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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE ST WILKESBORO, NC 28697

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, facility staff failed to provide privacy during incontinence care and while dressing a resident's clothes for one of two residents observed during incontinence care and dressing. Resident # 81. A review of the facility's policy entitled Perineal Care, dated September 2005, read in part, "Pull the privacy curtain." Resident #81 diagnoses included hypertension, diabetes, stroke and contracture's. Her most current Minimum Data Set (MDS) dated 11/05/11 revealed that she was totally dependent for care and had severe cognitive loss. Review of Resident #81's care plan dated 5/14/11 revealed the focus ares of "Incontinent of bowel and bladder and is not a candidate for retraining due to cognitive deficits." Interventions included, "Maintain dignity during incontinence care/toileting-pull privacy curtains." An observation was made on 11/16/11 at 4:34 PM of Licensed Nurse (LN) #1 and Nursing Assistant (NA) #1 providing incontinence care and changing Resident #81's clothes. Resident #81 shared a room with three (3) other female	F 241	1. The deficiency has been corrected. Resident #81 is receiving care that maintains dignity and respect. 2. All residents are receiving care That maintains dignity and respect. 3. Nurses's and CNA's were inserviced by the DON on dignity and respect. The DON/ADON/Nursing supervisors will perform ten random audits per week to monitor care being performed that ensures dignity and respect are provided. These audits will be documented on the Dignity and Respect Audit form. All audits will be turned in to the DON for review. Audits will be completed for three months or until a compliance rate of 99% is achieved. 4. The results of the Dignity/Respect Audit will be reviewed in the monthly Quality Assurance Meeting to identify trends and further action for three months or until a compliance rate of 99% is achieved. After compliance is achieved, a random monthly audit will be performed to monitor compliance for a period of three months and any need for further action.	11/17/11 12/14/11 12/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John P. Walden
TITLE: Administrator
(X6) DATE: 12/20/11

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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BY:

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F 241	Continued From page 1 residents. All three (3) residents were present in the room while care was being provided for resident #81. Staff did not pull the privacy curtain while care was provided for Resident #81. Resident #81 was undressed during this care. An interview was conducted with LN #1 on 11/17/11 at 10/12/11 at 10:12 AM. LN #1 reported that she should have pulled the privacy curtain while care was being provided. An interview was conducted on 11/17/11 with the Director of Nursing. She reported it was her expectation that privacy should always be provided during resident care.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer pain medication as ordered to one (1) of one (1) sampled resident with physician's orders for medication prior to wound care. (Resident #90). The findings are: Resident #90 was admitted to the facility with	F 309	1. The deficiency has been corrected. Resident #90 is receiving ordered Medications in accordance with his plan of care. 2. All residents are receiving care and services in accordance with the comprehensive assessment and plan of care. An audit of wound care resident's was performed to assure medications are being given in accordance with plan of care	11/17/11 12/13/11

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F 309	Continued From page 2	F 309		

diagnoses including Pressure Ulcers. On the quarterly Minimum Data Set (MDS), completed 09/14/11, Resident #90 was assessed as having short and long term memory problems and moderately impaired cognition for daily decision making. The MDS revealed Resident #90 received pain medication and displayed no signs of pain during the assessment period. The MDS further revealed Resident #90 had a Stage 3 pressure ulcer measuring 1.0 centimeters (cm) in length, 1.0 cm in width, and 3.3 cm in depth. Interventions on the pressure ulcer care plan, dated 09/29/11, included "medicate for pain as indicated and ordered prior to wound care."

Review of the November 2011 monthly physician's orders and Medication Administration Record (MAR) revealed orders, dated 07/19/11, for the pain medication Ultram 25 milligram (mg) to be administered by mouth two (2) hours prior to wound care. The MAR further revealed the Ultram was scheduled for administration at 10:00 AM even though the physician's order and MAR specifically noted "with time to be determined." Documentation on the MAR from 11/01/11 through 11/16/11 revealed initials of Licensed Nursing (LN) staff indicating that the medication was administer daily at 10:00 AM.

