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

PRINTED: 11/26/2013
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
	345172	A. BUILDING ______ B. WING ______	C 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, and record reviews the facility failed to use a systematic process of evaluation and care planning prior to using bed bolsters, perimeter mattresses, and geri-chair use for 4 of 4 sampled residents reviewed for physical restraints (Resident # 1, #23, #41, and #171). Findings included: 1. Resident #171 was admitted originally on 6/21/2012 with diagnosis that included schizophrenia and dementia. A review of Resident #171's Minimum Data Set (MDS) dated 10/17/13 indicated Resident #171 was severely cognitively impaired with impaired short term and long term memory. Resident #171 indicated symptoms of depression daily, trouble concentrating on activities, and restlessness. Resident #171 did not have any behavior problems. Resident #171 required extensive assistance with personal hygiene, toilet use, dressing, and bed mobility. Resident #171 was not coded as having restraints in place. A review of Resident #171's medical record revealed a Care Plan dated 7/31/13 with at risk for falls related to impaired mobility as one of the focused problems. Interventions in place were: A. encourage resident to communicate presence of pain B. assist to reposition for comfort	F 221	The filing of this plan of correction does not constitute an admission that the deficiencies alleged, did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulations and to provide high quality resident care. F221 1. Residents #1, #23, #41, and #171 had restraint/device evaluations completed on 12/2/2013. Each resident's care plan and RAI, if needed, was updated to reflect the resident's current condition and any medical device/restraint in use. 2. A device evaluation will be completed on all facility residents by DNS/ADNS/Unit Managers by 12/06/13. Their RAI and plan of care will be updated to reflect the outcome of the device evaluation and their current status. The device evaluation will be completed on new admissions, with quarterly, annual and change of condition assessments. The resident's RAI and care plan will be updated upon completion of the device evaluation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alice Hopping   TITLE: Adm.   (X6) DATE: 12/5/13

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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NAME OF PROVIDER OR SUPPLIER: TRIAD CARE AND REHABILITATION CENTER
STREET ADDRESS, CITY, STATE, ZIP CODE: 707 NORTH ELM STREET, HIGH POINT, NC 27262

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F 221	Continued From page 1 C. alarm to wheelchair D. alarm to bed E. floor mat F. place in open area G. refer to therapy for increased falls H. place alarm box out of reach of resident since he turns the alarm off himself. I. incontinence care after lunch J. anti-slip pad to wheelchair K. ensure call light is in place L. lay resident down when tired or agitated M. perimeter mattress N. offer resident to be out of bed up to wheelchair when restless or agitated as resident allows O. give pain medications as indicated P. anti-tipper and anti-rollback bars to wheelchair Q. resident to wear non slip footwear R. remind resident to use call light prior to ambulating or transfer S. therapy as needed, and ensure environment is free of clutter An observation of Resident #171 on 11/5/13 at 10:00 AM showed a resident in bed with a parameter mattress. Resident #171 had only a diaper on and was seen with his legs over the edge of the mattress without his feet touching the floor. An observation of Resident #171 on 11/6/13 at 12:00 PM showed a resident who was dressed in street clothes from his waist up. The resident was restless in bed and was attempting to get out of the bed. The resident had his feet and legs over the side of the perimeter mattress attempting to get out of bed. The bed alarm did not alarm. The resident was attempting to raise himself up over the edge of the bed with his arms and was unsuccessful at getting out of bed. The resident then laid back down on his right side.	F 221	3. The Director of Nursing/designee will audit newly admitted residents charts within 72 hours to ensure the device evaluation has been completed and care plan has been updated. The Clinical Reimbursement Coordinator will audit the resident's charts on a quarterly and annual basis to ensure the RAI and plan of care are comprehensive and accurate. 4. Residents who experience falls or other changes of condition will be discussed and assessed daily in the morning standup meeting by the IDT team. Care plan interventions will be updated and implemented immediately as needed. A weekly audit will be completed by the Director of Nurses to ensure residents who have had falls or changes in condition have had a fall assessment, device evaluation, RAI, if needed, and updated plan of care completed and signed off by the IDT team. Weekly audits will be conducted for 8 weeks the bi-weekly for 4 weeks. Results of the audit will be reported during the monthly PI meeting.	12/06/13

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F 221	Continued From page 2 A record review of Resident #171 Clinical at Risk Evaluation (CARE) Meeting Minutes Form dated 7/23/13 indicated the perimeter mattress was first implemented on 7/18/13. There was no explanation listed on the form as to why this was put in place. Further review of Resident #171's fall reports did not yield a fall report dated 7/18/13. An interview with Aide #9 was conducted on 11/7/13 at 7:00 AM. Aide #9 stated the perimeter mattresses are used to keep the resident from falling out of the bed. An interview with Nurse #5 was conducted on 11/7/13 at 7:30 AM. Nurse #5 stated the perimeter mattress is being used to keep the resident from falling out of the bed. An interview was conducted with the Assist Director of Nursing (ADON) on 11/7/13 at 7:30 AM. The ADON stated the perimeter mattresses were not being used as restraints but to cue the resident to not get out of bed and to give the staff " time to hopefully get there in time before he does fall. " An interview was conducted with the Regional Director Consultant on 11/7/13 at 11:20 AM. During the interview the Regional Director Consultant stated the perimeter mattress and bolsters used on Resident #171 were not restrictive to the resident because he is still falling out of bed. She further stated that the mattress and bolsters may have prevented the resident from falling more than the 14 times he did since the devices were put into place. Upon further inquiry the Regional Director Consultant stated the bolters and mattress were not reassessed to see if they did or did not decrease or increase Resident #171's falls. An interview with Aide #8 was conducted on 11/8/13 at 6:30 AM. Aide #8 stated the perimeter bed was being used for Resident #171 was to	F 221		

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F 221	Continued From page 3 keep the resident from falling out of the bed. An interview was conducted with Nurse #11 on 11/8/13 at 6:29 AM regarding the general use of bolsters on resident ' s beds. Upon inquiry, Nurse #11 acknowledged some of the residents had mattresses with bolsters in place because, " these people fall and get out of bed. " She indicated that since side rails could not be used, the bolsters with straps may be used and that, " the bolsters keep them from falling. " An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it ' s not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident ' s bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident ' s medical record. In addition, there would be an MD order, which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview,	F 221		

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F 221	Continued From page 4 she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident ' s chart. 2. Resident #1 was admitted on 5/7/1999 with a diagnosis of anoxic brain damage. Resident #1' s cumulative diagnosis included aphasia, dementia, anxiety, depression, and psychotic disorder. A review of Resident #1 ' s medical record revealed the resident had a past history of falls but had not had a fall since 8/2/12. A review of Resident #1's Minimum Data Set (MDS) dated 10/2/13 indicated the resident was totally dependent on staff for activities of daily living (ADL). The MDS stated Resident #1 was ambulatory with one person assist. The resident was not coded for use of restraints. A review of Resident #1's Clinical At Risk	F 221		

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F 221	Continued From page 5 Evaluation (CARE) Meeting Minutes Form indicate there was a CARE meeting on 8/2/12 but the minutes from the meeting did not indicate what the meeting was for. There was a notation on the meeting minutes form that stated " 8/2/12 ensure bolsters in place and secured " . This was crossed out and written below that was " nurses to ensure safety precautions in place during round @ shift change " . The resident's last CARE meeting was on 8/16/12 and concerned Resident #1's biting of her fingers with interventions of hand splints/ace wraps and a Wanderguard to be placed on Resident #1. A review of Resident #1's fall records indicated the resident had a fall without injury on 8/2/12 at 4:00 PM. The fall record included a notation under the heading Describe the circumstances of the event and what actions, if any, have been taken lately. The notation read, " While walking past residents room, saw resident sliding down off of right side of bedside, nurse ran to catch her, but was unable to catch her and lower her to floor, noted that small boosters were loosely attached, full body assessment done with no apparent injuries noted pain level 0 out of 10, bed alarm did not sound, 2 cna's and 2 nurses put resident in bed after taking vital signs, bolsters were attached tightly and alarm was functioning. ". The fall report further stated the resident's condition before even/accident was confused. Under the heading Fall Investigation/QA with a heading of Intrinsic Factors with a definition of " Factors that are, more or less, " built in " to the resident. They may increase the risk of falling and are generally not modifiable. Intrinsic factors consist of age-related changes (changes in vision, balance, gait, musculoskeletal system & cardiovascular system, pathological conditions (acute disease, chronic disease). Emotional	F 221		

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F 221	Continued From page 6 issues, like fear of falling. Clinical conditions, such as Parkinson's disease, multiple sclerosis, asthma, chronic obstructive pulmonary disease, osteoporosis, cancer, etc. " The form also listed just below the intrinsic factors a section with the heading Diagnosis/condition that may contribute with depression and other with check marks in the boxes. There was a section with the heading Extrinsic Factors with a definition that stated " External forces that affect the resident. They have the potential to increase the risk of falling and are considered to be modifiable. External factors consist of the physical environment, the design of furnishings, the condition of ground surfaces and illuminations. In addition, devices used to promote mobility (walkers, wheelchairs) or guard against falls (mechanical restraints, bed rails) have been implicated in causing falls. Also, the type and condition of footwear worn by patients and residents can play a primary role in fall causation. Medical conditions that affect mental status, such as delirium or infection, medications such as narcotics, analgesics, diuretics, cathartics, cardiovascular drugs, or psychoactive drugs. " The extrinsic factors listed for the residents fall were no footwear, bed alarm was not turned on, and the alarm did not sound. Under the heading Interventions initiated immediately after fall it was stated " bolsters were tightened and bed alarm turned on. " The Clinical Management Team determined that the fall was related to Resident #1's cognition and further recommendations to prevent further falls would be the " nurse to ensure safety precautions in place during rounds at shift change. " Under the heading Root Cause Conclusion the	F 221		

