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

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING ______ B. WING ______	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE RD CHARLOTTE, NC 28207

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities schedules, and health care consistent with his or her interests, assessments, and plans of care interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to assess and honor the choice for bathing frequency for 1 of 2 residents observed for choices. (Resident #8) The findings included: Resident #8 was admitted to the facility with diagnoses which included dementia, diabetes, and blindness. Resident #8's most recent Minimum Data Set (MDS) dated 11/14/13 assessed her as being cognitively intact. The MDS indicated resident #8 was dependent for bathing with the assistance of one person. On 11/18/13 at 3:15 PM an interview was conducted with Resident #8. Resident #8 stated she would like to have more than two showers per week. She stated she would like to have three showers per week. An interview was conducted at 2:44 PM with Nursing Assistant (NA) #3. NA #3 stated resident #8 received her showers on Wednesday and Saturdays. She stated there was a shower book which told what day residents received showers.	F 242	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the 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 the federal and state law. This plan of correction is submitted as the facility's credible allegation of compliance.** F242 Residents # 8 was interviewed regarding her bath choices and time preference 12/04/13. The Shower Schedule and CNA care card were revised to reflect the changes. All residents upon admission will be interviewed about their choices as it relates to shower preference.	12/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Johnson
TITLE: Executive Dir / NHA
(X6) DATE: 1/2/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original Signature Date: 12-17-13

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F 242	Continued From page 1 NA #3 when on to explain the shower schedule is determined by what room number residents have. NA #3 stated if residents want more than two showers per week they would have to ask. NA #3 stated she did not think anyone assessed how many showers the residents want per week. On 11/21/13 at 2:50 PM an interview was conducted with Nurse #3 who took care of Resident #8. Nurse #3 stated residents who want more than two showers per week would have to ask. She stated no one assessed how many showers residents would like when they were admitted. Nurse #3 stated Resident #8 never told her she wanted more than two showers per week. On 1121/13 at 5:19 PM an interview was conducted with the Director of Nursing (DON) The DON stated she did not think frequency of showers was assessed when a resident was admitted. She stated preference for frequency of showers should be assessed.	F 242	The Shower Schedules and CNA care cards were revised to reflect any changes. Preferences to be reviewed by social services or designee upon admission, quarterly, or change of condition. The nursing Staff was in-serviced regarding Residents Rights including making choices about his or her care. The Director of Nursing/designee will randomly select 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus on the bath preference and staff adherence to their choice. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.	12/23/13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide nail care for 1 of 3 sampled residents reviewed for activities of daily living (ADL). (Resident # 96	F 312		

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F 312	Continued From page 2	F 312		

Findings included:

Review of Resident #96's Annual Minimum Data Set (MDS) dated 08/26/13 revealed he was assessed as having severely impaired cognition and needed extensive assistance of 2 persons for most ADL including personal hygiene.

Review of resident #96's cognitive care plan dated 08/26/13 revealed interventions to anticipate resident needs and provide consistent staff to work with the resident.

Observations on 11/20/13 at 8:15 AM and 12:58 PM revealed his finger nails on both hands had a quarter inch dark debris underneath the nail beds. Subsequent observations on 11/21/13 at 11:16 AM and 5:40 PM revealed his fingernails on both hands continued to have a quarter inch dark debris underneath the nail beds.

An interview was conducted with Nurse Aide (NA) #1 on 11/21/13 at 9:35 AM. She stated showers are done 2 and 3 times a week depending on resident preference. At the time of showers, shaves and nails are cut, cleaned and trimmed. She said shaves and nails should not be done just on shower days but as needed.

An interview was conducted with NA #2 on 11/21/13 at 5:44 PM. She stated she had responsibility for care of Resident #96 and all residents residing on the short and long 100 hall. She reported she was the only NA on the 100 hall on second shift. She revealed Resident #96 had showers scheduled on Wednesdays and Saturdays. She said residents nails and facial hair should be monitored on a daily basis for

Provider's Plan of Correction:

F312
Residents # 96 was provided finger nail care.

All residents in the facility have the potential for being effected by the deficient practice.

An audit of all resident nails was conducted and nail care provided as needed. The nursing staff was in-serviced regarding care of residents nails.

Director of Nursing/designee will randomly select 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus on nail care including cleaning. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.

Completion date: 12/23/13

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F 312	Continued From page 3 trimming and cleaning. She said she does showers on second shift and washes residen 's hands before meals but had not always been able to clean and trim nails as needed. NA #2 observed Resident #96's fingernails and agreed they had not been cleaned on his shower days and needed to be cleaned. An interview with the Director of Nursing (DON) on 11/21/13 at 6:03 PM revealed she expected the NAs to monitor resident's fingernails during routine care and clean them on a daily basis. The DON observed Resident #96's fingernails and agreed they needed to be cleaned.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of medical records and facility investigations the facility failed to supervise 2 of 3 sampled residents assessed with impaired cognition and exhibiting wandering behavior. Resident #66 was unsupervised while on the facility's side porch and in the first floor back lobby. Resident #107 was unsupervised while in the facility's parking lot.	F 323	F323 Residents # 66 and #107 continue to wear Wanderguard bracelets and are monitored by staff. Upon admission, quarterly, or with a change of condition residents are assessed for the potential for Wandering the potential for being effected by the deficient practice. All residents in the facility were reviewed for the completeness and accuracy of their wandering assessment. A list was compiled of residents requiring a Wanderguard bracelet to assist in monitoring . The nursing Staff was in-serviced regarding Wandering and Elopement Policy. Exit door functions are checked daily by maintenance staff/designee. Door alarm codes will be changed. A poster to alert	12/23/13