Review of the medical record revealed on 11/04/11 the physician referred Resident #90 to physical therapy (PT) for Pulse Lavage With Suction (PLWS) for debridement and treatment of a chronic pressure ulcer on the right Ischial Tuberosity (base of the right buttock). The "PT Evaluation & Treatment Notes" dated 11/07/11 revealed Resident #90's pressure ulcer measured 0.5 cm in length, 0.5 cm in width, and 4.5 cm in

Provider's Plan of Correction (F 309):

3.
Licensed Nurses were inserviced by the DON on medication administration in accordance with the physician orders. A weekly audit will be performed by the DON/ADON of wound care residents to monitor any ordered medications are given according to plan of care and documented on the Medication Audit of Wound Care Residents. Audits will be reviewed by the DON Audits will be completed weekly for three months or until a 99% compliance rate is achieved.

Completion date: 12/14/11

4.
The results of the Medication Audit of Wound Care Residents weekly Audit will be reviewed at the monthly Quality Assurance Meeting to identify trends and further action for three months or until a 99% compliance rate is achieved. After compliance is achieved, a monthly random audit will be completed for a period of three months to monitor compliance and any need for further action.

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F 309	Continued From page 3 depth with tunneling. The treatment plan included PLWS with 1000 milliliters (ml) normal saline solution at 8 parts per square inch (psi) and 100 millimeters of mercury (mmHG) suction followed by dressing with Aquacel AG and duoderm. On 11/16/11 at 2:35 PM PT staff #1 was observed providing PLWS with dressing to Resident #90's pressure ulcer as ordered. Periodically during PLWS and placement of Aquacel AG into the wound with a cotton tip applicator Resident #90 was observed making low volume moaning noises. Resident #90 displayed no flinching, grimacing, or obvious signs of discomfort and responded by denying pain and stating "I'm fine" when PT staff halted treatment to assess the resident and inquire regarding the residence's moaning. On 11/16/11 at 2:55 PM an interview was conducted with the nurse routinely assigned to Resident #90. During the interview LN #3 reviewed the physician's order and November 2011 MAR and confirmed Resident #90's Ultram was ordered two (2) hours prior to wound care with specific directions for administration time "to be determined." LN #3 stated throughout the month Resident #90's Ultram was administered at 10:00 AM, as scheduled on the November MAR, even though specific directions included "time to be determined." LN #3 stated she did not coordinate with PT staff to arrange administration of the medication two (2) hours prior to wound care as ordered. LN #3 further revealed on 11/16/11 Resident #90 received Ultram at 10:00 AM and no additional pain medication was administered prior to wound care.	F 309		

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F 309	Continued From page 4 On 11/16/11 at 3:00 PM and 3:45 PM PT staff # 1 was interviewed. The interview revealed Resident #90 usually moaned during treatments and dressing changes. PT #1 stated Resident #90 expressed no pain/discomfort when treatments were interrupted in response to moaning. The interview revealed Resident #90 started with PT on 11/07/11 for wound care/treatments and dressings were completed daily between 2:00 PM and 4:00 PM. PT #1 stated he had not consulted with nursing staff to coordinate administration of pain medication prior to wound care. On 11/17/11 at 4:30 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON reviewed the November 2011 MAR and monthly physician's orders and confirmed, Resident #90's Ultram was ordered to be administered 2 hours prior to wound care with specific directions for administration time "to be determined." The interview further revealed Resident #90's Ultram was scheduled and administered at 10:00 AM daily even though orders specifically stated to for administration time "to be determined." The DON stated LN staff were responsible for coordinating with PT to ensure that Resident #90 was medicated 2 hours prior to dressing changes as ordered by the physician.	F 309		
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.	F 312	1. The deficiency has been corrected. Resident #45 and #81 are receiving services to maintain grooming and personal hygiene needs	11/17/11

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F 312	Continued From page 5	F 312		

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility staff failed to thoroughly clean a female resident's peri-area during incontinence care for one (1) of two (2) residents (Resident #81), and failed to change dirty clothes for one (1) of four (4) residents (Resident #45).

A review of the facility's policy entitled Perineal Care, dated September 2005, read in part, "Separate labia and wash area downward from front to back."

1. Diagnoses for Resident #81 included hypertension, mental retardation, stroke, osteoporosis and pressure ulcer. The most recent Minimum Data Set dated 11/5/11 revealed that Resident #81 was totally dependent for all activity of daily living needs, including hygiene and toileting.

A review of Resident #81's care plan dated 05/14/11 revealed the focus area, "Incontinent of bowel and bladder and is not a candidate for retraining due to cognitive deficits." Interventions included, "Cleanse promptly after each incontinence episode."