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F 221	Continued From page 7 intrinsic box was checked with a box below that with the heading Narrative Conclusion of Root Cause with the statement that read " Resident has a history of anoxic brain injury with explosure personality disorder. Resident has impulsive behaviors. " An observation of Resident #1 on 11/4/13 3:30 PM revealed the resident lying in bed, I the supine position with a perimeter mattress that had high winged sides and bed bolsters on either side of the resident. The resident was not seen up out of bed on 11/4/13. Resident #1 was not able to communicate her needs secondary to her aphasia but was aware of her surroundings within her room and made eye contact when spoken to or when someone entered the room. The residents call bell was within reach. An observation of Resident #1 on 11/5/13 at 2:30 PM noted the resident up in a rock and go chair sitting in her room eating ice cream with Nurse #15. An observation of Resident #1 on 11/6/13 at 2:30 PM revealed the resident lying in bed with bolsters in place on either side of her within a perimeter mattress. An interview was conducted with Aide #8 on 11/8/13 at 6:30 AM regarding the general use of bolster and perimeter mattresses on resident's beds. During this interview Aide #8 stated that bolsters on the resident ' s beds are there to keep the residents from falling out of bed. Upon further inquiry, Aide #8 stated the residents with perimeter mattresses that have the high curved edges are being used to keep the residents from falling out of the beds also. Aide #8 could not explain why some residents have both the bolsters with the perimeter mattresses. An interview was conducted with Nurse #11 on 11/8/13 at 6:29 AM regarding the general use of	F 221		

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F 221	Continued From page 8 bolsters on resident's beds. Upon inquiry, Nurse #11 acknowledged some of the residents had mattresses with bolsters in place because, " these people fall and get out of bed. " She indicated that since side rails could not be used, the bolsters with straps may be used and that, " the bolsters keep them from falling. " An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it's not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident's bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident ' s medical record. In addition, there would be an MD order which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it	F 221		

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F 221	Continued From page 9 was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart. 3. Resident #23 was re-admitted from an acute care hospital on 9/27/13 with a discharge diagnosis of altered mental status likely secondary to aspiration pneumonia. His cumulative diagnoses included a history of cerebrovascular accident (CVA or stroke) with dysphasia, dementia, and seizure disorder. A review of the Resident #23's medical record revealed the patient had a history of falls, which included a fall on 8/14/13. A Change of Condition Documentation form dated 8/14/13 (time of day not indicated) included the following narrative: " CNA reports upon entering the room Rsd (resident) was laying on the floor mat. Nurse assessed Rsd. Rsd denies pain no injuries noted. Staff assisted Rsd into geri-chair. Chair	F 221		

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F 221	Continued From page 10 alarm in place. Staff will continue to monitor neuro (neurological) checks in place. " A care meeting notation written in the Interdisciplinary Progress Notes dated 8/20/13 acknowledged the resident had a fall on 8/14/13 and stated, " Bed Bolsters placed on bed to alert Res (resident) to boundaries. " A review of Resident #23's fall records indicated the resident had a fall without injury on 10/2/13 at 7:50 AM. The fall record included a notation under the heading Describe the circumstances of the event and what actions, if any, had been taken lately. The notation read, " Staff responded to resident bed alarm and saw resident sliding to the floor in his room no apparent injury noted. " Resident #23's fall records indicated the resident had a fall without injury on 10/4/13 at 4:00 PM. The Fall Investigation Records for 10/4/13 provided details of the event as follows: Interventions initiated immediately after fall: " Resident was placed back to bed and repositioned; " The Clinical Management Team determined that the fall was related to: Cognition (designated by a checked box); Recommendations to prevent further falls: " Staff is to ensure proper placement and positioning of bolsters to ensure comfort of resident and therapy to evaluate and screen as indicated. " Summary of interview with witness(es): " Staff heard bed alarm. Staff walked in room and observed Rt (resident) hanging out of his bed with knee on floor. Staff called for assistance and Rt was transferred back into his bed. Raised feet of bed and repositioned Rt. " Root cause conclusion: Intrinsic (designated by a checked box);	F 221		

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F 221	Continued From page 11 Narrative conclusion of root cause: " Due to resident decreased cognition and impaired judgment he is at high risk for falls. As noted staff repositioned bolsters to ensure they are position properly for comfort. " The resident's MDS information from 10/18/13 for a significant change indicated he had severely impaired cognitive skills for daily decision making. Resident #23 was totally dependent on staff for locomotion and required extensive assistance for all other ADLs. He received G-tube feedings with no food or fluid intake by mouth. There were no behaviors nor rejection of care noted on the MDS. Coding of the MDS indicated that no restraints were used for this resident. A review of Resident #23's 10/25/13 Care Plan revealed the use of physical restraints was not addressed. However, a Focus Area related to the resident's risk of falls included the following interventions: --Bolsters to bed (Date Initiated 8/29/13; Revision on 10/9/13) --Out of bed (OOB) in geri-chair (a specialized wheeled recliner) when restless/agitated as resident allows (Date Initiated 5/7/13, Revision on 10/9/13) --Parameter mattress (no date noted) --Ensure bolsters in place; position appropriately in bed; PT to evaluate (Dated 10/4/13) Resident #23's fall records indicated the resident had a fall without injury on 11/3/13 at 8:30 PM. The Fall Investigation Records for 11/3/13 provided details of the event as follows: · What was resident doing at the time of the fall? "Attempting to Stand; " Interventions initiated immediately after fall: " Resident placed in the gerichair in open area; " The Clinical Management Team determined that the fall was related to: Cognition (designated by	F 221		

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F 221	Continued From page 12 a checked box); Recommendations to prevent further falls: "Resident to be placed in open area and provided oral/mouth care. Guardianship applied for." Summary of interview with witness(es): "Resident climbed over bolsters. Landed in the floor. Was going to go downstairs wants a drink. Denies pain, discomfort, no injury noted placed in geri chair at nursing station for monitoring." Root cause conclusion: Intrinsic (designated by a checked box); Narrative conclusion of root cause: "Impaired judgement resident stated he was going downstairs to drink water. Mouth possibly dry." A review of the resident's medical record revealed an Interdisciplinary Progress Note dated 11/3/13 at 9:30 PM reported the following: "Continues to scoot to bottom of the geri-chair. Lifts bottom off the chair. Slides legs to side of chair and twists body. Slides self back up when " caught." Continues to state he ' is getting up.' Combative with staff when repositions him." An observation made on 11/5/13 at 8:59 AM revealed Resident #23 was asleep and lying still in his bed with no obvious movements observed. His bed included a parameter mattress (a winged mattress) and bolsters placed on each side of the bed. An interview was conducted with Nurse #9 on 11/5/13 at 10:39 AM. Nurse #9 was the staff nurse assigned to Resident #23. The nurse indicated Resident #23 used an air mattress and parameter mattress as he " climbs out of bed. " Upon further inquiry, the nurse stated the parameter mattress " slows him down " and reported he could still get out of bed if he wanted to. Nurse #9 noted Resident #23 also had a bed alarm in place to alert staff when he was trying to get out of bed.	F 221		

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F 221	Continued From page 13 A follow-up interview was conducted with Nurse #9 on 11/7/13 at 2:15 PM regarding the type of bed used for Resident #23. Nurse #9 was the staff nurse assigned to the resident's hall. The nurse demonstrated how the bolsters were put into place on the bed and stated that without the bolsters, the resident was climbing out of bed. He indicated that having the bolsters in place, "prevents him or at least slows him down" so the bed alarm would go off if he was trying to climb out of bed. Nurse #9 also stated the resident did sit in a geri-chair from Noon to 4 PM each day while his tube feeding was turned off so that he could be mobile. When asked, Nurse #9 indicated that Resident #23 usually didn't try to get out of the geri-chair. However, the nurse noted that there was an alarm in place on the chair because Resident #23 had tried to get out of the chair in the past. The resident was observed to be awake and sitting with no obvious movements in the geri-chair in his room on 11/7/13 at 2:15 PM. An interview was conducted with Nurse #8 on 11/7/13 at 6:14 PM regarding the resident's bed. Nurse #8 indicated that Resident #23 had " bolsters " on his bed. Upon further inquiry about the purpose of the bolsters, Nurse #8 stated it was to " slow him down " so they could get to him. An interview was conducted with Nurse #11 on 11/8/13 at 6:29 AM regarding the general use of bolsters on resident's beds. Upon inquiry, Nurse #11 acknowledged some of the residents had mattresses with bolsters in place because, " these people fall and get out of bed. " She indicated that since side rails could not be used, the bolsters with straps may be used and that, " the bolsters keep them from falling. " An interview was conducted with Nursing	F 221		

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F 221	Continued From page 14 Assistant (NA) #1 on 11/8/13 at 6:46 AM. Although this nursing assistant noted she had not worked with Resident #23 very much in the past, she recalled the resident did have one leg on top of the bolster during the night and she had to reposition him. An interview was conducted with Nurse #2 on 11/8/13 at 6:48 AM. The nurse reported Resident #23 could work himself out of the bed but noted he could not do so safely because he falls. She reported the resident had an air mattress in place and the bolsters provided an extra height on the mattress to keep him from falling. Nurse #2 stated that without the bolsters in place he could get out of bed. The nurse indicated that she herself had not seen the resident get his feet over the bolsters when they were in place. However, the nurse noted that Resident #23 has pushed the bolster down to where staff had to reposition both the bolsters and his feet. When asked if the resident could out of the geri-chair, Nurse #2 stated, " It may be a feat for him to get out of there, I wouldn't put it past him. ". She reported that the resident use to have a broda chair (a wheelchair that adjusts to different positions) and that he had been able to get out of it. The nurse noted Resident #23 was changed to the geri-chair due to his decline and physical state. When asked whether the resident ' s inability to get out of the geri-chair was due to his physical decline or the change in chairs, Nurse #2 stated, "I think it ' s because of the difference in the chair." An observation made on 11/8/13 at 6:58AM revealed Resident #23 was asleep and lying still in his parameter bed with the bolsters in place. An interview was conducted with NA #2 on 11/8/13 at 6:36 AM. When questioned as to why the parameter mattress and bolsters were used for Resident #23 ' s bed, the CNA stated that the	F 221		

