STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, nurse practitioner interview and physician interview, the facility failed to communicate the results of a	F 157	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision on Federal and State regulations.** F157 1. On October 3, 2013, the Director of Nursing assessed Resident #193 and no harm was experienced as a result of failing to communicate a physician ordered psychological evaluation to the physician/nurse practitioner for review of recommendations. Recommendations were to consider increasing Zoloft for depression and Seroquel if behaviors issues continue. On October 3, 2013, the Director of Nursing reviewed the psychological evaluation with the Medical Director and no new orders were given. On October 3, 2013, the Director of Nursing assessed Resident #77 and no harm was experienced as a result of failing to notify the Registered Dietician of significant weight loss. Interventions already implemented included offering a substitute if resident consumed < 50% of meals and an HS snack. The ADON completed a Situation Background Assessment Recommendation (SBAR) on Resident #77 and the physician and responsible party were made aware of resident's weight loss. Resident #77 was seen by the dietician on October 2, 2013. New orders for restorative dining were implemented to assist resident with meals. A significant change assessment was done on October 22, 2013. Resident #77 will continue weekly weights and reviewed weekly in our resident at risk meeting for evaluation of interventions. Any further weight loss will be communicated to the Legal Representative/Registered Dietician/Physician for further evaluation. On October 4, 2013, the Executive Director educated the Dietary Manager, ADON and Staff Development Nurse on notifying the Resident/Legal Representative/Physician/Registered Dietician of a residents significant change in status requiring interventions for weight changes of 5% in 30 days, 7.5% in 90 days and 10% in 180 days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tanya Rocquemore — TITLE: Executive Director — (X6) DATE: 10-24-13

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.

DHSR NHU Received Asheville Raleigh Winston WRO
OCT 28 2013
by: PRM

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F 157	Continued From page 1 physician ordered psychological evaluation to the physician/nurse practitioner for review of recommendations for 1 of 1 sampled resident (Resident #193) and failed to notify the registered dietician of significant weight loss for 1 of 3 residents reviewed for weight loss (Resident #77). The findings included: 1. Resident #193 was admitted to the facility on 08/05/13 with diagnoses including aftercare for a fractured hip, history of falls, dementia, dizziness and giddiness, and delirium. Admission physician orders dated 08/05/13 included the antidepressant medication Zoloft 50 milligrams (mg) every day for mood symptoms and on 08/06/13 the antidepressant medication Trazodone HCL 50mg at bedtime for sleep. The admission Minimum Data Set (MDS) dated 08/12/13 coded Resident #193 as usually understanding, having moderately impaired cognition, having no mood or behaviors, requiring extensive assistance with most activities of daily living skills, being nonambulatory and receiving antidepressant medication. The Care Area Assessment dated 08/27/13 stated Resident #193 received medications for depression. The subsequent care plan for psychotropic medications, last updated 09/20/13 due to being combative with staff, included the interventions to redirect, provide activities and refer to mental health services as needed. A progress note written by the Geriatric Nurse Practitioner (GNP) dated 09/18/13 stated	F 157 (Con't)	2. On October 21, 2013, the Director of Nursing spoke with psychologist regarding communicating consultation evaluations during an exit conference with the DON/ADON/SW or physician if available. The DON/ADON/SW will ensure the consultation report be communicated with the physician or placed in the physician's book for review. The Social Worker will track all referrals made on residents to ensure follow up occurs. On October 9, 2013, the Regional Director of Clinical Services/ADON/Dietary Manager/Registered Dietician reviewed all current residents' weights for changes of 5% in 30 days, 7.5% in 90 days and 10% in 180 days. Sixteen residents were identified with significant weight changes and SBARs were completed. The Registered Dietician made recommendations and the ADON consulted the physician for new orders. Residents' legal representatives were notified. Residents' responses to interventions are discussed in our weekly resident at risk meeting and reviewed weekly until residents are stable. The ADON/Dietary Manager will review weekly a report of all residents with weight changes in our resident at risk meeting. Any significant change in status will be communicated to the Resident/legal representative/physician/Registered Dietician as indicated. A SBAR will also be completed. All daily physician orders will be reviewed Monday through Friday to ensure notification of change in status was communicated to Resident/legal representative/physician as indicated. As of October 23, 2013, The Director of Nursing/Assistant Director of Nursing educated 90% of current Licensed Nursing Staff on completing SBARs and notification of changes. The DON/ADON/SDC will educate newly hired Licensed Nurses regarding completing SBARs and notification of changes during orientation. The DON/ADON will review all SBARs for completion and notification of changes occurred.	

