STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON COMMUNITY HOSPITAL SNF	500 MORVEN RD WADESBORO, NC 28170

(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=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. 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. 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. The facility must furnish a written description of legal rights which includes:	F 156	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed soley because it is required by the provisions of Federal and State law. F 156 Resident #73 and resident #19 have received the updated Medicare letter CMS 10123 – NOMNC. All Medicare residents have the potential to be affected. All residents identified have been issued the updated Medicare letter CMS 10123 – NOMNC. The appropriate Medicare letter was implemented on August 4, 2012 and will be utilized going forward. A tracking log has been developed that includes: resident name, end of coverage, date of notification, and method of notification. The log will be completed by the Minimum Data Set Coordinator or the RN Supervisor when a Medicare resident's non-coverage is anticipated. The Administrator or the Director of Nursing will review the log for compliance on a weekly basis. Results of this monitoring will be shared with the Quality Assurance and Process Improvement Committee for a minimum of ninety days at which time frequency of monitoring will be determined.	8/29/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred G.T Rumpany PhD	President	08/22/2012

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	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; 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. 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. 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 includes a written description of the facility's	F 156		

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F 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include contact information for requesting an immediate appeal with the notice of Medicare non-coverage for 2 of 3 residents (Residents #19 and #73). The findings included: 1. Review of the "Notice of Medicare Non-Coverage" form for Resident #73, dated 7/5/12, revealed a section entitled "How to Ask for an Immediate Appeal." One of the steps read, "Call your QIO [Quality Improvement Organization] at: {insert QIO name and toll-free number of QIO} to appeal, of if you have questions." During an interview on 8/3/12 at 10:35 AM, the business office employee who issued the Notice indicated that they just recently started using this particular form and she did not realize that the QIO information was not included.	F 156		

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F 156	Continued From page 3 2. Review of the "Notice of Medicare Non-Coverage" form for Resident #19, dated 7/15/12, revealed a section entitled "How to Ask for an Immediate Appeal." One of the steps read, "Call your QIO [Quality Improvement Organization] at: {insert QIO name and toll-free number of QIO} to appeal, of if you have questions." During an interview on 8/3/12 at 10:35 AM, the business office employee who issued the Notice indicated that they just recently started using this particular form and she did not realize that the QIO information was not included.	F 156		
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).	F 279	F 279 On August 2, 2012, Resident #68 was transferred to an acute care facility for evaluation following a seizure and was subsequently admitted. Resident #68 did not return to the facility and currently is in an in-patient hospice facility. Because all residents with behaviors have the potential to be affected by the cited deficiency, the medical records and care plans (52 total) for residents with documented behaviors were reviewed by Administrator, Director of Nursing and (3) RN Supervisors on August 2, 2012 to assure appropriate behavior interventions were in place. No additional residents with unaddressed behaviors were identified during the reviews.	

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care plan with measurable goals and interventions to prevent further injuries for 1 (Resident #68) of 2 sampled residents with known self injurious behavior. Resident had bitten her fingers causing the right index finger to be necrotic and infected. The findings include: The immediate jeopardy (IJ) for Resident # 68 began on June 2, 2012 when the fingers were injured ~~from~~ biting. The administrator was notified of the immediate jeopardy (IJ) on August 2, 2012 at 2:45 PM. The IJ was removed on August 3, 2012 at 7:15 PM after the Credible Allegation was validated through staff interview and record review. The facility was left out of compliance at no actual harm with the potential for more than minimal harm that is not IJ (D) to allow completion of the employee training. Resident #68 was admitted to the facility on 09/29/09 with multiple diagnoses including Bipolar Disorder, Failure to Thrive on Feeding Tube, Dementia, Anxiety and status post cerebral aneurism. The quarterly Minimum Data Set (MDS) assessment dated 03/08/12 indicated that Resident #68 had no behavioral symptoms. Resident #68 had a doctor's order dated 04/03/12 for a hand mitten to the right hand to prevent her from removing the wound vac dressing from the	F 279	F 279 To address systemic changes the Minimum Data Set (MDS) Coordinator was provided additional education by the Post Acute Care Services Director of Quality Management on August 3, 2012. Education included review of care plan development, individualization of goals, interventions, updating procedures, and inclusion of staff and family in the development. In turn, the MDS Coordinator re-educated the Interdisciplinary Team on August 3, 2012. Additional education was provided to the team regarding Resident Behavior and Interventions offered by the Licensed Psychologist on August 6, 2012 and August 7, 2012. On-going systemic changes include; on a daily basis, the Charge Nurse will document any changes in behavior on the 24 hour report, which will be reviewed by the RN Supervisor. Performance will be monitored by the Acuity Intervention Team, which consists of the Administrator, Director of Nursing, 3 RN Supervisors, MDS Coordinator, Dietary, Social Work, Admissions Coordinator and Therapy will, on a weekly basis, audit five medical records to assure that appropriate behavioral interventions, assessment and care planning are in place. Results of this monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assurance/Process Improvement (QAPI) Committee monthly. Monitoring will continue for a minimum of ninety days at which time frequency of monitoring will be determined by the QAPI committee.	8/29/12

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stage IV pressure ulcers on the right and left hip. The hand mitten was discontinued on 06/04/12 when the wound vac was discontinued. On 07/16/12, the hand mitten was restarted to prevent self injury, removal of dressing, foley catheter and gastrostomy tube.

The significant change in status MDS assessment dated 04/19/12 indicated that Resident #68 had behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 4-6 days but less than daily during the review period. The Care Area Assessments (CAAs) for behavioral symptoms dated 04/19/12 revealed " resident is a (age) year old who triggered for a behavioral assessment due to displaying behavior such as hitting herself with soft mitten and shaking side rails. She has recently started receiving services from hospice. She has a diagnosis of bipolar, depression and anxiety. She also has a history of cerebrovascular accident (CVA) and seizures. She also displays behaviors when she was currently going to the wound center. Staff noticed a major change in her behavior when she returned back to the facility. Her family support is good. Resident is here for long term placement. " The assessment also indicated that referral to another discipline was not warranted and care plan will be developed to monitor resident's behavioral symptoms.

The care plan dated 04/25/12 was reviewed. The care plan problem was " name of the resident)

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needs monitoring of mood (crying/tearfulness, repetitive verbalizations, anxiousness, sad/anxious appearance) and behaviors (yelling/screaming out, resistive with care) associated with bipolar disorder requiring the use of multiple psychotropic medications. " The goal was " mood and behaviors will be better controlled while on psychotropic medications as evidenced by decreased episodes of anxiety/restlessness and decreased episodes of yelling/screaming out weekly over the next review. " The approaches included " monitor resident's mood and behavior status daily (e.g resistive with care, repetitive verbalizations, crying/tearfulness, etc.) on behavior flow sheet and or in notes. Notify physician of any increased behaviors or mood, administer Paxil (anti-depressant)as ordered, administer Geodon as ordered routinely for the treatment of bipolar disorder, administer xanax (anti-anxiety), provide reassurance and comfort when she appears to be upset, encourage her to express/ventilate feelings, explain all procedures prior to rendering care to help decrease chance of combativeness and or anxiety, encourage family visit, assist out of room activities for socialization and hospice services per their plan of care. "

Resident #68 was on psychoactive medications to control her behaviors. The physician's order for June, 2012 indicated that Resident #68 was on Valium 5 mgs 1 tablet daily for anxiety disorder, Geodon 40 mgs daily for bipolar disorder and Ativan 1 mgs every 8 hours for anxiety disorder.

The nurse's notes were reviewed. The notes dated 06/02/12 at 7:30 AM, revealed that

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Resident #68 was biting her right index finger trying to remove the hand mitten. A small amount of blood was noted on the mitten. After the hand mitten was removed and the finger was cleaned with warm water, cuts were noted on the dorsal and posterior area of the index finger. There were no changes made to the care plan to address the self injurious behavior. On 08/02/12 at 1:45 PM, the MDS/care plan nurse was interviewed. She stated that she did not make changes to the care plan because she was not aware of the 06/02/12 incident when Resident #68 had bitten her fingers.

