STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345424	A. BUILDING _____ B. WING _____	05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMH SEGRAVES CARE CENTER	200 HOSPITAL AVE JEFFERSON, NC 28640

(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 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interview the facility failed to implement their abuse and neglect policy by not thoroughly investigating allegations of alleged abuse and not protecting residents during an alleged abuse investigation for three (3) of five (5) alleged abuse investigations reviewed. The findings are: The facility's policy entitled "Abuse", updated 02/20/12 read in part, "Protection of Residents: During the investigation for abuse or neglect the resident will be protected from harm. Personnel will be suspended while an investigation is conducted." 1. a. Review of an abuse investigation revealed an allegation of abuse was reported on 10/14/11 at approximately 2:20 PM by Resident #23. Resident #23 accused Licensed Nurse #3 of inappropriately touching her. Review of a narrative document included in the investigation dated 10/14/11 and signed by the Director of Nursing read in part, LN #1 was instructed to not go back onto the hall while the social worker performed the Mini-Mental Status exam (an exam to determine cognition).	F 226	*483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES* *1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Due to the unavailability of affected residents, the five residents remaining at Segraves Care Center were interviewed. Resident #1 was interviewed, no evidence of alleged or suspected abuse noted. Resident #2 was interviewed, no evidence of alleged or suspected abuse noted. Resident #3 was interviewed, no evidence of alleged or suspected abuse noted. Resident #4 nonverbal, physical assessment revealed no evidence of abuse. Daughter of resident #4 interviewed, reported no suspected or alleged abuse. Resident #5 interviewed, was unable to cognitively understand questions. Family unavailable for interview. Physical assessment revealed no evidence of abuse. *2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:* Intradepartment email was sent to staff members stating: Any time there is an allegation or suspicion of abuse related to nursing home residents or patients, the resident/patient must be protected from harm during the investigation. If there is any possibility of staff involvement, immediately relieve the staff member from duty.	6/6/2012 6/1/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phil Willis — TITLE: CEO — (X6) DATE: 6/15/12

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.

Original Signature Date: 6-8-12

RECEIVED
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BY:

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F 226	Continued From page 1 Review of LN #3's (the alleged perpetrator) time sheet revealed he worked until 3:13 PM on 10/14/11 and returned to work the following day, Saturday, 10/15/11 and worked a twelve (12) hour shift. An interview was conducted on 05/17/12 at 11:10 AM with the Director of Nursing (DON) who is also the Abuse Coordinator. The DON reported that LN #3 was instructed to stay in her office while the Social Worker performed a Mini-Mental Status exam (a test to determine cognition) on Resident #23. She reported LN #3 finished his shift that day but was told not to go into Resident #23's room. She staled LN #3 returned to work the next day, Saturday 10/15/11 and worked a twelve (12) hour shift. The DON further stated that when issues of abuse are reviewed with risk management and human resources she is often instructed not to suspend staff. She stated it was a money issue, when staff are suspended and then find they did nothing wrong, staff still have to be paid. 1. b. The alleged abuse investigation included two written statements. These were written by LN #3 (the alleged perpetrator) and Nursing Assistant #2 to whom the resident reported the incident to. No interviews with other residents who lived in the facility were included in the investigation. A Mini-mental status exam was completed by the Social Worker. There was not an interview with the resident completed by the Social Worker. An interview was conducted on 05/17/12 at 11:10 AM with the DON. She reported she did not interview any other residents regarding	F 226	If an allegation or suspicion occurs, immediately contact the clinical person in charge and the administrator on call. Follow the chain of command. When there is an allegation or suspicion involving a staff person, the staff person must be suspended while the investigation is ongoing. "Abuse, SCC Resident" policy has been revised Segraves Care Center Policies and Procedures "Abused, SCC Resident" was amended/revised to state "All suspected/alleged abuse or inappropriate behavior will be reported immediately to the clinical person in charge. The clinical person in charge will remove from duty any staff person involved in suspected/alleged abuse or inappropriate behavior. The administrator on call will be notified and the staff person involved in suspected/alleged or inappropriate behavior will be suspended until the investigation is completed; following the Human Resource Department policy "Corrective Action Policy". "Corrective Action Policy" has been revised Staff meetings have occurred to review revised policy "Abuse, SCC Resident" and answer question. *3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:*	6/4/2012 6/4/2012 6/6/2012 6/4/2012 & 6/5/2012

