DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345370 | A. BUILDING _____ B. WING _____ | C 07/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINEHURST HEALTHCARE & REHAB | 300 BLAKE BOULEVARD PINEHURST, NC 28374 |

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| F 000 | INITIAL COMMENTS | F 000 | | |

The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification and complaint investigation survey on 06/26/12 through 06/29/12 and from 07/10/12 through 07/12/12. It was determined the facility had provided substandard quality of care at the immediate jeopardy level. An extended survey was conducted on 07/10/12 through 7/12/12 and an exit conference was held with the facility on 07/12/12. The Immediate Jeopardy began on 05/27/12 and was removed on 07/12/12.

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|---|---|---|---|---|
| F 156 SS=C | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES | F 156 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | [signature] | 8/22/2012 |

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 | F 156 | | |

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:
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

F 156 STANDARD DISCLAIMER:
This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).

The liability notices for Resident #'s 29, 72, and 112 have been re-generated to include the reasons for the notices of non-coverage. Additionally, the State Agency's contact information has been relocated to a more visible area of the facility-more accessible to visitors and/or residents.

For those residents having the potential to be affected by the same alleged deficient practice, the facility Business Office Manager shall ensure that the date when the letter is generated is displayed properly on the form. Additionally, the Business Office Manager has been in-serviced by the Administrator on 8/3/12 on the proper language to be included related to the termination of the Medicare covered service (e.g. beneficiary has met their maximum rehabilitation potential, etc.)

The Administrator shall monitor for compliance by reviewing all Medicare Non-Coverage letters prior to there being posted for one month and quarterly thereafter to ensure the accuracy of the form, the findings will be documented by obtaining a copy of the Medicare Non-Coverage letter. 8/16/12

The Administrator shall report any inconsistencies in accuracy to the QA committee monthly for three months and quarterly thereafter.

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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 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 list the date the liability notices were generated and failed to list the reasons for 3 of 3 residents (Residents # 29, #72 and #112) who received letters for Medicare Non-Coverage; as well as failed to post State Agency contact

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| F 156 | Continued From page 3 | F 156 | | |

information, in a prominent location.

The findings include:

1. A record review was conducted in the business office. It revealed that Resident #29 was issued a letter of Medicare Non-Coverage, which stated that therapy services would end on 2/27/12. The reason for the termination of services was not listed and the date the letter was generated was not on the form. The responsible party for Resident #29 signed receipt of the letter on 2/23/12.

On 6/29/12 at 4:00 pm, the Business Office Manager was interviewed. She indicated that she started handling the liability notices in April, 2012. She stated that she was trained by the previous Administrator and the MDS Coordinator (who previously performed this task) on the process but was unaware that she needed to place a date on the form, when she contacted the resident or responsible party. She also shared that ordinarily she doesn't list the reason the service ended unless the resident has refused therapy.

2. A record review was conducted in the business office. It revealed that Resident #72 was issued a letter of Medicare Non-Coverage, which stated that therapy services would end on 6/7/12. The reason for the termination of services was not listed and the date the letter was generated was not on the form. The responsible party for Resident #72 signed receipt of the letter on 6/5/12.

On 6/29/12 at 4:00 pm, the Business Office

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Manager was interviewed. She indicated that she started handling the liability notices in April, 2012. She stated that she was trained by the previous Administrator and the MDS Coordinator (who previously performed this task) on the process but was unaware that she needed to place a date on the form, when she contacted the resident or responsible party. She also shared that ordinarily she doesn't list the reason the service ended unless the resident has refused therapy.

3. A record review was conducted in the business office. It revealed that Resident #112 was issued a letter of Medicare Non-Coverage, which stated that therapy services the letter was generated was not on the form. The responsible party for Resident #112 signed receipt of the letter on 3/13/12.

On 6/29/12 at 4:00 pm, the Business Office Manager was interviewed. She indicated that she started handling the liability notices in April, 2012. She stated that she was trained by the previous Administrator and the MDS Coordinator (who previously performed this task) on the process but was unaware that she needed to place a date on the form, when she contacted the resident or responsible party. She also shared that ordinarily she doesn' t list the reason the service ended unless the resident has refused therapy.

4. On 6/27/12 at 9:55 am, during a follow up tour of the 500 hall, it was noted that a large bulletin board, that contained State Agency contact information, was isolated on an alcove on the 500 hall. The location was behind the nurse ' s station and near an alarmed emergency door that was not used by visitors.

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The Director of Nursing was interviewed on 6/27/12 at 11:30 am. She stated that she did not know why the bulletin board was placed at this location, but would share the concern with the Administrator.

On 6/28/12, at 8:00 am, the State Agency contact information was prominently displayed on a large bulletin, on a main hallway, near the lobby, dining and activities rooms.

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES — F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to implement their abuse policy by not conducting criminal background check for 2 of 5 new employees (NA #7 and Nurse #7); prior to their start dates.

The findings include:

The facility ' s "Employee Screening & Training Policy" , dated September, 2011, which was contained within their Abuse Policy, was reviewed. It read that " This facility will not knowingly hire any individual who has a history of abusing other persons. The Personnel Director, or other person designated by the Administrator, will conduct employment background checks and

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| F 226 | Continued From page 6<br>/or reference checks and criminal checks (including fingerprinting as required by state law). Such investigations will be initiated at the time of employment or offer of employment and shall be documented in the applicant ' s employment file. "<br><br>1. A record review was conducted of new employee files. It revealed on 4/19/12, Nurse Aide #7 (NA #7) was hired. She previously worked for the facility from May, 2011 until November, 2011. Her employee file contained a new request for a criminal background check that was dated on 6/28/12.<br><br>On 6/29/12 at 2:33 pm, the Personnel Manager was interviewed. She stated that her assistant audits all personnel charts, two weeks from the date of hire and on a quarterly basis as well. However, they did not realize that NA #7 ' s background check was not performed until a request to review her file was requested on 6/28/12. At that time, they issued a request to investigate her background.<br><br>2. A record review was conducted of new employee files. It revealed that on 2/16/12, Nurse #7 was hired, as a Registered Nurse. It revealed that a criminal background check request was made on 2/21/12.<br><br>On 6/29/12 at 2:33 pm, the Personnel Manager was interviewed. She stated that her assistant audits all personnel charts, two weeks from the date of hire and on a quarterly basis as well. However, she acknowledged that they made the request to investigate Nurse #7 ' s background late. | F 226 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>For those residents having the potential to be affected by the same alleged deficient practice, the Personnel Manager shall ensure that background checks are initiated upon acceptance of employment and that background checks are obtained before the start of employment. In addition, the Personnel Manager will ensure that national background checks are obtained for any employee who has lived in North Carolina for less than five consecutive years. All employee files were audited (beginning on 7/30/12 and completed by 8/6/12) to ensure statewide and/or national background checks have been obtained.<br><br>The Personnel Manager shall monitor for compliance by auditing all new hire records prior to the beginning of employment. The Personnel Manager will document any inconsistencies and report them to the Administrator.<br><br>The Administrator shall report any inconsistencies in accuracy to the QA committee monthly for three months and quarterly thereafter. | 08/16/12 |
| F 274 | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS | F 274 | | |

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SS=D AFTER SIGNIFICANT CHANGE

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to identify a significant decline in 2 of 2 residents.

Findings include:

1. Resident # 135 was admitted 2/5/12 with diagnosis of osteoarthritis, hypertension and Hypothyroidism.

The Minimum Data Set (MDS) dated 2/17/12 stated that resident # 135 required limited to extensive assist for Activates of Daily Living (ADL ' s) and she was occasionally incontinent of bladder and bowel (B/B). She was noted to be cognitively intact with some noted confusion.

A review of resident # 135 ' s nursing notes

STANDARD DISCLAIMER:

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Resident # 135 discharged on 6/17/12 and Resident # 44 discharged on 6/19/12. They are no longer residents of the facility.

For those residents having the potential to be affected by the same alleged deficient practice, the MDS Coordinator will audit all records of residents in-house using the Significant Change in Condition Screening Form, which prompts the MDS Coordinator to consider a number of factors, pursuant to the RAI Manual, to determine whether a resident's current condition would necessitate a significant change assessment or not. The Corporate Nurse Consultant in-serviced the MDS Coordinator on the proper use of the Significant Change in Assessment Form on 8/14/12. All licensed and non-licensed staff were in serviced on 8/8/12, 8/10/12, 8/13/12, and 8/14/12 on the recognizing a clinical change(s) in a resident's condition and reporting the noted change(s) accordingly. 8/16/12

The MDS Coordinator shall monitor for compliance by auditing 25% of resident MDS's monthly for 3 months and quarterly thereafter using the Significant Change in Condition Screening Form. The MDS Coordinator shall be audited by the Corporate Nurse Consultant quarterly to ensure the completed MDS's meet the current RAI requirements, specifically whether or not a significant change in condition assessment is required. (con't)

(con't)

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| F 274 | Continued From page 8 | F 274 | The audits will be documented in the Corporate Nurse Consultant's quarterly facility visit report and results of the audit shall be communicated to the Administrator for remediation.<br><br>The MDS Coordinator shall report any inconsistencies in accuracy to the QA committee monthly for three months and quarterly thereafter. | |

revealed a fall on 2/10/12 with no injuries and increased confusion with agitation on 2/19/12. She was started on an antibiotic on 2/22/12 for a Urinary Tract Infection (UTI).

A nursing note dated 2/24/12 states resident #135 was continent of B/B with incontinent episodes.

A nursing note dated 2/27/12 stated that resident #135 was up in wheelchair most of the day and she was continent of B/B.

On 2/28/12 in a nursing note it sated the resident complained of her bilateral heels hurting. Resident #135 ' s heels were floated on pillowed because resident refused to wear padded boots. She was given Tylenol 325mg x 2 given for the pain.

On 3/21/12, there was an order for Tramadol 50mg one by mouth every 6 hours as needed for pain.

On 4/1/12, a nursing noted stated resident #135 complained of her arm hurting and Tramadol given. Her feet were placed on a pillow because resident #135 refused to wear her padded bootie.

On 4/3/12 a dietary note stated he spoke with resident #135 ' s responsible party (RP) regarding weight loss and that Health shakes were order twice each day along with and Med pass 4 ounces by mouth 4 times each day.

On 4/13/12 the Dietitian recommended magic cups at lunch and dinner with an appetite stimulant. But there were no new orders given by the doctor.

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On 5/26/12 a nursing note stated resident #135 had and IV in left arm. She took her medications without difficulty and ate 8 ounces applesauce for dinner with 4 ounces of water. Her vital signs were B/P 118/70,Temprature 97.5,Pulse 68, Respiration 18. She had no complaints of pain.

On 5/27/12 1030pm nursing note stated her IV to her left forearm was running 1/2 D5W at 50cc/hr. A Note written per Dr. Patrick also stated no distress noted and he would continue to monitor.

The Minimum Data Set (MDS) dated 5/30/12 describes resident as severely cognitively impaired, total care of all ADL's, and frequently incontinent of B/B.

On 6/16/12 a nursing note stated resident #135 ' s chest x-ray had a very slight right lobe atelectasis and the Dr. Patrick was aware. He gave orders for Vital signs every shift x 10 days.

On 6/17/12 a nursing note stated O2 stats 76 on room air, Temperature 100.6, BP 112/70, Respirations 16. Oxygen 2l/min with Nasal cannula in place and Morphine 15m was given under the tongue because unable to swallow. Tylenol suppository was given and the RP was made aware.

On 6/17/12 at 1:15am nursing note stated resident #1315 was unresponsive and pronounced according to policy. Dr. Patrick notified and the body released to funeral home.

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On 6/29/12 at 7:30pm in an interview with the DON was conducted. She is unable to recall any conversation with resident #135 ' s daughter regarding any concerns about her mother.

On 6/29/12 at 8:00pm, in an interview with the Minimum Data Set Nurse stated there was a big decline in her functional status and she should have done a significant change MDS in May.
2. Resident # 44 was originally admitted to the facility 9/29/11 and readmitted 4/30/12 following a hospitalization for a fractured left hip. Cumulative diagnoses included: Diabetes Mellitus, Hypertension and severe Coronary Artery Disease.

A Quarterly Minimum Data Set (MDS) dated 10/7/11 indicated Resident #44 was cognitively intact. She was independent with bed mobility, transfers, ambulation in the room, locomotion on and off the unit. Limited assistance was required for ambulation in the corridor, dressing, toilet use, personal hygiene and bathing.

A Quarterly MDS dated 6/6/12 indicated Resident #44 was cognitively intact. She required extensive assistance with bed mobility, transfers, ambulation in the room and corridor. Total assistance was required for locomotion on and off the unit. Extensive assistance was needed for dressing, personal hygiene and bathing. Total assistance was required for toilet use.