On 06/04/12 at 10:00 AM, the nurse's notes revealed that Resident #68 was in bed, she had several scratches to the neck, chest and arms. On 06/08/12 at 11 PM, resident had self inflicted scratches on her body. On 07/08/12 at 10:30 PM, resident noted to have multiple areas of scratches to chest and left arm, resident was observed scratching self with right hand and displayed signs and symptoms of agitation. There were no changes made to the care plan to prevent Resident #68 from repeated self injurious behavior.

On 06/04/12, the wound vac and the hand mitten were discontinued. There was no doctor's order to discontinue the hand mitten, it was per the request of the administration.

The quarterly Minimum Data Set (MDS) assessment dated 07/12/12 indicated that Resident #68 had memory and decision making problems and had behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging,

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public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days during the review period.

The nurse's notes on 07/14/12 at 5:35 AM revealed that the resident was found with profuse bleeding coming from her right hand related to chewing on hand. Large amount of blood in the mouth, face and clothing was observed. The notes further indicated that the attending physician was notified and the resident was sent to the emergency room. At 7:45 AM, Resident #68 was back to the facility from the emergency room. On 07/16/12 at 11:30 AM, the notes indicated that an order was written to clarify use of untied mitten. Resident has harmed self over the weekend by chewing on hand. She had history of continually removing fully inflated foley, gastrostomy tube and dressing to wound.

The emergency room records dated 07/14/12 were reviewed. The notes revealed under the chief complaint was " bleeding fingers right hand, patient found chewing flesh from hand by staff. " On physical examination, the resident was noted to have deep abrasions on right hand fingers. The clinical impression was self inflicted abrasions right hand from patient biting. The notes further revealed multiple wounds on right hand due to patient chewing on first 2 fingers and thumb.

On 07/16/12, there was a doctor's order to wear mitten (untied) to right hand to prevent self injury, removal of dressing, foley catheter, and g-tube, remove every shift to provide care, monitor status.

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F 279	Continued From page 9 On 07/16/12, the utilization of the hand mitten to prevent self injurious acts was added to the care plan problem. On 07/17/12, " ativan as ordered to aide with agitation " was added to the approaches. There were no changes made to the care plan to prevent the self injurious acts from happening again aside from Ativan and hand mitten. The care plan dated 07/18/12 (review date) was reviewed. The care plan problems included " (name of resident) utilizes a hand mitten to prevent her from self injurious acts and " (name of resident) needs monitoring of mood (crying/tearfulness, repetitive verbalizations, anxious complaints, sad/anxious appearance and behaviors (yelling/screaming out, resistive with care, self abusive acts, etc.) associated with bipolar disorder requiring the use of multiple psychotropic medications. " The care plan did not have a measurable goal and interventions to address the care and treatment related to the self injurious behavior of Resident #68. On 08/02/12 at 1:45 PM, the MDS/care plan nurse was interviewed. She was aware of the incident when Resident #68 had chewed her fingers on 07/14/12. She updated the care plan on 07/18/12 by incorporating the use of the hand mitten to prevent her from self injurious acts to the mood/behavior and use of psychotropic medication care plan problem. She indicated that she did not develop a care plan with goals and approaches specific to the self injurious behavior. She added that Resident #68 was on hand mitten to prevent her from self injurious acts and her medications were adjusted after the 07/14/12 incident.	F 279		

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On 08/01/12 at 9:45 AM, Nurse # 11 was observed during the dressing change to the right hand of Resident #68. The right index finger was observed to be necrotic, swollen and with odor. The wound had yellowish wound bed. The thumb was macerated. Nurse #5 was observed to clean the fingers with Betadine, xeroform was applied and covered with dry dressing.

On 08/01/12 at 10:15 AM, Nurse #11 was interviewed. She indicated that hand mitten and socks were tried for Resident #68 to prevent her from biting her fingers.

On 08/01/12 at 11:20 AM, administrative staff #2 was interviewed. She stated that she was aware of the 2 incidents where Resident #68 had chewed her fingers. She indicated that she had not tried other measures aside from a hand mitten to prevent her from biting her fingers.

On 08/01/12 at 3:40 PM, Nurse #4 was interviewed. She stated that she was with the physician when he saw Resident #68 on 07/30/12. She found the finger to be macerated with slough tissue and with yellowish drainage. The physician had ordered surgical consult for debridement of the right index finger.

On 08/01/12 at 5:05 PM, Nurse #3 was interviewed. She stated that she was the nurse on 07/28/12 when she found maggots on the right index finger wounds. She added that she had removed four maggots from the wound. She further stated that hand mitten and socks were tried to prevent her from biting her fingers but they did not work, Resident #68 was able to

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F 279	Continued From page 11 remove them. On 08/02/12 at 9:00 AM, Resident #68 was scheduled for debridement of the right index finger at the hospital. She came back to the facility after lunch. Debridement was not performed to the resident's finger. At 2:20 PM, the hospital staff was interviewed. She stated that she was a surgical service supervisor who worked with the surgeon. She indicated that because of the extensive tissue loss, debridement was not of benefit so the surgeon had referred Resident #68 to the orthopedic doctor for amputation of the right index finger. The surgical consultation report dated 08/02/12 was reviewed. The report revealed examination of the right index finger. The debridement was unlikely to be of benefit considering extensive tissue loss. Recommend treatment by orthopedic, hand surgeon and wound care. On 08/02/12 at 10:39 AM, the administrative staff #1 was interviewed. She stated that Resident #68 was wearing a hand mitten when she chewed her finger on 06/02/12. She indicated that the hand mitten was ordered because she was pulling the wound vac, g-tube and foley catheter out. She also stated that when the wound vac was discontinued, the use hand mitten was also discontinued. The hand mitten was restarted when she chewed her fingers again. She added that she could not think of other measures that were tried to prevent her from biting her fingers aside from the hand mitten. The administrator was notified of the immediate jeopardy on 08/02/12 at 2:45 PM.	F 279		

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The facility provided a credible allegation of compliance on 08/03/12 at 7:08 PM.

The allegation of compliance indicated:

· On August 3, 2012, Resident #68 was transferred to (name of the hospital) for unrelated medical issues. Following hospitalization, Resident #68 will be transferred to Hospice House due to multiple medications, and very complex medical situation which includes Intracranial Hemorrhage, severe Altered Mental Status, & seizure disorder, long history of rash, itching, pain, agitation, & multiple infections. Hospice House was recommended by (name of the doctor), Chief Medical Officer for (name of the hospice care network) for medication management to control seizures & behaviors.

· Because all residents with behaviors have the potential to be affected by the cited deficiency, all medical records (52 total) and care plans for residents with documented behaviors were re-evaluated by Administrator, Director of Nursing, and (3) RN Supervisors, on August 2, 2012 to assure appropriate behavior interventions were in place. No additional residents with unaddressed behaviors were identified during the reviews.

· The MDS Coordinator will be educated by (name of the management group) Post Acute Care Director of Quality on August 3, 2012. The MDS Coordinator educated the IDT (interdisciplinary team) on August 3, 2012. Education included care plan development, individualization of goals and interventions and

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F 279	Continued From page 13 updating procedures. The team will also participate in education resident behavior and intervention offered by (name of the psychologist) on August 6, 2012 or August 7, 2012. · The Acuity Intervention Team, which consist of the Administrator, Director of Nursing, 3 RN Supervisors, Dietary, Social Worker, Admissions Coordinator, & Therapy, on a weekly basis, will audit five medical records to ensure that appropriate intervention, assessment, & care planning are in place. New admissions will be reviewed weekly at the Acuity Intervention Team meeting to ensure that appropriate behavioral intervention, assessment, & care planning are in place. Family and staff involved in resident care are offered an opportunity to provide input into the care plan process to assure resident centered care. · Results of the monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assurance and Assessment Committee monthly. Monitoring will continue a minimum of ninety days at which time the Quality Assurance and Assessment Committee will determine if the deficiency has been resolved. If it has been determined that the deficiency has been resolved, monitoring will be conducted on a quarterly basis. Corrective Action Date: August 3, 2012 The credible allegation was verified on 8/03/12 at 7:10 PM as evidenced by staff interviews and review of the in-service signed in sheets on care plan development, individualization of goals and interventions and how to update the care plan. The care plans of residents identified with	F 279		