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F 226	Continued From page 2 inappropriate touching so as not to cause alarm. She further indicated that she would make rounds everyday and speak to residents and ask how they are being treated. 2. a. Review of an abuse investigation dated 08/10/11 revealed an allegation of abuse was made by a resident accusing Nursing Assistant (NA) #1 of being rough and rude during her shower. Review of the twenty-four hour report revealed the incident occurred 08/10/11 at approximately 10:10 AM.. Review of a narrative document entitled "Conclusion of Investigation" dated 08/10/11 and signed by the Director of Nursing (DON) read in part,"My conclusion is that NA #1 has recently come from a fast food chain where she was employed as a manager. NA #1 supervised multiple employees and is used to telling others specific, direct comments to get their job done. She was unaware of her tone." Review of NA #1's time sheet revealed she worked until 6:00 PM on 08/10/11. An interview was conducted on 05/17/12 at 11:10 AM with the Director of Nursing who is also the abuse coordinator. She reported NA #1 was not suspended during the abuse investigation. She stated NA #1 went to lunch and to a medical appointment on 08/10/11. The DON stated that she was allowed to come back to work after the medical appointment and was allowed to work a double shift. She stated NA #1 worked until 6:00 PM the evening of 08/10/11. The DON stated she did not interview other residents that NA #1 had worked with. The DON reported that when issues of abuse are reviewed with risk management and human resources she is often instructed not to	F 226	The notification of the Administrator on Call has been added to the policy "Abuse, SCC Resident", all Administrator's on Call have been educated regarding the need to suspend involved staff when there is an incident of suspected/alleged or inappropriate behavior that involves a staff member. Clinical Leaders have also been inserviced regarding notification of the Administrator on Call and removing any staff member involved immediately from duty. The change in policy and practice regarding notification of the clinical person in charge rather than the DON of SCC ensures a person in the facility at all times who is aware that staff involved must be removed from patient care immediately and notification of Administrator on Call provides immediate administrative support. *4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.* All instances of suspected/alleged or inappropriate behavior will be discussed and reviewed in Key Management meetings. Each instance will be reviewed by Key Management to determine if policy was followed and appropriate actions taken. The investigation from each instance will be reviewed to determine if investigation is comprehensive and appropriate actions taken. Each instance will be reported through the Safety Committee for determination of trending analysis by Key Management.	6/6/2012 6/5/2012

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F 226	Continued From page 3 suspend staff. She stated it was a money issue, when staff are suspended and then find they did nothing wrong, staff still have to be paid. 2. b. The abuse investigation consisted of staff interviews who were working that day and with NA #1. There were no interviews with the resident or with other residents who lived in the facility. NA #1 was interviewed on 08/10/12 at 12:35 PM regarding the allegation of abuse made by the resident. A document entitled "Conclusion of Investigation" dated 08/10/11 and signed by the DON revealed a Mini-Mental Status (an exam to determine cognition) was completed by the Social Worker. There was not an interview with the resident completed by the Social Worker. An interview was conducted on 05/17/12 at 11:10 AM with the DON. She reported she did not interview any other residents who lived in the facility about being treated roughly or staff being rude to them. She further indicated that she made rounds everyday and would speak to residents and ask how they are being treated. 3. a. Review of an abuse investigation revealed an allegation of abuse was reported on 12/6/11 (no time provided) by a female resident who has been discharged from the facility. The resident stated NA #1 took away her call bell and threw it on the floor after she rang for assistance Review of staffing schedule revealed NA #1	F 226	Inservice was held for Key Management members to review update revisions in policy. Revisions have been added to the Safety Committee meeting agenda	6/5/2012 6/13/2012