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F 157	Continued From page 2 Resident #193 had increased behaviors and mood change and increased agitation towards evenings. The progress note indicated Resident #193 went to the orthopedic physician and had 5 more weeks of non weight bearing status. The note stated the GNP talked with the resident and family and the family reported Resident #193's behavior was worsening and she was not like she used to be. The note stated the plan was to add Seroquel 12.5 mg at 5 PM and order a consult with the psychologist for mood and depression. A physician's order, handwritten by the GNP dated 09/18/13, included the order for Seroquel 25 mg take half tab at 5 PM daily and a psychological consult with a specifically named psychologist for Alzheimer's Dementia, mood disorder and depression. Review of Nursing notes revealed nothing relating to these new orders. Review of the Psychology Progress Notes dated 09/20/13 revealed the occupational therapist reported Resident #193 was very sociable but in the last week was becoming increasingly angry and agitated. Per this evaluation, Resident #193's "mood is dysphoric (characterized by anxiety, depressed and restless) with irritable affect but she is polite and cooperative. She endorsed several symptoms of depression including feeling worthless, helpless and lonely." This evaluation listed her psychotropic medications including Zoloft, Trazodone and Seroquel (added 09/18/13). The evaluation ended as follows: "Consider (symbol for increase) Zoloft to 100 mg every am for depression. May need (symbol for increase) Seroquel in future if behavior issues continue. Dx (diagnoses)	F 157	(Con't) 3. The DON/ADON/SDC will conduct Quality Improvement monitoring using a QI tool to ensure notification of significant weight changes in are communicated to the Resident/Legal Representative/Physician/Registered Dietitian accordingly. The QI monitoring will be conducted weekly x 8 weeks, bimonthly x 8 weeks, then monthly x 8 months. The DON/ADON/SDC will re-educate as indicated. 4. The DON/ADON/SDC will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.	10-31-13

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F 157	Continued From page 3 Dementia, Probably mixed with Depression Behavioral Disturbance." Review of the medical record revealed there were no physician orders for the recommended increase in Zoloft. The nursing notes revealed nothing related to this evaluation, the recommendation, or any contact with the GNP or physician. Review of the Medication Administration Record revealed no changes were made to her psychotropic medications since the start of Seroquel on 09/18/13. A different Family Nurse Practitioner, part of the main physician's practice, saw Resident #193 on 09/23/13 for an unrelated medical issue and that note did not mention the psychologist evaluation or anything regarding moods or behaviors. Nursing notes dated 09/25/13 at 3:28 PM, written by the social worker, stated the interdisciplinary team reviewed the psychoactive medications. The note listed the Zoloft 50mg daily, Seroquel 12.5 mg daily and the Trazodone 50 mg at night as her current medications. The note did not mention the recent psychologist's evaluation or the recommendation for the increase in Zoloft. On 10/03/13 at 9:23 AM, Nurse #1 stated that when a psychological evaluation was ordered, nurses would fax the order to the psychology/psychiatric services who worked for the facility and after the evaluation was completed the evaluation would go into the chart. She further stated that if there was a recommendation in the evaluation, nurses would verify the recommendation with the physician and write subsequent orders based on what the physician wanted to do. Nurse #1 stated that Resident	F 157		

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F 157	Continued From page 4 #193's physician should have been informed of the recommendations noted on the evaluation. Nurse #1 stated the psychologist's note did not appear to be faxed to the facility and she could not determine if the evaluation was placed in the chart by the psychologist or by a nurse. During follow up interview with Nurse #1 on 10/03/13 at 9:57 AM she noted there was a book at the nursing station to inform physicians of requests. Review of this book revealed nothing related to the recommendations made by the psychologist to increase Resident #193's Zoloft to 100 mg per day. On 10/03/13 at 11:07 AM the social worker (SW) stated the facility had a contract with a local psychologist who came to the facility, did evaluations and made recommendations to the resident's physician. The SW was unsure of how this process worked and she stated she had never met the psychologist nor had she seen any evaluations completed by the psychologist. On 10/03/13 at 11:16 AM interview with the Assistant Director of Nursing (ADON) revealed the nurses who take an order for a psychological evaluation were responsible for faxing the order to the psychologist. Per the ADON, the psychologist generally came to the facility on Wednesdays and would talk to the resident, family and staff then leave a note in the chart. The ADON was not sure of the system and if the psychologist put the note in the chart or if it was given to a nurse or medical records staff. An attempt to telephone the psychologist revealed she was out of the office until 10/10/13. An interview with the Director of Nursing (DON)	F 157		