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F 221	Continued From page 16 bolsters, "keep him in the bed and from falling." When asked if the resident could get out of bed, on his own, the CNA said, " No. " Resident #23 was observed to be sitting with no obvious movements while resting in the geri-chair in his room on 11/8/13 at 8:36 AM. An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it ' s not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident ' s bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Occupational Therapy Aide (OTA) #1 on 11/8/13 at 11:53 AM. OTA#1 stated she was familiar with Resident #23 and that, " He ' s constantly trying to get out of everything. " She indicated that she believed he was trying to get out of the broda chair so he was changed to a geri-chair. She stated, " It just wasn't safe for him anymore. He's a butt-scooter...with the geri-chair reclined he is positioned better. " When asked if Resident #23 could follow simple instructions, OTA #1 indicated she did not really think so. When asked if he could understand how to get around the bolsters in bed, the OTA indicated she did not think so. An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 1:00 PM in regards to Resident #23 ' s bed. The DON and Regional Director Consultant indicated the bed alarm was put on the resident ' s bed to alert the staff that something was happening. They also stated that the addition of the parameter bed was to alert him (the resident) and the bed bolsters were also	F 221		

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F 221	Continued From page 16 used to alert him of the edge of the bed. They indicated that the resident was not cognitively aware of what he was doing. An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident's medical record. In addition, there would be an MD order which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting,	F 221		

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F 221	Continued From page 17 and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart 4. Resident #41 was admitted to the facility on 7/17/09. The cumulative diagnoses included Alzheimer dementia, history of falls, hypertension, seizure disorder and diabetes. The annual Minimum Data Set (MDS) dated 8/9/13, indicated that Resident #41 required total to extensive assistance with activities of daily living, two person assistance with transfers and 1 person assistance with mobility. The MDS did not code Resident#41 with any ambulation or falls during the assessment period. Review of the care plan revision dated 9/9/13 identified risk for falls related to history of seizure, poor safety awareness and impaired balance. The goal included no significant injury related to fall. The approaches included the use of the parameter mattress(10/20/2009) and wedge bolster, used hoyer lift for transfers, 2 person assist with transfers, wedge bolsters indicated 4/15/2010, if fall occurred assessed for injury notify physician and follow orders, bed alarm check functioning placement every shift. Review of physician orders dated 10/17/13 and 11/4/13, did not reveal there were no concerns identified with falls or the need for bed bolster or parameter bed. There was no physician order or therapy screen for the use of the parameter mattress or bed bolsters.	F 221		

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F 221	Continued From page 18 Review of physician progress noted dated 10/25/13, revealed the visit was associated with her other behaviors and chronic disease. No indication of falls or safety concerns related to her getting out of bed. Review of the nursing notes from 6/18/13 to 10/11/13 there was no indication or concern with resident attempting to get out of bed or stand independently. The notes revealed behavior concerns were noted as verbal abuse, yelling, hitting at staff removing clothing, self inflicted abrasions, scratches and medications were used to address behaviors. There were no concerns noted regarding falls. Nurse#15 reviewed the chart and acknowledged and confirmed the notes did not include or address and behaviors where resident fell or attempted to get out of bed or even threw her legs over side rails or bed bolster on a regular basis. The primary use was for safety. During an observation on 11/8/13 at 3:30PM, resident lying in bed half naked with top portion of her body exposed with the door open. Resident verbalized that she wanted to get out bed and go to the closet. Resident had a parameter bed and wedge bed bolsters in place and half side rails up. Resident very confused and holding onto side rails with legs over top of the bed bolster and side rails. During an interview with Nurse#12, on 11/8/13 at 3:30PM, indicated that resident did not walk and was very confused only throws legs to the side of the bed or side rails. She was unaware of the resident having any falls in the past few years. She generally was redirected to put legs back in bed without attempt to stand.	F 221		

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F 221	Continued From page 19 During an interview on 11/8/13 at 3:45PM, Nurse#15 indicated that Resident#41 had not had any falls in several years and the use of the parameter bed and bed bolster was a reminder for Resident #41 not to get out of bed and safety. She indicated that there was no assessment to determine the need for the use of the parameter bed with bed bolster since the resident was able to throw her legs over a regular bed without an attempt to stand. Nurse#15 added that staff would redirect the resident to put her legs back in bed and no assessment was done for either since it was not considered a restraint. During an interview on 11/8/13 at 4:05PM, the nurse consultant indicated that a new program would be implemented to assess for the use or need for bed bolster/parameter beds in the same format as a restraint would be on the newly devised form for the facility and staff would be in-serviced on the accuracy of assessments for devices.	F 221		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and	F 244	F244 1. Residents #89, #221, #132, #137, #7 were interviewed by the Dietitian/ Food Service Director (FSD) on 11/29/13 concerning the food preferences, food palatability and food temperatures.	

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F 244	Continued From page 20 review of resident council minutes, the facility failed to resolve ongoing group grievances for 5 of 5 sample residents (Resident # 89, 221, 132, 7, and 137) with concerns regarding cold food. The findings included: The facility identified the residents as alert and oriented. During an interview on 11/5/13 at 10:00 AM, Resident # 89 indicated lunch and super was not good and there were concerns with the preparation of the meal and the meal choices. During an interview on 11/5/13 at 11:13 AM, Resident #221 indicated all the meals were served cold and she had to go reheat the meals herself. Resident #221 added that this concern had been brought to the attention of several of the staff with no change. During an interview conducted on 11/5/13 at 11:56 AM, Resident #132 indicated that he had trouble eating the food for all three meals. Resident #132 stated he eats in his room and the trays typically sat out in the hallway for some time before being brought in and the food was typically cold. During an interview on 11/6/13 at 9:00 AM Resident #7 indicated as a resident council member there had been an ongoing concern regarding the food being late and cold. During a follow-up interview on 11/7/13 at 5:35PM, Resident #89 indicated that all the food comes out cold and that the trays sat on the hall for 30 minutes or more. He indicated that he had	F 244	2. Residents have the potential to be affected by this practice were Identified by conducting random interviews of residents on 12/02/13 by Dietitian concerning palatability of food and timeliness of tray delivery. An additional food cart is being utilized on two halls to reduce the amount of time the trays are waiting to be delivered which will ensure that food is at proper temperature. Plate warmer was serviced by the Maintenance Director on 12/02/13& is maintaining the correct temperature. 3. Re-educated Nursing staff on 12/03/13 by Staff Development Coordinator (SDC) concerning timely delivery of meal trays, asking resident if their food is warm enough and heating food if needed. Re-educated Dietary staff on 11/06/13 by the FSD/Dietitian concerning ensuring proper food temperatures prior to meal service.	

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F 244	Continued From page 21 reported this concern on several different occasions and no one has time to reheat the food. During an interview on 11/7/13 at 5:28PM, Resident #137 indicated that his lunch was cold when it arrived at 1:30PM. He indicated that the meals are normal late about 30 minutes and very cold. Staff indicated that they did not have time to reheat the food when asked. He indicated the process has been when the meal was delivered to the hall it sat on the hall another 30 to 40 minutes before it got to the room. He indicated that he has complained to nursing and dietician. He indicated that they also run out of food as well and they couldn't even get an alternate. He also indicated that some of his cold beverage would come hot or not at all. He indicated that a grievance had been filed in September regarding the food temperature and late arrivals of meals, but nothing was changed. During an interview on 11/7/13 at 6:10PM, the Administration indicated that she was aware of the residents concerns with meals temperatures. The expectation would be the DM and RD address the concerns with individual residents and the resident council and resolved them to resident satisfaction with the new changes. During an interview on 11/8/13 at 8:23AM, the activity director(AD) indicated that she was responsible for assisting the residents with the resident council meetings. The AD added that the resident concerns have been reviewed monthly and brought to the attention of the department head during the morning meetings. The residents continued to report issues related to cold food and late meal arrivals. She added that the	F 244	4. Dietitian and FSD will conduct food palatability interviews weekly times 4 weeks then monthly times 2 months and report the findings to the PI committee monthly times 3 months to ensure compliance and consistency. Menu Meetings will be held weekly times 4 weeks and then monthly. Temperature test trays to be completed 3 times per week times one month then weekly times one month, then monthly.	12/06/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING ______ B. WING ______	C 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 244	Continued From page 22 concerns had not been resolved to resident satisfaction. Review of the resident council months dated 5/30/13, 6/27/13, 7/25/13, 8/29/13, 9/26/13 and 10/24/13, revealed continued concerns regarding food temperatures, late meal arrivals, not being offered snacks or alternate meals, lack of posting of menus and running out of condiments. The concerns had not been resolved to the resident satisfaction.	F 244		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272	F272 1. Residents #1, #23, #41, and #171 had restraint/device evaluations completed on 12/2/2013. Each resident's care plan and RAI, if needed, was update to reflect the resident's current condition and any medical device/restraint in use. 2. A device evaluation will be completed on all facility residents by. Their RAI and plan of care will be updated to reflect the outcome of the device evaluation and their current status. The device evaluation will be completed on new admissions, with quarterly, annual and change of condition assessments. The resident's RAI and care plan will be updated upon completion of the device evaluation.	

