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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	INITIAL COMMENTS On 9/27/2013, the facility submitted an acceptable credible allegation for the removal of the immediate jeopardy for the deficiency cited on 9/20/2013 in the area of Notification of physician (F157)and the area of care and services (F309). The facility alleged that immediate jeopardy for residents was removed on 9/21/2013. The Division of Health Service Regulation conducted a follow up visit on 10/7/2013 to determine if the facility had removed the immediate jeopardy identified during the survey of 9/20/2013. The survey found that immediate jeopardy was removed for the area Notification of physician (F157) and the area of care and services (F 309) on 9/21/2013. The facility remains out of compliance at the D level (No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy), to implement monitoring systems and complete employee education.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
{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	{F 157}	1. Resident #188 was admitted 10/3/12 with the diagnosis of end stage renal disease requiring hemodialysis three times a week, generalized weakness requiring physical therapy and occupational therapy, Cornelia deLange syndrome, Gout, hypertension, dyslipidemia, asthma, hypothyroidism, obstructive sleep apnea, and obesity. Resident #188 was noted at 2:30 a.m. on 2/7/13 as being nonverbal and fluttering eyelids. Nursing assistant reported this to the nurse. Nurse assessed resident as being lethargic, both eyes redden and matted with yellowish green matter, cheeks flushed and warm, temperature taken and noted to be 100.6, blood pressure 100/60, pulse 66, respiration 20, resident thrashing both arm s and moaning during examination, oxygen saturation 84%, nasal cannula reapplied, oxygen stats increased to 98%. Nurse checked finger stick blood sugar and read high. At 3:30 a.m. temperature recheck 99.1, no nausea or vomiting. On 2/7/13 at 9:45 a.m. vital signs were temperature 98.6, pulse 60, respiration 18, blood pressure 90/52, oxygen saturation 84%, resident noted to be unresponsive, skin is dry to touch, moans with movement, lung sounds clear, finger stick blood sugar reading 57. Nurse Practitioner notified of resident's condition at 10:30 a.m., give order to transport to hospital for evaluation. The responsible party was call at 9:45 a.m. and 2:45 p.m. but license nurse unable to contact as no one answered the phone.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Carpenter — TITLE: Administrator — (X6) DATE: 10/16/13

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.

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{F 157}	Continued From page 1 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 observation, record review, physician, nurse practitioner, staff and Emergency Medical Services (EMS) interviews, the facility failed to immediately notify the physician of a significant change in a resident's condition for 1 of 4 residents, Resident #188, reviewed for notification of changes. Immediate Jeopardy began on 2/7/13 when facility staff became aware of Resident #188's change in condition including: lethargy, periodic thrashing, moaning, and elevated blood sugar, and failed to notify the physician. The Immediate Jeopardy is present and ongoing. Validation of the facility's credible allegation was conducted on 10/7/13. Residents on all halls	{F 157}	2. Residents residing in the Facility had their medical records reviewed for any change of condition to ensure that the physician had been notified. This review was done on 9/20/13 by Assistant Director of Nurses, the 1st Shift Registered Nurse Supervisor and the Registered Nurse Reimbursement Coordinator. During the review on 9/20/13 only one resident was noted to have a change of condition, complained of pain. Resident's physician was notified on 9/20/13 by Assistant Director of Nurses, obtained an order for x-ray and lab work. 3. 38 of 38 licensed nurses were re-educated by Nursing Administration by 9/21/13 on guidelines for physician notification by telephone and after office hours physician on call to notify by telephone. The education included notifying physician of abdominal pain that is severe or lasting more than one hour, any new pain or self-limited by vomiting, change in blood pressure greater than 210/120 or less than 80/50 or per patient baseline, blood sugars greater than 400or less than 70 or per physician's parameters, any new chest pain with shortness of breath, nausea or diaphoresis, diarrhea more than four times in two hours or if occurring with associated frank blood, any new onset with swallowing or speaking, pain new onset, or not responsive to prescribed medication, pulse greater than 120 less than 50 or change from baseline of resident, respirations greater than 24 or less than 8 and any new occurrence of shortness of breath, vomiting more than once in 24 hours or if any bright red blood is present, new onset of weakness of arm or leg. Any licensed nurses who were unavailable for re-education will not be allowed to work until the education is completed.	9/20/13 9/21/13

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{F 157}	Continued From page 2 (100, 200, 300, 400, and 500) in the facility records were reviewed and observations were conducted on residents who had changes in conditions. The observations included interventions associated with change in conditions , staff reporting/communication process from shift to shift, staff documentation of observed changes in condition in accordance with the facility newly developed guidelines/tools (9/21/13). The SBAR (Situation, Background, Assessment and Recommendation/Request)/Change in Condition Review Audit form for all residents from 9/21/13 -10/7/13 were reviewed. Record reviews were completed to verify the implementation of the assessment tools and the functional process of staff communication regarding resident change of condition use of the Stop and Watch tool and glucometer training with all shifts of medical staff. Staff interviews were conducted with all three shift to verify the implementation of the newly developed SBAR(Situation, Background, Assessment, Recommendation/Request) form, Guidelines for Change in Condition form , Glucometer training ,Early Warning " Stop and Watch " and the SBAR form indicating review of the assessment and knowledge of the resident change of condition had been completed by 9/21/13 per the Credible Allegation. Direct Care, and Management Staff interviews were conducted to verify current staff and agency staff had been in-serviced in the new systemic changes and protocols. The completion date for all in-services for nursing and nursing assistant became effective 10/7/13.	{F 157}	38 of 38 licensed nurses were re-educated by 9/21/13 by Nursing Administration on solving problems when using the glucose monitoring system including the codes that may appear: "HI" indicates that the blood glucose reading is above 600 mg/dl and "Lo" blood glucose reading is below 20 mg/dl. Education included that when these codes appear they should wash and dry hands of the resident and repeat the test with a new test strip. If results still are "Hi" or "Lo" contact physician. The Facility uses only one brand of glucometer. In the future, if the brand of glucometer is changed, licensed nurses will be educated on usage from the manual that is provided with the glucometer. The manual for the currently used glucometer are located on each medication cart. Administrative Nurses will complete competencies on licensed nurses when to notify physician on condition change, assessing change of condition, the use of the Interventions to Reduce Acute Care Transfers (INTERACT) Tools and troubleshooting glucose readings. Starting 9/21/13 five licensed nurses per week across all three shifts will complete their competencies weekly for one month, then monthly for two months. Licensed nurses will sign the education record at the time of completing competencies and a copy of competencies will be placed in the individual employee education file located in the Staff Development Coordinator's office.	9/21/13