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F 323	Continued From page 4 The findings included: 1. a. Resident #66 was admitted to the facility 12/4/08. Diagnoses included Alzheimer's dementia, psychosis and tobacco use. Resident #66's care plan initiated 05/18/11 included his risk for elopement related to impaired cognition and poor safety awareness with a goal of no incidence of elopement. Interventions included placement on a secured unit, daily use of wander guard, to redirect the Resident from doors and to assist the Resident to/from smoke breaks. Resident #66 had a physician's order dated 02/21/13 for a wander guard in place, requiring staff to monitor and check function/placement each shift. The facility maintained documentation on the medication administration records of routine monitoring for function and placement of the wander guard. A quarterly Minimum Data Set (MDS) dated 07/1/13 assessed Resident #66 with impaired cognition, exhibiting wandering behavior and requiring staff supervision with ambulation off the unit. A facility incident report and nurse's note dated 08/19/13 recorded in part that Resident #66 was noted by maintenance staff unsupervised on the side porch in the resident smoking area at approximately 11:30 AM. Resident #66 stated he was waiting for his cigarette. Resident #66 was escorted back into the facility and back to the secure unit by staff with no injuries noted. He was noted by staff to wear a functioning wander guard which sounded as he was assisted back to the	F 323	visitors not to allow residents to tailgate them out of the facility will be posted by the exit doors and elevators. Wanderguard bracelets are checked every shift for placement and function by the nursing staff. The Director of Nursing/designee will randomly select 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus Wanderguard documentation. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.	

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secured unit. The incident report documented that maintenance staff checked all facility exit doors and alarmed doors on the secured unit which were found functioning. Staff were re-educated on responding to door alarms.

Interview on 11/21/13 at 11:04 AM with Nurse #3 revealed on 08/19/13 Resident #66's nurse was on break when Nurse #3 received a phone call stating Resident #66 res was found on the side porch. Nurse #3 stated she saw Resident #66 leave the secured unit that morning with other residents for the 10:30 AM smoke break, but she did not see him return to the unit. Nurse #3 stated Resident #66 was in the habit of walking towards the elevator when anyone left the unit, but he was easily redirected if he was told that it was not time for his smoke break. Nurse #3 further stated that a staff member should take residents for their smoke break and bring all residents back to the unit together.

Interview on 11/21/13 at 11:17 AM with Nurse #7 revealed she was the 7-3 PM cart nurse assigned to Resident #66 on 08/19/13. She described Resident #66 as a confused Resident who frequently walked towards the elevator to look out the window on the unit, but he was easily redirected. Nurse #7 stated she observed Resident #66 leave the unit on 08/19/13 with staff for the 10:30 AM smoke break and then shortly thereafter she took her break. Nurse #7 stated while she was on break, nurse #3 called her and informed her that Resident #66 was found on the side porch unsupervised. Nurse #7 stated she brought Resident #66 back to the secured unit She stated he was wearing a wander guard that alarmed and was functioning when he entered the facility through the door to the back porch and

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also sounded at the first floor elevator door and at the elevator door on the secured unit. The nurse stated each time the alarm sounded she had to enter a code to disarm the alarm. Resident #66 was assessed without injury and placed on 1:1 observations. Nurse #7 stated afterwards staff was in-serviced to monitor door alarms and to make sure Resident #66 was escorted to/from smoke breaks and returned to the charge nurse on the secure unit.

Resident #66 was observed in his room on 11/21/13 at 12:07 PM confused and seated in a chair at his bedside dressed and groomed with a wander guard to his left wrist. He was observed to walk independently towards the elevator to the window at the far end of the hall. The elevator door alarm sounded and the alarm to the stairwell also sounded. Staff responded and entered a code to disarm the alarm.

An interview on 11/21/13 at 12:19 PM with the Maintenance Assistant (MA) revealed in August 2013 he was the facility's maintenance director at that time. On 08/19/13 around 11:30 AM he walked outside to the facility's side porch to take his lunch break and saw Resident #66 unsupervised leaning against the rail on the porch. Resident #66 stated he was waiting for a cigarette. The MA stated Resident #66 had never attempted to leave the property, but would get irritated if he did not get his smoke break. The MA stated Resident #66 was taken back to the secured unit by staff. He stated that on the secured unit doors leading to the stairwells and the elevator door was alarmed. If a resident wearing a functioning wander guard approached the alarmed doors or the elevator door, the alarm would sound to alert staff and required a staff

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member to enter a code to turn off the alarm. The MA stated while he was the maintenance director he conducted daily checks of the wander guard system. On 08/19/13, after this incident occurred he checked all the alarmed exit doors and elevators doors again and found the wander guard system working.