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F 272	Continued From page 23 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to assess for the least restrictive device before utilizing perimeter mattresses and bed bolsters for 4 of 4 sampled residents reviewed for physical restraints (Resident # 1, #23, #41, and #171). 1. Resident #41 was admitted to the facility on 7/17/09. The cumulative diagnoses included alzhiemer dementia, history of falls, hypertension, seizure disorder and diabetes. The annual Minimum Data Set(MDS) dated 8/9/13, indicated that Resident #41 required total to extensive assistance with activities of daily living, two person assistance with transfers and 1 person assistance with mobility. The MDS did not code Resident#41 with any ambulation or falls during the assessment period. The facility did not assess for any negative consequence of restraint, the underlying need for the restraint, any other least restrictive devices or determine what medical symptom the parameter mattress/bed	F 272	3. The Director of Nursing/designee will audit newly admitted residents charts within 72 hours to ensure the device evaluation has been completed and care plan has been updated. The Clinical Reimbursement Coordinator will audit the resident's charts on a quarterly and annual basis to ensure the RAI and plan of care are comprehensive and accurate. 4. Residents who experience falls or other changes of condition will be discussed and assessed daily in the morning standup meeting by the IDT team. Care plan interventions will be updated and implemented immediately as needed. A weekly audit will be completed by the Director of Nurses to ensure residents who have had falls or changes in condition have had a fall assessment, device evaluation, RAI, if needed, and updated plan of care completed and signed off by the IDT team. Results of the audit will be reported during the monthly PI meeting. Weekly audits will be conducted for 8 weeks then bi-weekly for 4 weeks.	12/06/13

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F 272	Continued From page 24 bolsters was treating because the facility thought the mattress was an enabler. Review of the care plan revision dated 9/9/13, identified risk for falls related to history of seizure, poor safety awareness and impaired balance. The goal included no significant injury related to fall. The approaches included the use of the parameter mattress(10/20/2009) and wedge bolster, used hoyer lift for transfers, 2 person assist with transfers, wedge bolsters indicated 4/15/2010, if fall occurred assessed for injury notify physician and follow orders, bed alarm check functioning placement every shift. Review of physician orders dated 10/17/13 and 11/4/13, did not reveal there were no concerns identified with falls or the need for bed bolster or parameter bed. There was no physician order or therapy screen for the use of the parameter mattress or bed bolsters. An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it's not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident ' s bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information	F 272		

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F 272	Continued From page 25 came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident's medical record. In addition, there would be an MD order which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. During an observation on 11/8/13 at 3:30PM, resident lying in bed half naked with top portion of her body exposed with the door open. Resident verbalized that she wanted to get out bed and go to the closet. Resident had a parameter bed and wedge bed bolsters in place and half side rails up. Resident very confused and holding onto side rails with legs over top of the bed bolster and side rails. During an interview on 11/8/13 at 3:45PM, Nurse#15 indicated that there was no assessment to determine the need for the use of the parameter bed with bed bolster and it was not considered a restraint. During an interview on 11/8/13 at 4:05PM,the nurse consultant indicated that a new program would be implemented to assess for the use or need for bed bolster/parameter beds in the same format as a restraint would be on the newly devised form for the facility and staff would be in-serviced on the accuracy of assessments for devices. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview,	F 272		

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F 272	Continued From page 26 she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart. 2. Resident #171 was admitted originally on 6/21/2012 with diagnosis that included schizophrenia and dementia. A review of Resident #171's Minimum Data Set (MDS) dated 10/17/13 indicated Resident #171 was severely cognitively impaired with impaired short term and long term memory. Resident #171 indicated symptoms of depression daily, trouble concentrating on activities, and	F 272		

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F 272	Continued From page 27 restlessness. Resident #171 did not have any behavior problems and required extensive assistance with personal hygiene, toilet use, dressing, and bed mobility. The resident was not coded as having a restraint in place. A review of Resident #171's medical record revealed a Care Plan dated 7/31/13 with at risk for falls related to impaired mobility as one of the focused problems. Interventions in place were encourage resident to communicate presence of pain, assist to reposition for comfort, alarm to wheelchair, alarm to bed, floor mat, place in open area, refer to therapy for increased falls, place alarm box out of reach of resident since he turns the alarm off himself, incontinence care after lunch, anti-slip pad to wheelchair, ensure call light is in place, lay resident down when tired or agitated, perimeter mattress, offer resident to be out of bed up to wheelchair when restless or agitated as resident allows, give pain medications as indicated, anti-tipper and anti-rollback bars to wheelchair, resident to wear non slip footwear, remind resident to use call light prior to ambulating or transfer, therapy as needed, and ensure environment is free of clutter. A review of Resident #171's Physician Orders dated 6/21/12 to present did not indicate a medical need for or an order to use bed bolsters or the perimeter mattress. An observation of Resident #171 on 11/5/13 at 10:00 AM showed a resident in bed with a perimeter mattress. Resident #171 had only a diaper on and was seen with his legs over the edge of the mattress without his feet touching the floor. An observation of Resident #171 on 11/6/13 at	F 272		

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F 272	Continued From page 28 12:00 PM showed a resident who was dressed in street clothes from his waist up. The resident was restless in bed and was attempting to get out of the bed. The resident had his feet and legs over the side of the perimeter mattress attempting to get out of bed. The bed alarm did not alarm. The resident was unsuccessful at getting out of bed and laid back down on his right side. An interview with Aide #9 was conducted on 11/7/13 at 7:00 AM. Aide #9 stated the perimeter mattresses are used to keep the resident from falling out of the bed. An interview with Nurse #5 was conducted on 11/7/13 at 7:30 AM. Nurse #5 stated the perimeter mattress is being used to keep the resident from falling out of the bed. An interview was conducted with the Assist Director of Nursing (ADON) on 11/7/13 at 7:30 AM. The ADON stated the perimeter mattresses were not being used as restraints but to cue the resident to not get out of bed and to give the staff " time to hopefully get there in time before he does fall. " An interview was conducted with the Regional Director Consultant on 11/7/13 at 11:20 AM. During the interview the Regional Director Consultant stated the perimeter mattress and bolsters used on Resident #171 were not restrictive to the resident because he is still falling out of bed. She further stated that the mattress and bolsters may have prevented the resident from falling more than the 14 times he did since the devices were put into place. Upon further inquiry the Regional Director Consultant stated the bolters and mattress were not reassessed to see if they did or did not decrease or increase Resident	F 272		

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F 272	Continued From page 29 #171's falls. An interview with Aide #8 was conducted on 11/8/13 at 6:30 AM. Aide #8 stated the perimeter bed was being used for Resident #171 was to keep the resident from falling out of the bed. An interview was conducted with Nurse #11 on 11/8/13 at 6:29 AM regarding the general use of bolsters on resident's beds. Upon inquiry, Nurse #11 acknowledged some of the residents had " mattresses with bolsters in place because, " these people fall and get out of bed." She indicated that since side rails could not be used, the bolsters with straps may be used and that, " the bolsters keep them from falling. " An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it's not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident's bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident's medical record. In addition, there would be an MD order	F 272		

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F 272	Continued From page 30	F 272		

which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P.

A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that.

An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion.

An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart.

3. Resident #1 was admitted on 5/7/1999 with a diagnosis of anoxic brain damage. Resident #1's

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F 272	Continued From page 31 cumulative diagnosis included aphasia, dementia, anxiety, depression, and psychotic disorder. A review of Resident #1's medical record revealed the resident had a past history of falls but had not had a fall since 8/2/12. A review of Resident #1's Minimum Data Set (MDS) dated 10/2/13 indicated the resident was totally dependent on staff for activities of daily living (ADL). The MDS stated Resident #1 was ambulatory with one person assist. The resident was not coded as having a restrain in place. A record review of the Physician Orders dated 8/2/12 through current orders did not reveal there were any concerns identified with falls or the need for a bed bolster or perimeter mattress. There was no Physician Order or therapy screen for the use of the perimeter mattress or bed bolsters. A review of Resident #1's Clinical At Risk Evaluation (CARE) Meeting Minutes Form indicate there was a CARE meeting on 8/2/12 but the minutes from the meeting did not indicate what the meeting was for. There was a notation on the meeting minutes form that stated " 8/2/12 ensure bolsters in place and secured ". This was crossed out and written below that was " nurses to ensure safety percautions in place during round @ shift change ". The resident's last CARE meeting was on 8/16/12 and concerned Resident #1's biting of her fingers with interventions of hand splints/ace wraps and a Wanderguard to be placed on Resident #1. An observation of Resident #1 on 11/4/13 3:30 PM revealed the resident lying in bed, in the supine position with a perimeter mattress that had	F 272		

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F 272	Continued From page 32 high winged sides and bed bolsters on either side of the resident. Resident #1 was not able to communicate her needs secondary to her aphasia but was aware of her surroundings within her room and made eye contact when spoken to or when someone entered the room. The residents call bell was within reach. An observation of Resident #1 on 11/5/13 at 2:30 PM noted the resident up in a rock and go chair sitting in her room with Nurse #15 eating ice cream. An observation of Resident #1 on 11/6/13 at 2:30 PM revealed the resident lying in bed with bolsters in place on either side of her within a perimeter mattress. An interview was conducted with Aide #8 on 11/8/13 at 6:30 AM regarding the general use of bolster and perimeter mattresses on resident's beds. During this interview Aide #8 stated that bolsters on the resident ' s beds are there to keep the residents from falling out of bed. Upon further inquiry, Aide #8 stated the residents with perimeter mattresses that have the high curved edges are being used to keep the residents from falling out of the beds also. Aide #8 could not explain why some residents have both the bolsters with the perimeter mattresses. An interview was conducted with Nurse #11 on 11/8/13 at 6:29 AM regarding the general use of bolsters on resident ' s beds. Upon inquiry, Nurse #11 acknowledged some of the residents had mattresses with bolsters in place because, " these people fall and get out of bed. " She indicated that since side rails could not be used, the bolsters with straps may be used and that, " the bolsters keep them from falling. "	F 272		