An observation was made on 11/16/11 at 9:50 AM of incontinence care being provided by Nursing Assistant (NA) #2. Resident #81's incontinence brief was saturated and a strong odor of urine was noted. NA #2 cleaned Resident #81's buttock area, she was rolled over and her

Provider's Plan of Correction (F 312):

2.
All dependent residents are receiving services to maintain grooming and personal hygiene needs. Administrative Team room rounds were completed to assure grooming and hygiene needs were received.

3.
Nurse's and CNA's were inserviced on ADL care of dependent residents. The Administrative Room Round Team will monitor on daily rounds cleanliness of clothing and report Findings in a.m. meeting for correction on Administrative Room Round Form. The DON/ADON/nursing supervisors will perform weekly ten random incontinence care audits of C.N.A's to monitor that correct incontinence care procedures are followed and document this on the Incontinence Care Audit Form. The room rounds and incontinence audits will be reviewed by the DON. These audits will be completed for three months or until a 99% compliance rate is achieved. — Completion date: 12/14/11

4.
The results of the Administrative Room Rounds and Incontinence Care Audits will be reviewed at the monthly Quality Assurance Committee Meeting to Identify trends and further action for three months or until a 99% compliance rate is achieved. After compliance is achieved, a monthly random audit will be completed for a period of three months to monitor compliance and any need for further action.

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F 312	Continued From page 6	F 312		

outer groin area was wiped twice with a wet wipe. During care NA #2 did not clean inside Resident #81's peri-area.

An interview was conducted on 11/17/11 at 10:31 with NA #2. She reported she normally cleaned female residents' perineal area thoroughly, she reported she thought that she had done this for Resident #81.

An interview was conducted on 11/17/11 at 2:48 PM with the Director of Nursing. She reported it was her expectation that during incontinence care for a female resident the peri-area should be thoroughly cleaned by separating the labial area and wiping front to back.

2. Resident #45 was admitted to the facility with diagnoses of dementia and muscle weakness. The most recent Minimum Data Set (MDS) dated 09/19/11 revealed the resident had severe cognitive impairment and required extensive assistance of one person with most activities of daily living including dressing and personal hygiene. The MDS also revealed the resident was unable to choose clothes to wear independently and she had no rejection of care behaviors.

On 11/15/11 at 10:00 AM Resident #45 was observed resting on her bed. The resident was wearing an opened jacket with six brown stains, approximately one inch in diameter, on the right arm and body of the jacket. There was one brown stain, approximately one inch in diameter, on the resident's pants. The shirt beneath the resident's opened jacket had a brown stain on the mid-chest area, approximately three inches in

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F 312	Continued From page 7 diameter. On 11/15/11 at 2:15 PM Resident #45 was observed in her wheelchair sitting in the doorway to her room. The resident was still wearing the stained jacket, pants, and shirt. On 11/16/11 at 11:00 AM Resident #45 was observed resting on her bed. Her opened jacket and pants appeared to be clean, but the resident was wearing the same stained shirt as observed on 11/15/11. On 11/16/11 at 12:10 PM Nursing Assistant (NA) #4 was interviewed. She stated if a resident was wearing dirty clothes she would ask if she could help the resident change. If the resident refused, she would re-approach later. If the resident refused again, she stated she would inform the nurse of the refusal. She stated today was the first day she had worked with the resident, but she had noticed her shirt was dirty and needed to be changed. NA #4 stated she had asked to assist the resident to change once that morning and she had refused. She stated she had re-approached the resident who had refused again. She stated she did not tell the nurse of the refusals to change out of the dirty shirt. On 11/16/11 at 12:32 PM Licensed Nurse #5 was interviewed. She stated she would expect an NA to re-approach a resident who refused care, but to inform her of any care refusals so she could talk to the resident. She stated NAs do not always tell her of care refusals. She stated she had not been informed of any refusals by Resident #45 to change out of dirty clothes on 11/15/11 or 11/16/11. She stated she would expect that an	F 312		