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{F 157}	Continued From page 3 The Quality Assurance Audit reports since 9/22/13 through 10/6/13 were reviewed along with all the supportive documentation of the Credible Allegation of Compliance, to verify the implementation of the facility's Credible Allegation of Compliance. The survey found that immediate jeopardy was removed for the area of notification of the physician of a significant of Condition as a result of lethargy, periodic thrashing, moaning, and elevated blood sugar, (F157) on 9/21/13. The facility remains out of compliance at the D level (No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy), in order to continue implementation of the process and monitor systems. Findings included: Resident #188 was admitted to the facility on 10/3/12. Her diagnoses included hypertension, diabetes, anemia, end stage renal disease, clostridium difficile, muscle weakness, muscle wasting, dialysis, and asthma. The quarterly Minimum Data Set (MDS) assessment dated 1/4/13 indicated the resident was cognitively intact, did not reject care, participated in the assessment, needed extensive assistance with activities of daily living (ADLs), was on oxygen, and received dialysis. A review of the February 2013 physician orders revealed there were no orders for blood glucose monitoring, oral or subcutaneous glucose medications. There was an order originally dated 1/2/13 for Vicodin 5-500 milligrams (mg) orally, as needed every 6 hours for pain.	{F 157}	50 of 57 Certified Nursing Assistants were re-educated on 9/21/13 on the *INTERACT Early Warning Tool "Stop and Watch"* that asks the Nursing Assistants to circle the noted resident change and discuss with their charge license nurse. Changes listed are Seems different than usual, Talks or communicates less than usual, Overall needs more help than usual, Participated in Activities less than usual, Ate less than usual, Drank less than usual, Weight change, Agitated or nervous more than usual, Tired, weak, confused or drowsy, Change in skin color or condition and Help with walking, transferring, toileting more than usual. Any Certified Nursing Assistants who are unavailable for re-education will not be allowed to work until the education is completed. Starting 9/22/13, Competency for the use of the Early Warning Tool will be completed on 15 Certified Nursing Assistants across the three shifts weekly for one month then monthly for two months. Certified Nursing Assistants will sign the education record at the time of completing competencies and a copy of the competencies will be placed in the individual employee education file located in the Nurse Educator's office.	9/21/13

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{F 157}	Continued From page 4 The nurse's note dated 2/6/13 at 9:30 am indicated the resident had a temperature of 100.3 degrees, was alert and verbal, made her needs known, and was up in her wheelchair. The nurse's note dated 2/6/13 at 10:30 am indicated the resident was transported to dialysis with no complaints of nausea or pain. Other than the Change of Condition Documentation, there were no other nurse's notes written on Resident #188 from 2/6/13 at 10:30 am to 2/7/13 at 9:45 am. The Change of Condition Documentation form, completed by Nurse #1 and dated 2/7/13, stated, "At 2:30 am [Nurse Aide #1] reported resident non-verbal and fluttering eye lids. Nurse noted resident lethargic, both eyes reddened [with] yellowish green matter. Cheeks flushed [and] warm. Temp 100.6. Periodically thrashing both arms during examination [and] moaning [with] sound similar to a cat ' s meow. Nasal cannula out of nostrils [and oxygen saturation] 84%. Reapplied [oxygen at] 4 L [with oxygen saturation increased to] 98%. Bipap replaced. Cleansed eyes, removing matter. Gave Vicodin 5-500mg [orally]. Crushed [due to] decreased [level of consciousness]. Checked blood sugar due to quality of moaning [with] reading HI. Decreased stimulus. Resident said 2-3 words but still not clear headed. At 3:45 am [temperature] 99.1. [No] nausea or vomiting. Continue to moan [and] throw arm slowly at times." Vitals signs were documented at 2:30 am as: blood pressure 100/60, pulse 56, temperature 100.6, respirations 20, and blood sugar "HI".	{F 157}	4. Nursing Administration will review 24-hour report and resident's clinical record for any documented change of condition and documentation of notification of physician daily for 30-days, then weekly for 60-days. A monitoring tool was developed to record the completion of the audits of the 24-hour report, resident's clinical record and documentation of notification of physician. This monitoring tool will be maintained in the Director of Nurses office. The Director of Nurses will present to the Performance Improvement Committee the results of the monitoring of medical records for notification, results of license nurses competencies for notification of physicians, assessing change of condition of residents and troubleshooting glucometer for 90-days.	9/21/13 ONGOING

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The Medication Administration Record (MAR) dated 2/7/13 indicated at 2:30 am Resident #188 was given Vicodin 5-500mg by mouth for pain. There was no documentation indicating if pain medication was effective.

Nurse #2's note dated 2/7/13 at 9:45 am stated, "Resident unresponsive. Opens eyes then roll back in head. Moans with movement of any kind by staff. Unable to verbalize anything. [Blood glucose level] 57. Refused breakfast this a.m. Hands cold to touch."

A Physician order dated 2/7/13 at 10:14 am stated, "Send to [emergency department] for [evaluation] unconsciousness."

The nurse's note dated 2/7/13 at 10:15 am stated, "Nurse notified supervisor at 9:45 am that resident was non responsive. Assessed [patient] - decreased [level of consciousness] noted. Pupils equal, reactive to light, sluggish."

Nurse #2's note dated 2/7/13 at 10:30 am indicated Emergency Medical Services (EMS) was at the facility to transport the resident to the hospital and the Nurse Practitioner was notified.

The Emergency Medical Service (EMS) transport report dated 2/7/13 stated, "Per nursing staff at nursing home, [Resident #188] began experiencing decreased [level of consciousness] last [night]. She is a dialysis [patient] and [non-insulin-dependent diabetic]. She had her dialysis yesterday then early this [morning] (around 2 am) began experiencing decreased [level of consciousness] with fever. Per nurse her [blood glucose level] at that time was over 400. This [morning], [resident] is not responding. Lies

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in bed and yells and moans (no words). Nursing staff calls 911." The chief complaint indicated on the report was "Unresponsive patient. Duration: 9 hours" and the diagnosis was "Altered level of consciousness, Diabetic symptoms."

During a telephone interview with the EMS Supervisor, on 9/22/13 at 5:40 pm, he indicated "Duration" time on an EMS report was "the amount of time the signs and symptoms had been occurring prior to EMS being called."

A review of the hospital discharge summary, dated 2/12/13, indicated Resident #188 was admitted on 2/7/13 and passed away on 2/11/13 from cardiopulmonary arrest secondary to septic shock. The discharge summary stated, "In [the emergency department] [patient] was found to be agitated, yelling nonsensically, and had multiple loose stools. She was subsequently intubated and admitted to the medical [intensive care unit]. She was partially resuscitated, requiring vasopressor support (medication to maintain her blood pressure), and a surgical consultation was obtained. Due to evidence of peritonitis (inflammation of the lining of the abdomen), an exploratory laparotomy (incision to examine the inside of the abdominal cavity) was performed, which demonstrated bowel perforation. Bowel resection was performed and the patient was transferred to the surgical intensive care unit. Aggressive attempts at resuscitation and stabilization were unsuccessful. Abdominal compartment syndrome (elevated intra-abdominal pressure) was recognized and a bedside laparotomy (incision into the abdominal cavity) was performed with relief of intra-abdominal pressure. However, the patient was not able to recover, and she expired."