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F 272	Continued From page 33 An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it ' s not a restraint. ". Upon further inquiry regarding the reason for the use of bolsters on a resident ' s bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down." An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident ' s medical record. In addition, there would be an MD order which would usually explain the reason for the restraint, and it would also be noted on the care plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15	F 272		

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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 272	Continued From page 34 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart. 4. Resident #23 was re-admitted from an acute care hospital on 9/27/13 with a discharge diagnosis of altered mental status likely secondary to aspiration pneumonia. His cumulative diagnoses included a history of cerebrovascular accident (CVA or stroke) with dysphagia, dementia, and seizure disorder. The resident's most recent MDS information from 10/18/13 (a significant change) indicated he had severely impaired cognitive skills for daily decision making. Resident #23 was totally dependent on staff for locomotion and required extensive assistance for all other ADLs. There were no behaviors nor rejection of care noted on the MDS. Coding of the MDS indicated that no restraints were used for this resident.	F 272		

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F 272	Continued From page 35 A review of Resident #23's 10/25/13 Care Plan revealed the use of physical restraints was not addressed. However, a Focus Area related to the resident's risk of falls included the following interventions: --Bolsters to bed (Date Initiated 8/29/13; Revision on 10/9/13) --Out of bed (OOB) in geri-chair (a specialized wheeled recliner) when restless/agitated as resident allows (Date Initiated 5/7/13, Revision on 10/9/13) --Parameter mattress (no date noted) --Ensure bolsters in place; position appropriately in bed; PT to evaluate (Dated 10/4/13) An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it ' s not a restraint. " Upon further inquiry regarding the reason for the use of bolsters on a resident's bed, the Regional Director Consultant indicated it was because the resident(s) try to get out of bed. She stated that use of the bolsters, " slows them down. " An interview was conducted with Nurse #17 on 11/8/13 at 2:45 PM. Nurse #17 shared responsibility for completing the MDS and she indicated the MDS nurses were responsible for completing Section P (Restraints) of the MDS assessment. When asked where this information came from, the nurse indicated that when a device was used as a restraint, it would be assessed as a restraint on a form under the " Assessment tab " in the resident ' s medical record. In addition, there would be an MD order, which would usually explain the reason for the restraint, and it would also be noted on the care	F 272		

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F 272	Continued From page 36 plan when it was put into place. Nurse #17 reported that if a device was assessed to be a restraint, it would be coded as such on the MDS in Section P. A follow-up interview was conducted with Nurse #17 on 11/8/13 at 4:00 PM. During this interview, she confirmed that the MDS nurse was not responsible for determining whether or not a device was considered to be a restraint and that it was up to the nurse managers to do that. An interview was conducted with Nurse #15 on 11/8/13 at 4:15 PM. Upon inquiry, Nurse #15 stated the nurse managers for each unit were responsible for completing a restraint assessment form for each resident who had a restraint. She indicated the Interdisciplinary Team (IDT) determined what was considered a restraint and what was not through group discussion. An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting. The DON indicated that if a resident was determined to have a restraint in place, a written restraint assessment would be completed and placed in the resident's chart.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	F309 1. Resident #218 insulin orders were reviewed, and clarified with the Physician on 11-7-13.	

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F 309	Continued From page 37 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 reviews and staff interviews, the facility failed to obtain and/or transcribe a physician's order for insulin coverage for 1 of 3 sampled residents receiving insulin; and failed to respond to elevated blood glucose results obtained for 1 of 3 sampled residents diagnosed with diabetes. (#218) The findings included: 1) Resident #218 was admitted to the facility on 11/2/13 from a hospital. Her cumulative diagnoses included diabetes, urinary tract infection and aphasia (a disorder of communication that impairs a person's ability to use and comprehend language). Upon admission, Resident #218 was assessed by the nursing staff to be severely cognitively impaired for daily decision making skills. The resident was dependent on staff for all Activities of Daily Living (ADLs). The list of admission medication orders for Resident #218 included the following: Humulin R insulin 100 unit/milliliter (ml) solution subcutaneous (SQ) given three times a day before meals. No dose was specified in the Humulin R order noted on 11/2/13 and signed by	F 309	2. All other residents receiving insulin orders will be reviewed by 12-6-13 for accuracy. 3. The Licensed nurses were in serviced on admissions/readmissions verification of orders by Staff Development Coordinator (SDC) by 12/06/13. The 11-7 nurses will check the Admission/Readmissions orders against hospital discharge summary and discharge medication list for accuracy. The nurse will initial on the Discharge Medication list after verifying. 4. The DNS or designee will review the new consolidated orders upon admissions, readmission, quarterly assessments and change of condition. Any finding from the review will be brought to the PI meeting each month for the next three months.	12/06/13

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F 309	Continued From page 38 the prescriber on 11/3/13. A review of the Medication Administration Record (MAR) for November 2013 revealed the following order was listed on the MAR for Resident #218: Humulin R insulin SQ three times a day before meals; Blood sugar below 200 no extra insulin; 200-250 give 2 units; 251 - 300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; 401 - 450 give 10 units; 451 to 500 give 12 units; If glucometer reads high give 14 units of Regular Insulin. Recheck blood sugar in 2 hours at that time if blood sugar is above 400 or under 100 notify physician. The blood sugar checks and sliding scale insulin coverage were scheduled on the MAR at 6:00 AM, 11:00 AM, and 4:30 PM each day. Further review of the MAR for November 2013 revealed the sliding scale insulin was administered to Resident #218 on the following dates and times: 1 time on 11/2/13 at 9:00 PM; 3 times on 11/3/13 at 6:00 AM, 11:00 AM, and 4:30 PM; 2 times on 11/4/13 at 6:00 AM and 11:00 AM; 2 times on 11/5/13 at 6:00 AM and 11:00 AM; 2 times on 11/6/13 at 6:00 AM and 11:00 AM; and 1 time on 11/7/13 at 6:00 AM. An interview was conducted on 11/7/13 at 11:46 AM with Nurse #15 who assumed responsibility as the Unit Manager Director. Upon review of the resident ' s medical record, Nurse #15 indicated that Resident #218's Discharge Medication Reconciliation (Med Rec) from the hospital was used as a basis for the admission medication orders dated 11/2/13.. Nurse #15 indicated the Discharge Med Rec had a hand-written notation	F 309		

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F 309	Continued From page 39 on it which documented the list of medications had been verified by the prescriber on 11/2/13. After a brief review of the Med Rec, Nurse #15 specifically pointed out that the list of medications on the Discharge Med Rec included Humulin R insulin given SQ three times a day in a dose ranging from 3- 18 units. However upon further review of the Discharge Med Rec, Nurse #15 acknowledged there was a checked box labeled " discontinue " next to the Humulin R insulin. Upon further discussion, Nurse #15 referred to the facility's Regular Insulin Sliding Scale (SSC) policy and indicated the insulin dosages on the resident ' s MAR reflected those of the facility's SSC. The physician's orders for Resident #218 were subsequently reviewed with Nurse #15. There was no documentation within the physician's orders which indicated an order had been received for initiation of the facility's Regular Insulin Sliding Scale protocol for this resident. A review of the facility's Regular Insulin Sliding Scale protocol revealed that when ordered, the protocol specified the following: " Blood Sugars need only be BID, unless otherwise specified by the clinician." Resident #218 was receiving blood sugar checks with Regular Sliding Scale insulin given three times daily. A follow-up review of Resident #218's medical record revealed the following orders were received from the prescriber on 11/7/13 at 2:10 PM: 1) Discontinue Levemir insulin, Discontinue three times daily (TID) Humulin R insulin 2) Lantus insulin 30 units SQ every night at bedtime (HS) 3) Fingerstick blood sugar (FSBS) before meals at bedtime (ACHS) daily	F 309		

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F 309	Continued From page 40	F 309		

4) Cover patient with sliding scale per nursing protocol with Humulin R insulin ACHS
5) Lantus insulin 10 units SQ every AM

A follow-up interview was conducted with Nurse #15 on 11/8/13 at 2:30 PM regarding the facility's process of obtaining admission medication orders for new residents. Nurse #15 indicated the facility would typically get a discharge summary from the hospital. She stated that the facility's nurse would be responsible to call and get a medication list from the discharge summary confirmed by either the physician or nurse practitioner.

An interview was conducted with the Director of Nursing (DON) on 11/8/13 at 4:34 PM regarding the process of obtaining admission medication orders for new residents. The DON reported that new residents usually had admission orders when they came in, including those for medications. She indicated that her expectation would be for the medication orders to be confirmed with the resident's provider and any changes in the orders to be noted as part of the admission orders.

2) Resident #218 was admitted to the facility on 11/2/13 from a hospital. Her cumulative diagnoses included diabetes, urinary tract infection and aphasia (a disorder of communication that impairs a person ' s ability to use and comprehend language).

Upon admission, Resident #218 was assessed by the nursing staff to be severely cognitively impaired for daily decision making skills. The resident was dependent on staff for all Activities of Daily Living (ADLs).