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F 279	Continued From page 14 behavior poblems were reveiwed. The care plan had goals and interventions in place for behaviors.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement the care plan for 2 of 3 sampled residents (Residents #11 and #101). 1. Resident #11 was originally admitted to the facility 11/21/08. Cumulative diagnoses included Seizure disorder, Dementia and Degenerative Joint Disease. A Quarterly Minimum Data Set (MDS) assessment dated 7/13/12 indicated Resident #11 was moderately impaired in cognition. Resident #11 had one fall without injury and one fall with injury (except major injury) since the last assessment done on 4/19/12. A Care plan reviewed on 7/18/12 included a problem of potential for falls secondary to impaired mobility, history of falls, use of psychotropic medications and mood and behavior problems. The goal read Resident #11 will have no injury as a result of a fall at any time over the next review. Approaches included: "Provide a	F 282	F 282 Corrective action for Resident #11included; transferring resident to the appropriate wheelchair with anti-tippers with Dycem and placement of fall mat next to the resident's bed. Corrective action for Resident #101 included; placement of Dycem in the resident's wheelchair. Because all residents with falls interventions have the potential to be affected by the cited deficiency, all residents identified as requiring safety devices/interventions to prevent falls and and corresponding care plans were reviewed to assure inclusion of safety devices/interventions. Systemic changes include re-education of the nursing staff by the Director of Nursing to assure devices/interventions to prevent falls are maintained as indicated in the resident's plan of care. This education will be incorporated into the facility education program at the time of hire and annually. A nurse will immediately assess the resident after a fall and implement corrective/preventive action. A post fall review will be conducted by the Interdisciplinary Team the next business day to determine if the appropriate prevention strategies are in place and to update the care plan if needed. Audits will be conducted by Nursing Administration weekly on a random sample of residents with care planned falls interventions. Audits to include resident observation to assure care planned interventions are in place. Results will be reported to the Administrator on a weekly basis and to the Quality Assurance/ Process Improvement(QAPI) Committee monthly for 90 days at which time frequency of monitoring will be determined.	8/29/12

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low bed with fall mat to help reduce the risk of injury from falls from the bed. Antitippers to wheelchair for safety. Dycem (a non-slip pad) to wheelchair."

An observation on 8/2/12 at 7:55 AM. revealed Resident #11 lying in her bed in her room. There was not a fall mat on the floor beside the bed.

On 8/2/12 at 8:00 AM., Nurse #1 went to Resident #11's room and noted that there was not a fall mat on the floor beside the bed. She stated she expected that all interventions for falls to be in place which included a fall mat to be on the floor.

On 8/2/12 at 9:49 AM., Resident #11 was observed sitting in a wheelchair in the hallway. The wheelchair did not have antitippers. There was a Dycem pad in the wheelchair with a cloth incontinent pad on top of the Dycem.

On 8/2/12at 9:58AM., Nurse #1 stated the nursing assistant had placed Resident #11 in the wrong wheelchair and she should have been in the wheelchair with the antitippers. During the interview, she instructed nursing staff to take Resident #11 back to her room and put her in the correct wheelchair.

On 8/2/12 at 10 AM., nursing assistant (NA) # 2 stated Resident #11 did not have her name on the wheelchair in the room. She said the other resident in the room indicated the wheelchair with the red Dycem was hers so she knew the other wheelchair belonged to Resident #11. during the interview, NA # 2 further stated the fall mat was not on the floor when she went in the room

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F 282	Continued From page 16 around 8:00 AM. On 8/2/12 at 2:13 PM., Administrative staff #2 stated she expected nursing staff to use all of the interventions for falls for Resident #11 which included the fall mat, antitippers on the wheelchair and Dycem. 2. Resident #101 was readmitted to the facility on 12/25/11. Diagnoses included dementia and Parkinson ' s disease. The most recent quarterly assessment, dated 5/4/12, revealed that Resident #101 had 1 fall with no major injury since the 2/23/12 assessment. Resident #101's care plan, updated on 7/17/12, included a problem of potential for falls secondary to requiring assistance with transfers, history of falls, unsteady gait, cognitive loss and presence of restless behaviors. The goal read, "No injury as a result of a fall at any time over the next review." Approaches included "Dycem [a non-slip pad] on wheelchair to prevent sliding out of wheelchair". Observation on 7/31/12 at 3:45 PM revealed Resident #101 up in her wheelchair at the nursing station. The resident was observed to frequently stand without fully straightening, then sit back down. No Dycem was on the wheelchair. During an interview on 7/31/12 at 3:45 PM, Nursing Assistant (NA) #1 indicated that Resident #101 should still be using a Dycem pad on wheelchair. During an interview on 8/2/12 at 2:10 PM,	F 282		

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F 282	Continued From page 17 Administrative Nurse #2 indicated she would expect the Dycem to be in Resident #101's chair as care planned.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure a urinary catheter to prevent excessive tension on the catheter and failed to keep the urinary catheter tubing from touching the floor for one of two sampled residents with urinary catheters (Resident # 92). Findings included: Resident # 92 was admitted to the facility 6/15/11. Cumulative diagnoses included: benign prostatic hypertrophy (BPH), bladder obstruction and hematuria (blood in the urine). An Annual Minimum Data Set (MDS) assessment dated 5/31/12 indicated Resident # 92 had short term memory impairment and was moderately impaired in decision-making. He was totally dependent on staff for transfers, toilet use,	F 315	F 315 Immediate corrective action for Resident #92 included properly securing the urinary catheter and placing off the floor. Because all residents with urinary catheters have the potential to be affected by the same deficient practice, all residents with urinary catheters were evaluated to assure that tubing was appropriately secured and catheter bag was positioned off the floor. Systemic changes included, all nursing staff including nursing assistants was re-educated by the Director of Nursing and Infection Preventionist regarding prevention of urinary tract infections with emphasis on proper care and positioning of urinary catheters. Positioning education included, maintaining off the floor position of catheter bag for resident's while in wheel chair and in bed. The Infection Preventionist will monitor compliance on a weekly basis and document on the established log. Results will be reported to the Administrator weekly and to the Quality Assurance and Process Improvement Committee on a monthly basis for a minimum of ninety days at which time frequency of monitoring will be determined.	8/29/12

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personal hygiene and bathing. Resident # 92 had an indwelling urinary catheter.

An observation on 8/1/12 at 3:49 PM. revealed Resident # 92 in his wheelchair in the dining area. His urinary catheter tubing was hanging on the floor. The urinary drainage bag was in a blue privacy bag that hung on the crossbars positioned under the seat of his wheelchair.

On 8/1/12 at 4:09 PM., Nurse # 7 stated the catheter tubing should be below the level of the bladder and not touch the floor. She removed Resident # 92 from the dining area and placed the urinary drainage tubing in the blue privacy bag.

During the observation of urinary catheter care on 8/2/12 at 10: 50 AM, the urinary catheter tubing was not secured to Resident # 92's leg. Nurse # 8 stated the urinary catheter tubing should be secured to the leg with a secure care strap. She further indicated that Resident # 92 would pull at the urinary catheter tubing and sometimes removed the secure care strap.

On 8/2/12 at 1:51 PM., nursing assistant # 3 stated Resident # 92's urinary catheter tubing was not secured when he provided ADL (activities of daily living) care. He stated he provided care for Resident # 92 once or twice a week and had not secured the urinary catheter tubing until 8/2/12 when one of the nursing staff told him to secure the urinary tubing that morning.