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F 226	Continued From page 4 worked her scheduled shift on 12/7/11, 12/9/11 to 12/12/11 during the facility investigation. On 5/17/12 at 3:30 PM an interview was conducted with the Director of Nursing (DON). The DON confirmed that NA #1 was not suspended and continued to provide resident care during the investigation. The DON stated when issues of abuse are reviewed with risk management and human resources she is often directed not to suspend staff. The DON stated that due to the facility's financial constraints when staff are suspended and the facility investigation concludes they did nothing wrong the staff still have to be paid. 3. b. The alleged abuse investigation included no written statements from residents or staff regarding NA #1 interaction with residents. Review of the Investigation Summary (no dated provided) revealed measures were put in place to secure the resident's call bell within her reach. On 5/17/12 at 3:30 PM an interview was conducted with the Director of Nursing (DON). The DON stated she talked with the resident and NA #1 and did not conduct any interviews with other residents and staff during the facility investigation. The DON stated she talked with NA #1 about making sure the resident's call bell was in reach at all times. The DON stated she spoke with the resident to call out for assistance if she was unable to reach her call bell. The DON stated she also contacted the Maintenance Department to place a clip on the call bell so that it could be secured in place. The DON stated she makes rounds daily to speak to the residents and asks	F 226		

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F 226	Continued From page 5 how they are being treated.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer Vitamin B-12 (Cyanocobalamine) tablets per physician orders for one (1) of ten (10) sampled residents reviewed for un-necessary medications. The Physician ordered Vitamin B-12 was not administered from May 1st to May 16th 2012. (Resident #27) The findings include: Resident #27 was admitted to the facility on 11/23/2011. Resident #27's diagnoses included Weakness, recovery from a pathological fracture, Asthma, Dementia and Hypertension. A review of the physician orders dated 11/28/2011 included Vitamin B-12 (Cyanocobalamine) 500 mcg (microgram) once daily by mouth in the morning. The Vitamin B-12 order was renewed for May 2012 and was scheduled at 8:00 AM per the Medication Administration Records (MAR's). A review of the MAR for the month of May 2012 revealed the entries for Vitamin B-12 were blank from May 1st to May 16th 2012 and no nurse's initial was present confirming the administration	F 281	*483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS* *1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Resident #27 record reviewed, no other medications were missed. Physician notified of missed medication. Vitamin B12 level ordered. Labs for Vitamin B12 drawn on 5/17/2012. Results obtained on 5/20/2012. Resident #27 transferred to Margate facility on 5/17/2012. Vitamin B12 results faxed to Margate on 5/21/2012. Vitamin B12 results 727; normal range 211-946 pg/ml Physician ordered the Vitamin B12 discontinued based on the current lab results. Since the resident now resides at the Margate facility these results and physicians orders where faxed to the Margate Facility and fax confirmation recorded. *2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:* Five residents remain at Segraves Care Center at this time. Each resident's record was audited from 6/1/2012 until discharge for missed medications. Four of the residents received all ordered medications. One resident received all but one medication which was circled seriquel XR on 6/3/2012 and one with no	5/17/2012 5/21/2012 6/4/2012