The list of admission medication orders for

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F 309	Continued From page 41 Resident #218 included the following: Levemir (Insulin Detemir) 100 unit/milliliter (ml) solution 10 units subcutaneously (SQ) daily; and Humulin R insulin 100 unit/milliliter (ml) solution subcutaneous (SQ) given three times a day before meals. No dose was specified in the Humulin R order noted on 11/2/13 and signed by the prescriber on 11/3/13. A review of the Medication Administration Record (MAR) for November 2013 revealed Resident #218's blood sugars were checked three times daily at 6:00 AM, 11:00 AM, and 4:30 PM. Documentation on the November MAR indicated the following blood sugar results were obtained: Blood sugar = 371 on 11/4/13 at 4:30 PM; Blood sugar = 345 on 11/5/13 at 4:30 PM; and Blood sugar = 381 on 11/6/13 at 4:30 PM. Normal blood sugar results typically range from 60-99 milligrams/deciliter (mg/dl) for a fasting blood sugar and below 140 mg/dl for a random blood sugar. Further review of the November MAR for Resident #218 revealed there was no record of insulin coverage recorded for the elevated blood sugar results obtained on 11/4/13 at 4:30 PM, 11/5/13 at 4:30 PM and 11/6/13 at 4:30 PM. A review of the resident's medical record revealed there was no additional documentation of the elevated blood sugar results recorded within either the Interdisciplinary Progress Notes or the Physician Orders. There was no documentation of an action taken in response to the elevated blood sugar results. An interview was conducted on 11/8/13 at 2:15 PM with Nurse #5 regarding documentation of	F 309		

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F 309	Continued From page 42 insulin coverage for elevated blood sugar levels. Nurse #5 stated there was a spot on the resident's MAR for accuchecks (blood sugar checks) and that the blood sugar results would be recorded there. She indicated that if the resident had an order for insulin coverage, the number of units of insulin given would also be recorded on the MAR. An interview was conducted on 11/8/13 at 2:30 PM with Nurse #15 who assumed responsibility as the Unit Manager Director. Nurse #15 stated that if a resident's blood sugar was checked, the nurse would note the results and put her initials on the MAR. If insulin coverage was provided, the nurse would also document the amount of insulin given on the MAR. Nurse #15 reported that if any insulin was given, the dose should be noted on the MAR. An interview was conducted with the Director of Nursing (DON) on 11/8/13 at 4:34 PM regarding insulin coverage for elevated blood sugar results. The DON indicated that she would expect any insulin coverage for an elevated blood sugar level to be documented on the resident's MAR. She stated, " If there is no documentation of insulin given, that means they did not need coverage. "	F 309		
F 323 SS=D	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.	F 323	F323 1. Resident #20 and #171 fall care plan was reviewed for effectiveness of Interventions on 12-2-13.	

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F 323	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observations, staff, and record reviews the facility failed to assess and re-evaluate interventions put in place to reduce falls for residents that had falls and continued to fall for 1 of 2 sampled residents reviewed for falls (Resident #171). Findings included: 1. Resident #171 was admitted originally on 6/21/2012 with diagnosis that included schizophrenia and dementia. A review of Resident #171's Minimum Data Set (MDS) dated 10/17/13 indicated Resident #171 was severely cognitively impaired with impaired short term and long term memory. Resident #171 indicated symptoms of depression daily, trouble concentrating on activities, and restlessness. Resident #171 did not have any behavior problems and required extensive assistance with personal hygiene, toilet use, dressing, and bed mobility. The resident was not coded as having a restraint in place. A review of Resident #171's medical record revealed a Care Plan dated 7/31/13 with at risk for falls related to impaired mobility as one of the focused problems. Interventions in place were encourage resident to communicate presence of pain, assist to reposition for comfort, alarm to wheelchair, alarm to bed, floor mat, place in open area, refer to therapy for increased falls, place alarm box out of reach of resident since he turns the alarm off himself, incontinence care after lunch, anti-slip pad to wheelchair, ensure call light is in place, lay resident down when tired or agitated, perimeter mattress, offer resident to be out of bed up to wheelchair when restless or	F 323	2. All other residents who have had a fall within the last 30 days will have their care plan reviewed for the effectiveness of their interventions any necessary changes will be made at that time. 3. All residents that have a fall will be reviewed the next day and Interventions updated and all other interventions reviewed for effectiveness by the IDT team. The falls will be reviewed at the weekly Care Meeting by the IDT team. 4. The Director of Nursing/Designee Will complete a weekly audit for 8 weeks then bi- weekly for 2 weeks. All finding will be brought to the PI monthly for review and evaluation.	12/06/13

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F 323	Continued From page 44 agitated as resident allows, give pain medications as indicated, anti-tipper and anti-rollback bars to wheelchair, resident to wear non slip footwear, remind resident to use call light prior to ambulating or transfer, therapy as needed, and ensure environment is free of clutter. The care plan was revised for falls when adding a new intervention but there was no assessment or evaluation of the interventions already in place and their effectiveness noted. A review of Resident #171's Physician Orders dated 6/21/12 to present did not indicate a medical need for or an order to use bed bolsters or the perimeter mattress. An observation of Resident #171 on 11/5/13 at 10:00 AM showed a resident in bed with a perimeter mattress. Resident #171 had only an incontinent brief on and was seen with his legs over the edge of the mattress without his feet touching the floor. An observation of Resident #171 on 11/6/13 at 12:00 PM showed a resident who was dressed in street clothes from his waist up. The resident was restless in bed and was attempting to get out of the bed. The resident had his feet and legs over the side of the perimeter mattress attempting to get out of bed. The bed alarm did not alarm. The resident was unsuccessful at getting out of bed and laid back down on his right side. An interview was conducted with the Regional Director Consultant on 11/7/13 at 11:20 AM. During the interview the Regional Director Consultant stated the perimeter mattress and bolsters used on Resident #171 were not restrictive to the resident because he is still falling out of bed. She further stated that the mattress and bolsters may have prevented the resident from falling more than the 14 times he did since	F 323		

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F 323	Continued From page 45 the devices were put into place. Upon further inquiry the Regional Director Consultant stated the bolters and mattress were not reassessed to see if they did or did not decrease or increase Resident #171's falls. An interview was conducted with the Director of Nursing (DON) and Regional Director Consultant on 11/8/13 at 8:40 AM. During this interview, the DON stated, " We don't use an assessment for the bolsters due to it's not a restraint. " An interview was conducted with the DON on 11/8/13 at 4:34 PM. Upon inquiry, the DON stated that if a resident was having any kind of falls and there was a need for a restraint, the issue would be discussed in an IDT meeting, a care meeting, and/or stand up meeting. The meeting would involve a verbal assessment and discussion among the team members. No written assessment tool would be produced during this meeting.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328	F328 1. Resident #220 received a full tank of Oxygen on 11-06-13.	

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F 328	Continued From page 46 Based on observation, staff interview and record review the facility failed to provide continuous oxygen for 1 of 16 Residents. (Resident #220) Findings included: Resident #220 was admitted on 10/9/13 with the diagnoses of hip fracture, peripheral vascular disease, asthma and anxiety. Review of the most recent Minimum Data Set dated 10/21/13, indicated he had no long or short term memory problems. He was able to make decisions of his daily care. He required extensive assistance with toileting and personal hygiene. He received oxygen therapy. Review of physician order dated 10/23/13, revealed continuous oxygen 2 liters per minute by nasal cannula. Review of physician order dated 11/1/13, revealed continue 02(oxygen) at 2LPM (liters per minute) NC (nasal cannula). During an observation on 11/6/13 at 9:57 PM, revealed Resident #220 was on contact isolation precautions. He was sitting at the sink in his room. His oxygen nasal cannula was in his nose and the end of the tubing was lying on the floor. No oxygen was in the pouch that holds the portable tank. Resident # 220 oxygen concentrator was on the opposite side of his room and was off. Aide #5 was in the hall putting on personal protective equipment. During interview Aide # 5 indicated she was going to provide incontinent care. When asked if resident #220 used continuous oxygen she said " Yes ". She indicted the physical therapist brought him back from therapy and left him sitting there	F 328	2. All the residents that had oxygen were reviewed on 11-6-13. If a tank was low it was replaced. Nursing Management updated resident care cards to alert staff when a resident is on oxygen and was placed on inside of residents closet. All rehabilitation therapist were in-serviced by Genesis Respiratory Therapist & SDC on 11/07/13 on the importance of oxygen therapy, timeliness of changing e-tanks, how to properly change and set-up e-tanks, location and storage of oxygen tanks. Maintenance Department will check oxygen closets and replace empty tanks on a daily basis. 3. All residents using E tanks and who have orders for oxygen saturation levels every 4 hours daily will be noted on the routine MARS, if tank is less than 500 PSI the tank will be changed. 4. Unit Manager/designee will Audits MAR weekly for oxygen sats and tanks checks on weekly basis for 8 weeks, then bi weekly for 4 weeks.	12/06/13

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F 328	Continued From page 48 Resident #220 takes his oxygen off anyway, and she acknowledged Aide#5 should have obtained the oxygen prior to starting incontinent care. During an interview 11/6/13 at 10: 30 am, the DON indicated her expectation was a resident with continuous oxygen ordered to have oxygen on at all times. During an interview on 11/6/13 at 4:20 pm DON indicated a breakdown in communication with new staff (physical therapist) and orienting them to where the oxygen was stored. There was also an identified breakdown with Aide # 5 who had not monitored or obtained oxygen for resident # 220 who was ordered continuous oxygen.	F 328		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on a meal observation, staff interviews and resident interviews, the facility failed to provide palliative foods and beverages for 2 of 4 halls to resident preferences. The findings included: During an interview on 11/5/13 at 10:00 AM, Resident # 89 indicated lunch and super was not good and there were concerns with the	F 364	F364 1. Residents #89, #221, #132 #137 were interviewed by the Dietitian/FSD on 11/29/13 concerning food preferences. Management team monitored tray delivery on 11/6/13, 11/7/13, & 11/18/13 to ensure timely delivery of meal trays.	