Interview with the interim Director of Nursing (DON) on 11/21/13 at 4:50 PM revealed residents on the secure unit who were assessed for risk of wandering/elopement should not be unsupervised at any point. The interim DON stated she started about two weeks prior and had no further information regarding the investigation from previous management to determine how Resident #66 was found unsupervised on the side porch. She stated that the current week she instructed staff to check all the wander guard bracelets for function, placement and expiration. The interim DON stated that each nurse was responsible for checking placement and function of wander guards each shift. The interim DON stated she was aware that on 08/19/13 maintenance staff checked all exit doors and the alarmed doors on the secured unit and all alarms were found functioning. The interim DON also stated that on 08/20/13 all staff were re-educated to monitor/respond to door alarms. Documentation of this in-service was provided for review.

Interview on 11/21/13 at 5:09 PM with Central Supply Staff revealed that she was already outside on the side porch supervising residents for the 10:30 AM smoke break on 08/19/13 when Resident #66 was assisted to the side porch by the restorative aide. It started raining and all residents were redirected back into facility.

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Central Supply Staff stated that the restorative aide took residents back into the facility through the side door leading to the porch and assisted residents back to the secured unit while she returned the smoke box to the front office by walking around the side of the facility and entering the facility through the front door. Central Supply Staff stated when she left the side porch there were no residents left on the porch.

Interview with Restorative Aide on 11/21/13 at 5:19 PM revealed she assisted residents to the side porch for the 10:30 AM smoke break on 08/19/13 including Resident #66. She stated it started raining and all the residents were assisted back inside the facility from the door leading to the side porch and taken back to their units. The Restorative Aide stated she assisted Resident #66 back to the secured unit to the nurse. She stated she observed him with a wander guard in place and the elevator door alarm sounded.

b. Resident #66 was admitted to the facility 12/4/08. Diagnoses included Alzheimer's dementia, psychosis and tobacco use.

Resident #66's care plan initiated 05/18/11 included his risk for elopement related to impaired cognition and poor safety awareness with a goal of no incidence of elopement. Interventions included placement on a secure unit, daily use of wander guard, to redirect from doors and to assist to/from smoke breaks.

Resident #66 had a physician's order dated 02/21/13 for a wander guard, requiring staff to monitor and check function/placement each shift. The facility maintained documentation on the

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medication administration records of routine monitoring for function and placement of the wander guard.

A facility incident report dated 09/09/13 recorded in part that around 7:30 PM, Resident #66 was observed by the Staff Development Coordinator (SDC) standing in front of the therapy gym on the first floor unsupervised. Resident #66 was assisted back to the secured unit by the SDC. He was found with a wander guard on his left wrist which sounded at the elevator doors on the first floor and on the secured unit and without injury. Staff was re-educated to make sure all residents were assisted back to their units after a smoke break and a change to the door code was recommended.

A quarterly MDS dated 09/30/13 assessed Resident #66 with impaired cognition, exhibiting wandering behavior and requiring limited staff assistance with ambulation off the unit.

An interview with the SDC on 11/20/13 at 7:18 PM revealed she was leaving for the day around 7:30 PM on 09/09/13 when she saw Resident #66 standing unsupervised in front of the therapy office on the first floor near the door leading to the side porch. The SDC stated she was unsure why Resident #66 was there alone, but she escorted him back to the secured unit, his wander guard was in place and the elevator door alarm sounded. The SDC entered a code to disarm the alarm. She described Resident #66 as a confused, independent with ambulation, with no previous attempts to leave the facility, but he did not like to miss a smoke break.

An interview with nurse aide #4 (NA #4) on

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F 323	Continued From page 10 11/21/13 at 07:30 AM revealed on 09/09/13 she assisted residents to/from the secure unit for the 6:30 PM smoke break, but Resident #66 did not go with her because he was eating his dinner. NA #4 stated she observed Resident #66 in his room eating dinner when she left the secured unit and when she returned about 30 minutes later. NA #4 described Resident #66 as a confused person who wore a wander guard and he did not like to miss his smoke break. Interview with the administrator and interim Director of Nursing (DON) on 11/21/13 at 10:00 AM confirmed Resident #66 wore a wander guard due to confusion/wandering behavior and that he should not be left unsupervised. The administrator and interim DON stated they were not part of the administrative team at the time of this incident and could not explain why Resident #66 was found unsupervised on the first floor. The administrator stated that on 09/10/13 staff were re-educated on the facility's elopement policy and to make sure all residents were assisted back to their units after a smoke break. Additionally, residents on the secured unit should be returned to the charge nurse. The DON stated the code to the elevator doors was also changed. Documentation of the in-service was provided for review. Interview with Nurse #2 on 11/21/13 at 10:10 AM revealed she was the assigned nurse for Resident #66 on the 3-11 PM shift on 09/09/13 Nurse #2 stated on 09/09/13 she administered evening medications to Resident #66 around 5:00 PM and later that shift she observed him in his room eating his dinner. After eating he took his tray to the meal cart and she entered a resident's room to complete a dressing change for about 15	F 323		