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F 157	Continued From page 5 on 10/03/13 at 1:23 PM revealed the DON herself called the psychologist after receiving the order for the referral. The DON stated that after the evaluation she was unsure if the psychologist flagged the evaluation for review or filed it in the chart. The DON further stated she was unsure of the system in place for how the evaluation was handled once written. The DON stated on the day of the evaluation of Resident #193, the psychologist stopped by her office, introduced herself to the DON and stated she found nothing unusual. The DON stated she did not look at Resident #193's evaluation. The DON further stated that if the psychologist had flagged the evaluation in the chart, the nurse would have seen it and made sure the physician was made aware of the findings. On 10/03/13 at 1:34 PM Nurse #2, who worked 09/20/13 (the day of the evaluation) was interviewed via telephone. Nurse #2 stated she was aware of the order for the psychological evaluation, however, she did not know the psychologist had already been in and evaluated Resident #193. She stated usually when a physician came in, they stopped and talked to the nurse. Nurse #2 did not recall ever seeing the psychologist or any evaluation for Resident #193. She stated if the psychologist would have flagged the evaluation in the resident's chart, she would have looked at it and made sure the physician also saw the evaluation. The GNP who ordered the psychological evaluation was interviewed via telephone on 10/03/13 at 2:36 PM. The GNP recalled ordering the Seroquel and the psychological evaluation. She stated she had not seen the report as of yet. She stated she came to the facility on	F 157		

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F 157	Continued From page 6 Wednesday afternoons. The GNP stated that if the psychologist recommended an increase in Zoloft, she most likely would have ordered the increase in Resident #193's Zoloft since a psychologist cannot write medication orders. The GNP further stated that sometimes the evaluation was copied and placed in the physician's book for review upon the next visit. On 10/03/13 at 3:06 PM the Medical Director stated the psychologist could not write any orders and he felt Resident #193 suffered no harm due to the GNP or physician not seeing the evaluation. The Medical Director further stated that the psychologist was not one to call physicians and make any verbal report after she made a visit. The Medical Director stated the facility needed to work on the system for flagging psychologist evaluations for review. The Administrator stated on 10/03/13 at 4:50 PM that once a consult was received and recommendations were made, the nurse would contact the physician. The administrator stated nurses also use the doctor's book to relay information received for physician review. The Administrator stated the results of the psychological evaluation should have been communicated to the GNP and the interdisciplinary team. The Administrator noted that all orders are reviewed daily and, because of that, facility staff should have been on the look out for the results of the psychological evaluation. 2. Resident #77 was admitted to the facility on 03/11/11 with diagnoses including cardiac dysrythmia, diabetes mellitus type II, dementia,	F 157		

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F 157	Continued From page 7	F 157		

and congestive heart failure. The most recent Minimum Data Set (MDS) dated 08/05/13 revealed the Resident with severely impaired cognition, inattention and disorganized thinking. Her behaviors included rejection of care for 1 to 3 days of the assessment period. Resident #77 required extensive one person assistance with eating. The MDS noted her height at 62 inches and her weight at the time of the assessment at 122 pounds. She was noted to have experienced weight loss of more than 5 percent (%) in the last month or loss of 10% or more in the past 6 months, prior to the assessment period, and to have a therapeutic diet. Resident #77's care plan noted her nutritional risk as evidenced by leaving 25% or more of her food uneaten at most meals, with a goal of experiencing no significant weight loss through the next review. Approaches to reach this goal included offering the Resident substitutes if 50% or less of her meals were consumed and provide a diet as ordered. Handwritten on this care plan were numerous weights with percentage of weight loss. Another handwritten entry dated 08/16/13 noted to add a bedtime snack of a sandwich and juice to the Resident's diet plan.

Review of Resident #77's medical record revealed a dietary manager (DM) note dated 05/19/13 documenting a goal to have the Resident's weight remain stable and her appetite to improve. A registered dietician (RD) note dated 05/23/13 stated to discontinue a concentrated carbohydrate restriction due to a normal blood glucose level and the Resident having limited food acceptance. An order dated 06/13/13 directed a regular diet.