On 8/2/12 at 2:04 PM., Administrative staff #2 stated the catheter tubing should not have been on the floor. Also, the catheter tubing should be

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F 315	Continued From page 19 secured unless otherwise noted by physician.	F 315		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to implement effective interventions to prevent repeated self inflicted injuries for 1 (Resident # 68) of 2 sampled residents with known self injurious behavior. Resident #68 had bitten her fingers causing the right index finger to be necrotic and infected. The facility also failed to implement interventions to prevent falls as care planned for 1 (Resident #11) of 3 sampled residents. The findings include The immediate jeopardy (IJ) for Resident # 68 began on June 2, 2012 when the fingers were injured from biting. The administrator was notified of the immediate jeopardy (IJ) on August 2, 2012 at 2:45 PM. The IJ was removed on August 3, 2012 at 7:15 PM after the Credible Allegation was validated through staff interview and record review. The facility was left out of compliance at no actual harm with the potential for more than minimal harm that is not IJ (D) to allow completion of the employee training. Example #2 (Resident 11) was cited at no actual harm with	F 323	F 323 1. On August 2, 2012, Resident #68 was transferred to an acute care facility for evaluation following a seizure and was subsequently admitted. Resident #68 did not return to the facility and currently is in an in-patient hospice facility. 2. Resident #11 was transferred to the appropriate wheelchair with anti-tippers. Dycem was also placed in wheelchair and falls mat next to the resident's bed. 1. Because all residents with behaviors have the potential to be affected by the cited deficiency, all medical records (52) total and care plans for residents with documented behaviors were re-evaluated by the Administrator, Director of Nursing and (3) RN Supervisors on August 2, 2012 to assure appropriate interventions were in place. In addition, inservice training on resident behavior was conducted by a Licensed Psychologist on August 6, 2012 and August 7, 2012. This educational program was videotaped for additional staff education purposes. Because all residents with wounds have the potential to be affected by the cited deficiency, all residents receiving wound treatments were evaluated by the Wound Care Coordinator. All wounds were found to be clean with no signs or symptoms of infection.	

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F 323	Continued From page 20 the potential for more than minimal harm that is not IJ (D). 1. Resident #68 was admitted to the facility on 09/29/09 with multiple diagnoses including Bipolar Disorder, Failure to Thrive on Feeding Tube, Dementia, Anxiety and status post cerebral aneurism. The quarterly Minimum Data Set (MDS) assessment dated 03/08/12 indicated that Resident #68 had no behavioral symptoms. The significant change in status MDS assessment dated 04/19/12 indicated that Resident #68 had behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 4-6 days but less than daily during the review period. The quarterly Minimum Data Set (MDS) assessment dated 07/12/12 indicated that Resident #68 had memory and decision making problems and had behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days during the review period. The care plan dated 07/18/12 was reviewed. The care plan problems included " (name of resident) utilizes a hand mitten to prevent her from self injurious acts and " (name of resident) needs monitoring of mood (crying/tearfulness, repetitive verbalizations, anxious complaints, sad/anxious appearance and behaviors (yelling/screaming out, resistive with care, self abusive acts, etc.)	F 323	F323 Mandatory inservices for all nursing staff began on August 3, 2012. Education included identification and reporting of wounds and signs and symptoms of infection. The inservices were conducted by the Administrator, the Director of Nursing and the RN Supervisors. 2. Because all residents with falls interventions have the potential to be affected by the cited deficiency, all resident identified as requiring safety devices/ interventions to prevent falls were reviewed to assure appropriate interventions were in place as care planned. 1. Systemic changes to address behaviors include assuring that appropriate procedures are followed at the time a resident behavior is identified. Procedures include the nurse observing the behavior will be responsible for the documentation on the 24 hour report which will be reviewed by the RN Supervisor. The Acuity Intervention Team will review each resident so appropriate interventions are maintained and revised on a weekly basis. Education regarding resident behaviors will be incorporated into new employee and annual mandatory education. Systemic changes to address wounds include; at the time a wound is identified, an incident report will be completed, immediate interventions implemented and documented. The Wound Care Coordinator will evaluate all wounds on a weekly basis to assure appropriate treatment/interventions are in place.	

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F 323	Continued From page 21 associated with bipolar disorder requiring the use of multiple psychotropic medications. " The care plan did not have a measurable goal and interventions to address the care and treatment related to the self injurious behavior. On 04/03/12, there was a doctor's order to apply mitten to right hand to prevent resident from removing the wound vac (vacuum) dressing from the stage IV pressure ulcers of the left and right hip. The physician's orders for June, 2012 were reviewed. Resident #68 was on Valium 5 mgs (milligram) 1 tablet daily for anxiety disorder, Geodon 40 mgs daily for bipolar disorder and Ativan 1 mgs every 8 hours for anxiety disorder. On 07/17/12, Ativan 1 mgs every 8 hours was changed to Ativan 2 mgs twice a day and Valium was discontinued. The nurse's notes were reviewed. The notes dated 06/02/12 at 7:30 AM, revealed that Resident #68 was biting her right index finger trying to remove the hand mitten. A small amount of blood was noted on the mitten. After the hand mitten was removed and the finger was cleaned with warm water, cuts were noted on the dorsal and posterior area of the index finger. The attending physician was notified and had ordered Rocephin (an antibiotic) 1 gm (gram) IM (intramuscular) times one with Lidocaine (local anesthetic) and to treat the wounds to the right index finger with betadine wash with dry dressing daily until healed. The notes at 8:30 PM revealed that the dressing to the right index finger was intact and no drainage was noted. Resident #68 was agitated and Ativan (use for the management	F 323	F 323 2. Systemic changes include re-education of the nursing staff by the Director of Nursing to assure devices/interventions to prevent falls are maintained as indicated in the resident's plan of care. This education will be incorporated into the facility education program at the time of hire and annually. A nurse will immediately assess the resident after a fall and implement corrective/preventive action. A post fall review will be conducted by the Interdisciplinary Team the next business day to determine if the appropriate prevention strategies are in place.	

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F 323	Continued From page 22 of anxiety disorder) was administered. There was no evidence in the records that non pharmacological interventions were implemented or tried to prevent the self injurious behavior from happening again other than Ativan. Review of the psychoactive medication monthly flow records for June and July, 2012, there was no self injurious behavior listed under target behavioral symptoms. On 08/01/12 at 5:05 PM, Nurse #3 was interviewed. She stated it should have been listed under target behavior but it was not. The notes dated 06/04/12 at 10:00 AM revealed that Resident #68 was in bed, she had several scratches to the neck, chest and arms. On 06/08/12 at 11 PM notes, resident had self inflicted scratches on her body, Ativan was administered as scheduled. There was no evidence in the records that non pharmacological interventions were implemented or tried to prevent the self injurious behavior from happening again other than Ativan. On 06/04/12 at 2:28 PM, the nurse's notes indicated that the hand mitten was discontinued. There was no doctor's order to discontinue the hand mitten, it was per the request of the administration due to no behaviors noted. The nurse's notes dated 07/08/12 at 10:30 PM, resident noted to have multiple areas of scratches to chest and left arm, resident was observed scratching self with right hand and displayed signs and symptoms of agitation. There was no evidence in the records that non pharmacological interventions were implemented	F 323	F 323 1. Monitoring of performance will be conducted by the Acuity Intervention Team, which consists of the Administrator, Director of Nursing, 3 RN Supervisors, MDS Coordinator, Dietary, Social Work, Admission Coordinator and Therapy, on a weekly basis, will audit five medical records and observe these residents to assure that appropriate behavioral intervention, assessment and care planning are in place. If the Acuity Intervention Team decides that certain behavior issues require an outside expert, a referral will be made to the local county mental health service for an evaluation. New admissions will be reviewed weekly at the Acuity Intervention Team meeting to assure appropriate behavior intervention, assessment and care planning are in place or to determine what changes need to be made. Results of this monitoring for Resident Behavior will be shared with the Director of Nursing on a weekly basis and with the Quality Assurance/Process Improvement Committee monthly for a minimum of ninety days at which time the frequency of monitoring will be determined. The Wound Care Coordinator will assess all bruises, skin tears, wounds and bites weekly and document status on the Ulcer/Wound Identification and Progress Report. The Acuity Intervention Team will monitor the progress records weekly for completeness and wound status. Results of this monitoring for Resident Behavior and Wound Status will be shared with the Director of Nursing on a weekly basis and with the Quality Assurance/Process Improvement Committee	