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F 323	Continued From page 11 - 20 minutes. Nurse #2 stated she received a phone call telling her that Resident #66 had been found unsupervised off the secured unit. Nurse #2 stated Resident #66 wore a wander guard that was checked for placement and functioning each shift and she verified earlier in the shift that it was functioning. Nurse #2 stated she was not sure if Resident #66 was assisted to the 6:30 PM smoke break that day and she could not account for how Resident #66 may have gotten off the secured unit. Nurse #2 stated after the phone call she immediately went to his room and found him washing his hands. Nurse #2 assessed Resident #66 without injury, she checked his wander guard on his left wrist and it was functioning. Staff conducted 15 minute visual checks for the duration of that shift. Nurse #2 stated staff was in-serviced regarding the facility's wander guard policy, to keep all residents leaving the secured unit together for smoke breaks and to return residents on the secured unit back to the nurse. Resident #66 was observed in his room on 11/21/13 at 12:07 PM confused, seated in a chair at bedside dressed and groomed with a wander guard to his left wrist. He was observed to walk independently towards the elevator to the window at the far end of the hall. The elevator door alarm sounded and the alarm to the stairwell door sounded. Staff responded by entering a code which disarmed the alarm. An interview was conducted on 11/21/13 at 12:10 PM with the Maintenance Director. The maintenance director stated he monitored the wander guard system weekly to ensure proper functioning. The maintenance director stated the 3rd floor was a secured unit and residents who resided on that unit and wore a wander guard	F 323		

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could not access the elevator or the doors to the stairwells without staff entering a code to disarm the alarm. The Maintenance Director stated if a resident exited the building wearing a wander guard, the wander guard system on any exit door should alarm to alert staff. Interview with the maintenance director and review of weekly maintenance logs dated 09/2013-11/2013 revealed no malfunction of the wander guard system.

Interview with the interim DON on 11/21/13 at 4:50 PM revealed residents on the secure unit who were assessed for risk of wandering/elopement should not be unsupervised at any point. The interim DON stated she started about two weeks prior and the week of the survey, staff began checking all the wander guard bracelets for function, placement and expiration. The interim DON stated that each nurse was responsible for checking placement and function of wander guards each shift.

2. Resident #107 was admitted 03/21/2013. Diagnoses included alzheimer's dementia. Minimum Data Set dated 09/04/13 assessed Resident #107 with severely impaired cognition, independent with ambulation, exhibiting wandering behavior.

On 11/20/13 at 12:40 PM Resident #107 was observed seated in the dining area on the 3rd floor secured unit with a wanderguard to his right ankle.

A care plan was initiated 04/16/13 for risk of elopement related to the resident wandering aimlessly throughout the facility; the resident had

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a wanderguard to alert staff of any unsupervised attempts to exit the facility. Care plan measures were implemented with the goal of having no incidence of elopement.

Review of physician orders with start date 04/15/13 indicated wanderguard placed on right leg for safety, check for placement and function each shift. Review of Medication Administration Record (MAR) dated 09/2013-11/2013 revealed wanderguard checks were performed each shift as ordered.

Review of social services note dated 05/13/13 indicated Resident #107 was readmitted to the facility and his family requested a room change off the 3rd floor secured unit. The social services note indicated Resident #107 was moved to the 2nd floor.

Review of incident report dated 10/05/13 at 12:28 PM indicated Resident #107 was found outside in the parking lot at the back of the building. Review of nurses notes indicated Resident #107 was returned to the 2nd floor hall where he resided, placed on 15 minute visual checks, and transferred to the 3rd floor secured unit. Record review indicated no apparent injury.

An interview was conducted on 11/20/13 at 11:46 AM with the restorative nurse aide. The restorative aide stated she observed Resident #107 on 10/05/13 from the 3rd floor window standing outside in the back parking lot unattended. The restorative aide stated she told the 3rd floor nursing staff who called to notify the 2nd floor nursing staff.

An interview was conducted on 11/20/13 at 12:03

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F 323	Continued From page 14 PM with Nurse #2. Nurse #2 stated she saw Resident #107 seated in the common tv area on the 2nd floor around 11:30 AM on 10/05/13. Nurse #2 stated she was contacted by the 3rd floor staff around 12:00 PM and was notified that Resident #107 was outside in the back parking lot unattended. Nurse #2 stated that she and one of the hall nurse aides went outside to bring the resident back to the unit. Nurse #2 stated Resident #107 walked back into the building through the double doors on the side of the building near the smoking patio. Nurse #2 stated the wanderguard alarm sounded as the resident entered through the doors. Resident #107 was escorted back to the 2nd floor, placed on 15 minute checks and transferred to the 3rd floor secured unit. Nurse #2 was unable to provide an explanation of how Resident #107 exited the building unattended without staff knowledge. An interview was conducted on 11/21/13 at 12:10 PM with the Maintenance Director. The Maintenance Director stated he monitored the wandergaurd system weekly to ensure proper functioning. The Maintenance Director stated the 2nd floor was not a secured unit and residents could access the elevator to go down to the 1st floor. The Maintenance Director stated if Resident #107 exited the building wearing a wanderguard, the wanderguard system on any exit door should alarm to alert staff. Interview with the Maintenance Director and review of weekly maintenance logs dated 09/2013-11/2013 revealed no malfunction of the wanderguard system. Interview with the Interim Director of Nursing (DON) on 11/21/13 at 5:15 PM stated she was not aware of any facility investigation that may	F 323		