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F 312	Continued From page 8 NA would not put a dirty shirt back on the resident this morning, but that Resident #45 may have refused to take it off last night at bedtime and slept in it, as she sometimes did. LN #5 stated that if the resident went to bed wearing the dirty shirt, she would expect it to be documented for follow-up by staff this morning, but she was not made aware of any problem. LN #5 observed the resident's stained shirt and stated it needed to be changed. On 11/16/11 at 12:53 PM, the Director of Nursing (DON) was interviewed. She stated she would expect an NA to attempt to get any resident to change out of dirty clothes, but if unable to do so, she would expect the NA to inform the nurse so she could make an attempt. If the nurse were unable to convince the resident to change, she would expect her to document the incident. She noted there was no documentation of a problem regarding this resident. The DON stated the NAs caring for Resident #45 on 11/15/11 and 11/16/11 should have changed the resident's clothes, but should have informed the nurse of any refusal to change. She stated if the resident had insisted on sleeping overnight in her dirty shirt, she would expect documentation so nursing staff could be made aware of the problem. The DON observed the resident's dirty shirt and noted it needed to be changed.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	1. The deficiency has been corrected. Resident #81 has been receiving necessary treatment and services to promote healing and prevention of pressure ulcers.	11/17/11

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F 314	Continued From page 9 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews facility staff failed to turn and reposition a resident with pressure ulcers every two (2) hours for one (1) of three (3) residents observed with pressure ulcers, Resident #81. Resident #81's diagnoses include hypertension, contracture's, pressure ulcers and stroke. Resident #81's most recent Minimum Data Set (MDS) dated 09/12/11, revealed that she was totally dependent for all care. The MDS further revealed she had range of motion impairment on both right and left sides and upper and lower extremities. Assessment of skin conditions on the MDS dated 09/12/11 revealed Resident #81 was at risk for pressure ulcers and she had no unhealed ulcers at that time. Review of Resident #81's care plan dated 11/14/11 revealed the focus area, "potential for skin breakdown secondary to bowel and bladder incontinence, impaired mobility and disease diagnoses." Interventions under this focus area included, "encourage to turn and reposition self approximately every two (2) hours for pressure relief and comfort. Assist as needed. Requires up to an extensive assist with bed mobility." Review of facility documentation entitled Weekly Pressure Sore Record, dated 11/14/11, revealed	F 314	2. All residents are receiving necessary treatment and services to promote healing and prevention of pressure ulcers. DON/ADON/Nursing supervisors are monitoring on rounds turning and repositioning of resident's. 3. The DON inserviced Nurse's and CNA's on the prevention of pressure ulcers. A weekly random audit of ten residents will be performed by DON/ADON/ Nursing Supervisors and documented on the Turning and Repositioning Audit Form to monitor for residents being turned and repositioned every 2 hours. These audits will be reviewed by the DON. These audits will be performed for three months or until a 99% compliance rate is achieved. 4. The results of the Turning and Repositioning Audit Form will be reviewed in the monthly Quality Assurance Meeting to identify trends and further action for three months or until a 99% compliance rate is achieved. After compliance is achieved, a monthly audit will be completed for a period of three months to monitor for continued compliance and the need for further action.	12/14/11

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F 314	Continued From page 10	F 314		

that Resident #81 had a new open area to the left buttock. This area was noted to be a Stage II pressure ulcer. Documentation dated 11/16/11 revealed that during routine wound care two new reddened areas were observed on her right and left buttock.

Review of Resident #81's Kardex, the document kept at the nurse's station that the nursing assistants use to know how to care for each resident, revealed the resident had pressure ulcers but nothing was written about turning and repositioning every two hours.

An observation was made of Resident #81 on 11/16/11 at 8:40 AM, she was in bed positioned on her back with the head of the bed elevated.

An observation was made on 11/16/11 at 9:50 AM of wound care and incontinence care provided for Resident #81. Prior to care Resident #81 was in bed positioned on her back with the head of the bed elevated. Resident #81 told Nursing Assistant #2 and #3 that she wanted to get up. Nursing Assistant #3 told the resident she would get her up in a minute. After care was performed, which took approximately ten (10) minutes, Resident #81 was positioned in bed on her back with the head of the bed elevated.

An observation was made on 11/16/11 at 10:40 AM of Resident #81 in bed on her back with the head of the bed elevated.

An observation was made on 11/16/11 at 11:40 AM of Resident # 81 in bed on her back with the head of the bed elevated.