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F 323	Continued From page 23 or tried to prevent the self injurious behavior from happening again. On 07/10/12, there was a doctor's order to discontinue the treatment to the right index finger, the area had healed. On 08/01/12 at 3:10 PM, Nurse #1 was interviewed. She stated that she was the treatment nurse on 07/10/12 and when she looked at the right index finger, the area was healed so she discontinued the treatment. The nurse's notes dated 07/14/12 at 5:35 AM revealed " found resident with profuse bleeding coming from left hand related to resident chewing on hand. Large amount of blood in the mouth, face and clothing. " The notes further indicated that the attending physician was notified and the resident was sent to the emergency room. At 7:45 AM, Resident #68 was back to the facility from the emergency room. On 08/01/12 at 10:10 PM, Nurse #2 was interviewed by phone. She stated that she was the night nurse on 07/14/12. She clarified that the affected hand was the right hand and not the left. She revealed that Resident #68 was on bolus tube feeding every 2 hours during her shift (12 AM, 2 AM and 4 AM). She went to the room to give Resident #68 her 4:00 AM bolus feeding. She found large amount of bright red blood in her mouth, face and clothing. Her right hand was in her mouth and when she removed her hand from her mouth she became agitated. After she cleaned the hand, she noticed that the bleeding was coming from her hand. The skin was removed including the cuticle from the first and second fingers and the fingernails were coming up from the base of the nail. She further indicated that she had to remove a lot of skin tissue from her mouth. She reported that prior to	F 323	Monitoring will continue a minimum of ninety days at which time the frequency of monitoring will be determined. 2. The RN Supervisor will on an ongoing basis monitor residents and review care plans to ensure that appropriate devices/interventions to prevent falls are in place. Five residents will be reviewed each week by the Acuity Intervention Team. Results of this monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assurance/Process Improvement Committee for a minimum of ninety days at which time frequency of monitoring will be determined.	8/29/12

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discovering the resident this way the last time she saw the resident was around 2:00 AM when she gave the bolus tube feeding.

The emergency room records dated 07/14/12 were reviewed. The notes revealed under the chief complaint was " bleeding fingers right hand, patient found chewing flesh from hand by staff. " On physical examination, the resident was noted to have deep abrasions on right hand fingers. The clinical impression was self inflicted abrasions right hand from patient biting. The notes further revealed multiple wounds on right hand due to patient chewing on first 2 fingers and thumb. The wounds were cleaned with NS (normal saline) and triple antibiotic ointment was applied, covered with 4 x 4 and kling. Pressure dressing was applied to the base of the thumb due to bleeding. Resident #68 was transferred back to the facility with orders to clean the right hand wounds daily with Hibiclens, Neosporin ointment (an antibiotic), dress fingers with non adhesive dressing and cover with bulky dressing, ace wrap over dressing and Augmentin (an antibiotic) 500 mgs 3 times a day for 10 days.

The nurse's notes dated 07/14/12 at 12:30 PM revealed that there was a small amount of bright red blood on the end of the dressing to right hand. When the old dressing was removed, the thumb, first and second fingers were noted to have multiple area of skin missing. The assigned nurse for this date/time was not available for interview.

The nurse's notes dated 07/15/12 at 4 AM revealed that the resident's right hand dressing was noted with small amount of bloody drainage,

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dressing was reinforced. At 10:15 AM, the notes indicated that the dressing was changed and noted multiple areas of skin missing from the thumb, first and second fingers and top of the hand. Moderate amount of bright red blood was noted from the areas. The assigned nurse for this date/time was not available for interview.

The nurse's notes dated 07/16/12 at 10 AM indicated that the index finger was red, the dressing was changed. At 11:30 AM, the notes indicated that an order was written to clarify use of untied mitten. Resident has harmed self over the weekend by chewing on hand. She had history of continually removing fully inflated foley, gastrostomy tube and dressing to wound.

The ulcer/wound identification and progress records were reviewed. On 07/16/12 (no time), the notes indicated scant amount of bright bloody drainage, very irregularly shaped wound over index finger and thumb. Both were dark like old blood but did not remove with dressing. They were 75 % necrotic and 25 % denuded (outer covering or surface layer of skin is removed). On 07/20/12, the fingers still had 75% necrotic tissue and 25% pink and denuded. No odor and with scant bloody drainage. On 07/28/12, the notes indicated that eschar persisted. The 07/30/12 notes revealed that the doctor was in and requested surgical consult. On 08/01/12 at 10:15 AM, Nurse #5 was interviewed. She stated that she had started as wound care nurse in June, 2012. She also indicated that hand mitten and socks were tried for Resident #68 to prevent her from biting her fingers.

On 07/16/12, there was a doctor's order to wear

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mitten (untied) to right hand to prevent self injury, removal of dressing, foley catheter, and g-tube, remove every shift to provide care, monitor status.

The nurse's notes dated 07/17/12 at 1:55 PM indicated that the physician was called to report resident's increased agitation by throwing her left arm and biting at her mitten. An order for Ativan 1 mg IM was received. There was no evidence in the records that non pharmacological interventions were implemented or tried to prevent Resident #68 from injuring herself other than Ativan.

The nurse's notes dated 07/24/12 at 4:30 PM, Resident #68 was seen and examined by her physician. New orders for treatment to the right index finger, culture and sensitivity of the right index finger wounds and Doxycycline (an antibiotic) 100 mgs for 10 days were received. The physician's progress notes dated 07/24/12 revealed that the resident had finger bites with areas of maceration and mild exudates.

The culture and sensitivity report of the right index finger wound dated 07/24/12 was " pseudomonas aeroginosa, heavy growth. "

The nurse's notes dated 07/28/12 at 12:45 PM revealed that the nurse was called to Resident #68's room to assess the right index finger. The wound tissue was yellowish, red slough with necrotic tissue mixture. Several maggots were noted imbedded in wound tissue. The wound was noted with bloody yellowish drainage with foul odor. The physician was notified with new orders to clean the right index finger with soap

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and water, betadine wash and xeroform dressing daily. X-ray of the right hand was also ordered. The notes further revealed that Nurse #3 was called to the room of Resident #68. Nurse #3 had noticed whitish objects around the necrotic tissue. The nurse indicated that she had removed 4 worms (maggots) from the wound. She cleaned the wounds with soap and water and covered with sterile dressing. On 08/01/12 at 5:05 PM, Nurse #3 was interviewed. She stated that she was the nurse on 07/28/12 when she found maggots on the right index finger wounds. She further stated that hand mitten and socks were tried to prevent her from biting her fingers but they did not work, Resident #68 was able to remove them.

The x-ray report of the right hand dated 07/28/12 was soft tissue swelling and no fracture or destruction of bone.

The nurse's notes dated 07/29/12 at 10 AM indicated that the dressing was changed to the wound on the right index finger. The color remained dull with small section of necrotic tissue.

The nurse's notes dated 07/30/12 at 6:10 PM revealed that the physician came to see Resident #68. He ordered Cipro (an antibiotic) 500 mgs twice a day for 10 days and surgical consult for debridement of the right index finger. On 08/01/12 at 3:40 PM, Nurse #4 was interviewed. She stated that she was with the physician when he saw Resident #68 on 07/30/12. She found the finger to be macerated with slough tissue and with yellowish drainage.

On 08/01/12 at 9:45 AM, Nurse # 5 was observed

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during the dressing change to the right hand of Resident #68. The right index finger was observed to be necrotic, swollen and with odor. The wound had yellowish wound bed. The thumb was macerated. Nurse #5 was observed to clean the fingers with Betadine, xeroform was applied and covered with dry dressing.

On 08/01/12 at 11:20 AM, administrative staff #1 was interviewed. She stated that she was aware of the 2 incidents when Resident #68 had chewed her fingers. She indicated that she had not tried other measures aside from a hand mitten to prevent her from biting her fingers.

On 08/01/12 at 3:30 PM, Nurse #6 was interviewed. She stated that she had observed Resident #68 biting her right hand even with the bulky dressing and a hand mitten on. She further stated that when she changed the dressing on 07/23/12, there was blood on the dressing.

On 08/02/12 at 8:30 AM, Resident #68 was sent to the hospital for debridement of the right index finger.