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F 323	Continued From page 15 have been conducted by previous management staff concerning the incident with Resident # 07. The Interim DON stated cognitively impaired residents with wandering behaviors should be monitored to maintain a safe environment and to ensure they did not exit the facility unattended.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on hospital records, chart review and staff interviews the facility failed to give the correct dose of insulin to 1 of 6 resident reviewed for medication errors. (Resident #152) The findings included: Resident #152 was admitted to the facility on 08/30/13 with diagnoses which included diabetes. Review of Resident #152's hospital discharge summary dated 08/30/13, listed under current medications was among others, Lantus (insulin) 50 units subcutaneous twice per day. Review of Resident #152's hospital medication reconciliation form dated 08/30/13 revealed an order for Lantus insulin 15 units injected twice a day. Review of Resident #152's August 2013 Medication Administration Record (MAR) revealed Lantus insulin 50 units was given	F 333	F333 Residents # 152 a blood sugar audit was reviewed an are within normal range. Newly admitted residents admission medication records were reviewed with current physician orders for accuracy and any conflicting data. All diabetic residents in the facility have been reviewed regarding their insulin dosages. . Two nurses will review and sign. The nursing Staff was in-serviced regarding the process of reviewing orders on admission for those residents receiving Lantus Insulin. The Director of Nursing/designee will randomly review all new admission/readmission charts of residents receiving Insulin for 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to review reconciliation hospital physician orders with admission orders signed by 2 nurses. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.	12/23/13

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subcutaneously at 9:00 PM on 08/30/13. Further review of the MAR revealed Lantus insulin 50 units was administered to Resident #152 on 08/31/13 at 6:30 AM. The 9:00 PM 08/31/13 dose of Lantus 50 units was not documented as given.

A nurse's note dated 08/31/13 at 9:40 PM indicated Resident #152 had a blood sugar of 28 mg/dl. Resident #152 refused his Lantus insulin.

Review of MAR for September 2013 indicated Lantus insulin was not given at 6:30 AM on09/01/13. Further review of the MAR on 09/01/13 at 6:30 AM Resident #152 had a blood sugar at of 58 mg/dl.

A physician order dated 09/01/13 at 12:15 PM to discontinue Lantus (insulin) 50 units, decrease Lantus (insulin) to 15 units subcutaneously twice per day.

On 11/20/13 at 4:33 PM an interview was conducted with Nurse #4 who admitted Resident #152 to the facility on 08/30/13. Nurse #4 stated when the resident came from the hospital he reviewed the resident's discharge summary read Lantus 50 units was to be administered twice a day. He stated that was the only order for Lantus he saw at the time of the resident's admission. He explained he called the nurse practitioner on 08/30/13 and went over the medications that were listed on the resident's discharge summary. Nurse #4 reported when the resident's blood sugar was low on 09/01/13 he reviewed the resident's chart and found the 08/30/13 hospital medication reconciliation sheet which contained an order for the resident to receive 15 units of Lantus twice a day. Nurse #4 stated he then called stated he called the nurse practitioner to

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notify her of this order and received an order fo the resident to receive Lantus 15 units twice a day.

An interview was conducted on 11/21/13 at 4:4: PM with the Nurse Practitioner (NP). The NP stated she was called regarding the admitting orders for Resident #152. She stated she did nt question the 50 units of Lantus twice per day as she sees residents in this population with highe doses of Lantus. She stated with Resident #152's diagnoses of severe diabetes the order for Lantus 50 units did not alarm her. The NP further stated the nurse should have reviewed with her the medications listed on the hospital medication reconciliation form, as it is the legal document that is signed by the physician, instead of reviewing with her the medications listed on the resident's hospital discharge summary.

An interview was conducted on 11/21/13 at 5:10 PM with the Staff Development Coordinator (SDC). The SDC stated that prior to the incident of Resident #152 receiving the incorrect doses of Lantus Insulin on 08/30/13 and 08/31/13 it was common practice for nurses who admitted residents to this facility to use the resident's hospital discharge summary to review medication orders. She further stated nursing staff are directed to always use the resident's hospital medication reconciliation with the medications listed on the resident's hospital discharge summary for discrepancies.

On 11/21/13 at 5:17 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for staff to look at both the discharge summary and the medication reconciliation form to compare any

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F 333	Continued From page 18 information that was available.	F 333		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility menus, the facility failed to serve ½ cup portion of mechanical soft roast beef according to the menu for 21 of 25 residents who received a mechanical soft diet per physician's order. (Residents #14, 86, 48, 17, 18, 47, 140 36, 88, 52, 8, 39, 34, 76, 126, 11, 62, 107, 10, 46 and 146) The findings included: An observation of the lunch meal tray line occurred on 11/20/13 at 12:09 PM. The lunch menu included roast beef, potatoes and Brussels sprouts. Further review of the menu revealed residents with a physician's order for a mechanical soft diet were to receive a ½ cup portion of mechanical soft roast beef. The tray line included mechanical soft roast beef served with a 1/3 cup utensil. Lunch trays were observed plated from 12:10 PM to 12:30 PM for Residents with a physician's order for a mechanical soft diet to include Residents #14, 86, 48, 17, 18, and 47.	F 363	F363 No specific residents were harmed by this action. The potential for harm to residents needing is used includes wt loss, skin breakdown, etc. Cooks in-serviced on for the use of proper scoop sizes to ensure proper portions for all diets to include those residents on mechanical soft diets. Tray line will be monitored 3 times per day time 3 weeks to assure that the proper scoop sizes are being used specifically those residents on a mechanical soft diet. Then the audit will then be 6 times per week times 3 weeks. Findings from the audits will be reported to Quality Assurance committee monthly for 6 months and quarterly thereafter.	12/23/13