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During an interview on 9/19/13 at 12:05 pm, Nurse #2 stated, "Her blood sugar was low that morning that she was sent to the [emergency room]. I had gotten report from [Nurse #1] that she was acting different and her blood sugars were elevated. [Nurse #1] said she filled out a Change In Condition form. When you fill out the form, you automatically notify the physician. The resident had behaviors that morning. She was usually very alert and oriented and would answer questions appropriately. She took her medicine for me that morning but didn't eat breakfast. When I talked to her after breakfast, she was not talking to me as much as before breakfast so I checked her blood sugar. She wouldn't respond when I said her name. I don't recall [Nurse #1] saying anything other than she had filled out the change in condition form."

During an interview on 9/19/13 at 12:30 pm, the Director of Nursing stated, "Intermittant [blood glucose monitoring] would be documented in the nurse's notes because it would not be on the MAR. If the reading said 'HI', I would expect the blood sugar to be rechecked. If it remained 'HI', I would expect the physician to be contacted, depending on the resident's condition and level of consciousness or a change for that particular resident. When I came in the nurse told me about her change in mental status and that the Nurse Practitioner was called and EMS was called." The DON indicated that had she known of the resident's condition, including change in behavior and elevated blood sugar, at 2:30 am she would have called EMS. She further indicated the change in behavior and low blood sugar that resulted in transport to the hospital on 2/7/13 at 10:30am would have been the same

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reason to transport the resident on 2/7/13 at 2:30 am when she had a documented change in behavior and high blood sugar.

During an interview with the Assistant Director of Nursing (ADON) on 9/19/13 at 11:39 am, she stated, "If there was an elevated blood sugar, there would be a doctor's note stating to give insulin. If someone was in distress and a blood sugar was checked, it would be documented in the nurse's notes. I see a blood sugar of 57 on 2/7/13. I do not see any documentation of an elevated blood sugar." "The night nurse would have faxed the change in condition to the physician. We don't keep the face sheets as part of the record so there is no way to know what time the physician was notified by fax. There is an on-call so I would expect the physician would have been called, not just a fax sent, since it was 2:30 in the morning when the change occurred."

During a telephone interview with Nurse #1 on 9/19/13 at 12:00 pm, she stated, "I think [Resident #188's] behavior led me to check her blood sugar. She wasn't really talking. This was different for her. She usually spoke in full sentences and was easy to understand. I took her blood sugar as a vital sign. 'HI' would mean it was over 500. She was not diagnosed with diabetes so I just checked because she was acting like other diabetics with high sugar. She started acting normal about an hour later and maintaining eye contact so I faxed the doctor the change in condition form. I did not call because she started acting better. I did not get an order for insulin or give any insulin or other medication related to her high blood sugar. If her behavior had not improved, I would have called the doctor. I can't remember writing a note about her

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condition improving. I did not recheck her blood sugar because she did not have an order for [blood glucose monitoring] or a diabetes diagnosis."

During a telephone interview with the Nurse Practitioner on 9/19/13 at 3:39 pm, she indicated when she is in the office, and not in the facility, she may not immediately receive an incoming fax and further stated, "If there is a change in a resident at night they should call the on-call provider. There is always someone on call. That is the expectation especially if the resident is acting differently. Even if they can't contact a provider, they should go ahead and call EMS with a high blood sugar and the resident being symptomatic. The expectation is the same if the blood sugar is low and they are symptomatic. They should call the physician and call EMS. They should not wait on a response from a fax that may not even get seen right away. I remember that day I was called and told she was sent out and I did not receive the faxed change in condition until after she had already left the facility."

During a telephone interview with the Physician on 9/19/13 at 3:51 pm, he stated, "If there is a change in a resident's condition, the facility should immediately contact EMS and contact the on-call physician. My group policy is a 10-15 minute call back. They should never wait. If the nurse is filling out a change in condition form, they should be calling the physician. They have my primary contact, secondary contact, and even my cell phone. I can always be contacted." The physician indicated, regarding Resident #188, the nurse should have called the physician at 2:30 am when the change in condition was recognized.

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During an interview with the Administrator on 9/20/13 at 1:25 pm, he stated, "I would expect in a change of condition for the nurse to follow protocol and procedure and follow her nursing judgment and then contact the physician and or family."

The Administrator was notified on 9/20/13 at 1:40 pm of the Immediate Jeopardy. The Immediate Jeopardy is present and ongoing.

{F 253} SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, staff and resident interviews the facility failed to provide maintenance services necessary to maintain a safe, orderly, and comfortable interior on 5 of 5 resident halls (100, 200, 300, 400 & 500).

The findings included:

On 9/17/2013 during a facility tour from 2:30 PM to 4:00 PM the following observations were made on five resident halls.
The main community shower room between resident halls 100 and 400 was observed unlocked and unused with pipes exposed and not covered in the main shower bay.
In the 500 hall shower room the sink water was running. The faucet and the mounted sink were

{F 157}

{F 253} Amended Plan of Correction

1. The Maintenance Director ordered parts on 9/23/13 and the exposed pipes in the main community shower room between 100 and 400 halls were removed and a door lock was installed by the Maintenance staff on 10/8/13.

The Maintenance staff repaired and secured the 500 hall shower room sink on 9/27/13.

The Maintenance staff repaired the door knob for Room 413 on 9/27/13.

The Maintenance Director ordered all appropriate material to correct the Room 206 deficiency on 9/23/13. The sheetrock work was completed and the ceiling panel was scheduled to be installed, as the ordered materials arrived, by 10/8/13.

The Maintenance Director ordered the appropriate materials to correct the Room 209 deficiency on 9/23/13 and the sheetrock in Room 209 was scheduled to be repaired, as ordered materials were delivered, by the Maintenance staff on 10/8/13.

