p> <p>D. The Quality Assurance Committee will be informed the notice has been posted and must remain posted. Quality Assurance Committee members will be instructed to be alert to the presence of the notice and to inform the social worker or administrator if a committee member becomes aware a required poster is missing or no longer posted.</p> <p>(2) A. Resident #29's billing was reviewed to ensure resident was not billed for services during the time period that resident did not receive notification of Medicare non-coverage and resident was notified of liability or need for application for non-Medicare coverage.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

William A. [Signature]

TITLE

ADMINISTRATOR

(X6) DATE

10/12/11

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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156	<p>B. The medical and billing records for each resident receiving Medicare coverage for skilled services was reviewed to ensure the chart contained copy of letter of notification provided to the resident and appropriate documentation regarding provision of the liability notification was contained within the chart.</p> <p>The administrator has informed by the Business Office Manager (or Designee) of responsibilities for issuing notification of Medicare non-coverage letters and documenting the issuance in the medical record.</p> <p>C. The Administrator or designee will audit the medical record and billing record for each resident receiving Medicare coverage for skilled services monthly to ensure notification of Medicare non-coverage letters are provided to the resident and issuance of the letter is documented in the resident's chart.</p> <p>D. Audit of the required letter of notification for Medicare non-coverage will be monitored by the Quality Assurance Committee quarterly.</p>	11/21/11	

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F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to (1) display information about how to apply for and use Medicare and Medicaid benefits and (2) failed to provide a written notice two days in advance of discontinuation of Medicare benefits for 1 of 1 sampled resident (Resident #29). The findings include:</p> <p>1. On 09/20/11 at 3:30 PM and on 09/21/11 at 7:55 AM, general observation of the building was conducted. There was no posting of information about how to apply for and use Medicare and Medicaid benefits observed in the facility.</p> <p>On 09/21/11 at 8:35 AM, the social worker was interviewed. She looked around and stated that she could not find them but will ask the administrator.</p>	F 156			

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F 156	Continued From page 3 On 09/21/11 at 9:15 AM, the administrator was interviewed. He stated that Medicare and Medicaid information had been posted by the social worker but now they were missing. He did not know when they started missing. He stated that he will have the social worker to post them again. 2. During an interview on 9/21/11 at 4:30 PM, the Business Office Manager (BOM) indicated that Resident #29 received Medicare benefits from 7/6/11 - 8/5/11. The BOM indicated that Administrative Nurse #2 was responsible for issuing notification of Medicare non-coverage letters. During an interview on 9/21/11 at 4:48 PM, Administrative Nurse #2 indicated that she was aware that Resident #29's Medicare coverage had terminated when therapy was discontinued; however, she had not been made aware that it was her responsibility to issue Medicare non-coverage letters. Administrative Nurse #2 said that no notification was issued to Resident #29 or the responsible party that Medicare coverage was ending.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	F 221	(1) Upon finding during survey that resident #51 did not have approaches listed in goal number two for (participates in a restraint reduction program) the care plan was reviewed and found that approaches for restraint reduction was included	

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F 221	Continued From page 4 by: Based on observation, record review, staff interview and policy review the facility failed to provide a specific medical symptom for the use of a restraining device, and to provide a gradual process in reducing the restraining device for one (1) of one (1) sampled residents using a restraining device. (Resident #51) Findings Include: Review of the facility policy titled "Policy: Restraints - Physical" (undated) read: "It is the policy of this facility that restraints only be used for the safety and well being of the residents and only after other alternatives have been tried unsuccessfully." The Procedures for the policy included the following: "Restraints will only be used after other alternatives have been tried unsuccessfully and/or only with informed consent." "Orders indicate the specific reason, type, and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint." "Orders for restraints must be reviewed and renewed on a routine basis (i.e., with each routine visit by the attending physician)." "A resident placed in restraint will be checked at least every thirty (30) minutes by nursing personnel." "The opportunity for motion and exercise is provided for a period of at least ten (10) minutes during each (2) hours in which restraints are employed, except at night." Resident # 51 was admitted 4/1/2006 and	F 221	in goal number one. (see attached careplan) careplan will be updated to include outcomes for goal #2. (1b) Upon finding during survey that resident #51, her restraint order dated 1/31/2011, had not been reviewed. The physician was notified and will review and update order upon screening by the physical therapist. PT notified and conducted screen on resident #51 with recommendations to change wheel chair and cushion for positioning. (1c) Upon finding during survey that resident #51 was not coded as having a restraint, physical therapy was asked to do a screen for possible restraint reduction. It was recommended by PT to change wheel chair related to sagging and to add new profile cushion for positioning. Physician order on 10/11/2011 to discharge lap buddy and anti-thrust cushion. (1d) Upon finding during survey that resident #51 was found to be unable to remove her lap buddy upon command. Resident had been previously coded as being able to remove lap buddy but had not recently been assessed. It was recommended by PT to change wheel chair related to sagging and to add new profile cushion for positioning. Physician order on 10/11/2011 to discharge lap buddy and anti-thrust cushion. Resident care plan has been changed to reflect this change. 2) An audit of all residents requiring lap buddy's was conducted with the Carolina Center for Medical Excellence representative (Maria Fisher) and staff. Residents identified will be assessed for possible restraint reduction. 3) All residents whose restraints are reduced will be followed by risk program x 4 weeks for further possible reduction of restraints. In addition, all restraints will be addressed on a weekly basis for possible restraint reduction x 4 weeks. All residents on restraint monitoring will be added to the restorative program to ensure approaches including release and exercises every 2 hours. A shift by shift in-service will be conducted to all nursing staff on the facilities policy and procedure with regards to constraints. 4) All restraint reductions were added to the monthly Quality Assurance meeting to monitor compliance. All restraints will be addressed at the quarterly QA which is attended by the Medical Director. As directed by DHHS, CCME was contacted and facility met with Maria Fisher for guidance for the POC concerning restraints. Copies of questionnaires and checklist were given to the		