On 08/02/12 at 10:39 AM, the administrative staff #2 was interviewed. She stated that Resident #68 was wearing a hand mitten when she chewed her finger the first time. She indicated that the hand mitten was ordered because she was pulling the wound vac, g-tube and foley catheter out. She also stated that when the wound vac was discontinued, the use of the hand mitten was also discontinued. The hand mitten was restarted when she chewed her fingers again. She added that she could not think of other measures that were tried to prevent her from biting her fingers

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aside from the hand mitten. The nurses should be monitoring her self injurious behavior too and document it on the psychoactive medication monthly flow record every shift.

On 08/02/12 at 1:30 PM, Nurse #3 indicated that Resident #68 was back and debridement was not performed. She further stated that the hospital staff stated that the surgeon had referred Resident #68 to an orthopedic doctor for amputation of the right index finger.

The surgical consultation report dated 08/02/12 was reviewed. The report revealed examination of the right index finger. The debridement was unlikely to be of benefit considering extensive tissue loss. Recommend treatment by orthopedic, hand surgeon and wound care.

On 08/02/12 at 2:20 PM, the hospital staff was interviewed. She stated that she was a surgical service supervisor who worked with the surgeon. She indicated that because of the extensive tissue loss, debridement was not of benefit so the surgeon had referred Resident #68 to the orthopedic doctor for amputation of the right index finger.

On 08/03/12 at 1:58 PM, Nurse Aide #1 was interviewed. She stated that she had observed Resident #68 biting her fingers sometime in July prior to having her fingers injured. She added that she was wearing a hand mitten but she was able to remove it. She further stated that the nurses were aware of this behavior.

The administrator was notified of the immediate jeopardy on 08/02/12 at 2:45 PM.

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The facility provided a credible allegation of compliance on 08/03/12 at 7:08 PM.

The allegation of compliance indicated:

· On August 3, 2012, Resident #68 was transferred to (name of the hospital) for unrelated medical issues. Following hospitalization, Resident #68 will be transferred to hospice house due to multiple medications, and very complex medical situation which includes Intracranial Hemorrhage, severe Altered Mental Status, & seizure disorder, long history of rash, itching, pain, agitation, & multiple infections. Hospice House was recommended by (name of the doctor), Chief Medical Officer for (name of the hospice care network) for medication management to control seizures & behaviors.

· A: Resident Behaviors: Because all residents with behaviors have the potential to be affected by the cited deficiency, all medical records (52 total) and care plans for residents with documented behaviors were re-evaluated by Administrator, Director of Nursing, and (3) RN Supervisors, on August 2, 2012 to assure appropriate behavior interventions were in place. No additional residents with unaddressed behaviors were identified during the reviews. An additional resident with self-injurious behaviors (Resident #51) was evaluated by the primary care physician on August 3, 2012 and no interventions were recommended.

B: Wound Evaluation: Because all residents with wounds have the potential to be affected by the cited deficiency, all residents currently

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receiving wound treatments were evaluated by the Wound Care Coordinator on July 30, 2012 and July 31, 2012. All wounds were found to be clean with no signs or symptoms of infection or maggot infestation.

· A. Resident Behaviors: Initial staff education started on August 3, 2012, via Behavior Educational Sheet, which emphasized the need for staff to report behaviors immediately to the Charge Nurse who will implement interventions as indicated. If resident behaviors pose an immediate serious threat, the resident will be placed on 1:1 monitoring, the physician and family/RP will be notified, and the resident is transferred to the emergency department if needed. The Charge Nurse will document on the 24-Hour report and will be reviewed daily by the Acuity Intervention Team, which consist of the Administrator, Director of Nursing, 3 RN Supervisors, Dietary, Social Worker, Admissions Coordinator, & Therapy, so appropriate interventions could be reviewed and revised as appropriate. This Behavior Education Sheet was provided to 293 employees, which includes all staff and ancillary staff that provide services to the facility. Additional mandatory inservices for all staff on how to handle residents with self injurious behavior and behavior monitoring began on August 3, 2012 and will conclude on August 10, 2012. The inservices will be conducted by the Director of Nursing, Administrator and RN Supervisor. In addition, education on resident behavior and interventions will be conducted for all staff by (name of the psychologist) on August 6, 2012 and August 7, 2012. This inservice will be video taped for additional staff education purposes. Staff unable to attend the inservices

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will be required to receive education prior to return to work. This education will be incorporated into the facility orientation program for new hires & annually.

B. Wound Evaluation: Mandatory inservices for all nursing staff began on August 3, 2012 and will conclude on August 10, 2012. Education will include identification and reporting of wounds, signs and symptoms of infection, and fly and/or maggot infestation. The inservices will be conducted by the Director of Nursing, Administrator and RN Supervisor. At the time a wound is identified, an incident report will be generated and immediate interventions implemented. The intervention will be documented on the 24 hour reported by the Charge Nurse and reported through the Acuity Intervention Team. The Wound Care Coordinator will evaluate all wounds on a weekly basis to assure appropriate treatment/interventions are in place. Staff unable to attend the inservices will be required to receive education prior to return to work. This education will be incorporated into the facility orientation program for new hires & annually.

· A. Resident Behaviors: The Acuity Intervention Team, which consist of the Administrator, Director of Nursing, 3 RN Supervisors, Dietary, Social Worker, Admissions Coordinator, & Therapy, on a weekly basis, will audit five medical records & observe these residents to ensure that appropriate behavioral intervention, assessment, & care planning are in place. If Acuity Intervention Team identifies that behavior issues need an outside expert, a referral will be made to (name of the local county mental health service) for an

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evaluation. New admissions will be reviewed weekly at the Acuity Intervention Team meeting to ensure appropriate behavioral intervention, assessment, & care planning are in place or if changes need to be made. Family and staff involved in resident care are offered an opportunity to provide input into the care plan process to assure resident centered care.

Wound Evaluation: The wound care nurse will assess all bruises, skin tears, wounds and bites weekly and document on the ulcer/wound identification and progress report. The Acuity Intervention Team will monitor the progress report weekly for completeness and progress.

· Results of the monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assurance and Assessment Committee monthly. Monitoring will continue a minimum of ninety days at which time the Quality Assurance and Assessment Committee will determine if the deficiency has been resolved. If it has been determined that the deficiency has been resolved, monitoring will be conducted on a quarterly basis.

Corrective Action Date: August 3, 2012

The credible allegation was verified on 8/03/12 at 7:10 PM as evidenced by staff interviews and review of the in-service signed in sheets on reporting behaviors, what type of behavior to report, to whom are you going to report, what would you fill out if behaviors noted and reported and what immediate interventions would you do to prevent resident injury. Interview also with the administrative staff revealed that the charts of residents with behavioral issues were reviewed

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for appropriate interventions and care planning and wounds were assessed for possible infection/infestation.

2. Resident # 11 was originally admitted to the facility 11/21/08. Cumulative diagnoses included Seizure disorder, Dementia and Degenerative Joint Disease.

An Annual Minimum Data Set (MDS) assessment dated 11/10/11 indicated Resident #11 had short term and long term memory impairment and was moderately impaired in decision-making. She required extensive assistance with bed mobility, transfers and toilet use. Ambulation did not occur during the assessment period. Balance was impaired in that she was only able to stabilize with human assistance for moving from a seated to standing position, moving on and off the toilet and surface to surface transfers. Impairment in functional ROM was noted on one side for the lower extremity.

A Care Area Assessment (CAA) summary for falls dated 11/11/11 indicated falls since prior assessment occurred on 10/23/11 and 10/24/11 (no injury with falls). Resident #11 was at high risk for falls based on her history of falls, impaired cognition causing a poor awareness of safety needs (dementia), impaired balance and use of psychotrophic medications (Haldol). At the time of the assessment, she was on a low bed with a fall mat and a non-slip pad had been applied to her wheelchair to help prevent further falls. She also wore a body alarm to alert staff when she attempted to transfer unassisted.