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{F 253}	Continued From page 11 not secure and both had a one inch movement. The main door knob to residents' room 413 was not secure exposing a sharp edge. Holes were observed in the walls. In residents' room 206 there was a hole through the sheetrock in the corner of room and the ceiling panel was drooping. 209 had 4 holes in sheetrock in the residents' room and 3 holes in the sheet rock in the bathroom, all at eye level. In room 404 the floor molding was pulling away from the wall providing a hole. The residents' room 311 bathroom was observed in disrepair with broken tile around the toilet and no door strip at the transition between room and bathroom. In residents' room 203 there were gouges in the wall and in resident room 511 there were gouges in the wall at both headboard locations. Exposed cables were observed. In residents' room 103 a television cable was observed hanging out of wall for a length of approximately 2 feet with a sharp edge exposed. In room 209 a television cable was observed hanging out of wall for a length of approximately ten feet knotted up and not in use. In residents' rooms 201, 207, 211, 212, 306, 307, 314, 315, 316 and 404 was observed with the folding closet doors off track and freely swinging. In residents' rooms 109, 202, 206, 316, 406, 410, and 415 the folding closet door knob was missing or loose and dangling. Observations of wall patches that were not sanded or painted were found in residents ' rooms 206 506 and 507. And in residents' room 412 the wall was observed patched with the un-matching paint. Observation of a third shower room being used for storage across from the 400 hall nurse station. The room was locked labeled shower room.	{F 253}	The Maintenance Director ordered material on 9/24/13 and the floor molding in Room 404 was repaired, by the Maintenance staff on 10/4/13. The Maintenance Director ordered the appropriate materials on 9/24/13 and the bathroom floor in Room 311 was repaired by the Maintenance staff on 10/1/13 The Maintenance Director ordered the appropriate materials on 9/23/13 and the sheetrock in Room 203 and 511 was scheduled to be repaired, as the ordered materials were delivered, by the Maintenance staff by 10/8/13. The television cables in Room 103 and 209 were removed on 9/28/13 by the Maintenance staff. The Maintenance Director ordered the appropriate parts on 9/23/13 for the folding closet doors. The folding closet doors in Room 201, 207, 211, 212, 306, 307, 314, 315, 316, 404 were scheduled to be repaired, as ordered parts were delivered, by the Maintenance staff on 10/8/13 The folding closet door knobs in Room 109, 202, 206, 316, 406, 410, and 415 were repaired by the Maintenance staff on 9/25/13. The Maintenance Director ordered the appropriate materials on 9/23/13 and the in-progress sheetrock repairs in Room 206, 412, 506 and 507 were continued and scheduled to be completed, as the ordered materials were delivered, by the Maintenance staff. Completed 10/8/13 The shower room across from the 400 hall nurse station was re-labeled as a storage room by the Maintenance Director. Completed 9/24/13	

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{F 253}	Continued From page 12 A second tour of the facility was conducted on 9/19/2013 from 10:00 AM to 11:00 AM. The same observations were made on resident halls 100, 200, 300, 400 and 500 excluding room 507. The patched sections of the walls in resident room 507 had been sanded and painted. On 9/19/2013 11:18 AM the Director of Nursing (DON) revealed the staff filled out a maintenance request forms or verbally told maintenance about needed repairs. Maintenance was on call for an immediate need like a water leak or a broken emergency door. The small things could wait till the next day like a broken wheelchair. The DON reported the staff knew how to fix the call lights. She had an expectation of her staff to notify her, fill out the form, or tell maintenance for facility disrepair. The DON revealed her staff was focus on call lights, beds and wheelchairs and maintenance went around and painted. She reported not knowing what maintenance system was for building repairs. The DON's expectation was for maintenance to handle structural concerns and the nurses were focused on equipment failures. A Resident interview on 9/19/2013 at 3:51 with Resident #73, who resided in room #209, revealed he reported the holes in the bathroom had been present for seven to eight months. On 9/19/2013 at 3:54 PM Resident #99, who resided in room # 316, who was cognitively intact revealed the closet door in the room had been off track and the knob missing for weeks. On 9/19/2013 at 3:57 PM Resident #136, who resided on in room #410 and was cognitively intact revealed the closet door knobs in the room had been loose for over a year. The resident explained the maintenance staff tightened the door knobs up but they are worn out.	{F 253}	2. The Maintenance Director, Maintenance Assistant, Housekeeping Supervisor and Administrator conducted a tour of all facility resident rooms, shower rooms, dining rooms and activity areas and identified any facility environmental repair needs. Completed 9/23/13 3. The facility's Maintenance Work Order process was re-organized by the Administrator and Maintenance Director. There are now four distinct locations within the facility, the main Nurses Station, the laundry, the kitchen and the 500 hall where Work Order forms may be obtained and placed when complete. The facility's Maintenance staff will check the Work Order locations at least twice daily on weekdays. The facility's Nurse Supervisor will check the Work Order locations at least twice daily on weekends and notify the Maintenance staff of needed repairs as appropriate. Completed 9/20/13 and Ongoing The facility Administrator will receive a copy of each Work Order when initially reported and then a copy of the Work Order when the work is completed. The Administrator will monitor the progress of each Work Order. Completed 09/23/2013 and Ongoing All facility staff was in-serviced on the facility's Work Order process including what and when to complete a Work Order and the locations for the Work Orders. Completed 9/20/13 The facility's Maintenance Director, Housekeeping Supervisor and Administrator will conduct rounds weekly of the facility, including all resident rooms, shower rooms, dining rooms and activity areas. Utilizing a facility auditing tool, environmental issues will be identified and scheduled for attention as appropriate. Completed 09/27/2013 and Ongoing.	

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On 9/19/2013 at 4:01 PM Resident #24, who resided in room 103 and was cognitively intact, revealed the exposed unused television cable in room 103 had been hanging out of the wall for over a year.
On 9/19/2013 at 4:06 PM Resident #160, who resided in room 203 and was cognitively intact revealed he was trying to create a homelike environment and the facility did not patch the wall in the room prior to his last roommate's arrival. He reported one of the shower rooms was being used for storage. He wanted to bring a refrigerator but was told by the staff the electrical system would not hold the bed and a refrigerator. And the handicap button for access to the courtyard had not been working since July 2013.
An interview with the Maintenance Supervisor on 9/19/2013 at 10:40 AM revealed he completed work orders received from staff with in 2 weeks if not sooner. He reported the facility was 44,000 sq feet and maintenance was busy with clogged toilets and sinks. There were constant holes in the walls from beds and wheelchairs. The maintenance Supervisor revealed he looked at stuff as he walk down the halls but he did not go into the resident rooms. The staff was always verbally asking for stuff to be fixed. He did not always write the staff request down.

A record review of the current maintenance work orders revealed request on 9/18/2013 for repair of the wall at the head of bed in room 306; on 9/17/2013 a wall needed repair at the head of bed in room 101; on 9/10/2013 a wheelchair request; and on 9/10/2013 the closet door was off track and bathroom needed a light bulb. The Maintenance Supervisor did not indicate there was a failure in the system.

4. The facility's Maintenance Director will present monthly reports to the facility's Performance Improvement Committee on 1. A summary of the month's Work Orders, identifying any trends and timeline rates for completion; and, 2. The results of the facility Weekly Rounds, including environmental trends and actions taken. Completed 10/4/2013 and Ongoing. 10/8/13

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{F 253}	Continued From page 14 On 9/19/2013 a tour was conducted with the Administrator viewing the interior of residents ' rooms. The Administrator did not have a problem with the exposed television cable hanging out of the wall in room 103 and reported he was aware of the bathroom floor in room 311. During an interview with the Administrator he revealed there was a process in place and the facility address issues as they were confronted with them. The requests for repairs were done verbally and if not then request were made through a work order. He felt the staff would report anything they felt they needed to report. The Administrators expected time frame for completing work orders was a week's time. Maintenance does not need a work order to patch walls. The maintenance supervisor does initiate projects on his own, " just if he notices them " .	{F 253}		
{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 record review, physician, nurse practitioner, staff and Emergency Medical Services (EMS) interviews, the facility failed to identify and assess the need for medical intervention for a resident with a significant change of condition; and failed to immediately	{F 309}		