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F 221	<p>Continued From page 5</p> <p>readmitted on 1/15/2011 with diagnoses including: hypertension, hyperlipidemia, dementia, Parkinson's disease and depression.</p> <p>Review of the active medical record revealed a Care Plan problem with an onset date of 9/5/2011 that read, in part "requires use of lap buddy as least restrictive restraint when in wheelchair due to history of falls with significant injury, leans forward in wheelchair and has poor trunk control." The goal for this problem read "(Resident #51) will be maintained in proper position and kept free from injury." The approaches for this goal included:</p> <p>"PT/OT (Physical Therapy/Occupational Therapy to screen for possible intervention and to ensure least restrictive restraint"</p> <p>"Explore alternatives to restraint use and use least restrictive device possible"</p> <p>"Check for needs, comfort at least every ½ hour and release every 2 hours."</p> <p>"Reassess need for restraints quarterly and prn (as needed)."</p> <p>The second goal statement for this problem area was "(Resident #51) will participate in a restraint reduction program." There were no approaches listed for this goal.</p> <p>Review of the Medical record for Resident #51 revealed a physician' order dated 1/31/11 for "may be oob (out of bed) in w/c (wheelchair) with anti-thrust cushion and lap buddy for safety and positioning per PT/OT." There was no documentation in the medical record of this order being reviewed or renewed after this date.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated 2/9/11 revealed</p>	F 221	<p>Director of Nursing to aide in restraint reduction. Recommendations for restraint reduction for monitoring along with audit tools were given to DON. The facility will incorporate their suggestions into our restraint reduction plan and will address progress in monthly and quarterly QA meetings to determine continued compliance. Substantial compliance will be completed November 21, 2011.</p> <p style="text-align: right;">11/21/11</p>		

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F 221	<p>Continued From page 6</p> <p>Resident #51 was not coded as having a physical restraint.</p> <p>Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 7/8/11 revealed that the resident was moderately cognitively impaired and was totally dependent requiring the assistance of two staff for transfer and toileting. She also required limited assistance of one person for locomotion on and off the unit but could eat with encouragement and set up. The MDS indicated that Resident #51 did not have functional limitation in her upper or lower extremities but that she was unsteady and could only stabilize with assistance when moving from a seated to a standing position. Resident #51 was not coded as having a physical restraint on this assessment.</p> <p>Review of the Nursing notes dated 9/17/11 at 2 pm read "res (resident) was sliding out of w/c assisted to floor by CNA (Nursing Assistant) no injury noted VS (vital signs) stable MD (Medical Doctor) aware"</p> <p>Review of the Falls Investigation Worksheet (dated 9/21/11) for the resident's 9/17/11, 2 PM fall revealed, in part, the following under 'statement of witnesses': "resident was sliding below lap buddy so staff eased her to floor. (No) overt injury noted." The resident was referred to PT for chair evaluation as documented on this Falls Investigation Worksheet.</p> <p>Further review of the medical record revealed no screens for least restrictive restraint.</p> <p>Observation of Resident #51 on 9/19/11 at 12:30</p>	F 221			

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F 221	Continued From page 7 PM revealed the resident was in the dinning area being assisted with lunch. She was seated in her wheelchair and had a lap buddy in place. Observation of Resident #51 on 9/22/11 at 2:40 PM revealed she was up in her wheelchair with a lap buddy in place. Resident #51 was unable to release or remove her lap buddy when requested to attempt to remove it. Interview with Nurse #3 on 9/22/11 at 2:41 PM revealed that she had not seen Resident #51 ever remove her lab buddy. She further stated that she did not think the resident was capable of removing it due to her contracted hands. On 9/22/11 at 2:42 PM interview with the Administrative Nurse #1 revealed that Resident #51 had been assessed for the use of her side rails but that the use of the lap buddy as the least restrictive device had not been assessed. When asked what the medical indication for the restraint was, Administrative Nurse #1 stated that it was the resident's fall risk.	F 221			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278			

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F 278	Continued From page 8 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to code the use of a restraining device on the Minimum Data Set for one (1) of one (1) sampled residents for physical restraints. (Resident #51) Findings include: Resident # 51 was admitted 4/1/2006 and readmitted on 1/15/2011 with diagnoses including: hypertension, hyperlipidemia, dementia, Parkinson's disease and depression. Review of the Medical record for Resident #51 revealed a physician's order dated 1/31/11 for "may be oob (out of bed) in w/c (wheelchair) with anti-thrust cushion and lap buddy for safety and positioning per PT/OT."	F 278	1) Upon finding during survey that resident #51 was not coded as having a restraint, physical therapy was asked to do a screen for possible restraint reduction. It was recommended by PT to change wheel chair related to sagging and to add new profile cushion for positioning. Physician order on 10/11/2011 to discharge lap buddy and anti-thrust cushion. 2) An audit of all residents requiring use of a lap buddy, was conducted on all residents with lap buddy's to ensure proper coding. 3) DON/ designee along with interdisciplinary team, will conduct weekly meetings to discuss issues involving restraints. Any significant changes requiring coding changes will be addressed and corrected at that meeting. 4) All residents requiring a coding change will be monitored at the monthly QA and quarterly QA meetings.		

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F 278	Continued From page 9 Review of the Significant Change Minimum Data Set (MDS) assessment dated 2/9/11 revealed Resident #51 was not coded as having a physical restraint. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 7/8/11 revealed that the resident was moderately cognitively impaired and was totally dependent requiring the assistance of two staff for transfer and toileting. She also required limited assistance of one person for locomotion on and off the unit but could eat with encouragement and set up. The MDS indicated that Resident #51 did not have functional limitation in her upper or lower extremities but that she was unsteady and could only stabilize with assistance when moving from a seated to a standing position. Resident #51 was not coded as having a physical restraint on this assessment. Observation of Resident #51 on 9/19/11 at 12:30 PM revealed the resident was in the dining area being assisted with lunch. She was seated in her wheelchair and had a lap buddy in place. Observation of Resident #51 on 9/22/11 at 2:40 PM revealed she was up in her wheelchair with a lap buddy in place. Resident #51 was unable to release or remove her lab buddy when requested to attempt to remove it. Interview with Nurse #3 on 9/22/11 at 2:41 PM revealed that she had not seen Resident #51 ever remove her lap buddy. She further stated that she did not think the resident was capable of removing it due to her contracted hands.	F 278		