Review of an interdisciplinary team (IDT) note for

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F 157	Continued From page 8 weight loss dated 07/19/13 revealed the Resident consuming 25-50% of meals, having a high weight of 160 lbs. on 05/01/13 and a current weight of 130 lbs., with an 18.75% weight loss in 61 days. Recommendations documented were to add fortified foods and weekly weight monitoring. Another IDT note for weight loss dated 07/29/13 revealed a current weight of 131 with an 18.13% weight loss in 82 days. Another IDT note for weight loss dated 08/09/13 revealed the Resident's current weight as 123 lbs. and down 7 pounds in a month, with a recommendation for weekly weights for 4 weeks. Review of a quarterly nutrition documentation form, dated 08/14/13 and completed by the DM, revealed the Resident's appetite varied, no supplementation documented, 25 to 50% of meals were consumed in her room, regular diet, intermediate diet assistance, no assistive devices and no behaviors affecting her nutritional status. A significant weight loss of 6.87% in 21 days and 23.75% in 122 days was also noted with direction to add a bedtime snack due to weight loss. Review of an IDT note for weight loss dated 08/16/13 revealed the team recommending to add a bedtime snack, a current weight of 122 and to continue weekly weights. Another IDT note for weight loss dated 09/06/13 revealed a current weight of 135 lbs, up 2 lbs. since 09/19/13 and down 21.88% overall in 125 days. Review of Resident #77's medical record revealed the following documented weights, rounded to the nearest whole pound (lb): 02/01/13 was 144 lbs. 04/02/13 was 145 lbs.	F 157		

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F 157	Continued From page 9 05/01/13 was 160 lbs. 06/03/13 was 132 lbs. 07/01/13 was 130 lbs. 08/05/13 was 123 lbs. 09/03/13 was 125 lbs. On 10/02/13 at 11:00 AM the RD was interviewed. She stated she had been covering the facility since August. She stated significant weight loss would be 5% in 30 days and 7.5% in 60 days. The RD stated she came to the facility every week and residents with significant weight loss were noted on her referral list by staff for her awareness to complete an evaluation. Upon review of Resident #77's weights the RD stated she would have expected to have been made aware of the Resident's weight loss. On 10/02/13 at 11:30 AM Resident #77 was observed being prepared for transfer from her wheelchair, following a shower, to an electronic chair scale by NA#1 and NA#2. The Resident was wearing a hospital gown, clean incontinence briefs and socks. The electronic chair scale had a calibration sticker dated March 2014 affixed to the scale. NA#1 was observed locking the scale in place and verified the digital screen read 0. NA#1 and NA#2 were observed transferring the Resident into the chair on the scale. NA#1 raised the chair until the Resident's feet left the floor and were freely dangling. The weight observed on the digital screen was 110.6 lbs. On 10/02/13 at 2:13 PM the DM was interviewed. She stated if a resident had more than a 3 lb. weight loss in a week, 5% loss in a month or 10% loss in six months then they should be referred to the RD. She stated the 7 lb. weight loss in August should have prompted her to make a	F 157		

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F 157	Continued From page 10 referral to the RD. The DM stated she could not speak to why the referral to the RD was not made.	F 157	F329 1. On October 3, 2013, the Director of Nursing assessed Resident #193 and no harm was experienced as a result of receiving Seroquel initiated 9/18/13. On October 21, 2013, our Social Worker assessed Resident #193 and updated her depression scale. Resident #193 did not communicate any worsening signs of depression nor were any signs of agitation noted. Resident #193 has a current diagnosis of depression for which she is receiving Zoloft 50 mg. On October 21, 2013, physician orders were received to discontinue the Seroquel. The Legal Representative for Resident #193 was made aware. 10-31-13 2. On October 21, 2013, the ADON/SW Pharmacy Consultant reviewed all current residents on antipsychotics. Eight residents were identified with medical justification for its use. Adequate monitoring was conducted through nursing notes and AIMS testing, and last gradual dose reduction attempted. Our Medical Director will educate our Clinicians regarding ensuring residents are free from unnecessary drugs. On October 21, 2013, The Director of Nursing educated the Social Worker on ensuring residents drug regimen are free from unnecessary drugs without medical justification for antipsychotics. The Social Worker and/or DON/ADON will conduct weekly psychotropic meetings to discuss all residents on antipsychotics, review current diagnosis, documented behaviors, adequate monitoring, and last gradual dose reduction attempted in order to determine the need for its continued use. The pharmacy consultant will continue monthly medication review for all residents on psychotropics and provide recommendations for GDR and/or monitoring needed. The IDT will review daily physician orders Monday through Friday identifying any new antipsychotic order. The ADON/Social Worker will ensure residents are logged for weekly review in the psychotropic meeting. 10-31-13 3. The Medical Director/DON/ADON/Pharmacy consultant will conduct Quality Improvement monitoring using a QI tool to ensure medical justification and monitoring use of antipsychotics. The QI monitoring will be conducted weekly x 8 weeks, then bimonthly x 8 weeks, then monthly x 8 months. The Medical Director/DON/ADON will re-educate as indicated. 4. The DON/ADON/Pharmacy Consultant will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide medical justification for the use of an antipsychotic medication and monitor the use of the	F 329		