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{F 309}	Continued From page 15 initiate emergency medical services for 1 of 4 residents (Resident #188) reviewed for change of condition. Immediate Jeopardy began on 2/7/13 when facility staff became aware of Resident #188's acute change in condition including: lethargy, periodic thrashing, moaning, and elevated blood sugar, failed to identify and assess her need for emergency medical interventions, and delayed calling EMS for 30 minutes after acute change in condition was recognized (receiving hospital was approximately an hour away). Immediate jeopardy began on 2/7/2013 and was identified on 9/20/13 at 1:40 PM. Validation of the facility's credible allegation was conducted on 10/7/13. Residents on all halls (100, 200, 300, 400 and 500) in the facility records were reviewed and observations were conducted on residents who had changes in conditions. The observations included interventions associated with change in conditions , staff reporting/communication process from shift to shift, staff documentation of observed changes in condition in accordance with the facility newly developed guidelines/tools (9/21/13). The SBAR (Situation, Background, Assessment and Recommendation/Request)/Change in Condition Review Audit form for all residents from 9/21/13 -10/7/13 were reviewed. Record reviews were completed to verify the implementation of the assessment tools and the functional process of staff communication regarding resident change of condition use of the Stop and Watch tool and glucometer training with	{F 309}	1. Resident #188 was admitted 10/3/12 with the diagnosis of end stage renal disease requiring hemodialysis three times a week, generalized weakness requiring physical therapy and occupational therapy, Cornelia deLange syndrome, Gout, hypertension, dyslipidemia, asthma, hypothyroidism, obstructive sleep apnea, and obesity. Resident #188 was noted at 2:30 a.m. on 2/7/13 as being nonverbal and fluttering eyelids. Nursing assistant reported this to the nurse. Nurse assessed resident as being lethargic, both eyes redden and matted with yellowish green matter, cheeks flushed and warm, temperature taken and noted to be 100.6, blood pressure 100/60, pulse 66, respiration 20, resident thrashing both arm s and moaning during examination, oxygen saturation 84%, nasal cannula reapplied, oxygen stats increased to 98%. Nurse checked finger stick blood sugar and read high. At 3:30 a.m. temperature recheck 99.1, no nausea or vomiting. On 2/7/13 at 9:45 a.m. vital signs were temperature 98.6, pulse 60, respiration 18, blood pressure 90/52, oxygen saturation 84%, resident noted to be unresponsive, skin is dry to touch, moans with movement, lung sounds clear, finger stick blood sugar reading 57. Nurse Practitioner notified of resident's condition at 10:30 a.m., give order to transport to hospital for evaluation. The responsible party was call at 9:45 a.m. and 2:45 p.m. but license nurse unable to contact as no one answered the phone.	

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all shifts of medical staff.

Staff interviews were conducted with all three shift to verify the implementation of the newly developed SBAR(Situation, Background, Assessment, Recommendation/Request) form, Guidelines for Change in Condition form , Glucometer training ,Early Warning " Stop and Watch " and the SBAR form indicating review of the assessment and knowledge of the resident change of condition had been completed by 9/21/13 per the Credible Allegation. Direct Care, and Management Staff interviews were conducted to verify current staff and agency staff had been in-serviced in the new systemic changes and protocols. The completion date for all in-services for nursing and nursing assistant became effective 10/7/13.

The Quality Assurance Audit reports since 9/22/13 through 10/6/13 were reviewed along with all the supportive documentation of the Credible Allegation of Compliance, to verify the implementation of the facility's Credible Allegation of Compliance.

The survey found that immediate jeopardy was removed for the area of Assessment of Resident Change of Condition as a result of lethargy, periodic thrashing, moaning, and elevated blood sugar, (F309) on 9/21/13. The facility remains out of compliance at the D level (No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy), in order to continue implementation of the process and monitor systems.

Findings included:

2. Residents residing in the Facility had their medical records reviewed for any documented change of condition on 9/20/13 by Director of Nurses, Assistant Director of Nurses, and first shift registered nurse. During the review one resident noted to have complained of pain on 9/20/13, in her legs, the resident was assessed by the Assistant Director of Nurses and physician called with new orders for x ray and lab work to be obtained. 9/20/13

3. 38 of 38 licensed nurses were re-educated by Nursing Administration by 9/21/13 on the Interventions to *Reduce Acute Care Transfers (INTERACT) Tools* including the Care Paths, guidelines for physician notification, which is notification by telephone and after office hours notify by telephone the on-call physician, templates which include but not limited to abnormal pain, abnormal pulse, abrasion, agitation, confusion and lethargy, weakness of arm or leg, cardio-pulmonary arrest, cough, diabetes, fall and hematuria. Any licensed nurses who were unavailable for re-education will not be allowed to work until the education is completed. Licensed nurses were re-educated 9/21/13 on solving problems when using the glucose monitoring system including the codes that may appear: "HI" indicates that the blood glucose reading is above 600 mg/dl and "Lo" blood glucose reading is below 20 mg/dl. Education included that when these codes appear they should wash and dry hands of the resident and repeat the test with a new test strip. If results still are "Hi" or "Lo" contact physician immediately by telephone. The 9/21/13

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{F 309}	Continued From page 17 Resident #188 was originally admitted to the facility on 10/3/12 and readmitted on 12/28/12. Her diagnoses included hypertension, diabetes, anemia, end stage renal disease, clostridium difficile, muscle weakness, muscle wasting, dialysis, and asthma. There was a physician order dated 12/28/12 for Zofran 4 milligrams (mg) orally, as needed every 4-6 hours for nausea or vomiting. The January Medication Administration Record (MAR) indicated Resident #188 received 17 doses of Zofran for nausea. There was a physician order dated 1/2/13 for Vicodin 5-500mg orally, as needed every 6 hours for pain. The quarterly Minimum Data Set (MDS) assessment dated 1/4/13 indicated the resident was cognitively intact, did not reject care, participated in the assessment, needed extensive assistance with activities of daily living (ADLs), was on oxygen, and received dialysis. The social work note dated 1/4/13 indicated the resident had no delirium or behaviors, was tired all the time with occasional lack of interest in doing things, "is understood and understands." The Medication Administration Record dated 1/15/13 indicated Resident #188 was given Vicodin 5-500mg by mouth once for pain. There was no documentation indicating location of pain or if pain medication was effective. The nurse's note dated 1/21/13 indicated Resident #188 had decreased nausea after her	{F 309}	Facility uses only one brand of glucometer. In the future, if the brand of glucometer is changed, licensed nurses will be educated on usage from the manual that is provided with the glucometer. The manuals for the currently used glucometer are located on each medication cart. Starting 9/21/13, Administrative Nurses will complete competencies on licensed nurses for glucose readings weekly for one month, then monthly for two months. The Staff Development Coordinator will provide education on the *INTERACT* Tool beginning on 9/20/13 and will continue weekly until all licensed nurses can demonstrate understanding through competency testing. Licensed nurses will sign the education record at the time of completing the competencies and a copy of the competencies will be placed in the individual employee education file located in the Staff Development Coordinator's office. Director of Nurses and/or Assistant Director of Nurses will review the *INTERACT* Tools weekly for consistency and accuracy. A monitoring tool was developed to audit the consistency and accuracy of the INTERACT Tools and will be maintained in the Director of Nurses office.	9/21/13