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F 281	Continued From page 6 of medication for all the days in May 2012. Additionally there was no explanation for having missed these doses of Vitamin B-12 in the month of May 2012. An inventory of medications for Resident #27 in the medication cart on 5/16/12 at 4:25 PM with Licensed Nurse (LN) #1 revealed the last refill date for Vitamin B-12 from the pharmacy was on 3/27/2012 and Vitamin B-12 was never reordered. An interview with Licensed Nurse (LN) #2 on 5/17/2012 at 11:25 AM revealed that if there was no signature in the MAR the medication had not been given. LN #1 was not sure why the medication had not been administered and stated that she was sure it had not been discontinued. Further interview with LN #1 revealed that this error in administration was not noticed by three nurses who had worked during this period. An interview with the Director of Nursing on 5/17/2012 at 11:32 AM confirmed that 'if not signed the dose was not given'. The DON was not aware why Resident #27 had missed so many doses and why this medication error in administration was not noticed by any of the nursing staff.	F 281	documentation, Seroquel XR on 6/4/2012. Staff interviewed indicates circled medications indicate that resident refused medication. Medication with no documentation will be forwarded to the Quality Committee for analysis and trending. *3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:* Each resident's medication administration and orders will be reviewed prior to their care planning meeting for missed medication or orders that were not implemented. Each resident's record and medication administration record will also be reviewed monthly during MAR checks. Every new order is to be checked by two individuals to ensure that new orders are not missed. Nurses were re-educated on the necessity of having two individuals to check record when new orders received to ensure that all orders were acted upon. *4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.* Each resident's medication administration and orders will be reviewed prior to their care planning meeting for missed medication or	6/8/2012 Scheduled based upon date of care plan meeting
F 441 SS=F	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.	F 441		6/8/2012 no residents in facility QA meeting will be scheduled when residents in facility

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F 441	Continued From page 7 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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, facility document reviews and staff interviews, facility staff failed to maintain hot water temperatures at the washing machines in the facility laundry at a minimum of 140 degrees Fahrenheit for thirteen (13) of		orders that were not implemented. Each resident's record and medication administration record will also be reviewed monthly during MAR checks. Each record audit that identifies a resident missed a dose of medication will be investigated and documented noting common factors for trending purposes. These reports will be tabulated and graphed for trends. The information will be reported quarterly to the Quality Committee to determine appropriate follow up when trends identified by the DON Segraves Care Center. *483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS* *1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Infection control meeting minutes data reviewed from 3rd Quarter 2011 to 1st Quarter 2012 with no evidence of spread of infection by laundry done within the facility.. Interviewed Infection Control Nurse who stated April and May 2012 has not been officially reported to the Infection Control Committee which meets quarterly but has noted no evidence of spread of infection by laundry done within the facility. Email and work order sent to Maintenance department to repair the temperature gauge on hot water line going into the washing machine in the laundry room at Segraves Care Center. Maintenance replaced hot water thermometer	*F441* 6/1/2012 6/4/2012 6/7/2012 6/1/2012 6/4/2012 6/7/2012

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F 441	Continued From page 8 thirteen (13) residents. The findings are: A review of a facility policy titled "Personal Laundry for Seagraves Care Center" with a revised date of August 25, 2011 indicated a purpose statement as follows: Soiled clothing is a significant source of microbial contamination. Adequate procedures for collection and processing of soiled clothing are essential in order to eliminate the possibility of infection from this source. Resident's soiled personal items are rinsed by nursing personnel in room if necessary then placed in a plastic, leak-proof bag in laundry hamper identified as personal laundry only. Soiled items are transported to the laundry room in the covered hamper. A review of a facility document titled "Master Job Assignment - EVS Laundry" and not dated indicated from Monday through Friday from 6:00 AM - 6:10 AM laundry staff to check water temperature and document in the log. A review of a facility document titled "Daily Water Temperature Control" indicated a space for each day to document date, time, temperature, staff initials, any concerns reported to maintenance and handwritten in the margin "Below 140" degrees. During an environmental tour with the Maintenance Director on 5/16/12 at 1:56 PM the laundry was located in a single room near the nurse's station with two household washers and a dryer stacked on top of each one. A temperature gauge with numbers in Fahrenheit and Celsius	F 441	in Segraves Laundry room. Temperature reading within normal range 140-145. Laundry staff re-educated that temperature of hot water to be measured and recorded from thermometer on the hot water line in the Segraves Laundry room. Also informed that laundry is not to be completed if the temperature is not within the normal range. Policy "Personal Laundry for Segraves Care Center" revised to specify temperature for hot water and actions to be taken if hot water not within the normal range. *2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:* Email and work order sent to Maintenance department to repair the temperature gauge on hot water line going into the washing machine in the laundry room at Segraves Care Center. Maintenance replaced hot water thermometer in Segraves Laundry room. Temperature reading within normal range 140-145. Laundry staff re-educated that temperature of hot water to be measured and recorded from thermometer on the hot water line in the Segraves Laundry room. Also informed that laundry is not to be completed if the temperature is not within the normal range. Policy "Personal Laundry for Segraves Care Center" revised to specify temperature for hot water and actions to be taken if hot water not within the normal range.	6/1/2012 6/4/2012 6/7/2012 6/7/2012