Based on the two quarterly assessments, Resident #44 had declined in eight (8) areas of ADL's (activities of daily living)--bed mobility, transfers, ambulation in the room and corridor, locomotion on and off the unit, dressing, toilet

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| F 274 | Continued From page 12<br>use, personal hygiene and bathing.<br><br>On 7/11/12 at 4:56 PM., the MDS Coordinator stated she thought Resident #44 would resume her independence with ADL's. When asked regarding the quarterly MDS completed in 6/6/12, she indicated she should have completed a significant change in status Minimum Data Set (MDS). | F 274 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review the facility failed to care plan pain | F 279 | | |

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management regimen for 1 of 3 residents (Resident # 163).

Resident # 163 was admitted on 4/27/12 with diagnosis including lumbar fracture and chronic pulmonary heart disease

The Admission Minimum Data Set (MDS) assessment dated 5/14/12 revealed Resident #163 was cognitively intact. The MDS resident interview for pain revealed Resident #163 indicated she had pain on occasion that she rated as a 5 on a 0 - 10 scale with 0 being no pain.

Review of the Care Plan dated 5/14/12 revealed there was no care plan for pain management.

Interview with the Resident #163 on 6/27/12 at 9:19 AM revealed she had severe pain from a fracture in her lumbar spine. She stated that she was on medication for pain that helped but then the pain would come back. Resident #163 also indicated that she was frustrated that the pain had not seemed to improve since her injury but that she did have a back brace that helped provide support while walking. Review of the care plan note dated 5/14/12 revealed Resident # 163 was present at the meeting and complained of frequent pain. The action indicated in the note was " will check into ultram (analgesic medication for pain management) schedule. "

Interview with the MDS Coordinator on 6/29/12 at 7 pm revealed pain did not trigger as a care area for Resident #163 ' s care plan because the Resident rated her pain as a 5 on the 0 - 10 scale during the Admission MDS assessment, and only ratings over 5 triggered the pain management

F 279

F 279

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The pain management regimen for Resident # 163 has been re-evaluated by the resident's attending physician and resident's pain management regimen was changed on 7/10/12.

For those residents having the potential to be affected by the same alleged deficient practice, the Interdisciplinary Team (MDS Coordinator, Social Worker, Dining Services' Manager, and Activities Director) has been in-serviced on 7/11/12 on the importance of addressing resident's and/or their legal representative's care concerns in a timely and professionally responsible fashion. 08/16/2012

During the reassessment process, no other residents were identified has having voiced concerns for which the facility has failed to address. All residents were considered to have had the potential to be affected by the same alleged deficient practice. The Director of Nursing, Clinical Coordinator, and/or MDS Coordinator shall monitor for compliance by reassessing all resident's current pain regimen to assess the effectiveness of the current pain management regimen. The pain management regimen shall be assessed for effectiveness by completing a Pain Assessment no less than quarterly. In the interim, licensed nurses shall document the effectiveness of the pain regimen in the resident's nurses' notes and/or on the (con't) (con't)

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care area for care planning. She also stated that if a resident had pain management concerns after the MDS was completed it would be up to nursing staff to initiate pain management on the resident ' s care plan. The MDS coordinator said that after each care plan meeting she reported anything that needed follow-up by nursing verbally to the nursing staff however she could not recall who she had talked to about Resident # 163 ' s pain.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on resident and staff interviews and record review the facility failed to assess the effectiveness of the pain management regimen for 1 of 3 residents (Resident # 163).

Resident # 163 was admitted on 4/27/12 with diagnosis including lumbar fracture and chronic pulmonary heart disease

The Admission Minimum Data Set (MDS) assessment dated 5/14/12 revealed Resident #163 was cognitively intact. The MDS resident interview for pain revealed Resident #163 indicated she had pain on occasion that she rated as a 5 on a 0 - 10 scale with 0 being no pain.

F 279 resident's Medication Administration Record. The MDS Coordinator shall ensure that those residents triggering for pain, pursuant to the RAI process, shall be care planned accordingly. Furthermore, the MDS Coordinator shall ensure those residents triggering for pain are care planned accordingly and that the care plans reflect the current interventions.

The Director of Nursing, Clinical Coordinator, and/or MDS Coordinator shall complete the Pain Management Critical Element Tool (a quality assurance document used to ensure those residents triggering for pain on the MDS are care planned accordingly) for 25% of residents in-house triggering for pain monthly for 3 months and quarterly thereafter, and will report any inconsistencies in accuracy to the QA committee monthly.

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Review of the Care Plan dated 5/14/12 revealed there was no care plan for pain management.

Review of the Physician ' s Order summary for 6/1/12 - 6/30/12 revealed an order dated 4/27/12 for Acetominophen (an analgesic for pain management) 325 mg (milligrams) 2 tablets every 4 hours as needed.

Review of the Physician ' s Order summary for 6/1/12 - 6/30/12 revealed an order dated 5/10/12 for Tramadol (Generic for Ultram, an analgesic for pain management) 50 mg, 1 tablet every 6 hours as needed.

Interview with the Resident #163 on 6/27/12 at 9:19 AM revealed she had severe pain from a fracture in her lumbar spine. She stated that she was on medication for pain that helped but then the pain would come back. Resident #163 also indicated that she was frustrated that the pain had not seemed to improve since her injury but that she did have a back brace that helped provide support while walking.

Review of the care plan note dated 5/14/12 revealed Resident # 163 was present at the meeting and complained of frequent pain. The action indicated in the note was " will check into ultram (analgesic medication for pain management) schedule. " Review of the Physician ' s Telephone Orders and medical record from 5/14/12 to 6/29/12 revealed no orders for scheduled Ultram, no further pain assessment or pain management review and almost daily use of prn Tylenol and/or Ultram. There was an order dated 6/26/12 for a spinal

F 309 F 309

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The pain management regimen for Resident # 163 has been re-evaluated by the resident's attending physician and resident's pain management regimen was changed on 7/10/12.

For those residents having the potential to be affected by the same alleged deficient practice, the Corporate Nurse Consultant in serviced Interdisciplinary Team (MDS Coordinator, Social Worker, Dining Services Manager, and Activities Director) on 7/11/12 on the importance of addressing resident's and/or their legal representative's care concerns in a timely and professionally responsible fashion.

The Director of Nursing, Clinical Coordinator, and/or MDS Coordinator shall monitor for compliance by assessing/reassessing each resident for unaddressed pain. The pain management regimen shall be assessed for effectiveness by completing a Pain Assessment no less than quarterly. In the interim, licensed nurses shall document the effectiveness of the pain regimen in the resident's nurses' notes and/or on the resident's Medication Administration Record.

The Director of Nursing, Clinical Coordinator, and/or MDS Coordinator shall complete the Pain Management Critical Element Tool (a quality assurance
(con't)

8/16/12

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x-ray for lumbar pain.

Interview with the MDS Coordinator on 6/29/12 at 7 pm revealed that she was present at the 6/14/12 Care Plan meeting and wrote the note about the meeting. She stated that after each care plan meeting she reports anything that needs follow-up by nursing verbally to the nursing staff however she could not recall who she had talked to about Resident # 163 ' s pain.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
SS=J

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews, physician interviews, family interview, medical record review, and observation, the facility failed to identify and implement interventions for one (1) of six (6) residents (Resident # 6) reviewed who developed pressure ulcers. The facility also failed to provide an air mattress and timely Wound Care Clinic referral for one (1) of (6) residents (Resident # 179) to prevent worsening of a pressure ulcer.

The immediate jeopardy (IJ) for Resident # 6 in Example #1 began on May 27, 2012. The

F 309 (con't)
document used to ensure those residents triggering for pain on the MDS are care planned accordingly) for 25% of residents in-house triggering for pain monthly for 3 months. and quarterly thereafter, and will report any inconsistencies in accuracy to the QA committee monthly. The results of the audit(s) shall be documented on the Critical Element Tool for Pain.

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administrator was notified of the immediate jeopardy (IJ) on July 10, 2012 at 8:40am. The IJ was removed on July 12, 2012 at 4:30pm when the facility demonstrated they had implemented their credible allegation of compliance. 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 ongoing in-servicing and monitoring to be accomplished. Example #2 (Resident #179) was cited at a scope and severity of (D) which constituted no actual harm with the potential for more than minimal harm that is not IJ.

Findings include:

1. Resident #6 was admitted 6/16/08 with diagnoses of stroke with right side late effect hemiplegia, coronary artery disease and peripheral vascular disease.

On 2/15/12, a Pressure Ulcer Risk Evaluation Form rated the resident at high risk for the development of a pressure ulcer.

On 4/10/12, a Renal Function Panel was done and revealed all labs within normal limits except for the Resident calcium was 8.2 (normal is between 8.9 and 10.3). His albumin was 3.0 with normal ranges 3.5 to 5.0.

On 5/10/12, Resident #6 was evaluated to be at high risk for the development of a pressure ulcer on his Pressure Ulcer Risk Evaluation Form.

The Annual Minimum Data Set (MDS) dated 5/14/12 for Resident #6 stated he was cognitively

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intact. This MDS further revealed the following: Resident #6 had unclear speech, but could make himself understood and understood others. He required extensive to total staff assistance with care except for eating in which he was coded as independent. He was coded as being able to move from a seated to a standing position with staff help and to move from one surface to another with staff help. There was no coding regarding any shortness or breath or edema. The annual MDS also indicated that the resident did not have 6 months or less to live as of 5/14/12. His skin assessment on the annual MDS dated 5/14/12 coded him at risk for pressure ulcers but there were no pressure ulcers noted and there was no documented history of healed pressure ulcers. The resident was not coded for the use of a Geri-chair. Resident #6 did trigger for weight loss and for pressure ulcers at this time. Resident #6 had a Care Area Assessment for pressure ulcers related to impaired mobility, incontinence and weight loss. His nutritional status Care Assessment Area triggered. It was noted that Resident #6 has had some weight loss due to illness, but was expected to return to previous level.

On 5/22/12, the physician ordered Resident #6 Cipro (antibiotic) for suspected cellulitis to the right lower extremity with 4+ pitting edema. A review of nursing notes stated, Resident #6 was encouraged to stay in bed or to sit in a Geri-chair in order to elevate his lower extremities due to edema. In addition, a physician progress note dated 5/23/12 indicated that an appointment was made for him at the wound clinic for 6/5/12 for his right lower extremity vascular ulcer.

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8/16/12

Resident # 6 discharged on 7/24/12 and Resident # 179 discharged on 9/8/11 and are no longer residents of the facility.

For those residents having the potential to be affected by the same alleged deficient practice, all licensed and certified nursing staff has been in-serviced on pressure ulcer prevention and care by an outside wound care expert. Upon evaluation by the consulting dietician, the recommendations shall be communicated to the Director of Nursing. The Director of Nursing shall ensure the attending physician is consulted regarding the orders by either telephone and/or fax and shall ensure the orders are carried out timely (e.g. within 48 hours of the recommendation's being made). The Clinical Coordinator shall audit all the consulting dietician's recommendations to ensure they have been carried out timely. Upon identification of the proper positioning, using the appropriate device and/or chair, the licensed therapists shall instruct the nursing staff, inclusive of licensed and certified nursing staff on the proper devices and/or devices to be used for proper positioning. In addition, all nursing staff will be in-serviced on proper positioning to prevent, identify, and care for Pressure Ulcers on July 11, 2012. The Director of Nursing and/or her designee shall audit all orders daily for 1 week, weekly for 8 weeks, and monthly thereafter

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| F 314 | Continued From page 19<br>On 5/27/12, a nursing note stated Resident #6 was up in a wheelchair self propelling around with the right foot up on a foot rest.<br><br>The first documentation of an area to the right buttock was in a weekly skin assessment dated 5/27/12 and it was described as a red area. There was no documentation in the medical record of any treatment initiated for the red area.<br><br>On 5/29/12, a nursing note stated that the resident was up in a wheelchair and staff was unable to put him in the Geri-chair because the Responsible Party did not want him to be in it. It was noted that the Responsible Party stated several times the day before that she wanted the resident to move about.<br><br>The first physician orders for wound care were dated 6/1/12 which stated "cleanse right buttocks near rectum with normal saline (NS) to open area, apply Triple Antibiotic Ointment (TAO) and Flexicol (a bordered foam dressing) until resolved daily."<br><br>A wound clinic note dated 6/5/12 read that the gluteus ulcer measured 1.5 centimeters (cm) x 2.0 cm x 0.1 cm and was characterized as an improving stage 2 (partial thickness skin loss involving the epidermis, dermis or both). There were new wound care orders for Aquacel AG and foam dressing. It was to be changed daily with follow up again on 6/19/12. The doctor also ordered an alternating pressure mattress for bed on 6/5/12 by writing a prescription for the facility to order it.<br><br>On 6/6/12 a nursing note stated Resident #6 sat | F 314 | to ensure orders are properly communicated to the appropriate personnel and implemented timely. For those residents having the potential to be affected by the same alleged deficient practice, all residents' skin has been assessed/re-assessed by a Corporate Nurse Consultant on July 11, 2012. Residents were assessed/re-assessed using a visual assessment process whereby each resident's skin (from head to toe) was assessed individually, using the facility's Wound Care Policy, the guidance found at F314, and the Weekly Skin Assessment Form. Assessments/Re-assessments were completed to ensure 1) the current condition of the residents' skin and to ensure appropriate measures (e.g. pressure relieving devices, air overlays, etc.) are in place to prevent pressure sores (if resident is assessed as being high-risk) and 2) the current condition of any existing wounds or pressure related areas to ensure accurate assessment and documentation. The admission skin assessment and risk assessment is done on every admission and re-admission. In addition, the Pressure Ulcer Risk evaluation is to be done quarterly thereafter.<br>Additionally, the facility made changes to its wound care personnel on June 20, 2012 and has begun training a new Wound Care Nurse using outside consultant(s) as the trainer. The training is multi-faceted and includes, but is not limited to, assessing the wound(s), measuring/monitoring for signs/symptoms of healing or further deterioration; family and physician notification; staging, relevant types of treatments for particular types of wounds, preventative measures, and potential pressure relieving dressings and/or devices, etc. In addition to her more than 11 years of nursing experience, the Wound Care Nurse received the essential training, as determined by the Corporate Nurse | |

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in a Geri-chair today and that both legs and feet were swollen.