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{F 309}	Continued From page 18 Renvela (phosphorus-binding medication) was discontinued on 1/18/13. The nurse's note dated 1/24/13 at 9:00 am stated, "[Resident] continues to refuse [appointment] for [upper gastrointestinal exam]. [Physician] in facility and in to assess [resident regarding] refusal. [Resident] continues to refuse despite discussion with [physician]." The physician assessment dated 1/24/13 stated, "Patient is being seen for routine monthly examination. Patients case and care discussed with nursing staff. Patient is seen and examined. Patient expresses no concerns or new issues. Patient is doing well and no complaints." Diagnoses included: "hypertension, diabetes mellitus without mention of complication, type II, not stated as uncontrolled." The Medication Administration Record (MAR) dated 1/30/13 indicated Resident #188 was given Vicodin 5-500mg by mouth once for pain. There was no documentation indicating location of pain or if pain medication was effective. A review of the February 2013 physician orders revealed there were no orders for blood glucose monitoring, oral or subcutaneous glucose medications. A review of the Behavior Monthly Flow Sheet for February 2013 revealed the resident exhibited no behaviors. The nurse's note dated 2/6/13 at 9:30 am indicated the resident had a temperature of 100.3 degrees, was alert and verbal, made her needs known, and was up in her wheelchair. There were	{F 309}	50 of 57 Certified Nursing Assistants were re-educated on 9/21/13 on the *INTERACT Early Warning Tool "Stop and Watch"* that asks the Nursing Assistants to circle the noted resident change and discuss with their charge license nurse. Changes listed are Seems different than usual, Talks or communicates less than usual, Overall needs more help than usual, Participated in Activities less than usual, Ate less than usual, Drank less than usual, Weight change, Agitated or nervous more than usual, Tired, weak, confused or drowsy, Change in skin color or condition and Help with walking, transferring, toileting more than usual. Any Certified Nursing Assistants who are unavailable for re-education will not be allowed to work until the education is completed. Starting 9/21/13, Competency for the use of the Early Warning Tool will be completed on 15 Certified Nursing Assistants across the three shifts weekly for one month. Certified Nursing Assistants will sign the education record at the time of completing competencies and a copy of the competencies will be placed in the individual employee education file located in the Staff Development Coordinator's office.	9/21/13

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no physician orders for a fever reducer, no nurse's notes of interventions for the resident's elevated temperature, or reassessment of Resident #188's temperature on 2/6/13.

The nurse's note dated 2/6/13 at 10:30 am indicated the resident was transported to dialysis with no complaints.

The February MAR indicated Resident #188 received Zofran 4mg orally for nausea on 2/6/13 at 5:00 pm.

The Change of Condition Documentation form, completed by Nurse #1 and dated 2/7/13, stated, "At 2:30 am [Nurse Aide #1] reported resident non-verbal and fluttering eye lids. Nurse noted resident lethargic, both eyes reddened [with] yellowish green matter. Cheeks flushed [and] warm. Temp 100.6. Periodically thrashing both arms during examination [and] moaning [with] sound similar to a cat ' s meow. Nasal cannula out of nostrils [and oxygen saturation] 84%. Reapplied [oxygen at] 4 L [with oxygen saturation increased to] 98%. Bipap replaced. Cleansed eyes, removing matter. Gave Vicodin 5-500mg [orally]. Crushed [due to] decreased [level of consciousness]. Checked blood sugar due to quality of moaning [with] reading HI. Decreased stimulus. Resident said 2-3 words but still not clear headed. At 3:45 am [temperature] 99.1. [No] nausea or vomiting. Continue to moan [and] throw arm slowly at times." Vitals signs were documented at 2:30 am as: blood pressure 100/60, pulse 56, temperature 100.6, respirations 20, and blood sugar "HI".

The Medication Administration Record (MAR) dated 2/7/13 indicated at 2:30 am Resident #188

4. Administrative Nursing will review 24-hour report and conduct resident rounds to assess the residents for change daily for 30-days, then weekly for 60-days. The facility designed a monitoring tool to be used which will include appearance of resident, facial expression, speech, odors, breathing, alertness, comfort level, extremities/skin color, posture/positioning, gait, medical equipment and safety. This monitoring tool will be used on routine rounds, episodic events and new admissions with any noted change the resident is to be assessed more thoroughly to include but not limited to vital signs, lung sounds and bowel sounds. The Director of Nurses will present to the Performance Improvement Committee the results of the monitoring of medical records for notification, results of license nurses competencies for notification of physicians, assessing change of condition of residents and troubleshooting glucometer for 90-days.

9/21/13
Ongoing

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was given Vicodin 5-500mg by mouth once for generalized pain. The as-needed Pain Management Flow Sheet indicated the resident was cognitively impaired and in mild pain at 2:30 am and cognitively impaired and in no pain at 6:30 am.

During a telephone interview with Nurse Aide #1 on 9/20/13 at 10:15 am, when asked about Resident #188's usual mental status and how she was different on 2/7/13, she stated, "That night she seemed like she was in a lot of pain. She complained a lot about pain that night and was screaming so loud she was waking up other residents. I reported it to the nurse (Nurse #1). [The resident] was not acting like herself that night."

During a telephone interview with Nurse #1 on 9/19/13 at 12:00 pm, she stated, "I think [Resident #188's] behavior led me to check her blood sugar. She wasn't really talking. This was different for her. She usually spoke in full sentences and was easy to understand. I took her blood sugar as a vital sign. 'HI' would mean it was over 500. She was not diagnosed with diabetes so I just checked because she was acting like other diabetics with high sugar. I did not check her sugar with another machine. I cannot remember if I ran controls on the machine. She started acting normal about an hour later and maintaining eye contact so I faxed the doctor the change in condition form. I did not call because she started acting better. I did not get an order for insulin or give any insulin or other medication related to her high blood sugar. If her behavior had not improved, I would have called the doctor. I can't remember writing a note about her condition improving. I did not recheck her

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blood sugar because she did not have an order for [blood glucose monitoring] or a diabetes diagnosis."

Other than the Change of Condition Documentation, there were no other nurse's notes written on Resident #188 from 2/6/13 at 10:30 am to 2/7/13 at 9:45 am.

Nurse #2's note dated 2/7/13 at 9:45 am stated, "[Temperature] 98.6, [pulse] 60, [respirations] 18, [blood pressure] 90/52, [oxygen saturation] 84%. Resident unresponsive. Opens eyes then roll back in head. Moans with movement of any kind by staff. Unable to verbalize anything. [Blood glucose level] 57 on facility accucheck machine. Refused breakfast this a.m. Hands cold to touch."