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F 314	Continued From page 11 An interview was conducted on 11/16/11 at 3:10 PM with Licensed Nurse #2. She reported when Resident #81 was in bed she needed to be repositioned every two (2) hours. She further reported that if the NA who she told she wanted to get up could not do it she should have told another NA the resident wanted to get up. An interview was conducted on 11/16/11 at 4:10 PM with the Wound Treatment Nurse. She reported Resident #81 should be turned at least every 11/2 -2 hours while resident was in the bed. She further reported Resident #81 was unable to move or scoot into another position on her own. She stated red areas were new from Monday, 11/14/11, when dressing was last changed. She reported staff should know through education to turn bed bound residents every two hours. An interview was conducted on 11/17/11 at 2:56 PM with the Director of Nursing. She reported it was her expectation that staff turn and reposition residents every two hours whether the resident had a pressure ulcer or not.	F 314		
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.	F 315	1. The deficiency has been corrected. Resident #148 no longer has a foley catheter	11/16/11

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	345133	A. BUILDING ______ B. WING ______	11/17/2011

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F 315	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to secure catheter tubing to prevent pulling and/or trauma for one (1) of one (1) sampled residents with an indwelling urinary catheter. (Resident #148). The findings are: A policy provided by the facility, revised September 2005, regarding prevention of urinary tract infections with use of indwelling urinary catheters read in part: "Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh). Report unsecured catheter to the supervisor " Resident #148 was admitted to the facility after hospitalization for fractures to the right tibial plateau and closed calcaneus fracture resulting from a fall, peripheral vascular disease, and history of acute renal failure during hospitalization. On the admission Minimum Data Set (MDS), completed 11/10/11, Resident #148 was assessed as having no short or long term memory problems and cognitively intact for daily decision making. Review of a 11/14/11 6:00 PM nurse's note revealed Resident #148's physician was notified of the resident's inability to urinate and orders were received for insertion of an indwelling urinary catheter. The nurse noted slight resistance and a small amount of bleeding during insertion and the catheter was draining	F 315	2. All residents that have foley catheters are receiving treatment and services to prevent trauma/pulling. An audit was completed on all residents with foley catheters and leg straps were applied for those residents who needed one to prevent trauma/pulling of catheter. 3. The DON inserviced Nurses and CNA's on the procedure for securing foley cathers to prevent pulling and trauma. A weekly audit will be performed by the DON/ADON on all residents with foley catheters to assure appropriate interventions are in place to prevent trauma and pulling of foley catheter. This audit will be documented on the Foley Cather Weekly Audit Form and reviewed by the DON. These audits will be completed for three months or until 99% compliance rate is achieved. 4. The results of the Foley Cather Weekly Audit Form will be reviewed in the monthly Quality Assurance Meeting to identify trends and further action for three months or until 99% compliance rate is achieved. After compliance is achieved, a monthly audit will be completed to monitor compliance and any need for further action.	12/13/11 12/14/11

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F 315	Continued From page 13	F 315		

without difficulty.

On 11/16/11 at 11:05 AM Resident #148 was observed in bed with indwelling urinary catheter tubing, extending from the top left leg of his incontinent brief, attached to a drainage bag on lower left bed frame. The catheter tubing crossed the resident's leg, just above the left knee, and was not secured to the inner thigh to prevent pulling. During the observation the Treatment Nurse (TN) and Nursing Assistant (NA) lifted the resident via a draw-sheet and moved him approximately eight (8) to ten (10) inches up and over to the right side of the bed. During the repositioning Resident #148 cried out "Oh, it's pulling" and placed his left hand on the catheter tubing. The drainage bag remained attached to the left lower bed frame and no slack was observed in the tubing. When the TN inquired the resident again stated "it's pulling" while his left hand remained on the catheter tubing. The TN immediately moved to the left side of the bed and unfastened the resident's brief. The catheter tubing was observed to be taut as the brief was pulled away and a small amount of dry red/brown matter was on the brief. The TN assessed the resident and repositioned the catheter tubing to reduce tension. The nurse covered the resident, left the room, and returned with a leg strap to secure the catheter tubing to the resident's left inner thigh/leg.