On 6/6/12 resident #6 had a General Chemistry Profile done which revealed all his lab results were within normal limits except his calcium was 8.5 (normal ranges between 8.9 to 10.3).The resident was started on Calcium 600mg with vitamin D by mouth twice daily. His Albumin was 3.0 with normal ranges between 3.5 to 5.0. Also his Alkaline Phosphatase, which is a measure of liver function, was low at 49 with normal ranges between 65 to 126. His Alkaline Aminotransferase, which is also a measure of the liver's function, was 13 with normal ranges between 17 to 63.

A review of the invoice from the durable medical equipment supplier revealed the alternating air mattress was ordered on 6/7/12 and was delivered on 6/8/12.

On 6/9/12, a review of the weekly skin assessment sheet stated the right gluteus measured 3.0 cm x 1.8 cm x 0.1 cm and was absent of odor. There was yellowish brown drainage and the tissue appeared pink to yellow.

Resident #6's care plan, dated 6/9/12, included a problem related to the resident's impaired skin integrity with stasis ulcers and pressure ulcer. Interventions included to reposition frequently, measure wound weekly, report any decline to the doctor, administer treatments, assess for pain during dressing change and administer pain medication as needed. On 6/20/12, a new intervention was added to the care plan to use the alternating air pressure mattress to bed and

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Consultant, necessary to provide wound care in accordance with the facility's policy(ies) and the applicable rules and regulations (e.g. F314). Such training was completed on July 2, 2012. Access to the Wound Consultant(s) is available in-person, via telephone, and on a 24-hour call basis. The Wound Care Nurse shall have the primary responsibility for the assessment and re-assessment of all wounds. Additionally, the Wound Care Nurse shall ensure compliance with MD/Responsibility Party notification(s). In the event a wound does not show improvement; the Wound Nurse will consult with the residents' attending physician to determine any treatment regimen changes including outside consultations. In the event the Wound Care Nurse is out of the building, the Director of Nursing, Clinical Coordinator, and/or RN Supervisor shall ensure wound care is provided according to the facility's policy and procedure and according to facility practice. The Director of Nursing and/or RN Supervisor shall monitor the Wound Care Nurse to ensure timeliness of assessments. The Pressure Ulcer Critical Element (a quality assurance tool which assists the facility in ascertaining whether a resident's pressure ulcer development and/or treatment meets the Federal compliance criteria) shall serve as a check/balance to ensure assessments are completed as required or as necessary.
The care plans have been reviewed to ensure that they reflect the needs of the resident. All residents have been reassessed to determine their risk for pressure sore development as of July 11, 2012. Those residents identified as being "high risk" based on the "Risk Assessment for Pressure Sores" shall have their skin integrity assessed weekly by the Wound Care Nurse. Similarly, residents' risk for development of pressure sores shall be assessed upon admission and/re-admission according to the facility's Pressure Sore Risk Assessment Policy.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345370 | A. BUILDING _____ B. WING _____ | C 07/12/2012 |

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| PINEHURST HEALTHCARE & REHAB | 300 BLAKE BOULEVARD PINEHURST, NC 28374 |

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| F 314 | Continued From page 21<br>check for inflation every shift.<br><br>On 6/10/12, a nursing note stated Resident #6 was placed in a Geri-chair yesterday and today. He refused to lean back so legs could be elevated. The Responsible Party was made aware of concerns regarding swelling.<br><br>On 6/11/12 a nursing note stated Resident #6 wanted to get in the wheelchair but he was encouraged to get in the Geri-chair with legs elevated. He agreed to do so.<br><br>On 6/15/11 a care plan was added regarding the resident risk for pressure ulcers related to his immobility, history of right sided weakness and incontinence. Interventions included weekly skin checks, to report rashes, redness, open areas or irritation. Further interventions were to initiate treatment per facility protocol, monitor lower legs for swelling, compression stockings on during the day and to be removed at night, prompt incontinence care with barrier cream, frequent reposition and a cushion in place to his wheel chair with date of 6/5/12.<br><br>On 6/15/12, a nursing note stated resident #6 had an order for an alternating air mattress designed to offload pressure to areas susceptible to skin breakdown. It continued to beep and was defective. It was removed from bed and sent back to get a replacement. Resident #6's previous pressure guard mattress was put back on his bed until new alternating mattress arrived. The company manufacturing the pressure guard mattress indicated the use was for the prevention and treatment of pressure ulcers. The resident's responsible party was made aware. | F 314 | Any resident identified as being high-risk for the development of pressure sores shall be assessed by the Wound Nurse and assessment shall be documented on the Weekly Skin Condition Report. Treatments are carried out in accordance with the facility's standing orders pursuant to the facility's Wound Care Policy and Procedure. Additionally, residents' attending physician is notified of an area requiring treatment. Notification is done by either telephone with a note made in the resident's medical record and/or by fax with a copy of the fax transmittal/confirmation filed in the resident's medical record. Facility will contact the attending physician and/or on-call physician within 24 hours in the event that the attending physician is unavailable for verbal confirmation.<br>Upon return from a consulting physician's visit/evaluation, any orders shall be carried out by the Clinical Coordinator, with copies provided to the Director of Nursing and/or RN Supervisor. The Director of Nursing and/or RN Supervisor or designee shall ensure the orders provided to the Clinical Coordinator are carried out by conducting a 24-hour audit of the resident's medical record. Similarly, those identified residents' care plans shall be updated to include any updates in the treatment regimen including the use of pressure relieving devices and any dietary recommendations. To ensure compliance, those resident's Care Plans shall be reviewed weekly during the facility's weekly PAR (Patient's at Risk) meeting.<br>All licensed and certified nursing staff were in-serviced on Pressure Ulcer prevention and care by outside consultant from American Medical Technologies on July 11, 2012. All staff who are not in attendance for this in-service will be scheduled for individual in-services and will not be permitted to return to work until they complete the training. In-services for Pressure Ulcer | |

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| F 314 | Continued From page 22<br><br>On 6/17/12 a review of the weekly skin assessment sheet stated the right gluteus measured 3.5 cm x 2.5 cm x 0.1 cm with mild odor noted and the drainage was yellowish brown. The tissue appeared pink and reddish brown around the outside circle and a blackened area fell off with the dressing change.<br><br>On 6/18/12, the Registered Dietician (RD) recommended Resident #6 have the following for wound healing: Med Pass (nutritional supplement) 2 ounces four times daily and Prostat Advanced Wound Care (protein supplement) 1 ounce three times daily until wounds were healed.<br><br>On 6/19/12, a nursing note stated alternating air mattress to bed and functioning properly. It was used to off load the gluteal area and a message was left for his responsible party.<br><br>A review of the durable medical equipment provider's invoice revealed the replacement alternating air mattress was reordered on 6/18/12 and arrived on 6/19/12.<br><br>A wound clinic noted dated 6/19/12 stated that an alternating pressure mattress was ordered for Resident #6. The RP stated that the facility sent it back because "it was not working". The treatment order to the right gluteal ulcer was Aquacel AG and foam dressing daily. The area measured 4.5 cm x 4.0 cm x 0.1 cm and was described as having areas of induration and fluctuance. When palpated, the physician was able to express brownish purulent material. The area was cultured and physician attempted to debride but | F 314 | prevention and care will be planned quarterly thereafter. All certified nursing staff shall be in-serviced related to the importance of notifying the resident's nurse and/or the facility's Wound Care Nurse of any reddened areas or any areas that may, based on the nursing assistant's training, may require intervention by a licensed nurse. Those residents assessed as being high risk for the development for pressure sores will be monitored daily for 1 week, weekly for 8 weeks, and monthly thereafter to ensure the following: 1) treatments are provided in accordance with physicians orders, 2) to ensure that appropriate nutritional interventions are in place, and 3) any pressure relieving/positioning devices as deemed appropriate by the licensed therapists are being correctly implemented by staff. Director of Nursing and/or designee will catalog all pressure relieving devices and shall conduct direct, visual assessments daily for 1 week (5 days), weekly (5 days) for 8 weeks, and monthly thereafter to ensure the devices are properly functioning. The PAR team will be responsible for auditing the catalog and monitoring to ensure that the devices are properly functioning and review at the weekly PAR meeting. In addition to the quarterly in-service training, the Director of Nursing will assess competencies of Nursing Assistants to ensure that Nursing Assistants possess the requisite competencies of reporting skin concerns to the Charge Nurse/Treatment Nurse/Director of Nursing. The Director of Nursing will conduct these audits weekly for 8 weeks and quarterly thereafter.<br>Prior to any Resident Care Plan Meeting(s) (i.e. Multidisciplinary Care Plan Meetings) and/or weekly Patients At Risk (PAR) [members include minimally, Administrator, Director of Nursing, Social Worker, Nutritional Services, Activities Director] meeting(s); the Director of Nursing, in consultation with the Wound Care Nurse, shall ensure; through a combination of | |

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| F 314 | Continued From page 23<br>did not continue, but noted the sacral area appeared to track backwards but not all the way to the rectum. At the visit, the ulcer was named a gluteal ischial decubitus ulcer with a complicating abscess and described as non-stageable. A Computed Tomography Scan (CT) was ordered by the wound clinic physician for the resident on 6/22/12 at 8:30am. (This test produces a 3 dimensional image to reveal a far more detailed test result).<br><br>On 6/20/12, a review of the weekly skin assessment sheet stated the right gluteus ulcer measured 4.4 cm x 3.2 cm x 0.8 cm with large amount of yellow brown drainage and small odor. The tissue color was yellow to tan and there was tan adherent slough.<br><br>A physician's order, by the medical director, dated 6/22/12 stated to clean the right gluteal fold with NS (normal saline), apply Santyl/Collaganase to wound bed, pack moist gauze and cover with foam and dry dressing daily and as needed. This was done at request of the wound nurse to debride the eschar from the area.<br><br>On 6/25/12, a nursing note stated the right gluteal fold measured 4.4 cm x 3.2 cm x 4.1 cm with an open area. There was moderate amount of brownish yellow drainage noted. The color was described as pink and black with adherent black/tan slough.<br><br>The notes from the wound clinic visit on 6/26/12 stated the CT scan looked "worrisome" for osteomyelitis. The wound clinic doctor stated in his notes that the right gluteal wound was unclear whether it started out as an ulcer or abscess. He | F 314 | record reviews, observations, but primarily by the completion of the Quality Assurance Critical Element for Pressure Ulcers; proper assessment(s) and documentation has been completed to address the following:<br>Location of Wound<br>Stage/Size of Wound<br>Brief Description of Wound (malodorous, draining, etc.)<br>Date Wound was identified<br>Date Family/RP was notified<br>Date MD was notified<br>Progress of wound from any previous assessment(s)<br>Necessity of any treatment changes based on the assessment of the wound<br>Any identified need for further outside consultation(s)<br><br>During the weekly PAR meeting; the Director of Nursing shall ensure the following information related to wounds and individuals identified as being at high-risk for pressure sore development is presented during PAR, if applicable:<br><br>Location of Wound<br>Stage/Size of Wound<br>Brief Description of Wound (malodorous, draining, etc.)<br>Date Wound was identified<br>Date Family/RP was notified<br>Date MD was notified<br>Progress of wound from any previous assessment(s)<br>Necessity of any treatment changes based on the assessment of the wound<br>Any identified need for further outside consultation(s)<br><br>Should the PAR group determine a wound is worsening; the PAR group will work to determine the systemic failure, if any, contributing to the worsening of the wound (e.g. lack of physician involvement, medical decline of the resident's health status, etc.). The PAR group, chaired by the Administrator, shall address any | |