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F 364	Continued From page 49 preparation of the meal and the meal choices. During an interview on 11/5/13 at 11:13 AM, Resident #221 indicated all the meals were served cold and she had to go reheat the meals herself. Resident #221 added that this concern had been brought to the attention of several of the staff with no change. During an interview conducted on 11/5/13 at 11:56 AM, Resident #132 indicated that he had trouble eating the food for all three meals. Resident #132 stated he eats in his room and the trays typically sat out in the hallway for some time before being brought in and the food was typically cold. During a kitchen observation on 11/7/13 at 11:45AM, the cook took the temperature of the food and beverages in the presence of dietary Manager (DM) and registered dietician (RD), there was concerns with temperatures with of cold beverages being warm. The beverages had to be refrigerated. The last cart left the kitchen at 1:49PM and last tray was served on the floor at 2:00PM. The meal included regular/pureed pork chops, regular/pureed cabbage and regular/pureed sweet potatoes. The beverages were thicken juice and tea. Test tray was set-up by the DM and RD whom tasted the food and proceeded to take temperature of food. The food was sampled with the following results: The DM (dietary manager) and RD took the temperature of the following items regular/pureed pork chop all agreed dry and not hot at proper temperature and chewy, regular/pureed cabbage cold and mushy no flavor with the pureed cabbage, sweet potatoes luke warm, the thicken	F 364	2. Residents having the potential to be affected by this practice were identified by conducting random interviews of residents on 12/02/13 by the Dietitian concerning palatability of food and timeliness of tray delivery. An additional food cart is being utilized on two halls to reduce the amount of time the trays are waiting to be delivered which will ensure that food is at proper temperature. On 11/18/13, the Food Service Director (FSD) re-implemented the ½ pint cartons of milk which aids in maintaining proper temperatures. The plate warmer was serviced by the Maintenance Director on 12/02/13 & temperatures are maintained. 3. The Nursing staff was in-serviced on 12/03/13 by the Staff Development Coordinator (SDC) concerning timely delivery of meal trays, asking residents if their meal is warm enough and re-heating the meal if needed. The Food Service Director/Dietitian in-serviced Dietary staff on 11/06/13 on ensuring proper temperature of food prior to meal service.	

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F 364	Continued From page 50 juice and tea was very warm. DM indicated that the food or the beverages were not served at proper temperature when the cart reached the floor. DM added he was aware of the resident's concerns regarding cold food through individual residents and resident council group. DM further stated the expectation would be the food and beverages remain at proper temperatures when delivered to the halls and the dining room. In addition, new kitchen equipment would be purchased to address the problem. During an interview on 11/7/13 at 5:28PM, Resident #137 indicated that his lunch was cold when it arrived at 1:30PM. He indicated that the meals are normal late about 30 minutes and very cold. Staff indicated that they did not have time to reheat the food when asked. He indicated the process has been when the meal was delivered to the hall it sat on the hall another 30 to 40 minutes before it got to the room. He indicated that he has complained to nursing and dietician. He indicated that they also run out of food as well and they couldn't even get an alternate. He also indicated that some of his cold beverage would come hot or not at all. He indicated that a grievance had been filed in September regarding the food temperature and late arrivals of meals, but nothing was changed. He further stated that the meal on 11/7/13, cabbage and sweet potatoes were cold and juice was luke warm when it should have been cold, had to ask for ice. The chicken was not hot but he tolerated it because he was hungry. During a follow-up interview on 11/7/13 at 5:35PM, Resident #89 indicated that all the food comes out cold and that they trays sat on the hall	F 364	4. The Dietitian and FSD will conduct food palatability interviews weekly times 4 weeks then monthly times 2 months and report the findings to the PI committee monthly times 3 months to ensure compliance and consistency. Menu Meetings will be held weekly times 4 weeks and then monthly. Temperature test trays to be completed by the FSD/designee 3 times per week times one month then weekly times one month, then monthly.	12/06/13

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F 364	Continued From page 51 for 30 minutes or more. He indicated that he had reported this concern on several different occasions and no one has time to reheat the food. During an interview on 11/7/13 at 5:35PM, NA#4 indicated that residents had complained of cold food and on occasion would request for the meal to be reheated. The microwave was located in mini kitchen. During an interview on 11/7/13 at 5:40PM, NA#6 indicated that there had been some complaints about cold foods and the expectation was staff should reheat the food. There were also complaints about the trays coming up late. NA#6 indicated that there was a microwave on the behavior unit, and mini kitchen located near nurse station. There was no micro wave in the dining room. During an interview on 11/7/13 at 5:46PM, NA#7 indicated that there had been reports of cold food and the expectation was to take the food to the microwave down the hall to warm up the food. During an interview on 11/7/13 at 5:48PM, the DON indicated that there were no microwaves in the dining room per the company to prevent the residents from getting burned and they were more secured in other locations. The expectation would be if the resident complained the food was cold staff would go to the designated area to warm the food. During an interview on 11/7/13 at 6:10PM, the Administration indicated that she was aware of the residents concerns with meals temperature and the expectation that the DM and RD would	F 364		

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F 364	Continued From page 52 address the concerns.	F 364		
F 371 SS=F	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 record review, the facility failed to remove fresh produce from rotten produce, in 1 of 1 walk in refrigerator, clean 4 of 4 meal carts, ensure the dishes and steam table pots and pans on the dry storage racks were clean, dry and free from dried food debris on 2 of 2 drying racks, discard an open bowl of cut fruit that had fruit flies in/out of bowl and failed to air dry dome lids/insulated bottoms and store them on a clean cart/racks. The findings included: 1. During an observation of the walk in freezer on 11/4/13 at 4:00PM, a box of rotten spoiled mushy cucumbers and bell peppers was mixed with fresh produce. During an interview on 11/4/13 at 4:05PM, the dietary manager(DM) indicated that there should be no rotten produce stored with fresh produce in	F 371	F371 1. All areas identified during the survey were discarded; all meal pots and pan were rewashed and stored appropriately, sliced melon was discarded immediately, and meal service was stopped and the identified dome lids and bases were rewashed and dried appropriately. On 11/08/13, EcoLab serviced the dish machine for proper drying.	

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F 371	Continued From page 53 the refrigerator. 2. During an observation on 11/7/13 at 12:15PM, 4 meal carts had dry brown matter and food debris stored on the carts. During an interview on 11/7/13 at 12:30PM, RD and DM indicated that the meal carts should cleaned and wiped down daily before trays are placed on the carts by the kitchen staff. 3. During an observation on 11/7/13 at 12:15PM, 14 silver steam table pots and pans were stored on 2 drying racks greasy with dried food debris and 7 sectional plates and low lip bowls were dirty with dried food particles were stacked on top of one another in preparation for use during the meals. During an interview on 11/7/13 at 12:30PM, the register dietician(RD) indicated that kitchen staff responsible for ensuring the pots/pans and dishes were clean prior to usage and stored clean on the designated racks. 4. During an observation on 11/7/13 at 12:15PM, 1 bowl of 14 1/2 sliced melons in a large silver bowl and silver storage pan located on top of the dirty sink dated 11/4/13 with fruit flies and nats flying in/out of opened seran wrapping. 5. During tray line observation on 11/7/13 at 12:35PM, 20 dome lids and 40 insulated bottoms was stacked wet on top of each other on the drying rack with dried food particles. The DM identified the lids and dome as cleaned and ready to be used. During an interview on 11/7/13 at 2:30PM, RD	F 371	2. The Food Service Director (FSD) to complete daily checks of walk-in cooler for items needing to be discarded, out of date items, and proper food rotation/storage. Environmental Services Department will pressure wash all food carts on a weekly basis and dietary Staff to sanitize between each meal. On 11/08/13 EcoLab serviced dish machine to include adjusting Rise Aid (Drying Agent) to aid in proper drying and also checked the 3 compartment sink sanitizer and soap dispenser for proper function. Maintenance director increased dish machine water temperature to aid in the drying process. FSD/Cook to complete spot checks daily of pots and pans and dishes. Stacking and storage of dome lids and bases are racked individually to allow for proper air drying. FSD to completed daily spot checks to ensure that dome lids and bases are dried prior to stacking. 3. Re-educated dietary staff on 11/07/13 by FSD & Dietitian on proper warewashing, proper air drying, and kitchen sanitation. 4. FSD will complete daily checks of walk-in cooler times 4 weeks, then weekly times 2 months, then monthly. Environmental Services Department will pressure	

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F 371	Continued From page 54 and DM indicated that training and cleaning in the kitchen would be conducted immediately. During an interview on 11/7/13 at 6:10PM, the Administration indicated that the DM and RD would address the concerns with the sanitation of the kitchen. She indicated that when the new renovations in the dining/kitchen occur this should eliminate some of the problems. The DM will begin in-service with staff on the sanitary conditions in the kitchen.	F 371	wash all food carts weekly. FSD or designee to check pot and pans, dishes, dome lids and bases daily times 4 weeks, then weekly times 2 months, then monthly for cleanliness and proper drying. All audits will be reported to the PI committee monthly times 3 months to ensure compliance and consistency.	12/06/13
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	F431 1. Expired medications on 1-North Cart #1, 1 south Cart#1, and 2 south Cart #1, were discarded appropriately. Expired medications in the medications store rooms were discarded appropriately. All medications not stored as specified by the manufacture were discarded appropriately. All other medications in carts were audited for the medication with the resident name and/or expiration date. 2. License Nurses will be in- serviced on monitoring expired medications and dating medication bottles when opened by Assistant Director of Nursing(ADNS)/SDC by 12/06/13.	