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F 323	Continued From page 35 On 6/2/12 at 6:45 AM., nursing notes revealed Resident # 11 was found on the floor lying on left side. A cut on her left eyebrow was noted. Her physician and family were notified. Resident #11 was sent to the emergency room for treatment. A Confidential Occurrence Report dated 6/2/12 at 6:45 AM. revealed Resident #11 was found on the floor lying on her left side with a noted laceration to the left eyebrow with a small amount of blood. Status before fall: no restraints in place, no side rails, call bell accessible. Resident was confused. A Post Fall Review form dated 6/2/12 indicated Resident #11 was lying in bed at the time of the fall. The fall mat was on the floor and the bed was in the low position. The Care plan was updated to reflect interventions as a result of this fall. A Quarterly Minimum Data Set (MDS) assessment dated 7/13/12 indicated Resident #11 was moderately impaired in cognition. Resident #11 had one fall without injury and one fall with injury (except major injury) since the last assessment done on 4/19/12. On 7/15/12 at 6:55 PM, nursing notes revealed Resident #11 was found sitting up on floor beside her bed. No acute injury was noted and no further treatment was indicated. A Confidential Occurrence Report dated 7/15/12 at 6:55 PM. indicated Resident #11 was found on the floor in a seated position. No injury was noted. Status before the fall was not completed.	F 323		

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A Post Fall Review report dated 7/15/12 revealed assistive devices at the time of the fall included mat on the floor. The care plan was updated.

A Care plan reviewed on 7/18/12 included a problem of potential for falls secondary to impaired mobility, history of falls, use of psychotropic medications and mood and behavior problems. The goal read Resident #11 will have no injury as a result of a fall at any time over the next review. Approaches included: "Provide a low bed with fall mat to help reduce the risk of injury from falls from the bed. Antitippers to wheelchair for safety. A non-slip pad to wheelchair "

An observation on 8/2/12 at 7:55 AM. revealed Resident #11 lying in her bed in her room. There was not a fall mat on the floor beside the bed.

On 8/2/12 at 8:00 AM., Nurse #1 went to Resident #11's room and noted that there was not a fall mat on the floor beside the bed. She stated she expected that all interventions for falls to be in place which included a fall mat to be on the floor.

On 8/2/12 at 9:49 AM., Resident #11 was observed sitting in a wheelchair in the hallway. The wheelchair did not have antitippers. There was a noon-slip pad in the wheelchair with a cloth incontinent pad on top of the non-slip pad.

On 8/2/12at 9:58AM., Nurse #1 stated the nursing assistant had placed Resident #11 in the wrong wheelchair and she should have been in the wheelchair with the antitippers. During the

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	345051	A. BUILDING _____ B. WING _____	C 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON COMMUNITY HOSPITAL SNF	500 MORVEN RD WADESBORO, NC 28170

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F 323	Continued From page 37 interview, she instructed nursing staff to take Resident #11 back to her room and put her in the correct wheelchair. On 8/2/12 at 10 AM., nursing assistant (NA) # 2 stated Resident #11 did not have her name on the wheelchair in the room. She said the other resident in the room indicated the wheelchair with the red non-slip pad was hers so she knew the other wheelchair belonged to Resident #11. During the interview, NA # 2 further stated the fall mat was not on the floor when she went in the room around 8:00 AM. On 8/2/12 at 2:13 PM., Administrative staff #2 stated she expected nursing staff to use all of the interventions for falls for Resident #11 which included the fall mat, antitippers on the wheelchair and the non-slip pad.	F 323		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	F 334 Resident#1, 5, 11, 19 were provided the necessary education and documentation was placed in the medical record. All residents and/or their responsible party were provided with the current (2011 -- 2012) Centers for Disease Control (CDC) influenza and pneumococcal vaccination education. This has been documented in each resident's medical record. A log indicating that this information was provided has been completed by the Social Worker.	

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F 334	Continued From page 38 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334	F 334 On admission and annually, the above CDC education will be provided to all residents and/or their responsible party by the Social Worker who will also document provision of this information in the resident's medical record. If the CDC immunization education is updated, all current residents and/or responsible party will receive a copy to assure changes are communicated. The Administrator or the Director of Nursing will review the immunization education portion of the New Admission Log weekly to assure that all new admissions as well as existing residents have been provided the current CDC influenza and pneumococcal vaccine education. Results of the monitoring will be shared during the monthly Quality Assurance and Process Improvement Committee for a minimum of ninety days at which time frequency of monitoring will be determined.	8/29/12

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F 334	Continued From page 39 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization before offering the immunization to 4 (Residents #1, #5, #11, #69) of 5 sampled residents. The findings include: The facility's policy and procedure for Influenza Vaccination (date of issue 8/09) was reviewed. The policy read in part " Before offering the influenza immunization, the facility will provide to each resident or the resident's legal representative education regarding the benefits and potential side effects of the immunization and assess each resident for possible medical contraindications. Documentation in the resident's medical record will include at a minimum: that the resident or legal representative was provided education regarding the benefits and potential side effects of influenza immunization." 1. Resident #1 was admitted to the facility on 07/2/1997 with multiple diagnoses including Dementia. The quarterly (MDS) Minimum Data Set assessment dated 07/05/12 indicated Resident #1 was cognitively intact.	F 334		

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F 334	Continued From page 40 Review of the Immunization Record revealed that Resident #1 had received the Influenza Vaccine on 09/26/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident prior to the immunization. On 8/2/12 at 3:05 PM., Nurse #1 stated the flu/ pneumonia vaccine information was sent out every year. She reviewed the medical records and stated she could not find any documentation in the chart that the information was sent out to the residents/ family members. On 8/2/12 at 4:30PM., Nurse #2 stated she was the Admissions Coordinator during the influenza season last year and remembered sending out the information to the families. She did not recall putting any information in the residents' records that the information had been sent. On 8/2/12 at 6:00 PM., Administrative staff #1 stated the facility had sent out the educational material about the flu/ pneumonia vaccine to the residents' families last year and had spoken to the residents' about the influenza vaccine during a Resident Council meeting but they had not recorded in the medical record that the education had been provided. 2. Resident # 5 had resided in the facility since 2004 with multiple diagnoses including Cerebrovascular Accident (CVA) and Multi-infarct Dementia. The quarterly MDS assessment dated 5/17/12 indicted Resident #1 was severely impaired in decision-making skills.	F 334		

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F 334	Continued From page 41	F 334		

Review of the Immunization Record revealed that Resident # 5 had received the Influenza Vaccine on 10/8/11. There was no evidence that education regarding benefits and potential side effects of influenza immunization was provided to the resident's family prior to the immunization.

On 8/2/12 at 3:05 PM., Nurse #1 stated the flu/ pneumonia vaccine information was sent out every year. She reviewed the medical records and stated she could not find any documentation in the chart that the information was sent out to the residents/ family members.

On 8/2/12 at 4:30PM., Nurse #2 stated she was the Admissions Coordinator during the influenza season last year and remembered sending out the information to the families. She did not recall putting any information in the residents' records that the information had been sent.

On 8/2/12 at 6:00 PM., Administrative staff #1 stated the facility had sent out the educational material about the flu/ pneumonia vaccine to the residents' families last year and had spoken to the residents' about the influenza vaccine during a Resident Council meeting but they had not recorded in the medical record that the education had been provided.

3. Resident #11 was originally admitted to the facility on 11/21/08 with multiple diagnoses including Dementia and Atypical Psychosis. The quarterly MDS assessment dated 7/13/12 indicated that Resident #11 had memory impairment and was moderately impaired in decision-making skills.