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| F 314 | Continued From page 24<br>cultured the wound and it was positive for enterococcus faecalis, Proteus Mirabilis and E-Coli. There was also an ultrasound ordered that was negative for Deep Vein Thrombosis (blood clot) to the right ankle brachial indices. The resident was then sent to the hospital for admission.<br><br>On 6/28/12 at 3:15pm, in an interview with the clinical coordinator (CC), she stated that the alternating air mattress was ordered and received on 6/8/12 The CC stated that before the alternating air mattress could be ordered, it had to be approved because the resident was a private pay resident. On or approximately 6/15/12, it "sprung a leak around the hose." The CC stated that the maintenance director called the company to get a technician to look at it. The CC said the staff removed the defective alternating air mattress and put Resident #6's regular pressure guard mattress back on the bed until the replacement arrived.<br><br>On 6/28/12 at 3:20pm a phone call was made to the sales representative for the durable medical equipment supplier regarding the defective mattress. He stated that on June 15, he was made aware about a problem with the air mattress and the alarm kept sounding. He said the company sent a technician out and repaired the mattress.<br><br>On 6/28/12 at 3:40pm, a phone call from the sales representative for the durable medical equipment supplier was received. He stated he was mistaken and that a service technician did not make an onsite visit but "tried to troubleshoot" with the maintenance director over | F 314 | identified discrepancies that may be demonstrative of a systemic failure.<br>Similarly, this information shall be presented to the Quality Assurance Committee monthly to determine any<br>systemic changes that may have been or may have to be made (personnel changes, changes in internal reporting requirements/practices, etc.).<br>Those resident's assessed as being high-risk for pressure ulcer development shall have an at-risk for pressure sore(s) care plan component added to their care plan to address 1) the problem of being at high-risk for pressure ulcer development and 2) the approaches necessary to aid in the prevention of pressure sores (pressure relieving devices, air mattresses, etc.). Interventions shall continue to be communicated to the direct care staff through the use of the Personal Care Flow Sheet, as has been the facility's standard for more than 2 years.<br>Staff Nurses shall continue to report to the Wound Care Nurse, RN Supervisor and/or Director of Nursing when they observe or suspect a resident may be developing a pressure sore or an existing sore may be worsening. Similarly, Certified Nursing Assistants shall continue to report suspected pressure sores or if they notice changes to an existing sore to their Charge Nurse, RN Supervisor, Wound Nurse, or the Director of Nursing. All certified nursing staff shall be in-serviced related to the importance of notifying the resident's nurse and/or the facility's Wound Care Nurse of any reddened areas or any areas that may, based on the nursing assistant's training, may require intervention by a licensed nurse.<br>The Director of Nursing shall ensure the Pressure Ulcer Risk Assessment is completed weekly on all residents for 1 month, then monthly on an ongoing basis thereafter for all residents assessed as either 1) having pressure sores or 2) are high-risk for the development of pressure sores. All residents who have or are at risk | |

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the phone but they were unable to fix it. He stated another mattress was ordered that following Monday and resident #6's old mattress was put back on the bed until the new one arrived.

On 6/29/12 at 8:40am, in an interview with the wound nurse she stated she began her job last Thursday (6/21/12), and up until that time, a treatment aide was doing treatments. The wound nurse stated, prior to her taking over as a wound nurse, the weekend nurses were the doing measurements and treatments every weekend while the treatment aide did the treatments during the week. The wound nurse said that on Monday (6/25/12) there was a small area that opened up and large amount of yellow brown tissue came out of Resident #6's right gluteus wound. She said she was able to see the wound bed. She said it was pink in some areas but at the right of base at 2pm to 6pm, there was necrotic tissue noted. She stated no odor was noted at this time.

On 6/29/12 at 8:45am, in an interview with the treatment aide, she said she was told about the area to his right buttock sometime the end of May. The treatment aide said when she looked at it, it looked like an area about the size of a 50 cent piece with yellow slough. The treatment aide stated she told nurse #2 and she (nurse #2) told her to put a duoderm on it. A review of the record revealed no orders for the duoderm. However, in a Physician Progress Note dated 6/1/12, it stated that Resident #6 had a "decubitus on his right buttock. Nursing has been instructed to place a DuoDerm over it."

On 6/29/12 at 9:00am in an interview with nurse #2, she stated she first noticed a red spot on

F 314 for pressure ulcers will be reviewed monthly with Quality Assurance Pressure Ulcer Critical Element tool. Instances where nursing policy/procedure(s) related to the provision of wound services are not followed as identified by either the PAR meetings and/or Quality Assessment Critical Elements shall be reported to the Director of Nursing, Administrator, and Assurance Committee for appropriate personnel action. Additionally, upon hire and quarterly thereafter, all licensed and certified nursing staff will be in-serviced on pressure ulcer prevention and care. Furthermore, the Southern Regional AHEC has been contracted to provide the directed in-service training on pressure ulcers on August 24, 2012 and August 31, 2012. In addition, Licensed Nursing Staff shall be in-serviced on the importance of carrying out physician's, including outside consulting clinician's (i.e. consulting dieticians and physicians), orders timely.

To ensure compliance, the Facility has implemented the following systemic measures; 1) the Director of Nursing shall audit all pressure relieving devices daily for 1 week, weekly for 8 weeks, and monthly thereafter to ensure that the devices are properly functioning and are determined to be the most appropriate to ensure the most effective pressure relief; 2) the Clinical Coordinator shall audit all recommendations from the Registered Dietician to ensure the recommendations are carried out timely. 3) the Director of Nursing shall conduct weekly audits for 8 weeks and quarterly thereafter to ensure Nursing Assistants possess the requisite competencies for reporting skin concerns to the Charge Nurse, Treatment Nurse, and/or Director of Nursing; 4) the Director of Nursing shall audit the weekly skin assessment forms completed by the Charge Nurses to ensure accuracy and timeliness of assessments; 5) the Director of Nursing shall ensure the Pressure Ulcer Risk Assessment is completed weekly on all residents for 1 month and then monthly

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Resident #6's buttock sometime the end of May and told the staff to put extra fanny cream to the area. She said she was assisting the treatment aide in the Resident's wound care one day when she removed the old dressing, it looked like a hole with an opening about a 50 cent piece, had some slough but no drainage and no odor. Nurse #2 said the treatment aide went and got the CC and DON (director of nursing) and they looked at the area on 6/1/12 and the medical director gave them orders to cleanse the right buttocks with normal saline, apply Triple Antibiotic Ointment daily until resolved. Nurse #2 said the resident was going to the wound clinic and that the doctor there would look at the area on 6/5/12. Nurse #2 stated the first air mattress that was sent had a problem with the tubing. The old mattress remained on the bed until the new one arrived. It may have taken 3 days to get new air mattress but when it did come, the old mattress was removed and the new one was put on the bed.

On 6/29/12 at 9:40am in an interview with the CC, she said that when the wound on Resident 6's buttock was brought to her attention, she and the DON both looked at it that day. The CC stated she called the medical director and there were no new orders for care except to go to the wound clinic on 6/5/12.

The CC stated it took 3 days (6/8/12) to get the alternating air mattress on the bed but the alternating air mattress was alarming frequently so they called to see if a technician could come to the facility to repair it. Resident #6's regular mattress was placed on the bed until the replacement alternating air mattress was delivered. The CC stated she did not look at the thereafter to determine a resident's risk for the development of pressure ulcers.
The Director of Nursing shall complete the Pressure Ulcers Critical Element Tool for 100% of the residents who have pressure ulcers monthly, and will report any inconsistencies in accuracy to the QA committee monthly. In addition, the Director of Nursing and Clinical Coordinator will report any inconsistencies in accuracy regarding all audits related to pressure ulcers to the QA committee monthly.

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wound again except for what she thought was 6/1/12.

On 6/29/12 at 10:55am, in an interview with the MDS nurse, she stated she felt the backside breakdown on Resident #6's buttock was a result of putting him the Geri-chair to elevate his feet due to the edema. She stated there was a cushion in the Geri-chair.

On 6/29/12 at 11:50am, in an interview with the RD, she stated she left a printed list of recommendations with the Administrator, the DON and the DM. She stated it was the facility's responsibility to contact the physician regarding her recommendations.

On 6/29/12 at 2:05pm, in an interview with the DON, she stated she first was involved regarding Resident #6's leg wounds. The DON stated several weeks later, she went in to check on him and the nurse told her about the place on the Resident #6's backside. The DON stated it didn't look bad and was a small area. The DON stated the resident had swelling in the lower extremities, and to get the swelling down, they put him in the Geri-chair. The DON stated she thought there was a cushion in the Geri-chair. The DON stated she performed rounds to assess pressure areas but did not know how often. She further indicated rounds were done on random residents and she did not have any documentation of the wound rounds. The DON stated there were no orders ever written for the supplements recommended by the RD. She stated she did not realize that the CC did not have a copy of the Dietary Recommendations Report and that she was used to having the CC talking with the doctor and

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getting the orders for any recommended dietary supplements. She stated the dietary recommendations for that week "fell through the cracks."

Resident #6 was hospitalized from 6/26/12 to 7/3/12 and on 7/3/12, Resident #6 was admitted to the hospice house with his primary diagnosis of infected decubitus to his right ischium with osteomyelitis and the goal of transition to outpatient hospice care and family teaching. Resident #6 was readmitted to the facility on 7/9/12.

On 7/10/12 at 9:20am, a phone interview with the physician at the wound clinic was conducted. He stated that on first observation, the area appeared at a stage 2 but on 6/19/12 he stated the area was consistent with pressure sore but did appear to tract like an abscess would have. The physician stated he would have assumed that any kind of deterioration would have resulted in a call to him. Regarding the CT results from 6/22/12, the physician stated that the nurse case manager would have reviewed the results and notified him or another doctor about the results.

On 7/10/12 at 10:50 am, an observation of the right ischial wound care for Resident #6 revealed the area appeared light pink with a soft area of what appeared to be old necrotic tissue. The area was moist and clinging the left of the wound's interior. The wound measured 4.5.x 3.5.x.4.0. There was no odor noted, moderate amount of yellowish drainage and no pain indicated by the resident.

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On 7/10/12 at 11:00am in an interview with Resident #'6 RP, she stated that she was told in the hospital and at the hospice house that the resident was likely left in the same position too long and not repositioned.

On 7/11/12 at 11:00am, in an interview with the treatment aide, she stated she would report any redness, opening areas, warmth, rashes or skin tears to the charge nurse.

On 7/11/12 at 11:30am, the Medical Director stated that Resident #6 "suddenly tanked" and that he felt Resident #6's right gluteus ulcer happened because he was "decompensating and his time has finally come." When questioned as to when he would expect to be notified by nurses regarding any changes in a wound, he stated within 24-48 hours but further stated he was in the building 5 days a week, and his nurse practitioner was in the building one or two days each week. He also said his nurse was in the facility every week as well.

The administrator provided a credible allegation of compliance on July 12, 2012 at 4:30 pm.