During an interview on 9/19/13 at 12:05 pm, Nurse #2 stated, "Her blood sugar was low that morning that she was sent to the [emergency room]. I had gotten report from [Nurse #1] that she was acting different and her blood sugars were elevated. [Nurse #1] said she filled out a Change In Condition form. When you fill out the form, you automatically notify the physician. The resident had behaviors that morning. She was usually very alert and oriented and would answer questions appropriately. She took her medicine for me that morning but didn't eat breakfast. When I talked to her after breakfast, she was not talking to me as much as before breakfast so I checked her blood sugar. She wouldn't respond when I said her name. I know [Nurse #1] didn't give any insulin because we would have to have an order for that. I don't recall [Nurse #1] saying anything other than she had filled out the change in condition form."

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A Physician order dated 2/7/13 at 10:14 am stated, "Send to [emergency department] for [evaluation] unconsciousness."

The nurse's note dated 2/7/13 at 10:15 am stated, "Nurse notified supervisor at 9:45 am that resident was non responsive. Assessed [patient] - decreased [level of consciousness] noted. Pupils equal, reactive to light, sluggish."

Nurse #2's note dated 2/7/13 at 10:30 am indicated Emergency Medical Services (EMS) was at the facility to transport the resident to the hospital and the Nurse Practitioner was notified.

The Emergency Medical Service (EMS) transport report dated 2/7/13 stated, "Per nursing staff at nursing home, [Resident #188] began experiencing decreased [level of consciousness] last [night]. She is a dialysis [patient] and [non-insulin-dependent diabetic]. She had her dialysis yesterday then early this [morning] (around 2 am) began experiencing decreased [level of consciousness] with fever. Per nurse her [blood glucose level] at that time was over 400. This [morning], [resident] is not responding. Lies in bed and yells and moans (no words). Nursing staff calls 911." The chief complaint indicated on the report was "Unresponsive patient. Duration: 9 hours" and the diagnosis was "Altered level of consciousness, Diabetic symptoms."

A review of the EMS assessment, dated 2/7/13 indicated:
At 10:18 am EMS received call
EMS arrived at 10:24 am.
At 10:25 am, the resident was agitated and combative, "eyes open but does not converse. [Patient] moans and yells", decreased level of

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consciousness, pulse 112, blood pressure 104/80, and had a blood glucose of 34.
At 10:35 am, EMS gave an intramuscular injection of Glucagon 1mg.
At 10:40 am, the resident's blood glucose was rechecked and was 20. Vascular access was started at 10:45 am.
At 10:48 am, Dextrose 25grams was administered through the vascular access.
At 10:50 am, the resident's blood glucose was rechecked and was 211.
At 11:05 am, there was no change in the resident's condition. She continued to not respond, yell, and moan.
At 11:25 am, the resident's blood glucose was rechecked and was 200.
At 11:45 am, the resident was released to the care of the emergency department and there was "no change in [patient] status throughout EMS care."

During a telephone interview with the EMS Supervisor, on 9/22/13 at 5:40 pm, he indicated "Duration" time on an EMS report was "the amount of time the signs and symptoms had been occurring prior to EMS being called."

A review of the emergency department assessment, dated 2/7/13 at 11:51 am indicated Resident #188 was anxious, appeared to be in pain, was agitated, had a blood pressure of 82/39, heart rate of 120, respiratory rate of 26, temperature of 99, oxygen saturation of 96% on 2 liters of oxygen, had a soft, nontender abdomen, cool skin, was "confused, combative and disoriented to person, place and time.", had incoherent responses, and inappropriate speech.

A review of the hospital discharge summary,

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{F 309}	Continued From page 24 dated 2/12/13, indicated Resident #188 was admitted on 2/7/13 and passed away on 2/11/13 from cardiopulmonary arrest secondary to septic shock. The discharge summary stated, "In [the emergency department] [patient] was found to be agitated, yelling nonsensically, and had multiple loose stools. She was subsequently intubated and admitted to the medical [intensive care unit]. She was partially resuscitated, requiring vasopressor support (medication to maintain her blood pressure), and a surgical consultation was obtained. Due to evidence of peritonitis (inflammation of the lining of the abdomen), an exploratory laparotomy (incision to examine the inside of the abdominal cavity) was performed, which demonstrated bowel perforation. Bowel resection was performed and the patient was transferred to the surgical intensive care unit. Aggressive attempts at resuscitation and stabilization were unsuccessful. Abdominal compartment syndrome (elevated intra-abdominal pressure) was recognized and a bedside laparotomy (incision into the abdominal cavity) was performed with relief of intra-abdominal pressure. However, the patient was not able to recover, and she expired." During an interview on 9/19/13 at 12:30 pm, the Director of Nursing stated,"Intermittant [blood glucose monitoring] would be documented in the nurse's notes because it would not be on the MAR. If the reading said 'HI', I would expect the blood sugar to be rechecked. If it remained 'HI', I would expect the physician to be contacted, depending on the resident's condition and level of consciousness or a change for that particular resident. When I came in the nurse told me about her change in mental status and that the Nurse Practitioner was called and EMS was	{F 309}		

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called." The DON indicated that had she known of the resident's condition, including change in behavior and elevated blood sugar, at 2:30 am she would have called EMS. She further indicated the change in behavior and low blood sugar that resulted in transport to the hospital on 2/7/13 at 10:30 am would have been the same reason to transport the resident on 2/7/13 at 2:30 am when she had a documented change in behavior and high blood sugar.

During an interview with the Assistant Director of Nursing (ADON) on 9/19/13 at 11:39 am, she stated, "If there was an elevated blood sugar, there would be a doctor's note stating to give insulin. If someone was in distress and a blood sugar was checked, it would be documented in the nurse's notes. I see a blood sugar of 57 on 2/7/13. I do not see any documentation of an elevated blood sugar." "The night nurse would have faxed the change in condition to the physician. We don't keep the face sheets as part of the record so there is no way to know what time the physician was notified by fax. There is an on-call so I would expect the physician would have been called, not just a fax sent, since it was 2:30 in the morning when the change occurred."

During a telephone interview with the Nurse Practitioner on 9/19/13 at 3:39 pm, she indicated when she is in the office, and not in the facility, she may not immediately receive an incoming fax and further stated, "If there is a change in a resident at night they should call the on-call provider. There is always someone on call. That is the expectation especially if the resident is acting differently. Even if they can't contact a provider, they should go ahead and call EMS with a high blood sugar and the resident being

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symptomatic. The expectation is the same if the blood sugar is low and they are symptomatic. They should call the physician and call EMS. They should not wait on a response from a fax that may not even get seen right away. I remember that day I was called and told she was sent out and I did not receive the faxed change in condition until after she had already left the facility."

During a telephone interview with the Physician on 9/19/13 at 3:51 pm, he stated, "If there is a change in a resident's condition, the facility should immediately contact EMS and contact the on-call physician. My group policy is a 10-15 minute call back. They should never wait. If the nurse is filling out a change in condition form, they should be calling the physician. They have my primary contact, secondary contact, and even my cell phone. I can always be contacted." The physician indicated, regarding Resident #188, the nurse should have called the physician at 2:30 am when the change in condition was recognized.