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F 329	Continued From page 11 antipsychotic medication for 1 of 5 sampled residents. (Resident #193). The findings included: Resident #193 was admitted to the facility on 08/05/13 with diagnoses including aftercare for a fractured hip, history of falls, dementia, dizziness and giddiness, and delirium. Admission physician orders dated 08/05/13 included the antidepressant medication Zoloft 50 milligrams (mg) every day for mood symptoms and on 08/06/13 the antidepressant medication Trazodone HCL 50mg at bedtime for sleep. The admission Minimum Data Set (MDS) dated 08/12/13 coded her as usually understanding, having moderately impaired cognition, having no mood or behaviors, requiring extensive assistance with most activities of daily living skills, being nonambulatory and receiving antidepressant medication. The Care Area Assessment dated 08/27/13 stated Resident #193 received medications for depression. The subsequent care plan for psychotropic medications, last updated 09/20/13 due to being combative with staff, included the interventions to redirect, provide activities and refer to mental health services as needed. A progress note written by the Geriatric Nurse Practitioner (GNP) dated 09/18/13 stated Resident #193 had increased behaviors and mood change and increased agitation towards evenings. The GNP note continued stating the resident went to the orthopedic physician and had 5 more weeks of non weight bearing status. The	F 329		

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note stated the GNP talked with the resident and family and the family reported Resident #193's behavior was worsening and she was not like she used to be. The note stated the plan was to add Seroquel 12.5 mg at 5 PM and order a consult with the psychologist for mood and depression. There was no documented reason for the addition of Seroquel.

A physician's order, handwritten by the GNP dated 09/18/13, included the order for Seroquel 25 mg take half tab at 5 PM daily (with no stated rationale) and a psychological consult with a specifically named psychologist for Alzheimer's Dementia, mood disorder and depression. Seroquel 12.5mg was administered as ordered per the Medication Administration Record.

Review of the Psychology Progress Notes dated 09/20/13 revealed the occupational therapist reported Resident #193 was very sociable but in the last week was becoming increasingly angry and agitated. Per this evaluation, Resident #193's "mood is dysphoric (characterized by anxiety, depressed and restless) with irritable affect but she is polite and cooperative. She endorsed several symptoms of depression including feeling worthless, helpless and lonely." This evaluation listed her psychotropic medications including Zoloft, Trazodone and Seroquel (added 09/18/13). The evaluation ended as follows: "Consider (symbol for increase) Zoloft to 100 mg every am for depression. May need (symbol for increase) Seroquel in future if behavior issues continue. Dx (diagnoses) Dementia, Probably mixed with Depression Behavioral Disturbance." Another visit was made on 09/25/13 by the psychologist. There was nothing in the progress note to support the

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F 329	Continued From page 13 ongoing use of Seroquel. A different Family Nurse Practitioner (part of the main physician's practice) saw Resident #193 on 09/23/13 for an unrelated medical issue and that note did not mention the psychologist evaluation or anything regarding moods or behaviors. Nursing notes dated 09/25/13 at 3:28 PM, written by the social worker, stated the interdisciplinary team (IDT) reviewed the psychoactive medications. The note listed the Zoloft 50mg daily, Seroquel 12.5 mg daily and the Trazodone 50 mg at night as her current medications. The note did not mention the recent psychologist's evaluation. The IDT meeting note did not mention the rationale for the Seroquel. On 09/30/13 at 2:56 PM Resident #193 was observed laying on her bed watching television. She was well dressed, verbal, calm and confused. While she spoke, she had a hard time putting her thoughts into words but did not appear to become frustrated or irritated. During the surveyor's attempt to interview Resident #193, staff came to give a bath, and the resident declined stating she had one today. On 10/01/13 at 10:15 AM, Resident #193 was sitting up in her wheelchair in her doorway, well dressed, and groomed with makeup. She stated she was going to the physician's but could not verbalize what physician or why. She was calm and did not appear anxious or irritable. On 10/02/13 at 7:47 AM, Resident #193 was up in her wheelchair, dressed and talkative, but confused. Her tray was served and set up at 7:53 AM and Resident #193 proceeded to start feeding	F 329		

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herself. On 10/02/13 at 9:16 AM, Resident #193 was in her room going through her dresser drawers.

On 10/02/13 at 9:46 AM, the rehabilitation manager stated that Resident #193's weight bearing status was keeping her from progressing in therapy. Once Resident #193 was off her weight bearing limitations, the rehab manager stated she expected the resident to progress well but she was not sure if she would be able to return to her assisted level of care. She did not mention any behavior problems.