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F 278	Continued From page 10	F 278			
F 279 SS=D	<p>On 9/22/11 at 2:42 PM interview with the Administrative Nurse #1 revealed that Resident #51 had been assessed for the use of her side rails but that the use of the lap buddy as the least restrictive device had not been assessed. When asked what the medical indication for the restraint was, Administrative Nurse #1 stated that it was the resident 's fall risk.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop</p>	F 279	<p>1. A. Resident #89 has been reassessed and care plan has been updated to include specific interventions to prevent worsening of contractures. 9/22/11</p> <p>B. Resident #24 has been reassessed and care plan has been updated to include management of anxiety and monitoring for possible side effects of anti-anxiety medications. 9/22/11</p> <p>C. Resident #24 has been reassessed and care plan has been updated to indicate resident receiving hemodialysis and to include nursing actions needed to provide care for a resident on hemodialysis. 9/22/11</p>		

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F 279	<p>Continued From page 11</p> <p>comprehensive care plans for 2 of 20 sampled residents (Residents #24 and #89).</p> <p>The findings included:</p> <p>1. Resident #89 was admitted to the facility on 4/24/09. Diagnoses included quadriplegia, dysarthria, and aphasia. The annual Minimum Data Set (MDS) dated 4/12/11 and the quarterly MDS dated 7/12/11 indicated that the resident had limitation of range of motion in all extremities.</p> <p>Resident #89's care plan dated 9/14/11 listed a problem of requiring assistance with activities of daily living due to quadriplegia and contractures. The goal included, "Will maintain current level of functional abilities" for the next 90 days. The approaches lacked any intervention to prevent worsening of contractures.</p> <p>Observation of Resident #89 on 9/19/11 at 3:16 PM revealed bilateral wrist and finger contractures. No interventions or devices were observed to prevent worsening of the contractures.</p> <p>During an interview on 9/22/11 at 11:50 AM, Administrative Nurse #2 acknowledged that Resident #89 should have been care planned for contractures/range of motion and she would do so now.</p> <p>2a. Resident #24 was admitted to the facility on 7/6/11. Cumulative diagnoses included anxiety. The admission Minimum Data Set (MDS) dated 7/19/11 revealed that the resident received antianxiety medication.</p>	F 279	<p>2. Each resident with contractures, receiving anti-anxiety medications or receiving dialysis will be reassessed and care plans will be developed or updated with specific goals and interventions necessary to meet each resident's individual needs.</p> <p>3. A. The Interdisciplinary Care Planning Team involved in the assessment or care planning process will be in-serviced regarding developing and updating comprehensive care plans to establish goals and determine interventions to address each resident's individual needs.</p> <p>B. Residents # 89 and # 24 will be monitored by the assessment nurse on a weekly basis x 4 for changes in condition related to contractures, side effects of medications, and issues related to dialysis. If these 2 residents are stable, they will then be monitored monthly by the assessment nurse.</p> <p>C. The Director of Nursing and/or designee will monitor the assessments and care plans of Residents # 89 and # 24 on a monthly basis x 3 months to ensure assessments are accurate and care plans are updated in a timely manner to prevent complications and prevent worsening of condition.</p> <p>4. A. The Director of Nursing and/or designee will audit MDS Assessments and Care Plans on a quarterly basis to ensure accuracy of the MDS and care plans that address each</p> <p>B. The Quality Assurance committee will monitor audit system on quarterly basis to ensure effectiveness</p> <p>C. Concerns identified by Quality Assurance Committee related to assessment and care planning process will be revised by the Director of Nursing and Administrator as needed.</p>	11/21/11	

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F 279	Continued From page 12 Review of Resident #24's care plan revealed no care plan for the treatment of anxiety. Review of Resident #24's September 2011 Medication Administration Record (MAR) revealed that Resident #24 was on Ativan (an antianxiety medication) three times a day as needed. The MAR indicated that the resident requested and received the Ativan 1 - 3 times a day. During an interview on 9/21/11 at 11:05 AM, Administrative Nurse #2 indicated that Resident #24 should have been care planned for management of anxiety and possible side effects of his medication and would do so now. 2b. Resident #24 was admitted to the facility on 7/6/11. Cumulative diagnoses included end stage renal disease and hypertension. Admission orders included hemodialysis 3 times a week. The admission Minimum Data Set (MDS) dated 7/19/11 revealed that the resident received dialysis. Review of Resident #24's care plan revealed no nursing care plan indicating that the resident received hemodialysis or nursing actions needed to provide care for a resident on hemodialysis. During an interview on 9/21/11 at 11:48 AM, Administrative Nurse #2 acknowledged a nursing care plan should have been done for Resident #24 to address his needs related to dialysis and would do so now.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	<p>Continued From page 13</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the resident's care plan for the use of the leg strap and catheter care were implemented for 3 (Residents # 80, #83 & # 31) of 3 sampled residents with an indwelling urinary catheter. The findings include:</p> <p>1. Resident # 80 was admitted to the facility on 06/13/08 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 07/15/11 indicated that Resident #80 had severe cognitive impairment and had an indwelling catheter.</p> <p>The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap, catheter care every shift and to position tubing to avoid tension/pulling.</p> <p>On 06/24/11, there was a telephone order to clean the tube site and to apply new gauze dressing daily.</p> <p>The Treatment record for September, 2011 was</p>	F 282	<p>1. A. Resident #80 has been reassessed and care plan has been updated to include specific interventions to promote proper use of a leg strap and catheter care.</p>	

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F 282	<p>Continued From page 14 reviewed. There were no nurse's initials for 3 days (09/19, 09/20 & 09/21/11) to indicate that the tube site was cleaned and dressed.</p> <p>On 09/21/11 at 8:15 AM, the resident was observed in bed. There was a wheelchair beside the bed and the catheter bag was hung under the wheelchair seat. There was no leg strap observed and the catheter site had no dressing on it. The site had a small amount of fresh and old blood around it.</p> <p>On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. She also stated that it was the night shift nursing assistant who hung the catheter bag under the wheelchair seat.</p> <p>On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed.</p> <p>On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times. She also stated that everybody (nurses and nursing assistants) was responsible to check if the resident had a leg strap or not.</p> <p>On 09/22/11 at 9:05 AM, the treatment nurse was interviewed. She stated that the nurse who works 3-11 shift was responsible for the care of the indwelling catheters.</p> <p>On 09/22/11 at 3:47 PM, Nurse # 2 was</p>		<p>B. Resident # 83 has been reassessed and care plan has been updated to include specific interventions related to catheter and skin care</p> <p>C. Resident # 31 has been reassessed and care plan has been updated to include specific interventions to prevent infection with proper use of a leg strap and catheter care.</p> <p>2. Each resident with an indwelling urinary catheter and leg strap has been reassessed and care plans have been developed or updated with specific goals and interventions necessary to meet each resident's individual needs.</p> <p>3. A. All licensed nurses will be in-serviced regarding proper indwelling urinary catheter care, usage application of catheters and leg straps, treatments ordered by physician, properly implementing care plan interventions based upon routine standards of care and accurate documentation of treatments provided and assessments conducted.</p> <p>B. All nursing assistants will be in-serviced regarding proper indwelling urinary catheter care, usage application of catheters and leg straps.</p> <p>C. The Interdisciplinary Care Planning Team involved in the assessment or care planning process will be in-serviced regarding monitoring to ensure comprehensive care plans are implemented to address each resident's individual needs.</p> <p>D. Each resident with a catheter will be monitored by the Director of Nursing and/or designee for correct usage of catheter, proper application of leg strap and positioning of catheter tubing, weekly x 4, then monthly.</p> <p>4. A. The Quality Assurance committee will monitor indwelling urinary catheter and leg strap application audit system on quarterly basis to ensure effectiveness.</p> <p>B. Concerns identified by Quality Assurance Committee</p>		