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F 363	Continued From page 19 Interview with cook #1 on 11/20/13 at 12:32 PM revealed she used the menu and the utensil guide located in a book kept at the tray line to determine which utensils to use for the meal service. Cook #1 was observed to review the menu and then the utensil guide and stated that she should have served ½ cup portion of mechanical soft roast beef using a gray handled utensil. Cook #1 further stated that she typically served residents ordered a mechanical soft diet 1/3 cup portion of meat, but the current menus were new to her and she did not realize the portion size for mechanical soft meat was different. Cook #1 stated she was currently serving the last cart for the 2nd floor and residents on the 1st and 3rd floors had already served. An interview with assistant dietary manager (ADM) occurred on 11/20/13 at 12:34 PM. The interview revealed that she usually checked the serving utensils prior to the start of the tray, but she did not check that day. An interview with the dietary manager/registered dietitian (DM/RD) occurred on 11/20/13 at 12:37 PM. The DM/RD stated that the portion sizes for foods served to residents with a physician's order for a mechanical soft diet varied per meal. He stated that cooks were trained to refer to the colored utensil guide and were responsible for making sure they served foods in portions according to the menu. He also stated that residents who ate at least 50-75% of their meal would meet their nutritional needs, but those who ate less than 50% of their meal and who also received portions smaller than the menu required would not have their nutritional needs met. The DM/RD stated that one Resident on the 1st floor	F 363		

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F 363	Continued From page 20 (Resident #140) and 14 Residents on the 3rd floor (Residents #36, 88, 52, 8, 39, 34, 76, 126, 11, 62, 107, 10, 46, and 146) with physicians orders for mechanical soft diets had already been served their lunch meal.	F 363		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to 1) provide warm water at the hand sink in the dietary department and 2) complete hand hygiene using warm water prior to meal preparation for 2 of 2 meal observations. The findings included: The facility's policy "Dining Services, Hand Washing", undated, recorded in part the following instructions, "Turn on water and run until warm. Wet hands and exposed forearms with warm water. Rinse thoroughly with warm water. Perform hand hygiene before putting on disposable gloves, before handling food, clean equipment, utensils, dishes or service wear."	F 371	F 371 No residents were harmed by the deficient practice. All Residents could potential be at risk secondary to no warm water in dietary hand sink. Hand sink water temperature will be recorded twice a day for 4 weeks, then checked and recorded daily on a monthly basis thereafter. Reduction of temperature will be reported to the Dietary Service Manager, maintenance, and Executive Director. Staff in-serviced on complete hand hygiene using warm water prior to meal preparation. Twice daily water temperatures in the hand washing sink times one month then once daily temps for 2 weeks, then 3 times per week until 1-22-14. Registered Dietician or Dietary Service Manager Findings from the audits will be reported by the Registered Dietician or Dietary Service Manager to the Quality Assurance committee monthly for 6 months and then quarterly thereafter.	12/23/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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An observation of water from the hand sink occurred on 10/18/13 at 10:50 AM. The hot water only was allowed to run for two minutes and remained cold to touch.

Interview with the assistant dietary manager (ADM) occurred on 10/18/13 at 10:52 AM. During the interview the ADM revealed that for the past few days the hot water at the hand sink had been hot at times and cold at times. The ADM further stated that it took a while for the water to warm up. The ADM stated she had not reported this concern. Further observations with the ADM at 10:55 AM revealed the prep sink with only cold running water which remained cold to touch after two minutes. Additionally the two staff bathrooms were observed at 11:00 AM on the basement floor with only cold running water that remained cold to touch after two minutes. The ADM stated she was unaware that the water at the prep sink and in the staff bathrooms on the basement floor was also cold.

Interview with the dietary manager/registered dietitian (DM/RD) occurred on 11/18/13 at 11:05 AM and revealed he was just made aware that the hand sink, prep sink and the hand sinks in the staff bathrooms on the basement floor did not have hot water. He stated he informed the maintenance director of the cold water and he was aware that the maintenance director was addressing plumbing concerns.

A second observation of the water at the hand sink, prep sink and staff bathrooms on the basement floor occurred on 11/18/13 at 4:12 PM and revealed the water remained cold to touch after running for two minutes.

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A follow-up interview with the ADM occurred on 11/18/13 at 4:15 PM and revealed the second shift dietary staff were not informed of the cold water at the hand sink, prep sink or the staff bathrooms or given any new instructions regarding hand hygiene. The ADM also stated that she had not monitored the temperature of the water at the hand sink, prep sink or staff bathrooms and she thought the water was hot now.

An interview with a second shift dietary aide (DA #1) occurred on 11/18/13 at 4:16 PM and revealed that she washed her hands at the hand sink about 30 minutes prior and the water was cold. DA #1 stated she was unsure why the water was not hot, but she did not report this. DA #1 was observed during the interview plating cake for the dinner meal while wearing gloves.

An interview with a second shift DA #2 occurred on 11/18/13 at 4:22 PM, during the interview he was observed pouring tea for the dinner meal into individual cups with bare hands. DA #2 stated he washed his hands at the hand sink about 30 minutes ago and the water was cooler than usual. DA #2 stated he was not sure why the water was not hot and he had not received any instructions regarding alternate hand hygiene options since coming on shift. DA #2 stated since coming to work he had poured thickened water/tea and made four pitchers of lemonade for residents. He stated he had not reported the concern with water tempterature at the hand sink.