On 10/0213 at 4:20 PM Nurse Aide (NA) #3 stated this resident only needed a two person physical assistance with transfers if she was more confused or acted weaker. She did not mention any behavior issues.

Review of the Behavior/Intervention Monthly flow record for September 2013 through first shift of October 2, 2013 revealed nursing was monitoring insomnia and depression only. Medications listed included Trazodone and Zoloft. These forms noted no documented behaviors for insomnia or depression. There was no monitoring of any other types of behaviors for the ordered medication of Seroquel.

On 10/03/13 at 7:50 AM interview NA #4 revealed Resident #193 sometimes took herself to the bathroom despite being on non-weight bearing status and she had to be monitored for this behavior. NA #2 mentioned nothing about other behaviors.

Nurse #1 stated on 10/03/13 at 9:57 AM, there was a book at the nursing station to inform

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physicians of requests or things for the physician to follow up on. Review of this book revealed nothing related to any increase in behaviors or changes relating to Resident #193.

On 10/03/13 at 11:07 AM the social worker (SW) stated the facility had a contract with a local psychologist who came to the facility, did evaluations and made recommendations to the resident's physician. The SW was unsure of how this process worked and she stated she had never met the psychologist nor had she seen any evaluations completed by the psychologist.

An attempt to telephone the psychologist revealed she was out of the office until 10/10/13.

An interview with the Director of Nursing (DON) on 10/03/13 at 1:23 PM revealed the DON herself called the psychologist after receiving the order for the referral. The DON stated on the day of the evaluation of Resident #193, the psychologist stopped by her office, introduced herself to the DON and stated she found nothing unusual. The DON stated she did not look at Resident #193's evaluation.

The GNP who ordered the psychological evaluation was interviewed via telephone on 10/03/13 at 2:36 PM. The GNP recalled ordering the Seroquel and the psychological evaluation. The GNP stated she had not seen the report as of yet.

The Administrator stated on 10/03/13 at 4:50 PM that all orders were reviewed daily and then IDT meetings were set up and addressed a variety of issues i.e. psychotropic medications. The Administrator stated it was her understanding that

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F 329	Continued From page 16 Resident #193 had a urinary tract infection and was sad about an infected abdomen wound. She stated the IDT members should have looked at the medications and reviewed the resident holistically. She stated she had identified that these meetings lacked any additional steps to determine what the facility would do next to address the triggered areas.	F 329	F360 1. On October 3, 2013 the Director of Nursing assessed Resident #193 and no harm was experienced as a result of not receiving fortified foods as ordered by the physician. On October 3, 2013, The ADON wrote an order for resident #193 to have fortified foods to all meals. A dietary communication slip was completed and given to the Dietary Manager and her tray card was updated in addition to her care plan. An incident report was completed, the physician and responsible party were both notified. On October 24, 2013, The Assistant Director of Nursing provided a one on one education with the licensed nurse verifying the order regarding completing a dietary communication slip for resident #193. 2. On October 24, 2013, the ADON/Dietary Manager conducted an audit of all current residents' diet orders and reconciled them with their tray cards. 100% accuracy was noted. The 11-7 Licensed Nurse will conduct a 24 hour chart check for transcription of physician orders and completed dietary communication slips located in the chart. The physician orders will be reviewed Monday through Friday with the IDT team identifying new orders for diet changes. As of October 24, 2013, The DON educated 90% of current Licensed Nursing Staff on transcription of physician's orders and completing dietary communication slips as indicated through demonstration. The DON/ADON will educate newly hired Licensed Nurses regarding transcription of physician's orders and completing dietary communication slips as indicated during orientation. 3. The DON/ADON/Dietary Manager will conduct Quality Improvement monitoring using a QI tool to ensure dietary communication slips are completed per physician's order. The QI monitoring will be conducted 5 times a week x 8 weeks, then 4 times a week x 4 weeks, then 3 times a week x 4 weeks, then twice a week x 4 weeks, weekly x 4 weeks, and then monthly for 6 months. The DON/ADON will re-educate as indicated. 4. The DON/ADON/Dietary Manager will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.	10-31-13
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide fortified foods as ordered by the physician for 1 of 3 sampled residents reviewed for nutrition. (Resident #193). The findings included: Resident #193 was admitted to the facility on 08/05/13 with diagnoses including after care for a fractured hip, acute posthemorrhagic anemia, dementia, and nutritional deficiency. Resident #193 was ordered a pureed diet with nectar thick liquids upon admission. The initial Minimum Data Set (MDS) dated 08/12/13, coded Resident #193 with moderately impaired decision making skills, requiring set up	F 360		