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F 441	Continued From page 9 and a needle to indicate the current temperature of the hot water was observed connected to a hot water pipe above the top of the dryers and below the ceiling of the room. The temperature reading on the thermometer was difficult to read because of the size of the numbers on the dial and the height of the thermometer on the water pipe above the dryers. A tour of an electrical room located past the nurses station and on a resident hallway revealed a large hot water tank with a thermometer at the top of the tank with a mercury tube that indicated the current temperature of the hot water in the tank, two large water storage tanks with a thermometer above one of them and the main mixing valve with a thermometer attached. During an interview on 5/16/12 at 2:05 PM the Maintenance Director explained the hot water tank in the electrical room was the main source of all hot water in the facility. He further explained there was a separate hot water line for the laundry with a pipe directly from the hot water tank through the ceiling and down the hallway to the laundry room and into the washing machines. He stated the laundry staff should document the temperatures each day from the thermometer in the laundry room that was connected to the hot water line above the washing machines to ensure the hot water was at a minimum of 140 degrees Fahrenheit. He verified the current reading on the thermometer above the washing machines was 135 degrees Fahrenheit and the hot water had probably cooled in the pipe. He stated the laundry had been done for the day and the staff member had gone home. During an interview on 5/17/12 at 9:00 AM the	F 441	*3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:* Laundry staff re-educated that temperature of hot water to be measured and recorded from thermometer on the hot water line in the Segraves Laundry room. Also informed that laundry is not to be completed if the temperature is not within the normal range. Policy "Personal Laundry for Segraves Care Center" revised to specify temperature for hot water and actions to be taken if hot water not within the normal range. Environmental Services Manager will audit temperature logs from Segraves Care Center laundry weekly when laundry is operational to ensure compliance and follow up as appropriate. *4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.* Environmental Services Manager will audit temperature logs from Segraves Care Center laundry weekly when laundry is operational to ensure compliance and follow up as appropriate. The information will be reported quarterly to the Quality Committee by the Environmental Services Manager.	6/7/2012

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	345424	A. BUILDING _____ B. WING _____	05/17/2012

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F 441	Continued From page 10 Laundry Clerk stated she had worked in the laundry for approximately five (5) years and she was the only staff person who worked in the laundry. She explained when she was first hired she was told the hot water temperature for the washing machines had to be at 140 degrees Fahrenheit or higher and if it was less than 140 degrees Fahrenheit she was supposed to call maintenance. She further explained the previous laundry staff told her to check the thermometer attached to the hot water line above the washing machines in the laundry room but it always had a temperature reading below 140 degrees Fahrenheit and it was so high off the floor it was difficult to see the gauge and read the temperature. She stated she did not record the daily temperature from the gauge on the hot water pipes above the washing machine but documented the water temperature in the electrical room each morning from the thermometer at top of the hot water tank. She explained the thermometer above the hot water tank in the electrical room was usually 140 to 142 degrees Fahrenheit. She stated she talked to one of the maintenance staff about the lower temperature reading in the laundry room and was told to check the temperature on the thermometer above the main hot water tank in the electrical room and document that temperature each day. The Laundry Clerk verified her documentation on the monthly logs of temperature readings from 140 - 142 degrees Fahrenheit at the main hot water tank. She stated the hand written note in the margin of the log was a reminder for her to call maintenance if the water temperature was below 140 degrees Fahrenheit. She explained residents who currently lived in the facility could have items sent to the laundry for washing and	F 441		