On 11/16/11 at approximately 11:15 AM the TN was interviewed. During the interview the TN confirmed Resident #148's catheter tubing was fully extended when the resident was repositioned resulting in pulling. The TN reported the catheter tubing was too tight and the brief was not

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	345133	A. BUILDING ______ B. WING ______	11/17/2011

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F 315	Continued From page 14 effective in securing the tubing such that it would prevent pulling or trauma. The TN stated catheter tubing should always be secured with a leg strap/band. On 11/17/11 at 9:50 AM Resident #148 was interviewed. Resident #148 stated prior to 11/16/11 when he felt the catheter tube being pulled a leg strap had not been used to secure the tubing. The resident reported the catheter was causing pressure and was not comfortable and when the tubing pulled "a little" he was afraid it was going to hurt. The resident stated the catheter was removed 11/16/11. During an interview, 11/17/11 at 1:55 PM, the Director of Nursing (DON) stated leg straps were utilized to secure catheters if residents complained that tubing was getting pulled or causing problems. The DON stated the general policy included use of leg straps but this had not been the facility's usual practice.	F 315		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer a prescribed psychotropic medication as ordered to avoid a significant medication error for one (1) of ten (10) sampled residents reviewed for unnecessary medications. (Resident #90).	F 333	1. The deficiency has been corrected. Resident #90 is receiving medication as ordered. 2. All residents are receiving medications as ordered. Physician orders were reviewed for accuracy.	11/16/11 12/1/11

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F 333	Continued From page 15 The findings are: Resident #90 was admitted to the facility with diagnoses including dementia, psychosis, and history of agitation. Review of the medical record revealed a 09/19/11 physician's order for oral administration of Risperidone 0.125 milligram (mg) every morning and 0.25 mg at bedtime for increased delusions. Review of the September and October 2011 Medication Administration Records (MAR) revealed Resident #90 received Risperidone as ordered. Review of the November 2011 MAR revealed the 09/19/11 physician's order for administration of Risperidone was inaccurately reflected. The order for Risperidone 0.125 mg every morning was omitted from the MAR and the 0.25 mg dosage at bedtime was reflected as 0.125 mg. Further review of the MAR revealed from November 01 through November 16, 2011 Resident #90 received Risperidone 0.125 mg daily rather than 0.375 mg as ordered by the physician. Review of the medical record revealed Resident #90 experienced no increased behaviors as a result of the omitted and reduced dosage of prescribed Risperidone. During an interview, 11/17/11 at 3:15 PM, LN #3 reviewed Resident #90's physician's orders and November 2011 MAR and confirmed the 09/19/11 physician's order for Risperidone was inaccurately reflected on the MAR. LN #3 reported each month MARs were printed, reconciled, and reviewed by three nurses to ensure accuracy. LN #3 reported, during reconciliation the third shift nurse compared the new and current MARs and completed	F 333	3. The DON inserviced Nurse's and CNA's on the procedure for making corrections to Medication Administration Records. A weekly random audit will be made of 10 resident Medication Administration Records by the DON/ADON/nursing supervisors to verify any hand corrections that are made match the physician order and are correctly carried through to the computer orders. This audit will be documented on the Medication Administration Record Audit Form. These audits will be reviewed by the DON. These audits will be completed for three months or until 99% compliance rate is achieved. 4. The Medication Administration Record Audit Form will be Reviewed in the monthly Quality Assurance Meeting to identify trends and further action for three months or until 99% compliance rate is achieved. When compliance is achieved, a monthly audit will be completed for a period of three months to monitor compliance and any further action needed.	12/14/11

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F 333	Continued From page 16 corrections as needed. The first day of the month the nurses on the hall were responsible for reviewing the old and new MARs while administering medications, making corrections as needed. LN #3 stated the 09/19/11 physician's order was missed during reconciliation of the November MAR and Resident #90 did not get the morning dose of Risperidone as ordered and only 0.125 mg was administered at bedtime during the month. The interview further revealed Resident #90 displayed no increase in behaviors as a result of the medication error. During an interview, 11/17/11 at 4:15 PM, the Director of Nursing (DON) revealed the original 09/19/11 physician's orders failed to be entered into the computer to update the MARs. During reconciliation the order was manually entered on the MARs for September and October 2011 however in November the MAR was not updated correctly. The DON stated as a result of the error, during the month of November Resident #90 received 0.125 mg of Risperidone daily rather than 0.375 mg as ordered. The DON stated the error should have been recognized and corrected during reconciliation.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	1. The deficiency has been corrected. Resident #82 is receiving services to prevent infection.	11/17/11