An interview occurred with the maintenance director on 11/18/13 at 4:30 PM. The interview revealed that he was hired on 08/26/13. Since he

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F 371	Continued From page 23 was hired he had identified the inability to control water routed for resident use at individual valves. He stated that some valves would not operate so in order to make repairs he turned off water for the facility at night using the main valve. He further stated that in order to determine if the replaced valves where operational, he had to assess this during the day. The maintenance director stated he was unaware that this would affect hot water for the dietary department. As a result he did not inform the dietary staff that hot water would be unavailable while he assessed the valves. He stated that as soon as the DM/RD informed him that hot water was unavailable at the hand sink, he turned the hot water back on, the hot water was checked and observed to be warm, but knew it would take a while for the hot water to return. He stated he was not sure what caused the water to be cold again, but he was in the process of trying to resolve this. A follow-up interview with the DM/RD on 11/18/13 at 4:35 PM revealed maintenance staff informed him earlier that morning that the hot water was back on. The DM/RD stated that he checked the water at the hand sink himself after the lunch tray line and the water was hot. He further stated that he had not checked the water at the hand sink or the prep sink since lunch and he was not aware that the water at these sinks was cold again. The DM/RD stated that dietary staff was trained to wash their hands using hot water and soap and he had also placed hand sanitizer at the hand sink for staff use.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from	F 412		

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	345008	A. BUILDING ______ B. WING ______	C 11/21/2013

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an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews the facility failed to provide dental services for 1 of 3 sampled residents reviewed for dental concerns. (Resident #36).

The findings included:

Resident #36 was admitted to the facility on 12/09/11. A Significant Change Minimum Data Set (MDS) dated 08/19/13 revealed Resident #36 was cognitively intact. The MDS noted Resident #36 required limited assistance of 1 person for most activities of daily living (ADL) including personal hygiene. The MDS also noted Resident #36 had no mouth or facial pain or broken or loose fitting teeth.

An interview was conducted with Resident #36 on 11/20/13 at 9:22 AM. She said she had a top denture when she was admitted to the facility. She revealed she had dropped the denture while sitting in her room and it had been lost. Resident #36 said she reported the denture had been lost and was seen by a dentist but was unable to recall the date of this appointment. She revealed she had been fitted for a partial for missing teeth

F 412

F412
An appointment for a dental consult was made for Residents # 36 on 12/09/13. Resident #36 was seen by Beacon Dental Center, Dr Conner.

All residents with natural teeth have the potential for being effected by the deficient practice.

The resident received dental services and a plan for dental extractions was submitted for payment to Medicaid. The resident is being monitored for oral pain. The 24 Hour reported has been monitored for residents with complaints of oral pain. The nursing Staff was in-serviced regarding reporting oral pain.

The Director of Nursing/designee will randomly 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus on the dental concerns. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.

12/23/13

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observed on her lower arch. She reported she had not heard anymore about the partial and a follow-up scheduled dental appointment had not been done. She said she did not have mouth pain but had some chewing problems if meat was not soft.

Observation on 11/20/13 12:48 PM revealed Resident #36 eating her lunch meal in the 300 hall dining room. She was observed with adaptive utensils eating ground pot roast and brussel sprouts. Resident #36 stated she was able to chew the ground meat and eat the brussel sprouts because they were soft. Observation of her tray card revealed she had a soft mechanical diet with ground meats.

An interview was conducted with the MDS Coordinator on 11/21/13 at 4:40 PM. She stated Resident #36 came back from the hospital on 08/12/13 and a significant change MDS was completed. The MDS Coordinator reported she had not coded Resident #36 as having broken or loose natural teeth. The MDS Coordinator revealed she had not noticed the resident had broken teeth. She revealed the expectation would be if a resident required dental services staff should follow up with residents and schedule the dental appointments.

Record review of consults revealed no dental consult sheets provided for Resident #36. Review of Nurses progress notes provided no documentation dental services had been provided for Resident #36. There were no dental consults found in Resident #36's entire chart.

An interview was conducted on 11/21/13 at 4:58 PM with the Social Worker. The Social Worker

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F 412	Continued From page 26 stated a dental service had been provided to the facility since January, 2012. When the dentist came to the facility he evaluated every Medicaid resident in the building and made dental procedural recommendations for residents to outside dental offices. The Social Worker reported Resident #36 would have been eligible to be seen by the dentist. She stated Resident #36's medical record provided no dental consult sheets or dental information in progress notes The Social worker revealed she called the dentist office on 11/21/13 and was informed that Resident #36 ' s last dental appointment occurred on 11/21/12. The Social Worker reported that the dental office told her they had been working on a full upper denture and partial bottom recommended during the visit of 11/21/12 but Resident #36's remaining teeth would have to be removed before a dental procedure could be done. The Social Worker stated when a resident needed a dental appointment she informed the unit manager on the hall and the unit manager would schedule the dental appointment and set up transportation. The Social Worker revealed the facility had been without a unit manager for awhile so dental appointments probably had not been scheduled. The Social Worker stated a year was a long time for Resident #36 not to have had another scheduled appointment to address her dental needs. An interview was conducted with the Director of Nursing (DON) on 11/21/13 at 5:51 PM. The DON stated facility dental services was contracted with a dental company who have provided resident assessments and evaluations internally every 6 months. Residents who have required dental procedure evaluations are sent out for dental consults. The DON revealed she	F 412		

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expected referrals to be scheduled when ordered and she had not been aware Resident #36 had not been seen by a dentist since 11/21/12.