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F 334	Continued From page 42 Review of the Immunization Record revealed that Resident #11 had received the Influenza Vaccine on 9/26/11. There was no evidence that education regarding benefits and potential side effects of influenza immunization was provided to the resident ' s family prior to the immunization. On 8/2/12 at 3:05 PM., Nurse #1 stated the flu/ pneumonia vaccine information was sent out every year. She reviewed the medical records and stated she could not find any documentation in the chart that the information was sent out to the residents/ family members. On 8/2/12 at 4:30PM., Nurse #2 stated she was the Admissions Coordinator during the influenza season last year and remembered sending out the information to the families. She did not recall putting any information in the residents' records that the information had been sent. On 8/2/12 at 6:00 PM., Administrative staff #1 stated the facility had sent out the educational material about the flu/ pneumonia vaccine to the residents' families last year and had spoken to the residents' about the influenza vaccine during a Resident Council meeting but they had not recorded in the medical record that the education had been provided. 4. Resident # 69 was admitted to the facility 1/4/11 with multiple diagnoses including Dementia and Depression. The Significant change MDS assessment dated 5/10/12 indicated that Resident # 69 had short term/ long term memory impairment and was severely impaired in decision-making skills.	F 334		

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F 334	Continued From page 43 Review of the Immunization Record revealed that Resident # 69 had received the Influenza Vaccine on 10/8/11. There was no evidence that education regarding benefits and potential side effects of influenza immunization was provided to the resident's family prior to the immunization. On 8/2/12 at 3:05 PM., Nurse #1 stated the flu/ pneumonia vaccine information was sent out every year. She reviewed the medical records and stated she could not find any documentation in the chart that the information was sent out to the residents/ family members. On 8/2/12 at 4:30PM., Nurse #2 stated she was the Admissions Coordinator during the influenza season last year and remembered sending out the information to the families. She did not recall putting any information in the residents' records that the information had been sent. On 8/2/12 at 6:00 PM., Administrative staff #1 stated the facility had sent out the educational material about the flu/ pneumonia vaccine to the residents' families last year and had spoken to the residents' about the influenza vaccine during a Resident Council meeting but they had not recorded in the medical record that the education had been provided.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356	F 356 The nursing staffing posted at the time of the survey was modified to reflect the appropriate levels. Correct nursing staffing will be posted on a daily basis.	

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F 356	Continued From page 44 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post accurate data on the daily staff posting by including supervisory nursing staff. The findings included: During the initial tour of the facility on 7/30/12 at 11:30 AM, the staff posting was observed to include 2 RNs (registered nurses) and 4 LPNs (licensed practical nurses) for the 7/30/12 7-3 shift. The facility was observed to have 4 nursing units. Interviews conducted with the LPNs	F 356	F 356 A review of current administrative nursing responsibilities was conducted and those that are "directly responsible for resident care" are well defined. The RN Supervisor will on a daily basis monitor the nursing staffing posting to assure accuracy and completeness. Results of this monitoring will be shared with the facility Quality Assurance/Process Improvement Committee monthly for a minimum of ninety days at which time frequency of monitoring will be determined.	8/29/12

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F 356	Continued From page 45 revealed that each of them was responsible for a nursing unit. On 8/2/12 at 12 PM, the staff posting was observed to include 3 RNs and 5 LPNs for the 7-3 shift. During an interview on 8/2/12 at 12:15 PM, Administrative Staff #1 indicated that the RNs on the posting were supervisors but were included on the staff posting because they spent some of their time helping with intravenous lines, assessments and dressings as needed throughout the day. Administrative Staff #1 acknowledged that the RN supervisors did not have direct resident care assignments.	F 356		
F 371 SS=D	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 observation, staff interview and facility policy review, the facility failed to discard outdated milk and juice in 2 of 4 nourishment refrigerators (Unit 1-Sunflower Hall and Unit 4 -Rose Hall). The findings include:	F 371	F 371 All containers of expired milk and juice were removed from the (2) refrigerators and discarded. The Certified Dietary Manager inspected the nourishment refrigerators to assure all items were within expiration dates. Staff will check all nourishment refrigerators twice weekly and will on each occasion assure that items in the refrigerator as well as items being delivered are within expiration date.	

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F 371	Continued From page 46 A facility policy entitled "Resident Food Services/Unit Pantry Stock" revised10/09 read in part, "Discard items as follows:" "Milk: if opened >4 days or the manufacturer expiration date has passed (whichever comes first)." Observation of the Unit 1 nourishment refrigerator on 8/2/12 at 4:46 PM and on 8/3/12 at 9:53 AM revealed 1 unopened single serve cup of prune juice with an expiration date of 7/12/12 and 1 unopened single serve cup of orange juice with an expiration date of 7/31/12. Observation of the Unit 4 (Rose Lane) nourishment refrigerator on 8/3/12 at 10:02 AM revealed 4 unopened single serve milk cartons and 1 unopened single serve cup of orange juice, all with expiration dates of 7/31/12. During an interview on 8/3/12 at 10:02 AM, the Dietary Manager indicated that it was the responsibility of the dietary department to discard outdated items from the nourishment refrigerator and the expired milks and juices should have been discarded.	F 371	F 371 The dietary supervisor will audit the refrigerators after each is stocked to assure all items are within dates. Results of the monitoring will be shared with the Administrator and shared with the Quality Assurance and Process Improvement Committee on a monthly basis for 90 days at which time frequency of continued monitoring will be determined.	8/29/12
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	F 428 The pharmacy recommendation for Resident #14 were reviewed and a response was provided by the attending physician. All residents have the potential to be affected by this deficient practice. The pharmacy recommendations for June, July and August 2012 have been reviewed to assure that all recommendations have been addressed by the physician.	

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F 428	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow up on the consultant pharmacist's recommendation for the physician for 1 of 10 residents (Resident #14). The findings included: Resident #14 was admitted to the facilty on 3/4/11. Diagnoses included old cerebrovascular accident, severe dementia, cachexia, anemia and vitamin D deficiency. Resident #14's physician orders included calcitriol (a drug used for management of hypocalcemia) 0.5 mcg (microgram) daily with a start date of 3/29/12. The consultant pharmacist drug regimen review dated 6/21/12 included a recommendation to decrease the calcitriol to 0.25 mcg daily to avoid hypercalcemia. Record review revealed no documented response to the consultant pharmacist's recommendation. A drug regimen review dated 7/17/12, written by one of the hospital pharmacists, included "monitor labs, follow calcium level". During an interview on 8/1/12 at 3:10 PM, Nurse #4 indicated that the Consultant Pharmacist either faxed the physician directly with recommendations or gave the recommendations to the hospital pharmacist to fax to the physician. Nurse #4 stated that the facility did not know what	F 428	F 428 The pharmacy, at the time the recommendations are completed, will fax a copy to the physician's office as well as provide copies to the Director of Nursing and the RN supervisor to assure follow-up with in a month. The RN Supervisor will on a daily basis monitor compliance to assure that physician response is timely. Dependent on the extent of the recommendation, the supervisor will follow-up with the physician as appropriate.	8/29/12

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F 428	Continued From page 48 recommendations were made to the physician until the physician faxed the facility with a response. During an interview on 8/3/12 at 12:10 PM, the hospital pharmacist who wrote the 7/17/12 review indicated that the Consultant Pharmacist put recommendations in a manilla envelope at the facility for the hospital pharmacist to pick up and fax to the physician. No tracking was done to ensure the physician responded to the recommendation. The pharmacist stated that if the physician did not respond to a recommendation in a couple of months a second recommendation would be issued.	F 428		

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	345051	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/30/2012

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(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
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is considered two buildings, the older portion and a newer addition with building one Type V protected construction. Building one is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000		
K 029 SS=E	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 19.3.5.4 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 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/30/2012 the following item was observed as noncompliant, specific findings include: The boiler room in building one on the first floor has an unsealed penetration in the rated ceiling at a pipe support attached to the steel support above the rated ceiling. This support has	K 029	Pipe support attached above rated ceiling assembly had moved, causing damage to rated ceiling. Pipe support was re-attached to structure and adjusted to carry weight of pipe. Ceiling was repaired to restore rating. 8/31/2012 Building was surveyed to identify other damage from what is suspected to be result of minor earthquake tremor. 8/31/2012 Monthly facility safety inspection rounds have been modified to include inspection of supports extending through rated ceilings and semi-annual safety surveillance rounds will include inspecting exterior of structure for foundation damage. 9/12/2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Louis Segars RN — Administrator — 9/12/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON COMMUNITY HOSPITAL SNF	500 MORVEN RD WADESBORO, NC 28170

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K 029	Continued From page 1 moved and damaged the rated ceiling in that space. CFR#: 42 CFR 483.70 (a)	K 029		