The identified resident has recently returned from a hospitalization. Upon re-admission, the identified resident's wound was a Stage IV. Upon readmission, the resident had treatment orders for cleanse wound to right gluteal crease with normal saline apply collagenase to necrotic tissue in wound bed. Pack wound with calcium alginate and cover with bordered foam every day and as needed. The resident currently has interventions in place to prevent the worsening of the gluteal wound, which is the only pressure sore the

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resident has. Interventions include, consultation(s), with First Health Moore Regional Wound Clinic on July 20, 2012. The resident is scheduled for assessment by his attending physician on July 11, 2012 and currently has treatment orders performed in accordance with the attending/consulting wound physician's orders. The identified resident receives PROStat 64-30cc via peg bid, Zinc, Vitamin C, and Multivitamin once daily starting on July 9, 2012. Additionally, resident is currently receiving isosource 66 cc/hr with 200 cc water qid. The resident has a properly functioning alternating pressure air mattress which is functioning according to the manufacturer's specifications. Additionally, the identified resident is turned and repositioned every two hours, side to side. The resident was reviewed by the consulting dietician on June 18th, 2012 and the resident shall be evaluated no less than monthly by the consultant dietician to ensure appropriate nutritional interventions are in place to prevent further worsening of the wound and promote wound healing as may be practicable. Upon evaluation by the consulting dietician, the recommendations shall be communicated to the Director of Nursing. The Director of Nursing shall ensure the attending physician is consulted regarding the orders by either telephone and/or fax and shall ensure the orders are carried out timely (e.g. within 48 hours of the recommendation's being made). The Clinical Coordinator shall audit all the consulting dietician's recommendations to ensure they have been carried out timely. The resident shall be evaluated by Physical and/or Occupational Therapy to ensure the resident is properly positioned while in and out of bed on July 11, 2012. Upon identification of the proper

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positioning, using the appropriate device and/or chair, the licensed therapists shall instruct the nursing staff, inclusive of licensed and certified nursing staff on the proper devices and/or devices to be used for proper positioning. In addition, all nursing staff will be in-serviced on proper positioning to prevent, identify, and care for Pressure Ulcers on July 11, 2012. The resident's attending physician is aware of the resident's pressure area(s) and shall examine the resident weekly. Following the attending and/or consulting physician's rounds/visit/consultation, the Clinical Coordinator shall ensure all orders are communicated to the applicable nursing staff (i.e. licensed/certified nursing staff, dietary, etc.). The Director of Nursing and/or her designee shall audit all orders daily for 1 week, weekly for 8 weeks, and monthly thereafter to ensure orders are properly communicated to the appropriate personnel and implemented timely. The family is aware of the resident's clinical condition. While out of bed, the resident shall use a pressure relieving device deemed clinically appropriate by the care plan team and/or licensed therapy staff which may include but not necessarily limited to: pressure relieving cushions and/or chairs specifically designed to reduce and/or eliminate pressure to the affected site. While in bed, in addition to the alternating air mattress, the staff shall turn and reposition the identified resident at least every two hours and may use other devices which may include but shall not be limited to: pillows, positioning wedges, etc. The identified resident's wound was reassessed upon the resident's readmission to the facility on July 9, 2012, and has been reassessed as of July 10, 2012. The identified resident's care plan has been updated on July 11, 2012 to include

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information related to the resident's having a pressure sore and the interventions currently in place to treat the pressure sore and other interventions being utilized to prevent the area from worsening. The resident's current treatment was ordered by the treating physician in the hospital.
For those residents having the potential to be affected by the same alleged deficient practice, all residents' skin has been assessed/re-assessed by a Corporate Nurse Consultant on July 11, 2012. Residents were assessed/re-assessed using a visual assessment process whereby each resident's skin (from head to toe) was assessed individually, using the facility's Wound Care Policy, the guidance found at F314, and the Weekly Skin Assessment Form. Assessments/Re-assessments were completed to ensure 1) the current condition of the residents' skin and to ensure appropriate measures (e.g. pressure relieving devices, air overlays, etc.) are in place to prevent pressure sores (if resident is assessed as being high-risk) and 2) the current condition of any existing wounds or pressure related areas to ensure accurate assessment and documentation. The admission skin assessment and risk assessment is done on every admission and re-admission. In addition, the Pressure Ulcer Risk evaluation is to be done quarterly thereafter. Additionally, the facility made changes to its wound care personnel on June 20, 2012 and has begun training a new Wound Care Nurse using outside consultant(s) as the trainer. The training is multi-faceted and includes, but is not limited to, assessing the wound(s), measuring/monitoring for signs/symptoms of healing or further deterioration; family and physician notification; staging, relevant types of treatments for particular

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types of wounds, preventative measures, and potential pressure relieving dressings and/or devices, etc. In addition to her more than 11 years of nursing experience, the Wound Care Nurse received the essential training, as determined by the Corporate Nurse Consultant, necessary to provide wound care in accordance with the facility's policy(ies) and the applicable rules and regulations (e.g. F314). Such training was completed on July 2, 2012. Access to the Wound Consultant(s) is available in-person, via telephone, and on a 24-hour call basis. The Wound Care Nurse shall have the primary responsibility for the assessment and re-assessment of all wounds. Additionally, the Wound Care Nurse shall ensure compliance with MD/Responsibility Party notification(s). In the event a wound does not show improvement; the Wound Nurse will consult with the residents' attending physician to determine any treatment regimen changes including outside consultations. In the event the Wound Care Nurse is out of the building, the Director of Nursing, Clinical Coordinator, and/or RN Supervisor shall ensure wound care is provided according to the facility's policy and procedure and according to facility practice.

Currently, there are 8 residents with pressure sores with a total of 12 areas; of which 11 areas were acquired In-House. The Director of Nursing and/or RN Supervisor shall monitor the Wound Care Nurse to ensure timeliness of assessments. The Pressure Ulcer Critical Element shall serve as a check/balance to ensure assessments are completed as required or as necessary. All 11 areas have been assessed by the Corporate Nursing Consultant and, based on her clinical

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judgment, she believes the treatment methodologies and treatment regimens are current with acceptable standards of practice for the type of wound(s) being treated. The care plans have been reviewed to ensure that they reflect the needs of the resident. All residents have been reassessed to determine their risk for pressure sore development as of July 11, 2012. Those residents identified as being "high risk" based on the "Risk Assessment for Pressure Sores" shall have their skin integrity assessed weekly by the Wound Care Nurse. Similarly, residents risk for development of pressure sores shall be assessed upon admission and/re-admission according to the facility's Pressure Sore Risk Assessment Policy.

The credible allegation was verified 7/12/12 at 4:30pm. Staff interviews across various shifts were conducted. Staff demonstrated verbally knowledge about the contents of the in-services on assessing the wound(s), measuring/monitoring for signs/symptoms of healing or further deterioration; family and physician notification; staging, relevant types of treatments for particular types of wounds, preventative measures, and potential pressure relieving dressings and/or devices, etc.

A review of the in-servicing records verified education and those employees not having attended in-servicing as of 7/12/12 at 4:30pm were removed from scheduling until such time, in-servicing was completed.

A review of skin assessment documentation for all residents was completed. It was found to provide evidence of all resident's skin

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assessment were completed as of 7/12/12.

A review of the care plans, treatment orders and skin assessments was conducted for the 8 identified residents who had documented pressure areas developed in house.
2. Resident # 179 was admitted to the facility 1/5/11 and discharged 9/8/11. Cumulative diagnoses included: Debility, Sacral Decubitus, Diabetes and Diverticulosis.

Pressure ulcer risk assessment dated 3/2/11 revealed a score of 19. A score of 22 or less indicated Resident # 179 was at risk for pressure ulcers.

An Admission Minimum Data Set (MDS) assessment dated 3/9/11 indicated Resident # 179 was cognitively intact. She required extensive assistance of two people for bed mobility and extensive assistance of one person for transfers. Resident # 179 was frequently incontinent of bladder and bowel. The assessment stated she was at risk for pressure ulcers. No unhealed pressure ulcers were documented during the assessment period. Pressure ulcer device for bed was checked on the assessment.

A Care Area Assessment (CAA) for pressure ulcers dated 3/11/2011 revealed Resident # 179 needed a special mattress/ seat cushion to reduce/ relieve pressure. She required staff assistance to move sufficiently to relieve pressure over any one site. The CAA indicated a pressure guard mattress was on the bed. Skin was documented as intact at the time of the assessment.

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A Skin assessment form dated 4/29/11 noted all skin was intact.

A nursing note dated 4/30/11 indicated Resident # 179's buttocks was checked per family request. Redness was noted. Area cleansed and skin protectant cream applied. Family was notified and made aware of redness of buttocks.

A Nursing note dated 5/1/11 at 1 PM. stated Resident # 179 had an open area on her sacrum that measured 2 centimeters (cm.) wide x 0.6 cm. length. Skin was pink around the area with several small pin size areas around a larger area.

On 5/1/11, a physician's order stated to cleanse the sacral wound with normal saline once daily. Apply moist collagen and dry dressing until healed.

A Care plan dated 5/2/11 indicated Resident # 179 had a pressure ulcer to the sacrum. Approaches included: place resident on a turning and repositioning program: assess for pain during dressing changes; if appropriate, administer pain medicine thirty (30) minutes prior to dressing change. Measure wound weekly. Record measurements of wound, appearance, amount and odor of any drainage. Report any decline in wound status to physician. Turn and position resident frequently to relieve pressure and maintain proper body alignment.

Weekly skin condition reports, skin assessment forms and physician orders for May 2011 revealed the following:
A physician's order dated 5/2/11 noted to cleanse

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the wound to the left side of buttocks with normal saline, apply moist collagen and dry dressing until healed. A skin assessment dated 5/4/11 noted Resident # 179 had a yeast-like rash to the sacrum. A physician's order dated 5/4/11 was received for Mycolog II to be applied twice daily for one week. The skin condition report dated 5/4/2011 noted a six centimeter(6) red area on the buttocks as rashy, unable to define as a wound. The Physician and family were notified. The skin condition report dated 5/10/11 noted the rash had cleared and a Stage 3 wound 2.3cm x 0.5cm x 0.2cm depth and red in color was on the sacrum. The physician and family were notified. The skin assessment form dated 5/13/11 noted a stage 3 decubitus to sacrum and area was being treated with Santyl( a product used to help heal skin ulcers) daily. The skin condition report dated 5/18/11 noted Resident # 179 with a stage 3 sacrum wound measuring 2.1cm x 0.5 cm x 0.2 cm depth with minimal exudate and red in color. The skin condition report dated 5/24/11 noted a stage 3 sacrum wound 1.8cm x 1.0cm x 0.2cm depth with minimal exudate(fluid) and red in color with 20% yellow slough (shedding tissue). A physician's order dated 5/24/11 noted to cleanse the Stage 3 area on the sacrum with normal saline, apply santyl and moistened collagen twice daily until resolved. A physician's order dated 5/25/11 ordered a multivitamin daily by mouth and Prostat(protein supplement) one ounce twice daily until the wound heals.

A Quarterly MDS dated 6/7/11 indicated Resident # 179 was cognitively intact. She required extensive assistance with bed mobility and transfers. She was always incontinent of bladder and bowel. Resident # 179 was at risk for

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pressure ulcers with one or more unhealed pressure ulcers checked. A stage three (3) pressure ulcer was indicated with dimensions 1.8 centimeters (cm) in length, 1.2 cm. wide and 0.1 cm. depth. The most severe type of tissue was granulation tissue. Skin and ulcer treatments included: pressure reducing device for bed; nutrition or hydration intervention; ulcer care and application of non-surgical dressing.

Weekly skin condition reports, skin assessment forms and physician orders for June 2011 revealed treatments continued to the sacral wound. The skin condition report dated 6/13/11 noted the stage 3 sacral wound measured 9.0cm x 4.6cm with no depth. The wound had increased in size, was light yellow in color with some drainage. A physician's progress note dated 6/17/11 indicated Resident # 179 ate between 50-75% of her meals. She had some weight loss of six (6) pounds from May to June. Her albumin level was slightly low at 3.1. Skin was warm, dry, intact. Treatments continued until a physician's order dated 6/21/11 had Resident #179 sent to the emergency room.

A History and Physical dated 6/21/11 from (name) hospital indicated Resident # 179 was sent to the Emergency Room because of low oxygen saturation levels. Reportedly, she had oxygen saturations of 83% on two (2) liters of oxygen (normal levels-90 or above). Resident # 179 had complained of pain in her buttocks. Skin assessment revealed skin warm and dry with no obvious rashes noted. A stage one (1) to two (2) sacral decubitus was present.

A consultation for the sacral pressure wound from

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(name) hospital dated 6/22/11 noted that Resident # 179's sacral area was an open wound which measured approximately 5 cm. x 3.5 cm. x 0.1 cm. deep. The wound was 50% pink, clean skin and 50% moist adherent yellow slough. There was rash which extended to both areas of the buttocks. The consultant documented her impression as an unstageable pressure sore that was present on admission.

A nursing note dated 6/24/11 indicated Resident # 179 had returned to the facility following the hospitalization. The dressing was dry and intact to the sacral wound.

A review of the Notice of Pressure Reduction/ Relieving/ Redistributing Mattress and/or chair cushion form revealed an alternating pressure mattress was added on 6/28/11.

The weekly skin condition report dated 6/29/11 noted the sacral wound as stage 3 measuring 2.5 cm x 4 cm with no depth. The wound was light yellow in color with some drainage. The wound was described as healing with a decrease in size.

Weekly skin condition reports, skin assessment forms and physician orders for July 2011 revealed the following:
The weekly skin condition report dated 7/6/11 noted a stage 3 sacral wound 2.5 cm x 3.5 cm x 0.1cm depth and light yellow in color with drainage. The report noted the wound was healing and decreased in size. Treatments would continue. A physician's order dated 7/6/11 requested a Wound Clinic consultation for the sacral wound. A skin assessment form dated 7/12/11 noted wound care continued for ulcer.