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F 282	Continued From page 15 interviewed. She stated that she did not clean and dress the tube site on 09/19, 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube site. 2. Resident #83 was admitted to the facility on 05/02/10 and was re-admitted on 08/02/11 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #83 had moderate cognitive impairment and had an indwelling urinary catheter. The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap and catheter care every shift. On 08/31/11, there was a telephone order to clean the tube site with NS (normal saline) and to apply a clean drain sponge everyday in the afternoon. The Treatment record for September, 2011 was reviewed. There were no nurse's initials for 2 days (09/20 & 09/21/11) to indicate that the tube site was cleaned and dressed. On 09/21/11 at 8:30 AM, the resident was observed in bed. There was no leg strap observed and the catheter site dressing had a small amount of dried blood on it. There was no date on the dressing observed.	F 282	related to indwelling urinary catheter and leg strap application process will be revised by the Director of Nursing and Administrator as needed. 11/21/11		

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F 282	<p>Continued From page 16</p> <p>On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was.</p> <p>On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed.</p> <p>On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times. She also stated that everybody (nurses and nursing assistants) was responsible to check if the resident had a leg strap or not.</p> <p>On 09/22/11 at 9:05 AM, the treatment nurse was interviewed. She stated that the nurse who works 3-11 shift was responsible for the care of the indwelling catheters.</p> <p>On 09/22/11 at 3:47 PM, Nurse # 2 was interviewed. She stated that she did not clean and dress the tube site on 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube site.</p> <p>3. Resident #31 was admitted to the facility on 12/21/08 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #31 had moderate cognitive impairment and had an indwelling urinary catheter.</p> <p>The care plan was reviewed. One of the care plan problems was "at risk for infection due to the</p>	F 282		
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F 282	Continued From page 17 presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap and catheter care every shift. On 09/21/11 at 8:20 AM, Resident #31 was observed in bed. He had an indwelling catheter and there was no leg strap observed to anchor the catheter. On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed. On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times. She also stated that everybody (nurses and nursing assistants) was responsible to check if the resident had a leg strap or not.	F 282			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an 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	F 315			

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F 315	<p>Continued From page 18</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the indwelling urinary catheter to prevent excessive tension which can lead to dislodging the catheter for 3 (Residents #80, #83 & #31) of 3 sampled residents with an indwelling urinary catheter. The facility also failed to clean and dress the urinary catheter site as ordered for 2 (Resident #80 & #83) of 3 sampled residents. The findings include:</p> <p>1a. Resident #80 was admitted to the facility on 06/13/08 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 07/15/11 indicated that Resident #80 had severe cognitive impairment and had an indwelling urinary catheter.</p> <p>The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap, catheter care every shift and to position tubing to avoid tension/pulling.</p> <p>Review of the urology consult notes revealed that on 08/29/11, Resident #72 was sent for a urology consult due to leakage from penis and no drainage from the suprapubic tube. The urology</p>	F 315	<ol style="list-style-type: none"> <p>A. Resident #80 has been reassessed and care plan has been updated to include specific interventions to promote proper use of a leg strap and catheter care.</p> <p>B. Resident # 83 has been reassessed and care plan has been updated to include specific interventions related to catheter and skin care</p> <p>C. Resident # 31 has been reassessed and care plan has been updated to include specific interventions to prevent infection with proper use of a leg strap and catheter care.</p> <p>Each resident with an indwelling urinary catheter and leg strap has been reassessed and care plans have been developed or updated with specific goals and interventions necessary to meet each resident's individual needs.</p> <p>A. All licensed nurses will be in-serviced regarding proper indwelling urinary catheter care, usage application of catheters and leg straps, treatments ordered by physician, properly implementing care plan interventions based upon routine standards of care and accurate documentation of treatments provided and assessments conducted.</p> <p>B. All nursing assistants will be in-serviced regarding proper indwelling urinary catheter care, usage application of catheters and leg straps.</p> <p>C. The Policy and Procedure regarding Urinary Incontinence and Indwelling Urinary Catheter will be revised and updated as needed. All direct care staff will be inserviced regarding the updated policy and procedure.</p> <p>D. Each resident with a catheter will be monitored by the Director of Nursing and/or designee for correct usage of catheter, pericare, proper application of leg strap and</p> 		

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F 315	<p>Continued From page 19</p> <p>notes revealed that the suprapubic tube was not in correct position.</p> <p>On 09/21/11 at 8:15 AM, the resident was observed in bed. There was a wheelchair beside the bed and the catheter bag was hung under the wheelchair seat. There was no leg strap observed and the catheter site had no dressing on it. The site had a small amount of fresh and old blood around it.</p> <p>On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was.</p> <p>On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed.</p> <p>On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times to secure the catheter. She also stated that everybody was responsible to check if the resident had a leg strap or not.</p> <p>1b. Resident # 80 was admitted to the facility on 06/13/08 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 07/15/11 indicated that Resident #80 had severe cognitive impairment and had an indwelling urinary catheter.</p> <p>The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The</p>	F 315	<p>positioning of catheter tubing, weekly x 4, then monthly.</p> <p>4. A. The Quality Assurance committee will monitor indwelling urinary catheter and leg strap application audit system on quarterly basis to ensure effectiveness.</p> <p>B. Concerns identified by Quality Assurance Committee related to indwelling urinary catheter care and leg strap application process will be revised by the Director of Nursing and Administrator as needed.</p> <p style="text-align: center;">11/11/11</p>		