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F 360	Continued From page 17 and supervision for eating, being 66 inches tall and weighing 119 pounds. Resident #193 was receiving Speech Therapy. The initial Nutritional assessment dated 08/13/13 indicated her Body Mass Index (BMI) was 19. She was assessed as eating 50% of all meals. The Registered Dietician assessed Resident #193 on 08/16/13 and noted her nutritional needs were estimated at 1458 calories and 54 grams of protein per day. Resident #193 was noted to consume an average of 52% of each meal equaling 1170 calories and 46.8 grams of protein per day. The note indicated the plan was to add fortified foods to all meals which would equal 1640 calories and 60 grams of protein per day. Review of physician orders revealed a telephone order dated 08/16/13 to add fortified foods to all meals. This order was taken by the Assistant Director of Nursing (ADON). Review of the medical record revealed no dietary communication slip corresponding to this physician's order was found in the medical record. The Care Plan dated 08/20/13 noted Resident #193 left 25 percent of most meals and had a chewing problem. The goal was to sustain no weight loss with interventions including provide diet as ordered and to see the physician orders. Review of the documented weights revealed Resident #193 weighed 129 pounds on 08/20/13 and 128 on 08/26/13. On 08/30/13 the care plan was updated to reflect a 9 pound weight gain, indicated she ate 75% of her meals and her current diet was pureed with nectar thick liquids. The recorded weight in the medical record for	F 360		

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F 360	Continued From page 18 Resident #193 on 09/02/13 was 128 pounds. Physician orders dated 09/24/13 changed Resident #193's diet to mechanical soft with thin liquids. On 10/02/13 at 7:53 AM, Resident #193 was served her breakfast. The breakfast meal consisted of scrambled eggs, oatmeal, one piece of french toast, a container of syrup, coffee and orange juice. She proceeded to begin to feed herself immediately. Review of the tray card revealed nothing related to fortified foods. On 10/03/13 at 8:11 AM, interview with the Dietary Manger (DM) revealed there were different types of hot cereal made every morning. The DM stated one batch of oatmeal was made plain and the other batch of oatmeal was fortified with evaporated milk, brown sugar and extra butter. The DM stated mashed potatoes were also fortified and the tray card would reflect if the resident was to receive a fortified portion of the food. The DM stated if the tray card did not say fortified, the oatmeal would have been the regular variety without the added milk, sugar and butter. The DM further stated that the nurse who normally took the physician's order for any diet change would subsequently complete a diet communication sheet which would go to the kitchen and the tray card would be updated. At this time, DM pulled Resident #193's tray card and noted that no meal was designated to include fortified foods. Then the DM and surveyor reviewed the chart and could not locate a copy of the communication form changing Resident #193's diet to include fortified foods at each meal. On 10/03/13 at 8:16 AM the ADON stated she	F 360		

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F 360	Continued From page 19 verified she wrote the order for fortified foods for Resident #193. The ADON reviewed the medical record of Resident #193 and could not locate the communication slip and stated she could not explain how the dietary department was not notified of the change. On 10/03/13 at 8:20 AM the Director of Nursing stated physician orders were faxed to the pharmacy and at the end of the month and the computerized orders were reconciled by different nursing staff. Review of the computerized physician orders for the month of October 2013 revealed the original printed orders for pureed diet with nectar thick liquids was crossed out by hand and changed manually to reflect the order for mechanical soft and thin liquids. The addition for fortified foods was not located on the orders. The DON stated the fortified foods was not caught as missing during the end of the month reconciliation. The DON also stated the ADON was very meticulous and she "can't believe" she missed filling out the communication sheet for the dietary department. On 10/03/13 at 8:23 AM, Resident #193's tray was observed to include oatmeal, but the card indicated it was not fortified. Resident #193 had only eaten the biscuits and gravy.	F 360		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 20 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to properly disinfect blood glucose monitors (glucometers) for 4 of 4 monitoring observations (Residents #63, #206 and #212).	F 441	F441 1. On October 3, 2013, the Director of Nursing assessed Resident #212, #206, and #63 and no harm was experienced as a result of failing to properly disinfect blood glucose monitors. On October 21, 2013, the Director of Nursing provided one on one education with Nurse #3, Nurse #4, Nurse #5, and Nurse #6. 2. On October 21, 2013, the DON conducted an audit of all sani wipes used in the facility to ensure the 2 minute contact time was used for all glucometers. The facility eliminated ordering germicidal wipes used for glucometers with varying effective times. As of October 24, 2013, The DON has educated 90% of current Licensed Nursing Staff on properly disinfecting blood glucose monitors using sani wipes with a 2 minute contact time for effectiveness then allowing the glucometer to air dry through return demonstration. The DON/ADON/SDC will educate newly hired Licensed Nurses regarding properly disinfecting glucometers using 2 minute contact time sani wipes then allowing to air dry during orientation. 3. The DON/ADON/SDC will conduct Quality Improvement monitoring using a QI tool to ensure licensed nurses are properly disinfecting glucometers. The QI monitoring will be conducted 3 times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, then monthly x nine months. The DON/ADON/SDC will re-educate as indicated. 4. The DON/ADON/SDC will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.	10-31-13