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F 441	Continued From page 17 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to store hand held nebulizer equipment in a manner to prevent infection for one (1) of one (1) sampled residents receiving nebulizer/continuous aerosol treatments. (Resident #82). The findings are:	F 441	2. All residents are receiving services to prevent infection. An audit was completed of all residents with Nebulizer equipment to assure proper storage is in place	12/12/11
			3. The DON inserviced Nurse's and CNA's on the proper storage of oxygen/nebulizer equipment when not inuse. The Adminstrative RoomRounds Team will perform rounds of their assigned rooms and monitor for proper storage of equipment. Any identified concerns will be reported to Nursing during the a.m. meeting for corrective action. A random audit of 10 residents will be performed weekly by DON/ADON for proper storage of nebulizer equipment. This will be documented on the Nebulizer Storage Audit Form. These auditswill be reviewed by the DON and be completed for three months or until 99% compliance rate is achieved.	12/14/11
			4. The results of the Nebulizer Audit Form will be reviewed at the Monthly Quality Assurance Meeting to identify trends and further action for three months or until 99% compliance rate is achieved. When compliance is achieved, a monthly audit will be completed for a period of three months to monitor compliance and any need for further action.	

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F 441	Continued From page 18 Review of a facility policy, Revised April 2006, titled Departmental (Respiratory Therapy) - Prevention of Infection read in part: "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment." The policy provided instructions to rinse the nebulizer reservoir with fresh tap water, clean the mouthpiece, dry with clean paper towel or gauze, and store in clean plastic bag when not in use. Resident #82 was admitted to the facility with diagnoses including obstructive chronic bronchitis and asthma. Review of the medical record revealed an original physician's order, dated 01/18/10, for inhalation nebulizer treatments to be administered at 9:00 AM daily for treatment of Asthma. On 11/16/11 at 9:00 AM a hand held nebulizer device was observed on the bedside table of Resident #82. The nebulizer tubing and reservoir were lying partially on a plastic bag and the mouthpiece was in direct contact with the table. At 9:25 AM Licensed Nurse (LN) #3 was observed administering a nebulizer treatment to Resident #82. LN #3 retrieved the nebulizer from the resident's bedside table placed the medicated solution in the reservoir, placed the mouthpiece in the resident's mouth and proceeded to administer the inhalation nebulizer treatment. At 10:30 AM Resident #82's nebulizer device was observed on the bedside table lying on a plastic bag. The mouthpiece was in direct contact with the table and moisture droplets were observed in the solution reservoir. Additional observations of the hand held nebulizer included: 11/16/11 at 12:00 PM - Nebulizer was observed lying on a plastic bag with the mouthpiece directly	F 441		

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F 441	Continued From page 19 on the table. A bath powder container was observed approximately ten inches from the mouthpiece and white powder residue was observed scattered on the table and under the plastic bag. No powder was observed on or around the mouthpiece. Moisture droplets were observed in the nebulizer reservoir. 11/16/11 at 2:45 PM - Storage of the nebulizer, positioning of the mouthpiece, and condition of the bedside table with powder residue remained unchanged. No moister droplets were observed in the solution reservoir. 11/17/11 at 9:30 AM - Nebulizer was observed on plastic bag and the mouthpiece was observed in direct contact with the table. Moisture droplets were observed in the nebulizer reservoir and the bath powder container and power residue remained on the table. No residue was observed on the plastic bag or mouthpiece. During an interview on 11/17/11 at 9:40 AM LN #3 confirmed Resident #82 was administered a nebulizer treatment this morning at approximately 9:00 AM. On 11/17/11 at 2:50 PM LN #3 was present during observations of Resident #82's nebulizer device. Storage of the nebulizer, positioning of the mouthpiece, and condition of the bedside table with powder residue remained unchanged. During the observation LN #3 identified the powder residue as bath powder and confirmed the nebulizer's should be stored in plastic bags when not in use. Immediately after the observation, LN #3 confirmed on 11/16/11 at 9:25 AM during medication administration the hand held nebulizer stored on the plastic bag with the mouthpiece directly on the table were utilized to administer Resident #82's treatment. LN #3 stated the nebulizer and mouthpiece were not	F 441		

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F 441	Continued From page 20 cleaned prior to or after the treatment and were not placed in the plastic bag after use on 11/16/11 or 11/17/11. Interview on 11/17/11 at 4:30 PM with the Director of Nursing (DON) revealed LN staff were responsible for rinsing and cleaning nebulizer's after treatments and for storing devices in plastic bags when not in use. The DON stated, improperly stored equipment should be replaced and not used for residents' treatments.	F 441	This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.	