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F 315	<p>Continued From page 20</p> <p>goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap, catheter care every shift and to position tubing to avoid tension/pulling.</p> <p>On 06/24/11, there was a telephone order to clean the tube site and to apply new gauze dressing daily.</p> <p>The Treatment record for September, 2011 was reviewed. There were no nurse's initials for 3 days (09/19, 09/20 & 09/21/11) to indicate that the tube site was cleaned and dressed.</p> <p>On 09/21/11 at 8:15 AM, the resident was observed in bed. The catheter site had no dressing on it. The site had a small amount of fresh and old blood around it.</p> <p>On 09/22/11 at 9:05 AM, the treatment nurse was interviewed. She stated that the nurse who works 3-11 shift was responsible for the care of the indwelling catheters.</p> <p>On 09/22/11 at 3:47 PM, Nurse # 2 was interviewed. She stated that she did not clean and dress the tube site on 09/19, 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube site.</p> <p>2 a. Resident #83 was admitted to the facility on 05/02/10 and was re-admitted on 08/02/11 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #83 had moderate cognitive impairment and had an indwelling urinary catheter.</p>	F 315			

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F 315	<p>Continued From page 21</p> <p>The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap and for catheter care every shift.</p> <p>On 09/21/11 at 8:30 AM, the resident was observed in bed. There was no leg strap observed and the catheter site dressing had a small amount of dried blood on it</p> <p>On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was.</p> <p>On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed.</p> <p>On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times to secure the catheter. She also stated that everybody was responsible to check if the resident had a leg strap or not.</p> <p>2 b. Resident #83 was admitted to the facility on 05/02/10 and was re-admitted on 08/02/11 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #83 had moderate cognitive impairment and had an indwelling urinary catheter.</p>	F 315		

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F 315	<p>Continued From page 22</p> <p>The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap and catheter care every shift.</p> <p>On 08/31/11, there was a telephone order to clean the tube site with NS (normal saline) and to apply a clean drain sponge everyday in the afternoon.</p> <p>The Treatment record for September, 2011 was reviewed. There were no nurse's initials for 2 days (09/20 & 09/21/11) to indicate that the tube site was cleaned and dressed.</p> <p>On 09/22/11 at 9:05 AM, the treatment nurse was interviewed. She stated that the nurse on floor was responsible for the care of the indwelling catheters.</p> <p>On 09/22/11 at 3:47 PM, Nurse # 2 was interviewed. She stated that she did not clean and dress the tube site on 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube.</p> <p>3. Resident #31 was admitted to the facility on 12/21/08 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #31 had moderate cognitive impairment and had an indwelling urinary catheter.</p> <p>The care plan was reviewed. One of the care</p>	F 315			

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F 315	Continued From page 23 plan problems was "at risk for infection due to the presence of catheter". The goal was "catheter will remain patent and resident will be free from urinary tract infection x (times) 90 days". The approaches included the use of a leg strap and for catheter care every shift. On 09/21/11 at 8:20 AM, Resident #31 was observed in bed. He has an indwelling catheter and there was no leg strap observed to anchor the catheter. On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of bed. On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times to secure the catheter. She also stated that everybody (nurses and nursing assistants) was responsible to check if the resident had a leg strap or not.	F 315			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318			

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F 318	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide services to prevent worsening of contractures for 1 of 3 sampled residents (Resident #89). The findings included: Resident #89 was admitted to the facility on 4/24/09. Diagnoses included quadriplegia, dysarthria, and aphasia. The annual Minimum Data Set (MDS), dated 4/12/11 and the quarterly MDS dated 7/12/11 indicated that the resident had limitation of range of motion in all extremities. The care plan, last reviewed 9/14/11, listed a problem of requiring assistance with activities of daily living due to quadriplegia and contractures. The goal included, "Will maintain current level of functional abilities" for the next 90 days. The approaches lacked any intervention to prevent worsening of contractures. Review of restorative nursing form dated April 2011 revealed that passive range of motion and splinting to upper extremities were discontinued. Observation of Resident #89 on 9/19/11 at 3:16 PM revealed bilateral wrist and finger contractures. During an interview on 9/22/11 at 11:51 AM, Administrative Nurse #3 stated that restorative nursing services were stopped because Resident	F 318	1. A. Resident #89 has been reassessed and care plan has been updated to include specific interventions to prevent worsening of contractures. 9/22/11 B. Based upon Physical Therapy recommendations, resident #89 will receive restorative nursing services for range of motion and splinting to prevent decline in range of motion or worsening of contractures. 9/22/11 2. A. Each resident with contractures will be reassessed and care plans will be developed or updated with specific goals and interventions necessary to meet each resident's individual needs related to preventing decline in range of motion or worsening contractures. 11/11/11 B. Each resident with decline in range of motion or contractures will be evaluated for potential restorative services to prevent further decline in range of motion or worsening of contractures. 3. A. Resident # 89 will be monitored by the assessment nurse on a weekly basis x 4 for changes in condition related to contractures. If resident is stable, will then be monitored monthly by the assessment nurse. B. The Director of Nursing or designee will monitor the restorative services provided to Resident # 89 on a monthly basis x 3 months to ensure services are provided to prevent complications and prevent worsening of contractures.		

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F 318	Continued From page 25 #89 was not making any progress. During an interview on 9/22/11 at 2:00 PM, the Physical Therapist (PT) indicated that restorative services for range of motion and splinting would be beneficial in preventing a decline in range of motion or worsening of contractures for Resident #89.		C. The Director of Nursing or designee will monitor the restorative services provided to each resident with decline in range or motion or worsening contractures on a monthly basis x 3 months to ensure services are provided to prevent further decline in range of motion and prevent worsening of contractures. 4. A. The Quality Assurance committee will monitor contracture and restorative services audit system on quarterly basis to ensure effectiveness B. Concerns identified by Quality Assurance Committee related to restorative services and prevention of decline in range of motion or worsening of contractures will be revised by the Director of Nursing and Administrator as needed. 11/11/11		
F 329 SS=D	483.25(I) 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 drugs. This REQUIREMENT is not met as evidenced	F329			