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The sacral/coccyx wound was described as red with a small amount of brown drainage noted to the wound bed. The skin condition report dated 7/14/11 noted a stage 3 sacral wound measuring 1.9 cm x 2.9 cm x 0.2 depth, light yellow in color with no odor.

A Wound Care Clinic note dated 7/15/11 revealed Resident # 179 was referred to the Wound clinic for a sacral decubitus as well as left buttock and above the rectum areas of skin breakdown. Resident # 179 had developed some pressure sores that predated admission to the hospital on 6/21/11. Physical examination revealed a 2cm x 3.5cm x 0.1cm sacral decubitus. Above the rectum was an open area 2cm x 3.5cm x 0.1 cm. Nothing was amenable to debridement( surgical removal of foreign matter and dead tissue from a wound). The whole area of the perineum and the perirectal area were hyperemic (engorgement and inflammation). This was a sacral decubitus and gluteal decubitus that was complicated by urinary incontinence and stool incontinence. Consideration should be given to either schedule in and out catheterization versus indwelling catheter or suprapubic placement. Also, the perirectal decubiti was going to be almost impossible to heal because the resident was consistently incontinent of stool.

On 7/15/11, a physician's order noted to apply coloplast paste to open wound area followed by foam dressing and change daily.

The skin assessment form dated 7/17/11 noted the coccyx and sacral area red in color. The sacral wound bed had a small amount of pink drainage noted. The new treatment was in

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progress as ordered.

A Wound Care Clinic note dated 7/22/11 revealed the sacral decubitus measured 2cm x 3.2cm x 0.1 centimeters (cm.) which was a decrease in the size of the decubitus. The left buttocks measured 3cm x 1.7cm x 0.1 cm. compared to 1cm x 0.5cm x 0.1cm on 7/12/11. Above the rectum, measurements were 0.9cm x 2.1cm x 0.2 cm. The whole generalized area of the gluteal regions in the sacrum and coccyx areas suggested it was erythematous (redness), blanched and was probably chemical irritation due to incontinence as well as fungal overlay. Some concern was noted that right above superior to the sphincter there was skin breakdown which appeared to be essentially eroding along the sphincter. Notes indicated an indwelling catheter was to be inserted and left in place until the next wound clinic visit. Coloplast paste and lotrimin cream was to be applied to open wound areas followed by foam dressings. Dressings would be changed twice daily and as needed.

The weekly skin condition report dated 7/27/11 noted an unstageable sacral wound 2cm x 2cm with no depth and no drainage. The wound was healing and light yellow in color.

Weekly skin condition reports, skin assessment forms and physician orders for August 2011 revealed the following:
A physician's order dated 8/2/11 was noted to discontinue the urinary catheter. The weekly skin condition report dated 8/3/11 noted an unstageable sacral wound 1.8cm x 1.9cm x 0.1cm depth with some drainage. A SDTI

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(suspected deep tissue injury) healing with decreased size. The resident had no pain. A skin assessment form dated 8/3/11 documented wound care continued. The indwelling catheter was to remain in place until further notice for wound healing.

Wound Care Clinic physician's orders dated 8/8/11 revealed the indwelling catheter should be left in place until next follow- up visit. Apply Santyl to sacral area followed by gauze and foam dressing. The dressing was to be changed daily and as needed. Air mattress-medical clearance from medical physician needed to be obtained by facility. Measurements for the sacral wound were recorded -7cm x 5cm x 0.1cm; above the rectum-1.5 cm x 2cm x 0.4cm.

The skin condition report dated 8/10/11 noted an unstageable sacral wound 7cm x 5cm x 0.1cm depth. The wound was light yellow in color with a small amount of light yellow drainage. No signs/ symptoms of infection were noted. The weekly skin assessment noted treatment continued with healing noted. A new wheelchair cushion was implemented for pressure relief and frequent repositioning. The skin condition report dated 8/17/11 an unstageable sacral wound 5.5cm x 4.4cm x 0.1cm in depth with slough and a small amount of light yellow drainage. Noted 50% slough and 50% granulation tissue. The wound was described as a healing wound with a decrease in size.

A physician's order dated 8/19/11 was noted to discontinue Santyl to sacrum. Cleanse sacrum unstageable with normal saline. Apply Santyl and collagen followed by gauze and then dry foam

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bordered dressing daily until resolved. The skin condition report dated 8/20/11 noted an unstageable sacral wound 5cm x 4.5 cm, unable to determine depth and light yellow in color. The wound was described as decreased in size with a small amount of yellow drainage presenting with 30% slough and 70% granulation tissue. The resident had an indwelling urinary catheter and was incontinent of bowel.

The Wound Care Clinic physician's orders dated 8/22/11 indicated the indwelling catheter was to be left in place until the next appointment. Wound treatment would be Santyl to sacrum followed by gauze and foam dressing; changed daily. The Sacrum wound measurements were 4.9cm x 5.5cm x 0.1cm.

The weekly skin condition report dated 8/31/11 noted an unstageable sacrum wound 4.5cm x 3.9cm x depth unable to determine. The wound color was light yellow with slough. The size was decreased and odor was noted. Antibiotic treatment was started. A small amount of yellow drainage was noted. The wound bed was 60% slough and 40% granulation pink tissue. There was redness around the entire wound. A new treatment was to be started.

Weekly skin condition reports, skin assessment forms and physician orders for Sept 2011 were reviewed and revealed the following:
A physician's order dated 9/2/11 was noted to discontinue current Santyl to unstageable sacrum. The wound was to be cleansed with normal saline and apply Dakin's ¼ solution soaked gauze to the wound bed. Bordered foam dry dressing was to be applied daily twice a day

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for seven days.
The skin condition report dated 9/8/11 noted an unstageable sacrum wound 7cm x 6.5cm and depth unable to be determined. The wound was noted to have slough 5%; 95% necrotic. Odor remained. The physician and responsble party were notified. A physician's order dated 9/8/11 was noted to culture sacrum wound.

An Emergency Department History and Physical from (name) hospital dated 9/8/11 revealed Resident # 179 had a baseball-sized decubitus with necrotic tissue and draining purulent material. Cellulitis was noted. The assessment included, in part, acute sepsis likely due to significantly worsened sacral decubitus.

A History and Physical from (name) hospital dated 9/8/11 indicated Resident # 179 was brought to the hospital because of worsening mental status and draining sacral decubitus. She had a sacral decubitus ulcer that had been getting worse and facility had noticed recently that the wound was draining and had some redness around it. The drainage had started over the past few days. Skin assessment revealed skin warm and dry with no obvious rashes noted. She had a large sacral decubitus ulcer noted with a large amount of surrounding erythema and cloudy drainage noted.

A wound consultation done at (name) hospital dated 9/9/11 indicated the following: skin-to the sacral area, Resident # 179 had a large area of intact, moist and draining eschar that measured approximately 7 cm. x 5 cm. There area was debrided and there was moderate purulent exudate with no bleeding noted.

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A culture report for the decubitus ulcer dated 9/11/11 revealed the following: a light growth of coryncbacterium species resembling diptheroids, moderate growth of Escherichia coli and light growth of MRSA (methcillin resistant staphylococcus aureus).

A Discharge Summary from (name) hospital dated 9/14/11 included a discharge diagnosis of infected stage four (4) sacral decubitus with cellulites. The discharge summary also revealed a CT (computed tomography) of the abdomen and pelvis showed a decubitus ulcer seen overlying the coccyx extending to the right of the midline. Involvement of the bone could not be excluded based on the CT. Extensive inflammation in the right buttocks and flank region noted which may have represented cellulitis.

On 7/10/12 at 2:47 PM., the MDS Coordinator stated all beds in the facility had pressure guard mattresses. An air mattress overlay was added to the bed when a resident developed a skin breakdown. There would be a physician's order and it would be added to the resident's care plan. Also, any additions or changes would be documented on the pressure form titled "Notice of Pressure Reduction/ Relieving/ Redistributing Mattress and/or chair cushion".

A review of the medical record revealed no physician orders for an air mattress. The care plan for Resident # 179 was reviewed with no indications noted that an air mattress was added to the bed when Resident # 179 developed a stage 3 pressure ulcer.

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| F 314 | Continued From page 46<br>On 7/11/12 at 11:40 AM., Resident # 179's attending physician stated he would expect to be notifed when there was a deterioration in a resident condition within 24--72 hours. He further indicated he would have consulted American Medical Technologies (AMT-a company that specialized in wound care education) for recommendations for decubitus treament if he had been told the decubitus was deteriorating. For a stage 3 decubitus, he expected to have an order for an alternating air mattress. The attending physician indicated Resident # 179 was seen by the Wound Care Clinic in July, 2011 which was probably a month late. | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to assess signs and symptoms of a potential Urinary Tract Infection (UTI) for 1 of 4 residents (Resident #92) and failed to attempt strategies to maintain urinary continence for 1 of 3 residents (Resident # 135). | F 315 | | |

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Resident #92 was admitted on 9/22/08 with diagnoses including Diabetes and chronic venous hypertrophy. Resident #92 also had an indwelling foley catheter and a Stage 4 pressure ulcer to the left gluteal fold.

The Quarterly Minimum Data Set (MDS) assessment dated 7/9/12 revealed Resident #92 was cognitively intact and was totally dependent for toileting and required extensive assistance of 1 person for personal hygiene. Resident #92 was also coded as having an indwelling catheter.

Review of the indwelling catheter Care Plan dated 11/2/11 (no dated updates after 11/2/11 were apparent) revealed " Resident uses an indwelling catheter to aid in ulcer healing " and the following goal " Resident will experience no infections from catheter use x (times) 90 days. " The approaches listed were " ongoing assessment of color, clarity and character of resident ' s urine; ongoing assessment of resident for symptoms of urinary tract infection; observe resident for acute behavioral changes that may indicate UTI; catheter care for resident every shift; monitor resident ' s catheter tubing for kinks or twists in tubing; change resident catheter tubing/bag as ordered. "

On 6/26/12 at 4:25 pm the resident was observed in bed. The resident ' s indwelling catheter bag was hung on the left side of the bed and was covered with a privacy bag. A urine odor was noticeable in the room and this odor became stronger when standing next to the resident ' s urinary catheter bag.

On 6/29/12 at 2:30 pm, Nursing Assistant #1 (NA

F 315 F 315
STANDARD DISCLAIMER:
This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).

Resident # 135 discharged on 6/17/12 and is no longer a resident of the facility. Resident # 92 was evaluated by the resident's attending physician and is currently receiving antibiotic for UTI. 08/10/2012

For those residents having the potential to be affected by the same alleged deficient practice, Director of Nursing and/or Clinical Coordinator in-serviced all licensed and certified nursing staff on 7/25/12 and 7/27/12 on identifying signs and symptoms of a Urinary Tract Infection particularly in those residents with indwelling catheters. The MDS Coordinator will ensure that a Bladder System Review (an assessment tool used to assess a resident's bladder system functioning and the likelihood a resident's bladder functioning may improve and/or decline) is done on all admissions and re-admissions and quarterly thereafter for all residents in-house. In addition, MDS Coordinator will audit all records of residents in-house to ensure the resident's condition would not necessitate a significant change assessment.

The Director of Nursing shall conduct weekly audits for 8 weeks and quarterly thereafter to ensure that Nursing Assistants possess the requisite competencies for reporting Urinary Tract Infection concerns to the Charge Nurse, Clinical Coordinator, and/or Director of Nursing.

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| F 315 | Continued From page 48 | F 315 | The MDS Coordinator will audit all records of residents in-house using the Significant Change in Condition Screening Form to ensure the resident's current condition would not necessitate a significant change assessment. In addition, the Director of Nursing shall monitor the Bladder System Review monthly for 3 months and quarterly thereafter to ensure that any declining in bladder continence is noted and the most appropriate measures are in place.<br><br>The Director of Nursing or Clinical Coordinator shall report any inconsistencies in accuracy to the QA committee monthly. | 8/16/12 |

#1) was observed providing catheter care to Resident #93. When she emptied the catheter bag of urine, the urine had a foul smell and was observed to be dark and cloudy. The urine drained from the bag measured 175 ml (millliters).

During interview with NA #1 on 6/29/12 at 2:35 pm she stated that the resident ' s output of 175 ml was about the same amount she had taken in fluids that day so it was the amount of output she expected to see and would therefore not report it to the nurse. When asked what things she would need to report to the nurse about a resident ' s urine she said she would tell the nurse if the resident had no output, if there was blood in the urine or if it smelled different than unusual. When asked, NA #1 acknowledged that Resident #92 ' s urine had a foul smell but she stated that it was no different that before.