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F 441	Continued From page 11 drying and she had already done several loads of laundry that morning and the last two (2) loads were ready to go into the dryers. She stated the thermometer above the washing machines always stayed the same and stated it currently was 135 degrees Fahrenheit. She further explained she washed resident's personal clothing but all sheets, blankets and towels were sent out to a commercial laundry. She also stated sometimes she washed personal wipes used to clean residents. She explained she used a powdered detergent that was individually packaged and sometimes she used bleach if there was blood or a stain that was difficult to remove. During an Interview on 5/17/12 at 9:22 AM the Maintenance Director stated if the Laundry Clerk was documenting temperatures at the main hot water tank she was documenting the actual hot water coming out of the tank but not the temperature of the hot water at the washing machines. He stated the water temperatures should be the same at the hot water tank and in the hot water line at the washing machines but the temperatures could cool as the water traveled in the pipes to the laundry room down the hallway. He stated the laundry clerk should check the thermometer in the laundry room to do the daily temperature checks because that would give the actual temperature of the hot water going into the washing machines and if it was less than 140 degrees Fahrenheit maintenance should be called to evaluate it. He further stated the temperature gauge in the laundry room needed to be checked to see if it needed to be calibrated or if a new one should be installed.	F 441		

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F 441	Continued From page 12 During an interview on with 5/17/12 at 9:42 AM the Manager of Housekeeping stated he routinely reviewed temperature logs for the laundry. He verified the thermometer on the hot water line above the washing machines in the laundry room was lower because of water cooling in the pipe and it was currently at 135 degrees Fahrenheit. He further stated the minimum temperature of hot water for the washing machines was supposed to be at 140 degrees Fahrenheit. During an interview on 5/17/12 at 2:28 PM with the Infection Control Nurse/Employee Health Nurse she stated she looked at the temperature logs for the laundry monthly or every other month. She explained she didn't know anything about the actual procedure for monitoring water temperatures but she stated the hot water for the washing machines should not be below 140 degrees Fahrenheit and it was her expectation that the hot water temperature should be 140 degrees Fahrenheit or above since they used detergents in the wash cycle. She further explained she had not had any infections reported from the facility that were linked to the laundry. During an observation on 5/17/12 at 2:42 PM the Manager of Housekeeping measured the distance from the floor to the bottom of the thermometer at the main hot water tank in the electrical room and verified it was six (6) feet eight (8) inches off the floor. He then measured the distance from the floor to the bottom of the thermometer in the laundry room and verified it was seven (7) feet eight (8) inches off the floor. During a follow up interview on 5/17/12 at 2:45 PM the Manager of Housekeeping confirmed	F 441		

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F 441	Continued From page 13 there was a problem with the water temperatures cooling as water traveled from the main hot water tank through the pipe to the washing machines and the temperature gauge was difficult to read in the laundry room because it was so high off the floor.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, facility staff failed to send physician's orders to the therapy department to evaluate for restorative PT/OT secondary to weakness in one (1) of three (3) sampled residents. (Resident #27). The findings are: Resident #27 was admitted with diagnoses including osteoarthritis; dementia, and a history of fractures in her spine and hip. The most recent	F 514	*483.75(l)(1) RES RECORDS – COMPLETE / ACCURATE / ACCESSIBLE* *1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:* During survey, Resident #27 was noted to have an order to evaluate for restorative PT/OT secondary to weakness. The order was noted but not entered into computer system. Physician notified of missed order 5/22/2012. Resident discharged to Margate on 5/17/2012. On 5/24/12 Segraves Care Center received request that order for PT to be faxed to Margate. This was done. *2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:* Five residents remain at Segraves Care Center at this time. Each resident's record was audited from 6/1/2012 until discharge for missed orders. .No missed orders noted	5/24/2012 6/7/2012