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F 329	Continued From page 26 by: Based on record review and staff interview, the facility failed to monitor the serum Potassium level as ordered for 1 (Resident #72) of 10 sampled residents. The finding includes: Resident #72 was admitted to the facility on 03/29/11 with multiple diagnoses including Hypertension, Coronary Artery Disease (CAD), Pernicious Anemia and Fibromyalgia. The quarterly MDS assessment dated 07/20/11 indicated that Resident #72 had no memory and decision making problems. Review of the physician's order for September, 2011 revealed that Resident #72 was on Zestril for Hypertension. On 05/03/11, the resident's serum Potassium level was high, 5.9 meq (milliequivalent)/L (liter). The normal range was 3.5 meq/L - 5.3 meq/L. The package insert from the manufacturer of Zestril indicated that the drug can cause Hyperkalemia (high Potassium level) and recommended to check serum Potassium level frequently. On 06/03/11, the pharmacist had addressed the high serum Potassium level to nursing and recommended to repeat the BMP (basic metabolic panel) which included Potassium level. There was no evidence that the facility acted upon this recommendation. On 09/01/11, Resident #72 was seen by the physician. The progress notes had addressed the high Potassium level and ordered to check	F 329	1. Resident #72's physician orders, laboratory reports, pharmacy consultant reviews and pharmacy consultations will be audited and laboratory tests have now been performed as ordered. 2. A. Medical records for all residents with laboratory blood tests ordered will be audited to ensure laboratory tests are performed as ordered B. Pharmacy recommendations will be reviewed to ensure follow up on each recommendation. C. Inservice education will be provided to all licensed nursing staff regarding policy and procedure for obtaining and follow up of laboratory tests based upon physician orders and pharmacy recommendations, accurate completion of laboratory request forms, and accurate and timely documentation of laboratory samples obtained 3. A. Director of Nursing or designee will audit medical records monthly for all residents with laboratory blood tests ordered to ensure laboratory tests are performed as ordered B. Director of Nursing will monitor Pharmacy recommendation monthly to ensure follow up on each recommendation. C. Director of Nursing will evaluate all licensed nursing staff regarding compliance with policy and procedure for obtaining and follow up of laboratory tests based upon physician orders and pharmacy recommendations, accurate completion of laboratory request forms, and accurate and timely documentation of laboratory samples obtained.		

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F 329	Continued From page 27 the BMP. As of 09/21/11, there was no BMP drawn. On 09/21/11 at 4:32 PM, the administrative nurse #1 was interviewed. She stated that she did not know where the pharmacist recommendations were kept and who was responsible. She also stated that there was no policy when to draw the labs (laboratory) as ordered. She indicated that when labs were ordered the nurse who carried out the order had to fill out the request form and had to enter it in the lab book to be drawn. She stated that there was no lab request filled out and it was not entered in the lab book to be drawn.		D. Director of Nursing, Administrator and Medical Director will ensure Policy and Procedure regarding laboratory tests has been reviewed and will be revised and updated as needed	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard outdated food in the kitchen refrigerator/dry storage room, failed to date open food in the freezer and failed to monitor the freezer temperature in 2 (100 & 200 hall)of 2 nourishment refrigerators. The findings include:	F 371	4. Quality Assurance Committee will review Policy and Procedure regarding laboratory tests and will recommend to Administrator if the policy needs to be revised and updated 11/11/11	
			1. The following corrections were made while survey team was in the facility: A. Discarded outdated food in kitchen refrigerator/storage room B. Dated open food in the freezer if it had not exceeded appropriate time frame C. Checked freezer temperature in nourishment refrigerators D. On 9/21/11, a new policy on Nourishment rooms/Refrigerators was provided to the survey team which indicates nursing will check the temperatures in the nourishment refrigerator and freezer in a.m. and p.m. and housekeeping will be responsible for cleaning/defrosting the freezer.	

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F 371	<p>Continued From page 28</p> <p>1. The facility's policies on leftover food (undated) and cold food storage dated 05/27/09 were reviewed. The policy on leftovers read in part "leftovers are utilized within 48 hours (by next meal whenever possible)". The policy on cold food storage read in part "food item/example (side salad/lettuce) and cooked items such as roast beef or turkey to use in 3 days after placing in refrigerator and 30 days after placing in freezer".</p> <p>On 09/19/11 at 10:40 AM, an initial tour of the kitchen was conducted. There was a package of mini marshmallow with expiration date of September 16, 2010 observed in the dry storage room. In the walk in refrigerator, there was an opened bag of lettuce that was not dated or sealed.</p> <p>On 09/19/11 at 10:45 AM, the dietary manager was interviewed. She stated that she was responsible for checking the expiration dates of all food items in the storage room. She further stated that she did not think that marshmallow had an expiration date, so she did not check it. She also stated that the dietary aide should have dated and closed the pack of lettuce before putting it in the refrigerator.</p> <p>2. On 09/21/11 at 10:30 AM, a kitchen tour was again conducted. A zip lock bag of chicken nuggets and a zip lock bag of chopped nuggets were observed in the refrigerator dated 09/17/11.</p> <p>On 09/21/11 at 10:38 AM, the dietary manager was interviewed. She stated that leftover foods were good for 3 days and she discarded both bags.</p>	2.	<p>The following have been implemented:</p> <p>A. Food in kitchen refrigerator/storage room will be discarded as dates expire</p> <p>B. Open food in the freezer will be dated when opened</p> <p>C. Freezer temperature in nourishment refrigerators will be checked twice daily by nursing staff</p> <p>D. Policies have been updated regarding leftover food, cold food storage; and bulk food storage</p> <p>E. Dietary manager is responsible for checking the expiration dates of all food items in the storage room.</p> <p>F. Inservice has been provided to dietary manager and dietary staff regarding expiration dates</p> <p>G. Buildup of ice on top of freezer has been cleaned. Maintenance will be responsible for monitoring for buildup and ensuring ice is removed immediately from the top of the freezer.</p> <p>H. Nursing staff will check temperature twice daily and clean the nourishment refrigerators weekly</p> <p>I. Housekeeping will clean the freezer section of the nourishment refrigerator on a weekly basis or as needed.</p>		
		3.	<p>A. Inservice education will be provided to all dietary and nursing staff regarding the above items.</p> <p>B. Monitoring of dietary action steps identified above will be conducted by the administrator or designee on a monthly basis</p>		
		4.	<p>The administrator will report to Quality Assurance on a quarterly basis regarding the dietary and nourishment compliance issues identified above.</p>		