During an interview with the Administrator on 9/20/13 at 1:25 pm, he stated, "I would expect in a change of condition for the nurse to follow protocol and procedure and follow her nursing judgment and then contact the physician and or family."

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. NOV 13 2013	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) The smoke wall located on 400 hall at the nurse station has holes and penetration above the corridor doors and along the wall above the ceiling tile in the dinning room on the 400 hall the were not sealed in order to maintain the required fire resistance rating of the smoke barrier.	K 025	1. The hole and penetration, above the corridor doors and along the wall above the ceiling tile, was sealed by the Maintenance staff in order to maintain the required fire resistance rating of the smoke barrier. Completed 10/28/13 2. The facility's Maintenance staff conducted a visual inspection of all the facility's smoke walls for holes and penetrations. Holes and penetrations were sealed if discovered. Completed 11/30/13 3. The facility's Maintenance staff will conduct monthly visual inspections of the facility's smoke walls for holes and penetrations, for three months and then ongoing quarterly visual inspections. Completed 11/30/13 and Ongoing 4. The Maintenance Director will present a report of the results of the facility visual smoke wall inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/13 and Ongoing	10/28/13 11/30/13 11/30/13 11/7/13

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

Jeffrey Carpenter | Administrator | 11/8/13

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.

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K 025	Continued From page 1	K 025		
K 029 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) The corridor door to the central supply room was wedged open preventing the door from closing. The central supply room corridor door did not close latch and seal. 2) The corridor door to the kitchen din not close latch and seal. 3) The door between the kitchen and dinning room did not latch and was not in goood repair. 4) The corridor door to the laundry room did not close latch and seal.	K 029	1. The facility's Maintenance staff removed the barriers preventing the Central Supply Room from closing on 10/22/13. The corridor door to the kitchen was repaired so that it will latch and seal on 10/22/13. A replacement door between the kitchen and dining room had been ordered on 10/24/13 and will be installed upon its arrival. The corridor door to the Laundry Room was repaired so that it will latch and seal on 10/22/13. Completed 11/30/13 2. The Maintenance staff inspected all facility doors on 10/23/13 to ensure that they will latch and seal as required. Completed 10/23/13 3. The facility's Maintenance staff will conduct weekly inspections of all facility doors, to ensure that they latch and seal, for one month and then monthly ongoing. The facility's Staff Development Coordinator and Maintenance Director/Safety Coordinator provided facility staff education on fire safety and the importance of doors. Completed 11/22/13 4. The Maintenance Director will present a report of the results of the facility door inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/13 and Ongoing	11/30/13 10/23/13 11/22/13 11/7/13
K 056 SS=D	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056	Continued From page 2 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 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) A sprinkler head will need to be added above the dryers in the laundry room. 2) The sprinkler heads in the Kitchen and Laundry room were not clean and in good repair. 3) Throughout the facility in the sprinkler heads in the bedroom closets did not have the 18 inch clearance around the head to allow for proper coverage. 42 CFR 482.41(a)	K 056	1. The facility had a sprinkler head installed above the dryers in the laundry room. Completed 11/04/13. The facility Maintenance staff inspected the sprinkler heads in the kitchen and laundry room to ensure that they were clean and in good repair. Any sprinkler heads discovered to be in need of repair will be replaced. Completed 11/30/13 The facility Maintenance staff checked the sprinkler heads in the bedroom closets for 18 inch clearance around the head. Completed 11/30/13 2. The facility Maintenance staff inspected all facility sprinkler heads to ensure that they were clean and in good repair. Any sprinkler heads discovered to be in need of repair will be replaced. Completed 11/30/13 3. The facility's Maintenance staff will inspect all facility sprinkler heads to ensure that they are clean and in good repair monthly and for 18 inch clearance for three months and then quarterly ongoing. Completed 11/30/13 and Ongoing 4. The Maintenance Director will present a report of the results of the facility sprinkler head inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/2013 and Ongoing	11/04/13 11/30/13 11/30/13 11/30/13 11/30/13 11/7/13
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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SILER CITY CARE AND REHABILITATION CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) Throughout the facility surge protector/multi outlet power strips were found to be in use in resident rooms and/or patient care areas for lights, large TVs and other equipment. 42 CRT 483.70(a)	K 147	1. Using the Life Safety Surveyor's recommendations as a guide, the facility Maintenance staff checked each facility surge protector/multi outlet power strip to ensure that lights, large TVs and other equipment were not attached for use. Completed 11/30/13 2. The facility's Maintenance staff will check the facility's surge protectors/multi outlet power strip for recommended Life Safety usage weekly for four weeks and monthly ongoing. Completed 11/23/13 and Ongoing 3. The Maintenance Director will present a report of the results of the facility surge protector/multi outlet power strip inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/13 and Ongoing	11/30/13 11/23/13 11/7/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING 02 - BUILDING 02 B. WING _____	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) The shower curtain to the shower room on 500 hall is a solid curtain installed at ceiling height. A mesh curtain top is need in order to allow for coverage of the shower stalls.	K 056	1. The facility Maintenance and Housekeeping staff replaced the solid shower curtains in the 500 Hall shower room with shower curtains with a mesh top and were adequately positioned. Completed 11/15/13 2. The facility Maintenance and Housekeeping staff checked all facility shower rooms to ensure that each shower curtain had a mesh top and was adequately positioned. Completed 11/15/13 3. The facility Housekeeping staff will check all facility shower curtains to ensure that they have a mesh top and are adequately positioned weekly for four weeks and monthly ongoing. Completed 11/15/13 and Ongoing 4. The Maintenance Director will present a report of the results of the facility shower curtain inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/13 and Ongoing	11/15/13 11/15/13 11/15/13 11/7/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Carpenter	Administrator	11/8/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 1 42 CFR 482.41(a)	K 056		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/22/13 at approximately 8:30 AM onward the following deficiencies were noted: 1) The remote annunicator for the generator located on 500 hall did not show Emergency Power Supplying (EPS) load when the emergency power was transferred from normal to emergency power. 42 CFR 483.70(a)	K 144	1. The facility Maintenance Director arranged for the facility's vendor, Atlantic Power Systems to check the remote annunciator for proper operation. Completed 10/29/13 2. The facility's remote annunciator is operating properly. Completed 11/8/13 3. The facility will continue its monthly check and inspection of the remote annunciator as part of the facility monthly fire alarm system and emergency generators checks. Completed 11/30/13 and Ongoing 4. The Maintenance Director will present a report of the results of the facility remote annunciator inspections to the facility's Performance Improvement Committee monthly for three months and then quarterly on an ongoing basis. The Performance Improvement Committee will make recommendations as appropriate. Completed 11/7/13 and Ongoing	10/29/13 11/8/13 11/30/13 11/7/13