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F 514	Continued From page 14 quarterly admission Minimum Data Set (MDS) dated 3/6/12 indicated short and long term memory problems and moderate impairment in cognition for daily decision making. The resident required extensive assistance by staff for transfers and ambulation with two plus person physical assistance. A review of therapy notes dated 12/28/11 through 1/17/12 indicated Resident #27 received physical therapy for therapeutic exercise, therapeutic activity, gait training and modalities as needed for pain control. The notes further indicated Resident #27 had periods of back pain that impacted her ability to participate in therapy and sometimes she refused therapy. The notes revealed Resident #27 was discharged from physical therapy on 1/17/12 because goals were met and she was able to complete transfers from her bed to a wheelchair and from her wheelchair to a toilet seat safely and independently but Resident #27 may not choose to transfer independently and then required staff assistance. A review of therapy notes dated 3/16/12 indicated Resident #27 had shown a functional decline and a physical therapy evaluation was done and therapy was resumed. The notes further indicated Resident #27 made progress with transfers and ambulation with assistance and was discharged from therapy on 4/6/12 due to goals were met. A review of a "Mount Jefferson Progress Note" signed by a physician and dated 5/10/12 indicated to evaluate for restorative PT/OT etc. secondary to weakness.	F 514	*3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur:* Each resident's orders will be reviewed prior to their care planning meeting for missed orders that were not implemented. Each resident's record will also be reviewed monthly during MAR checks. Every new order is to be checked by two individuals to ensure that new orders are not missed. Nurses were re-educated on the necessity of having two individuals to check record when new orders received to ensure that all orders were acted upon. *4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.* Each resident's orders will be reviewed prior to their care planning meeting for missed orders that were not implemented. Each resident's record will also be reviewed monthly during MAR checks. Every new order is to be checked by two individuals to ensure that new orders are not missed. Nurses were re-educated on the necessity of having two individuals to check record when new orders received to ensure that all orders were acted upon.	06/08/2012 Scheduled based upon date of care plan meeting

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F 514	Continued From page 15 A review of a physician's order noted on 5/10/12 at 12:55 PM by LN #4 indicated to evaluate for restorative PT/OT etc. secondary to weakness. During an interview on 5/17/12 at 3:48 PM with the Director of Nurses (DON) she stated she talked with a Physical Therapy Assistant on Sunday 5/13/12 about the order to evaluate for therapy and was told a Physical Therapist would see Resident #27 on Monday 5/14/12. The DON verified the order was not put in the computer by LN #4 when she transcribed the orders. She explained LN #4 noted the orders but did not put it in the computer so the order did not go to the physical therapy department. She stated the therapy order should have been entered into the computer when LN #4 noted the orders on 5/10/12. During an interview on 5/17/12 at 3:53 PM the Licensed Physical Therapy Assistant (LPTA) stated Resident #27's daughter took her to see her private physician last week and came back with orders which included an order for a therapy evaluation. She stated she told the physical therapist about the order and then she forgot about it and didn't say anything more to anyone about it. She explained it was the usual process that nursing staff entered the physicians order in the computer and sent it to the therapy department where it was printed for their therapy records. During an Interview on 5/17/12 at 4:01 PM the Physical Therapist stated she did not see a physician's order for a therapy evaluation for Resident #27 and she did not see or evaluate the	F 514	Each record audit that identifies a resident missed order will be investigated and documented noting common factors for trending purposes. These reports will be tabulated and graphed for trends. The information will be reported quarterly to the Quality Committee to determine appropriate follow up when trends identified by the DON Segraves Care Center.	6/8/2012 no residents in facility QA meeting will be scheduled when residents in facility

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F 514	Continued From page 16 resident. She explained if a physician ordered for a resident to be screened by therapy those requests were usually done verbally but if the physician ordered for an evaluation to be done they had to have an actual physician's order before they could evaluate the resident.	F 514		