11/11/11

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F 371	Continued From page 29 3. On 09/21/11 at 10:45 AM, the nourishment refrigerators on 100 & 200 halls were observed. Inside the freezer of the nourishment refrigerator on the 200 hall, there were several ice cream stored and the ice cream were noted to be soft. There was a big build up of ice on top of the freezer. On 09/21/11 at 10:55 AM, the administrative nurse #1 was interviewed. She stated that the facility staff was checking the temperature of the fridge but not the freezer. On 09/21/11 at 11:00 AM, the Registered Dietician was interviewed. She stated that the staff should check the temperature of the freezer in the nourishment refrigerators. She added that "right now nobody was responsible for checking the temperature of the freezer and in cleaning/defrosting the freezer". On 09/21/11 at 4:30 PM, a copy of the new policy on Nourishment rooms/Refrigerators was provided. The policy indicated that nursing will check the temperatures on the refrigerator and freezer in AM and PM and housekeeping will be responsible for cleaning/defrosting the freezer.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428			

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F 428	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the pharmacist failed to report to the attending physician and/or director of nursing the need to repeat serum Potassium level as recommended by the pharmacist and as ordered for 1 (Resident #72) of 10 sampled residents. The finding includes: Resident #72 was admitted to the facility on 03/29/11 with multiple diagnoses including Hypertension, Coronary Artery Disease (CAD), Pernicious Anemia and Fibromyalgia. The quarterly MDS assessment dated 07/20/11 indicated that Resident #72 had no memory and decision making problems. Review of the physician's order for September, 2011 revealed that Resident #72 was on Zestril for Hypertension. On 05/03/11, the resident's serum Potassium level was high, 5.9 meq (milliequivalent)/L (liter). The normal range was 3.5 meq/L - 5.3 meq/L. The package insert from the manufacturer of Zestril indicated that the drug can cause Hyperkalemia (high Potassium level) and recommended to check serum Potassium level frequently. On 06/03/11, the pharmacist had addressed the		1. Resident #72's physician orders, laboratory reports, pharmacy consultant reviews and pharmacy consultations will be audited and laboratory tests have now been performed as ordered. 2. A. Medical records for all residents with laboratory blood tests ordered will be audited to ensure laboratory tests are performed as ordered B. Pharmacy recommendations will be reviewed to ensure follow up on each recommendation. C. Inservice education will be provided to all licensed nursing staff regarding policy and procedure for obtaining and follow up of laboratory tests based upon physician orders and pharmacy recommendations, accurate completion of laboratory request forms, and accurate and timely documentation of laboratory samples obtained D. Policy and Procedure regarding pharmacy consultation will be reviewed and will be revised and updated as needed 3. A. Director of Nursing or designee will audit medical records monthly for all residents with laboratory blood tests ordered to ensure laboratory tests are performed as ordered B. Director of Nursing will monitor Pharmacy recommendation monthly to ensure follow up on each recommendation. C. Director of Nursing will evaluate all licensed nursing staff regarding compliance with policy and procedure for obtaining and follow up of laboratory tests based upon physician orders and pharmacy recommendations, accurate completion of laboratory request forms, and accurate and timely documentation of laboratory samples obtained. 4. Quality Assurance Committee will review Policy and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/22/2011
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360		
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F 428	<p>Continued From page 31</p> <p>high serum Potassium level to nursing and recommended to repeat the BMP (basic metabolic panel) which included Potassium level. There was no evidence that the facility acted upon this recommendation.</p> <p>On 07/01/11, 08/05/11 and 09/05/11, the pharmacist had reviewed the resident's records. The DRR (drug regimen review) notes did not address the high K+ level and the missing BMP result as recommended by the pharmacist on 06/03/11. The notes dated 09/05/11 also did not mention the missing BMP result as ordered by the physician on 09/01/11.</p> <p>On 09/01/11, Resident #72 was seen by the physician. The progress notes had addressed the high Potassium level and ordered to check the BMP. As of 09/21/11, there was no BMP drawn.</p> <p>On 09/21/11 at 4:32 PM, the administrative nurse #1 was interviewed. She stated that she did not know where the pharmacist recommendations were kept and who was responsible. She also stated that there was no policy when to draw the labs (laboratory) as ordered. She indicated that when labs were ordered the nurse who carried out the order had to fill out the request form and had to enter it in the lab book to be drawn. She stated that there was no lab request filled out and it was not entered in the lab book to be drawn.</p> <p>On 09/27/11 at 10:26 AM, the pharmacist was interviewed. He stated that he did not address the missing BMP result ordered on 09/01/11 because he thought the result had not been faxed</p>	F 428	<p>Procedure regarding laboratory tests and will recommend to Administrator if the policy needs to be reviewed and updated</p> <p style="text-align: right;"><i>11/11/11</i></p>		

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F 428	Continued From page 32	F 428			
F 461 SS=C	<p>to the facility yet. He stated that he was not aware that the ordered BMP was not drawn.</p> <p>483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET</p> <p>Bedrooms must have at least one window to the outside; and have a floor at or above grade level.</p> <p>The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident.</p> <p>CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, the facility failed to provide each resident with individual closet space with</p>	F 461	<ol style="list-style-type: none"> Resident # 99's single closet which she shares with her husband/roommate has been remodeled to provide separate space for each resident. <ol style="list-style-type: none"> All resident closets have been evaluated. Plans have been developed for remodeling all closets in resident rooms to separate resident belongings in the closets. This remodeling project will take several months to complete, but when completed, will provide separate clothes storage space for each resident. <ol style="list-style-type: none"> The maintenance supervisor will oversee the closet renovation project to ensure completion. The administrator will monitor to ensure timely completion of the closet separator project. The administrator will report to Quality Assurance Committee progress of the closet separator project on a quarterly basis. 		