F 441 SS=D — 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

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.

(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

Provider's Plan of Correction:

F441
Nurse # 1 was in-serviced regarding policy and procedure for cleaning the glucometer.

All residents in the facility receiving glucometer checks have the potential for being effected by the deficient practice.

The nursing Staff was in-serviced regarding the cleaning procedure for glucometers.

The Director of Nursing/designee will randomly select 3 nurses twice per week for 4 weeks, 3 nurses per week for 4 weeks, and randomly each month thereafter to focus on

cleaning the glucometer properly. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.

Completion date: 12/23/13

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transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews the facility failed to disinfect a glucometer (used for blood sugar monitoring) following a finger stick blood sugar for 1 of 2 sampled residents observed for medication administration. (Resident #3)

The findings included:

The facility policy titled "Blood Glucose Monitor Decontamination" with revision date 08/2012 read in part: "A wipe that is an EPA registered as tuberculocidal; effective against HIV, HBV, and a broad spectrum of bacteria will be utilized to clean the monitor. The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents."

Resident #3 was admitted 4/29/2003. Diagnoses included diabetes with accuchecks ordered to monitor the resident's blood glucose levels.

On 11/20/13 at 4:59 PM Nurse #1 was observed completing a finger stick blood sugar. Nurse #1 exited Resident #3's room and cleaned the glucometer with an alcohol pad. An interview was conducted with Nurse #1 at the time of this observation. Nurse #1 stated she routinely cleaned the glucometer at the beginning and end of her shift with germicidal wipes and used alcohol pads after each resident use to disinfect

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F 441	Continued From page 29 the glucometer. Review of Nurse #1's medicat on cart at the time of the observation revealed a supply of germicidal wipes on hand. On 11/21/13 at 12:25 PM an interview was conducted with the Staff Development Coordinator/Infection Control Nurse. The Infection Control Nurse stated nurses were trained on infection control practices and were expected to clean glucometers with germicidal wipes after each use. The Infection Control Nu se stated alcohol pads were not appropriate to effectively disinfect glucometers for multiple residents use.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	F 520 Residents # 66 and #107 continue to wear Wanderguard bracelets and are monitored by staff. All residents in the facility with a potential for Wandering the potential for being effected by the deficient practice. All residents in the facility were reviewed for the completeness and accuracy of their wandering assessment. Wandering assessments are completed on admission and quarterly. A list was compiled of residents requiring a Wanderguard bracelet to assist in monitoring . The nursing Staff was in-serviced regarding Wandering and Elopement Policy. Exit door functions are checked daily by maintenance staff/designee. Door alarm codes will be changed. A poster to alert visitors not to allow residents to tailgate them out of the facility will be posted by the exit doors and elevators. Wanderguard bracelets are checked every shift for placement and function by the nursing staff.	12/23/13

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F 520	Continued From page 30 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility documents, record review and staff interview the facility failed to effectively implement and monitor interventions put into place by the Quality Assessment and Assurance committee for 2 of 3 residents reviewed for wandering behavior. (Residents #66 and #107) The findings included: Resident #66 admitted to the facility with diagnoses which included Alzheimer's dementia. Resident #66's most recent Annual Minimum Data Set (MDS) dated 09/20/13 revealed he had moderate cognitive impairment. Resident #66 was also assessed with wandering behavior and was independent with ambulation. Resident #66's care plan dated 09/20/13 revealed he was at risk for elopement due to impaired cognition and poor safety awareness. Review of facility documentation revealed Resident #66 was found outside the facility and in an unauthorized area 08/19/13 and 09/09/13. Resident #66's wanderguard did not alarm or alert staff he was out of the building or in an unauthorized area of the building. Resident #107 was admitted 03/21/2013. Diagnoses included Alzheimer's dementia. Minimum Data Set dated 09/04/13 assessed Resident #107 with severely impaired cognition,	F 520	The Director of Nursing/designee will randomly 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus Wanderguard documentation. The Director of Nursing/designee will report any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.	

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independent with ambulation, and exhibiting wandering behavior.

A care plan was initiated 04/16/13 for risk of elopement related to the resident wandering aimlessly throughout the facility; the resident had a wanderguard to alert staff of any unsupervised attempts to exit the facility. Care plan measures were implemented with the goal of having no incidence of elopement.

Review of facility documentation revealed Resident #107 was found outside the building on 10/05/13. Resident #107 was wearing a wanderguard when he was found outside the building.

An interview with the Administrator on 11/21/13 at 6:10 PM regarding the Quality Assessment and Assurance (QAA) committee's work on the area of wandering/elopement. He stated there had been discussion in the 10/09/13 QAA meeting. The Administrator stated these residents would not have been considered safe outside alone. He stated when residents go outside to smoke there should be two staff members with the residents at all times. He stated he did not know what had been put into place to prevent this from happening again. He stated the QAA process was still working on this problem, to identify how it occurred and how they are going to fix it.