On 6/29/12 at 4 pm interview with the Clinical Coordinator revealed that NA #1 had not reported that Resident #92 ' s urine was dark and cloudy and had a foul odor, or that her output was only 175 ml. The Clinical Coordinator indicated the NA should have reported this information as it could indicate a UTI. She also stated that a urine culture and sensitivity would be done to test for a UTI.

2. Resident # 135 was admitted 2/5/12 with diagnosis of osteoarthrosis, Hypertension, and Hypothyroidism.

The Minimum Data Set (MDS) dated 2/17/12 stated that resident # 135 required limited to extensive assist for Activates of Daily Living (ADL ' s) and she was occasionally incontinent of

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bladder and bowel (B/B). She was noted to be cognitively intact with some noted confusion.

On 2/5/12, a Bladder System Review Assessment was completed and stated that resident #135 was totally Continent of bladder

A review of resident # 135 ' s nursing notes revealed a fall on 2/10/12 with no injuries and increased confusion with agitation on 2/19/12. She was started on an antibiotic on 2/22/12 for an Urinary Tract Infection (UTI).

A nursing note dated 2/24/12 states resident #135 was continent of bowel and bladder (B/B) with incontinent episodes.

A nursing note dated 2/27/12 stated that resident #135 was up in wheelchair most of the day and she was continent of B/B.

On 5/30/12, a nursing note stated that resident of was incontinent of B/B and was total assistance for all her actives of daily living.

6/29/12 8pm: Minimum Data Set nurse interviewed and stated that resident was not put on a restorative program and chart review revealed no documentation to support any attempt to preserve B/B function or decline. MDS nurse also stated she should have done a significant change MDS on resident #135 in May.

F 328 SS=E — 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS — F 328

The facility must ensure that residents receive proper treatment and care for the following special services:

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Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility (which allowed smoking in a designated area), failed to post the proper precaution signs for 6 of 20 residential rooms (Residents # 87, #91, #113, #119, #176 and #177), where oxygen equipment was present.

The findings include:

The facility's " Oxygen Administration " policy, dated July, 2001, was reviewed. It read under Procedure:
" Utilize proper precautions, for example, post NO SMOKING: OXYGEN IN USE sign.

1. During a tour of the facility, on 6/28/12 at 9:25 am, Resident #113 was observed in bed, using oxygen from a tank, without a NO SMOKING: OXYGEN IN USE sign posted on his door.

On 6/28/12 at 1:10 pm, the Maintenance Director was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

F 328 F 328

STANDARD DISCLAIMER:
This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).

Resident #'s 87, 91, 113, 119, 176, and 177 have precautionary signs posted outside their room indicating NO SMOKING: OXYGEN IN USE.

For those residents having the potential to be affected by the same alleged deficient practice, the Clinical Coordinator in-serviced all licensed and certified nursing staff on 8/8/12, 8/10/12, 8/13/12, and 8/14/12 on posting "NO SMOKING: OXYGEN IN USE" precaution signs outside the room of any resident requiring oxygen. Director of Nursing and/or Clinical Coordinator reviewed orders for all residents requiring oxygen to ensure that precaution signs were correctly posted.

Director of Nursing and/or Clinical Coordinator will conduct weekly audits using an oxygen sign audit form to ensure that proper signage is posted for 4 weeks and monthly thereafter. In instances where the audit(s) identify the need for precautionary signage (e.g. NO SMOKING: OXYGEN IN USE), the signs shall be posted and those individuals determined to be responsible shall receive remedial education on the proper use and purpose of the NO SMOKING: OXYGEN IN USE signage. 8/16/12

The Director of Nursing or Clinical Coordinator shall report any inconsistencies in accuracy to the QA committee monthly.

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On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

On 6/29/12 at 6:00 pm, Nurse #1 was interviewed. She shared that as the Charge Nurse, it was her responsibility to put the magnetic oxygen precaution signs on the doors on her hall, for residents that required oxygen. She stated that she couldn ' t explain how she overlooked the task.

2. During an initial tour of the facility, on 6/26/12 at 8:00 am, Resident #119 was observed in bed, with an oxygen concentrator in the room. The equipment was turned off; however a NO SMOKING: OXYGEN IN USE sign was missing from her door.

On 6/28/12 at 1:10 pm, the Maintenance Director

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was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

On 6/29/12 at 6:00 pm, Nurse #1 was interviewed. She shared that as the Charge Nurse, it was her responsibility to put the magnetic oxygen precaution signs on the doors on her hall, for residents that required oxygen. She stated that she couldn ' t explain how she overlooked the task.

3. During an initial tour of the facility, on 6/26/12 at 8:05 am, Resident #91 was observed in her room, with an oxygen concentrator at her bedside. The

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machine was turned off, and the doorway was missing a
NO SMOKING: OXYGEN IN USE, sign.

On 6/28/12 at 1:10 pm, the Maintenance Director was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

On 6/29/12 at 6:00 pm, Nurse #1 was interviewed. She shared that as the Charge Nurse, it was her responsibility to put the magnetic oxygen precaution signs on the doors on her hall, for residents that required oxygen. She stated that she couldn ' t explain how she overlooked the task.

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4. During a tour of the facility, on 6/28/12 at 9:15 am, Resident #87 ' s room contained an oxygen concentrator at the bedside, without a NO SMOKING: OXYGEN IN USE sign posted on his door.

On 6/28/12 at 1:10 pm, the Maintenance Director was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

5. During a tour of the facility, on 6/28/12 at 9:20 am, Resident #176 ' s room contained an oxygen concentrator, without a NO SMOKING: OXYGEN IN USE sign posted on his door.

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On 6/28/12 at 1:10 pm, the Maintenance Director was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

On 6/29/12 at 6:00 pm, Nurse #1 was interviewed. She shared that as the Charge Nurse, it was her responsibility to put the magnetic oxygen precaution signs on the doors on her hall, for residents that required oxygen. She stated that she couldn't explain how she overlooked the task.

6. During a tour of the facility, on 6/26/12 at 9:22

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am, Resident # 177 ' s room contained an oxygen concentrator, without a NO SMOKING: OXYGEN IN USE sign posted on her door.

On 6/28/12 at 1:10 pm, the Maintenance Director was interviewed. He stated that nurses post the magnetic signs on the doors whenever oxygen is in use and that he does not monitor this activity.

On 6/28/12 at 5:10 pm, the Director of Nursing was interviewed. She stated that they are supposed to put a sign on the door when oxygen is in use. She indicated that she would investigate why the signage was missing.

On 6/29/12 at 4:30 pm, Clinical Coordinator was interviewed. She stated that she toured the facility, after the concern regarding the oxygen precaution signs were brought to her attention. She acknowledged that she found rooms where oxygen was present that did not have a precaution sign. She stated that magnetic signs should be applied by the nurse at the admission assessment and placed in the room, where the concentrator would get used. She felt that some of the PRN (as needed) orders for oxygen use were overlooked, thus the signs were not placed on the doors. She also shared that after one of their halls was renovated, signs might not have been put back in place.

On 6/29/12 at 6:00 pm, Nurse #1 was interviewed. She shared that as the Charge Nurse, it was her responsibility to put the magnetic oxygen precaution signs on the doors on her hall, for residents that required oxygen. She stated that she couldn ' t explain how she overlooked the task.

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| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>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:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff posting and interviews, the facility failed to post accurate Daily Facility Staffing sheets by including the Minimum | F 356 | F 356<br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>For those residents having the potential to be affected by the same alleged deficient practice, the facility no longer counts the MDS Coordinator in the total and actual hours worked calculation(s) for the daily staffing posting requirement. The facility will report only registered nursing hours worked by Registered Nurses providing direct resident care.<br><br>The Personnel Manager and/or Administrator shall monitor the daily nursing time records weekly for 4 weeks and monthly thereafter to ensure the hours related to the posting requirement include only hours worked by Registered Nurses providing direct resident care.<br><br>The Personnel Manager shall report any inconsistencies in accuracy to the Director of Nursing and/or Administrator. | 8/16/12 |

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| F 356 | Continued From page 58<br>Data Set (MDS) nurse who is not involved in direct resident care in total and actual hours worked calculations.<br><br>Findings include:<br><br>On 6/26/12 a review of the Daily Facility Staffing sheets from 6/14/12 to 6/26/12 included the MDS nurse in the total and actual hours worked calculations.<br><br>On 6/27/12, it was noted that the Daily Facility Staffing sheets included the MDS nurse in the daily total and actual hours worked calculations.<br><br>On 6/28/12, it was noted that the Daily Facility Staffing sheetb included the MDS nurse in the total and actual hours worked calculations.<br><br>On 6/28/12 at 11:50 am, the Director of Nurse stated she and the MDS nurse were the only Registered Nurses (RN) employed during the week and the facility employees RN ' s to work on weekends.<br><br>On 6/28/12 at 12:00pm, the administrator stated the MDS nurse was incorrectly included in the Daily Facility Staffing sheets and would likely result in a lowering of the total and actual hours worked calculations for direct resident care. | F 356 | | |
| F 368 SS=E | 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME<br><br>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. | F 368 | | |

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| F 368 | Continued From page 59<br>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.<br><br>The facility must offer snacks at bedtime daily.<br><br>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interviews, the facility failed to assure that 4 of 4 sampled residents (Residents # 72, #90, #113 and #176) were offered a bedtime snack.<br><br>The findings include:<br><br>1. Resident #90 was admitted to the facility on 3/21/09 with the following diagnosis, diabetes mellitus type II. On the most recent quarterly Minimum Data Set (MDS), 4/10/12 she was assessed as being cognitively intact.<br><br>On 6/27/12 at 9:25 am, Resident #90 approached Nurse #1 and Dietary Manager at the station and told them that she hasn't been getting her peanut butter and jelly sandwiches for snack at night, for days. The Dietary Manager told the resident, that he would look into her concern.<br><br>During a follow up conversation with Resident | F 368 | F 368<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>Resident #'s 72, 90, 113, and 176 are currently offered a nourishing snack nightly by 2nd shift Nursing Assistants.<br><br>For those residents having the potential to be affected by the same alleged deficient practice, the Dietary Manager in-serviced all licensed and certified nursing staff on 8/8/12, 8/10/12, 8/13/12, and 8/14/12 on the importance of offering nourishing snacks nightly to every resident. The Dietary Manager also in-serviced all dietary staff on 8/8/12 to ensure that snack carts are being prepared nightly and that carts offer a variety of snack options to meet the needs of all residents in-house. In addition, Nursing Assistants shall document on the Snack Verification Form (a form used to monitor snack offering to ensure that every resident is being offered a snack) is completed nightly. Nursing Assistants shall document in the Snack Verification Form to ensure that each resident either; 1) received snack 2) refused snack or 3) was unable or unavailable to receive a snack.<br><br>Dietary Manager will conduct weekly audits to ensure the accuracy of the Snack Verification Form for 8 weeks and quarterly thereafter by speaking with residents to ensure that snacks are being offered. As stated in the citation, the licensed nurses shall continue to have access by key so the Charge Nurse(s) on each shift may have access to the kitchen during periods with the kitchen is locked. (con't) | 8/16/12 |

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| F 368 | Continued From page 60 | F 368 | (con't) The Dietary Manager shall report any inconsistencies in accuracy to the QA committee monthly. | |

#90 on 6/28/12 at 8:00 am, she stated that last night, she received her sandwich. She recalled that it had her name on it and the date. She indicated that it was the first time this week that she got an evening snack. She stated that for about a week, she didn ' t receive one and before then, she would get her sandwich sporadically.

On 6/28/12 at 09:45 am, a follow up conversation was held with the Dietary Manager. He stated that he has a list of residents who get bedtime snacks and provided the list with the names of 20 residents. Resident #90 appeared on the list, indicating to prepare a peanut butter and jelly sandwich, however she did not have an assigned 7 pm snack time, like the others who received evening snacks.

On 6/29/12 at 11:20 am, Nurse Aide (NA) #6 was interviewed. She stated that she works on night shift and sometimes Resident #90 would report to her that she was hungry and she would tell the nurse and they would have to get her a sandwich.

Nurse #1 was interviewed on 6/29/12 at 6:05 pm; she stated that she was usually still present at 7:00 pm, when the evening snacks arrived on the hall. She commented that since last year, not every resident had snacks prepared for them by dietary. She shared that the cooler, only had snacks for the residents who have orders for them. She pointed out, if a resident wanted a snack, they could get a snack from the kitchen. She then added that until this week, she was unaware that Resident #90 hadn ' t received her evening snack daily.

The Dietary Manager explained on 6/29/12 at

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8:30 pm that he has been in his position for two years and polls residents at the time of their admission if they desire an evening snack. If they indicate that they would like one, he placed their names on his evening snack list. His staff prepares snacks only for the individuals on this list; however any resident can request a snack at night. To his knowledge, Resident #90 had only missed one sandwich this week for her bedtime snack.