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NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360		
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F 461	Continued From page 33 accessible clothes racks and shelves on 2 (100 & 200 hall)of 2 halls. The findings include: Resident #99 was admitted to the facility on 03/25/10 with multiple diagnoses including Deep Vein Thrombosis (DVT) and Pulmonary Embolus (PE). The quarterly MDS assessment dated 07/18/11 indicated that Resident #99 had no memory or decision making problems. On 09/19/11 at 4:03 PM, Resident #99 was interviewed. She stated that she and her husband were sharing the same room and there was only one small closet space in the room with one shelf. She further stated that the closet space was too small for 2 people in the room. On 09/21/11 at 4:30 PM and on 09/22/11 at 8:30 AM, observation of residents' rooms was conducted. There were rooms with 2, 3 or 4 residents in the room. All residents in 100 and 200 halls were observed sharing a closet space. There was one shelf in each closet which was not accessible to residents. Disposable briefs were observed stored on top of the shelf. Resident's clothes and personal items were noted on the floor in the closet. There were clothes observed hanging on the door knobs and outside the closet space. When shared with administrative staff on 09/22/11 at 4:30 PM, he stated that he was aware that all residents were sharing a closet space. He stated that he would figure it out to ensure that each resident has individual closet space with accessible clothes racks and shelves.	F 461			

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NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360	
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K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) The smoke wall in 200 Hall has holes and penetrations that were not sealed in order to maintain the required fire resistance rating of the smoke barrier. 42 CFR 483.70(a)	K 025	A. Upon becoming aware during the survey of the deficient practice, the smoke barrier was repaired on 10/24/2011, by the maintenance director, with cement to maintain the rating of said smoke barrier. B. An audit has been conducted of all smoke barriers to ensure that no holes are present, and any repairs necessary to maintain the fire resistance rating have been completed. 11/21/2011 C. The maintenance director, or designee will complete monitor tool weekly x 4 weeks then monthly to ensure no penetration or holes are in the fire walls. All staff in-serviced by the Staff Development Coordinator(SDC) by 11/21/2011 D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the smoke barriers (Q.A. committee members are: Administrator, Director of Nursing, Dietary, Housekeeping, Maintenance, Admissions, Staff Development, MDS Nurse, Business Office Manager)	11/11
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.6.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029 1)	A) Upon becoming aware during the survey of the deficient practice, the kitchen ceiling has been repaired with 5/8" fireguard sheetrock. Completion Date: 11/1/2011 B. An audit has been conducted of all ceilings to ensure that no wood has been used to repair ceilings, and any repairs necessary to maintain the fire resistance rating have been completed. 11/21/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 10/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) The ceiling in the Kitchen has a 1/8 inch piece of plywood covering a large hole. The plywood does not meet the requirements for a one hour rated ceiling. 2) The stock room ceiling have penetration of the ceiling by PVC pipes that are not equipped with UL approved fire rated assembly. The are also holes in the ceiling that have not been sealed in order to maintain the required rating of the ceiling. 3) There is a penetration in the ceiling above the light above the driers in the laundry room. 42 CFR 483.70(a)	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) Based on record review and staff interview, the facility sprinkler system was not being tested in accordance with NFPA 25 - Standard for the Inspection, Testing and Maintenance of	K 062	CONT. ON NEXT PAGE 1) A) Upon becoming aware during the survey of the deficient practice, the sprinkler system was tested on 10/24/2011 by High Point Sprinkler Company at 2PM as a quarterly inspection. At this time LibertyWood has a contract with HPSC to due the quarterly, semi-annual and annual inspections. (see attached contract please) B. This is the only sprinkler system in the facility. C. The facility now has a contract with High Point Sprinkler Co. to maintain facility compliance with NFPA requirements. 10/25/2011 D. The Quality Assurance Committee will review the contract x 3 months to determine compliance.	

K 029
CONT.

C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure no wood has been used for repairs to ceilings. All staff in-serviced by the SDC by 11/21/2011

D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to any ceiling repairs.

2)

A) Upon becoming aware during the survey of the deficient practice, the stock room ceiling has been repaired with fire rated caulk, and a UL approved fire rated assembly has been installed to maintain the rating of said smoke barrier. 11/1/2011

B. An audit has been conducted of all ceilings to ensure that no holes are present, and any repairs necessary to maintain the fire resistance rating have been completed. 11/21/2011

C. The maintenance director, or designee will complete monitor tool weekly x 4 then monthly to ensure no holes are in the ceilings. All staff in-serviced by the SDC by 11/21/2011

D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the ceilings.

3) A) Upon becoming aware during the survey of the deficient practice, the laundry room ceiling has been repaired with fire rated caulk to maintain the rating of the ceiling. 10/28/2011

B. An audit has been conducted of all ceilings to ensure that no holes are present, and any repairs necessary to maintain the fire resistance rating have been completed.

C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure no holes are in the ceilings. All staff in-serviced by SDC by 11/21/2011

D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the ceilings

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K 062	Continued From page 2 Water-Based Fire Protection Systems (1999 edition). Interview with facility staff confirmed the fire sprinkler inspection contractor is performing annual inspection and testing only. There was not documentation of quarterly or semi annual inspection.	K 062		
K 067 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) In the water closet in room 207 and in the sprinkler closet room the exhaust fans were removed and not operational. 2) In the laundry room the gas fired drier located outside the drier enclosure is not equipped with high and low combustion inlets.	K 067 1.	A. Upon becoming aware during the survey of the deficient practice, new exhaust fans were installed in the water and sprinkler rooms by Hill's Electric Company on 10/24/2011 at 11:00 AM. B. An audit has been conducted of all water/sprinkler closets to ensure that exhaust fans/lights are functional. There is only 1 water room and 1 sprinkler room. C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure compliance. All staff in-serviced by SDC by 11/21/2011 D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the ceilings	
K 147 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

K067
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- 2. A. Upon becoming aware during the survey of the deficient practice, the drier was moved into the drier enclosure on 10/20/2011, and the gas inlets capped by ~~Hill's Electric Company~~ **JOHN'S PLUMBING**.
- B. An audit has been conducted of the other gas fired drier to ensure it is in the proper enclosure, and is equipped with high and low combustion inlets. This is the only drier enclosure in the facility.
- C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure compliance. Staff in-serviced by SDC by 11/21/2011
- D. The Quality Assurance Committee will review

the audits x 3 months to determine continued compliance

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) In resident rooms 218 and 121 surge protector/multi outlet power strips were found to be in use for lights and other equipment. 2) The exhaust fan in housekeeping closet Wing #2 did not operate when tested. 42 CRT 483.70(a)	K 147	1. A. Upon becoming aware during the survey of the deficient practice, the power strips were removed on 10/11/2011 from rooms 218 and 121. B. An audit has been conducted of all rooms to ensure that all rooms are void of power strips. C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure continued compliance. Staff in-serviced by SDC by 11/21/2011 D. The Quality Assurance Committee will review the audits x 3 months to determine continued compliance	