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F 441	Continued From page 21 The findings included: A facility policy entitled Cleaning and Disinfection of the Glucometer, dated 03/10, specified disinfection with a disinfecting wipe effective against blood borne pathogens. The policy further stated to "follow the manufacturer's guidelines for wet time when applying disinfectant." A review of a product information sheet from the manufacturer's website for a bleach wipe revealed it was effective against blood borne pathogens with a 4 minute contact time. A review of directions for another germicidal disposable wipe, printed on the dispensing container with a red lid, specified special instructions for cleaning and decontamination against blood borne pathogens including thoroughly wetting the surface for 2 minutes, then letting it air dry. On 10/01/13 at 4:00 PM Nurse #3 was observed wiping down a glucometer with an alcohol pad for approximately 10 seconds at the medication cart. She approached Resident #212 and performed a finger stick, obtaining a drop of blood and placing it on the strip in the glucometer. Obtaining a blood glucose level, she removed the strip from the glucometer and left the Resident's room. At the medication cart, Nurse #3 was observed wiping the glucometer with an alcohol pad. Nurse #3 stated when the glucometer had dried it could be used again. Nurse #3 stated she worked at the facility for a month and did not recall receiving training on the cleaning and disinfecting of the glucometer during her orientation. On 10/01/13 at 4:27 PM Nurse #4 was observed approaching Resident #206 with a glucometer.	F 441		

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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
F 441	Continued From page 22 He performed a finger stick, obtained a drop of blood and placed in on the strip in the glucometer. Obtaining a blood glucose level, he removed the strip from the glucometer and left the Resident's room. Nurse #4 stated another nurse previously disinfected the glucometer. Nurse #4 was observed wiping the glucometer at the medication cart with a bleach wipe for approximately 20 seconds. He stated after 5 minutes of drying the glucometer could be used again. Nurse #4 stated he could not remember when he received instruction on glucometer disinfection using the bleach wipes. On 10/02/13 at 4:34 PM Nurse #5 was observed removing a glucometer from her medication cart. She approached Resident #63 and performed a finger stick, obtaining a drop of blood and placing it on the strip in the glucometer. Obtaining a blood glucose level, Nurse #5 removed the strip from the glucometer and left the Resident's room. Nurse #5 was observed wiping the glucometer at the medication cart with a bleach wipe for approximately 15 seconds. She stated she was told to let the glucometer dry after which time it could be used again. The glucometer was observed as being wet for approximately 2 minutes before it was dry. Nurse #5 stated she did not know how long to leave the glucometer wet. On 10/02/13 at 5:05 PM Nurse #6 was observed removing a glucometer from her medication cart. She approached Resident #212 and performed a finger stick, obtaining a drop of blood and placing it on the strip in the glucometer. Obtaining a blood glucose level, she removed the strip from the glucometer and left the Resident's room. Nurse #6 was observed removing a wipe from the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 10/03/2013

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F 441	Continued From page 23 dispensing container with the red lid and with it wiped the glucometer for approximately 30 seconds. Nurse #6 stated the glucometer had to completely dry for 5 minutes before it could be used again. Nurse #6 was observed reading the directions on the dispensing container, stated the instruction read to leave the object wet after wiping for 2 minutes and that she did not confirm the glucometer remained wet for 2 minutes. On 10/03/13 at 9:30 AM the facility's Infection Control (IC) representative was interviewed. She stated nurses were expected to use either the bleach wipe or the disinfectant wipes from red top dispensing container. She stated use of the bleach wipe required getting the glucometer wet for 15 seconds and then to let it air dry for up to five minutes. The IC representative stated her expectation that per policy staff follow manufacturer's directions to achieve disinfection. She stated alcohol pads were not recommended anymore to clean glucometer as they were not effective against all pathogens. After review of product information and printed directions on the dispensing container, she stated the directions for the bleach wipes and those from the red lid container clearly noted required wet contact times for each of these products to achieve disinfection. On 10/03/13 at 11:22 AM the Director of Nursing was interviewed. She stated her expectation was that glucometers be disinfected between resident use, with appropriate products and based on manufacturer's instructions.	F 441		