2. Resident # 113 was admitted to the facility on 5/23/12 with an active diagnosis of diabetes mellitus type II. On the admission MDS, 5/30/12, he was assessed as being cognitively intact.

On 6/27/12 at 8:33 pm, Resident #113 stated that he had not been offered an evening snack since he was admitted to the facility.

On 6/28/12 at 09:45 am, the Dietary Manager was interviewed. He stated that he has a list of residents who get bedtime snacks and provided the list with the names of 20 residents. Resident #113 ' s name was not on the list.

Nurse #1 was interviewed on 6/29/12 at 6:05 pm; she stated that she was usually still present at 7:00 pm, when the evening snacks arrived on the hall. She commented that since last year, not every resident had snacks prepared for them by dietary. She shared that the cooler, only had snacks for the residents who have orders for them. She pointed out, if a resident wanted a snack, they could get a snack from the kitchen.

The Dietary Manager explained on 6/29/12 at

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| F 368 | Continued From page 64<br>prepares snacks only for the individuals on this list; however any resident can request a snack at night. | F 368 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to serve fresh milk, for 1 of 29 sampled residents (Resident #90), discard expired perishable foods from 2 of 2 refrigerators in the dietary department and failed to change gloves, after handling contaminated items, while serving food from the steam table.<br><br>The findings include:<br><br>1. Resident #90 was admitted to the facility on 3/21/2009. On 6/26/12 at 8:25 am, during an observation of the morning meal, it was noted that Resident #90 had an expired carton of non-fat milk on her retrieved food tray that read, 6/23/12.<br><br>On 6/26/12 in an interview with the dietary manager (DM) at 8:30am, he stated that one | F 371 | | |

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| F 371 | Continued From page 65<br>case of expired milk was found in the cooler and was disposed of by the dietary staff.<br><br>2. On 6/26/12 at 8:30 am, during the initial tour of the kitchen the following items were discovered: In the walk in refrigerator 1 of 2 cans of whipped light cream, was opened with the date stamped 5/23/12. In the reach in cooler, a carton of cole slaw that was half empty was dated 6/20/12.<br><br>The dietary manager was interviewed during the tour. He stated that the dietary department discards perishable foods after 72 hours/3 days of opening. He stated when food arrives in their department; staff placed a label on the container, as well as wrote a date of when it was added to the inventory. Once it ' s opened and prepared to be used as a leftover, a 2nd date should be added to the container.<br><br>A second observation was made in the kitchen on 6/27/12 at 1:30 pm. The whipped light cream was discarded, as well as the half empty carton of coleslaw. However, a new container of cole slaw was placed in the reach in cooler and had the date 6/24/12 on it. Cole slaw was listed on the dinner menu for 6/27/12.<br><br>3. The dinner meal preparation was observed on 6/27/12 at 4:45 pm. The cook was present, as well as two dietary aides assisting her with assembling the trays. The cook was observed to wear disposable gloves on both hands. One of the items on the menu was French fries. The cook used her gloved hands to place French fries on nine plates, before she paused to remove a | F 371 | F 371<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>Resident # 90 currently receives fresh milk.<br><br>For those residents having the potential to be affected by the same alleged deficient practice, the Dietary Manager in-serviced all dietary staff on 7/2/12 on prevention of cross-contamination, rotation of stock, and discarding expired stock. In addition, Assistant Dietary Manager (ADM) will complete a Weekly Inventory Check Form (a checklist form upon which the ADM shall record the date(s) upon which expired items were discarded) to ensure that stock is being properly rotated and expired items are discarded.<br><br>Dietary Manager will monitor the Weekly Inventory Check Form weekly for 4 weeks and monthly thereafter to ensure accuracy in addition, the Dietary Manager will monitor 3 meals a week (one at each meal time) for 4 weeks and monthly thereafter to ensure that cross-contamination is being prevented.<br><br>The Dietary Manager shall report any inconsistencies in accuracy to the QA committee monthly. | 8/16/12 |

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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 |
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| F 371 | Continued From page 66<br>bag of frozen French fries from the reach in cooler, and drop into the deep fryer. She was then observed to take a can of tomato soup from the shelf, open it and pour it into a bowl, then resume handling the French fries on the steam table, without changing the gloves. She placed French fries on one plate, before she was asked if the gloves that she wore, were possibly contaminated.<br><br>The cook responded by removing the vinyl gloves, getting a new pair and resumed handling the French fries with a metal tong. The contaminated contents were discarded.<br><br>On 6/29/12 at 7:30 pm, the dietary manager was interviewed. He stated that the cook was relatively new and that he was continuing to train her. He shared that the cooks normally wear gloves during food handling. He stated that once the gloves become contaminated by either picking up something off the floor or going from the steam table to a dirty area, the gloves should be changed. His stated that his expectation was for the cook to use the tongs to place the French fries on the dinner plates or to change the gloves she wore once she had contact with the appliances and canned good. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically | F 431 | | |

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| | 345370 | A. BUILDING _____ B. WING _____ | C 07/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINEHURST HEALTHCARE & REHAB | 300 BLAKE BOULEVARD PINEHURST, NC 28374 |

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| F 431 | Continued From page 67<br>reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility documentation, medication label and staff interview, the facility failed to discard expired insulin and store unopened insulin in the refrigerator on 1 of 4 medication carts (600 hall medication cart). The facility also failed to lock 1 of 4 medication carts (100 hall medication cart) when not in view by the nurse. The findings included: | F 431 | F 431<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>For those residents having the potential to be affected by the same alleged deficient practice, the Consulting Pharmacist in-serviced all facility medication staff on 8/13/12 and 8/14/12 on the proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart.<br><br>The Director of Nursing will monitor proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart weekly for 4 weeks and monthly thereafter. Director of Nursing will monitor by completing the Medication/Biologicals & Medication Cart Observation Worksheet weekly for 4 weeks and monthly thereafter to ensure proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart locked when unattended.<br><br>The Director of Nursing and/or appropriately trained staff (e.g. licensed nurse, ward clerk, etc.). Consultant shall report any inconsistencies in accuracy to the QA committee monthly. In addition, the Pharmacy Consultant shall report any inconsistencies in accuracy to the QA committee quarterly. | 8/16/12 |

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| F 431 | Continued From page 68 | F 431 | | |

1a. In lieu of a policy, the facility provided a copy of a laminated card posted in each medication room entitled, "Expiration Dates to Remember " " Insulin at room temperature Novolin R 30 days (opened or unopened)."

Observation of the 600 hall medication cart on 6/28/12 at 11:40 AM revealed one Novolin R (insulin) vial with a date opened of 3/15/12.

During an interview on 6/28/12 at 11:40 AM, Nurse #3 stated that the insulin was too old and needed to be discarded.

During an interview with the Director of Nursing (DON) on 6/29/12 at 8:09 PM, she stated that she expected nurses to keep up with their own medication carts. The DON added that she periodically checked the medication rooms but she would also start checking the carts.

1b. Observation on 6/29/12 at 10:40 AM of the 600 hall medication cart revealed 2 vials of unopened insulin. A label was affixed to each vial which read, "Refrigerate until opened."

During an interview on 6/29/12 at 10:40 AM, Medication Aide #1 indicated that she did not handle insulin herself, but told a nurse when a resident needed insulin.

During an interview with the Director of Nursing (DON) on 6/29/12 at 8:09 PM, she stated that she expected nurses to keep up with their own carts. The DON added that she periodically checked the medication rooms but she would also start checking the carts.

2. On 6/28/12 at 5:00pm, while giving resident

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| F 431 | Continued From page 69 | F 431 | | |

#14 her medications, nurse #2 turned around leaving her back to her medication cart while unlocked and unattended

On 6/28/12 at 5:07pm, while giving resident #163 her medications, nurse #2 turned around leaving her back to her medication cart while unlocked and unattended.

On 6/28/12 at 5:10pm, while giving resident #23 her medications, nurse #2 turned around leaving her back to her medication cart while unlocked and unattended.

On 6/28/12 at 5:15pm in an interview with nurse #2, she stated she thought if the medication cart was in front of the doorway, she did not have to lock it.

On 6/29/12 at 7:20pm in an interview with the Director of Nursing, she stated her expectation is the for medication cart to be locked when leaving the medication cart for any reason.

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

PRINTED: 08/28/2012
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|
| | 345370 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/14/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 27871<br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III-prot. construction, one story, with a complete automatic sprinkler system. Also building is using NCSBC-special locking.<br><br>The deficiencies determined during the survey are as follows: | K 000 | K038<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>The Exit access from main dining room to a public way has been removed. Permission to remove the exit access was granted by Deputy Chief Fritz of the Pinehurst Fire Department.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance has removed the signage to ensure that it is not considered an exit access and has assessed all other exit pathways to ensure they terminate into a publically accessible way.<br><br>The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly. | 9/28 |
| K 038<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings exit access was not a solid path (easily maintained in inclement weather) to a public way from main dining room.<br><br>42 CFR 483.70(a) | K 038 | | |
| K 045<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in | K 045 | K045<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). (con't) | |

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

Matthew Burson — Administrator — 9/8/12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 is following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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| | 345370 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/14/2012 |

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| K 045 | Continued From page 1<br>darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: the loss on normal power in library room leaves area in darkness on 600 hall<br><br>42 CFR 483.70(a) | K 045 | (con't)<br>No residents were identified as having been affected by the same alleged deficient practice.<br><br>Director of Maintenance installed fixtures wired to the generator circuit in the library on 600 Hall to ensure that continuous 24-hour lighting is provided.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance has installed fixtures wired to the generator circuit and will ensure that the continuous 24-hour lighting is properly functioning.<br><br>The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly. | 9/8/12 |
| K 056<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 11:30 am onward, the following | K 056 | K 056<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by the same alleged deficient practice. Facility is scheduled for a 3-year full flow trip test with the Company's sprinkler service vendor. In addition, the facility is scheduled to have a 5-year obstruction investigation completed by the Company's sprinkler service vendor.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance will ensure that the 3-year full flow trip test and 5-year obstruction<br>(con't) | 9/28/12 |

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| K 056 | Continued From page 2<br>items were noncompliant, specific findings include: facility could not provide proper documentation that sprinkler system has had 3 year full flow trip test and 5 year obstruction investigation.<br><br>42 CFR 483.70(a) | K 056 | (con't)<br>investigation are completed and subsequent tests/investigations are scheduled with the vendor accordingly.<br><br>The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly. | |
| K 066 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871 | K 066 | K 066<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by the alleged deficient practice.<br><br>Self-closing metal containers have been provided on 09/07/12 and are readily available in all areas where smoking is permitted. In addition, noncombustible ashtrays have been purchased and are readily available in all areas where smoking is permitted.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance and/or his designee will monitor to ensure that containers are readily available in all areas where smoking is permitted by completing an audit to verify the items' presence weekly for 1 week and monthly thereafter.<br><br>The Director of Maintenance will report any system failures quarterly to the Quality Assurance Committee for further evaluation. | 9/28/12 |

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| K 066 | Continued From page 3<br>Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: area for residents smoking did not have proper ash trays nor self closing metal container.<br><br>42 CFR 483.70(a) | K 066 | | |
| K 067 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: fire/smoke damper in service hallway has excess lent build up on damper. | K 067 | K067<br><br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>All fire/smoke dampers in facility have been thoroughly cleaned to remove any build up on damper.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance and/or his designee will monitor the fire/smoke dampers weekly for one month and monthly thereafter to ensure that the dampers are free from any build up.<br><br>The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly. | 9/8/12 |
| K 076 SS=E | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than | K 076 | | |

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| K 076 | Continued From page 4<br>3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: both rooms used for oxygen storage(200 and 500 hall) had mix empty with full cylinders.<br><br>42 CFR 483.70(a) | K 076 | K 076<br>STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by the same alleged deficient practice.<br><br>All oxygen tanks have been separated to ensure that empty cylinders are not mixed with full cylinders and have been placed in the appropriate holders.<br><br>To ensure that this alleged deficient practice does not recur, the Director of Maintenance installed separated storage enclosures to ensure that empty and full cylinders are stored separately. In addition, the Director of Nursing will in-service nursing staff on oxygen storage including but not limited to: 1) Keeping empty and full oxygen cylinders separated, and 2) Storing empty and full oxygen cylinders in the appropriate locations. Additionally, the Maintenance Director shall complete a weekly inspection/audit of Oxygen storage weekly for 4 weeks and monthly thereafter to ensure full and empty cylinders are not comingled.<br><br>The Director of Nursing and/or designee will routinely inspect the oxygen storage to ensure that oxygen cylinders are being stored properly. The Director of Nursing will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly. | 9/28/12 |