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F 431	Continued From page 55 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to: 1) remove expired medications from 3 of 9 medication carts (1-North Cart #1, 1-South Cart #1, and 2-South Cart #1); 2) failed to discard expired medications in 1 of 4 medication store rooms (1 North Medication Storeroom); 3) failed to store medications as specified by the manufacturer in 3 of 9 medication carts (1-North Cart #2, 2-North Cart #1, and 2-South Cart #1); and 4) failed to label medications with a resident's name and/or expiration date in 3 of 9 medication carts (1-North Cart #1, 1-North Cart #2 and 2-North Cart #1). The findings included: 1a) An observation of the 1-North Medication Cart #1 on 11/8/13 at 12:50 PM revealed the following medications stored on the cart were expired: Expired Medication # 1: An expired vial of Novolog insulin (a rapid-acting insulin) labeled for Resident #113 was stored on the cart. The insulin was labeled as having been opened on two dates, 10/2/13 and 10/4/13. The manufacturer's product	F 431	3. Unit Manager/designee will check the medication carts and medication storage rooms on a weekly basis, for 8 weeks then monthly for 2 months. Omnicare Pharmacy Representative will do a complete audit of all carts and medication carts for expirations. 4. The DNS will be responsible over the audits and the results of the audits will be brought to the PI meeting monthly for analysis and evaluation.	12/06/13

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F 431	Continued From page 56 information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #113's November 2013 Physician Orders revealed there was a current order for Novolog insulin to be used on a sliding scale basis as needed (which indicated the insulin was to be used only as needed and that the insulin dose used was dependent on the resident's blood glucose level). Expired Medication # 2: An expired vial of Lantus insulin (a long-acting insulin) labeled for Resident #113 was stored on the cart. The insulin was labeled as having been opened on 10/2/13. The manufacturer's product information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #113's November 2013 Physician Orders revealed there was a current order for Lantus insulin to be given once daily. An interview was conducted with the nurse assigned to the 1-North Medication Cart #1on 11/8/13 at 12:50 PM. During the interview, Nurse #6 stated a vial of insulin should be labeled with the date when opened and that both the Novolog and Lantus insulin needed to be discarded 30 days after the date opened. Nurse #6 indicated that she would need to discard the remaining amount of the insulin and order a replacement from the pharmacy. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated	F 431		

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F 431	Continued From page 57 her expectation was that all unopened vials of insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. Once a vial of insulin was opened, it should be dated. The DON specified that the facility ' s policy was to discard opened vials of insulin 30 days from the date opened. 1b) An observation of the 1-South Medication Cart #1 on 11/8/13 at 1:10 PM revealed the following medications stored on the cart were expired: Expired Medication # 1: An expired vial of Lantus insulin labeled for Resident #18 was stored on the cart. The insulin was labeled as having been opened on 9/30/13. The manufacturer ' s product information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #18's November 2013 Physician Orders revealed there was a current order for Lantus insulin to be used once daily. Expired Medication # 2: An expired vial of Lantus insulin labeled for Resident #121 was stored on the cart. The insulin was labeled as having been opened on 10/5/13. The manufacturer's product information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #121's November 2013 Physician Orders revealed there was a current order for Lantus insulin to be given once	F 431		

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F 431	Continued From page 58 daily. An interview was conducted with the nurse assigned to the 1-South Medication Cart #1 on 11/8/13 at 1:10 PM. During the interview, Nurse #4 stated the policy was to discard insulin after 28 days once the vial has been opened. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. Once a vial of insulin was opened, it should be dated. The DON specified that the facility ' s policy was to discard opened vials of insulin 30 days from the date opened. 1c) An observation of the 2-South Medication Cart #1 on 11/8/13 at 12:10 PM revealed the following medications stored on the cart were expired: Expired Medication # 1: An expired vial of Novolog insulin labeled for Resident #170 was stored on the cart. The insulin was labeled as having been opened on 9/9/13 and labeled with a calculated expiration date of 10/13/13. The manufacturer's product information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #170's November 2013 Physician Orders revealed there was a current order for Novolog insulin to be used on a sliding scale basis as needed.	F 431		

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F 431	Continued From page 59 Expired Medication # 2: An expired vial of Lantus insulin labeled for Resident #170 was stored on the cart. The insulin was labeled as having been opened on 9/12/13. The manufacturer's product information indicated, " once punctured (in use), vials may be stored at room temperature; use within 28 days. " A review of Resident #170's November 2013 Physician Orders revealed there was a current order for Lantus insulin to be given twice daily. An interview was conducted with the nurse assigned to the 2-South Medication Cart #1 on 11/8/13 at 12:10 PM. During the interview, Nurse #7 stated that insulin was stored in the medication storeroom refrigerator until needed on the cart. Once the vial of insulin was opened, it was dated and kept on the medication cart for 28 days. Nurse #7 indicated that after being open for 28 days, the vial of insulin would be pulled from the medication cart and put in the med room on the shelf to be sent back to the pharmacy or thrown away. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. Once a vial of insulin was opened, it should be dated. The DON specified that the facility ' s policy was to discard opened vials of insulin 30 days from the date opened. 2) An observation of the 1 North Medication Storeroom on 11/7/13 at 5:20 PM revealed an expired bottle of azithromycin (an antibiotic) 200	F 431		

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F 431	Continued From page 60 mg/5ml suspension was stored in the refrigerator. The azithromycin was labeled with an expiration date of 11/4/13. A review of Resident #199's November 2013 Physician Orders revealed there was a current order for azithromycin to be given as 30 ml suspension by mouth once weekly. Nurse #13 (a nurse responsible for staff development) was present during the Storeroom observation. An interview was conducted with Nurse #13 on 11/7/13 at 5:20 PM. At that time, Nurse #13 stated the expired azithromycin would need to be discarded. Nurse #13 indicated the medication storerooms were routinely checked by the staff development coordinators and it was her expectation that all expired medications would either be discarded or returned to the pharmacy. 3a) An observation of the 1-North Medication Cart #2 on 11/8/13 at 1:20 PM revealed an unopened vial of Humalog insulin (a rapid-acting insulin) labeled for Resident #152 was stored on the cart. The insulin was dispensed from the pharmacy on 10/29/13. The vial was not labeled with the date it was put on cart and stored at room temperature. According to the product manufacturer, unopened vials may be stored under refrigeration until the manufacturer's expiration date or at room temperature for 28 days. A review of Resident #152's November 2013 Physician Orders revealed there was a current order for Humalog insulin to be used on a sliding scale basis. An interview was conducted with the nurse assigned to the 1-North Medication Cart #2 on 11/8/13 at 1:20 PM. During the interview, Nurse #10 stated that unopened insulin should be kept in the refrigerator until needed and not stored at	F 431		

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F 431	Continued From page 61 room temperature on the cart. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. The facility was unable to provide information about how long an unopened vial of insulin had been in the unrefrigerated medication cart as the vial would not be dated until it was opened. The DON specified that the facility's policy was to discard opened vials of insulin 30 days from the date opened. 3b) An observation of the 2-North Medication Cart #1 on 11/8/13 at 12:23 PM revealed the following medications were stored on the medication cart without being dated as to when they were moved to storage at room temperature: Medication # 1 Stored at Room Temperature: An unopened vial of Lantus insulin was stored on the cart. The insulin was dispensed from the pharmacy on 11/2/13. The vial was not labeled with the date it was put on cart and stored at room temperature. According to the product manufacturer, unopened vials may be stored under refrigeration until the manufacturer's expiration date or at room temperature for 28 days. Medication # 1 Stored at Room Temperature An unopened vial of Levemir insulin was stored on the cart. The insulin was dispensed from the pharmacy on 10/23/13. The vial was not labeled with the date it was put on cart and stored at room temperature. According to the product manufacturer, unopened vials may be stored	F 431		

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F 431	Continued From page 62 under refrigeration until the manufacturer's expiration date or at room temperature for 42 days. An interview was conducted with the nurse assigned to the 2-North Medication Cart #1 on 11/8/13 at 12:23 PM. During the interview, Nurse #9 stated that unopened insulin vial should be kept in the refrigerator until needed and not stored on the cart. He noted that once insulin is taken from the refrigerator it is good for 28 days. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. The facility was unable to provide information about how long an unopened vial of insulin had been in the unrefrigerated medication cart as the vial would not be dated until it was opened. The DON specified that the facility's policy was to discard opened vials of insulin 30 days from the date opened. 3c) An observation of the 2-South Medication Cart #1 on 11/8/13 at 12:10 PM revealed an unopened vial of Novolog insulin labeled for Resident #170 was stored on the cart. The insulin was dispensed from the pharmacy on 9/25/13/13. The vial was not labeled with the date it was put on cart and stored at room temperature. According to the product manufacturer, unopened vials may be stored under refrigeration until the manufacturer's expiration date or at room temperature for 28 days. A review of Resident #170's November 2013 Physician Orders revealed there was a current order for Novolog insulin to be used on a	F 431		

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F 431	Continued From page 63 sliding scale basis as needed. An interview was conducted with the nurse assigned to the 2-South Medication Cart #1 on 11/8/13 at 12:10 PM. During the interview, Nurse #7 stated that insulin was stored in the medication storeroom refrigerator until needed on the cart. Once the vial of insulin was opened, it was dated and kept on the medication cart for 28 days. Nurse #7 indicated that after being open for 28 days, the vial of insulin would be pulled from the medication cart and put in the med room on the shelf to be sent back to the pharmacy or thrown away. During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. The facility was unable to provide information about how long an unopened vial of insulin had been in the unrefrigerated medication cart as the vial would not be dated until it was opened. The DON specified that the facility ' s policy was to discard opened vials of insulin 30 days from the date opened. 4a) An observation of the 1-North Medication Cart #1 on 11/8/13 at 12:50 PM revealed an Advair Diskus 100mcg/50mcg inhaler (a dry powder inhaler used for asthma or chronic obstructive lung disease) labeled for Resident #35 was not dated as to when it had been opened and removed from the foil pouch. The inhaler ' s meter indicated there were 51 doses remaining in the inhaler. Supplemental labeling from the dispensing pharmacy noted the Advair Diskus inhaler " Expires 1 month after opening. " The	F 431		

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Advair Diskus inhaler was dispensed from the pharmacy on 9/14/13. A review of Resident #35's November Physician Orders revealed there was a current order for Advair Diskus inhaler 100/50 mcg/dose to be given twice daily.

During an interview with Nurse #6 on 11/8/13 at 12:50 PM, the nurse stated she thought an Advair Diskus inhaler could be used until all doses were taken, regardless of the date the inhaler was removed from the foil packaging. Nurse #6 indicated she was not aware that the inhalers needed to be dated upon opening or that the expiration date of the inhaler would need to be adjusted once the inhaler was removed from the foil packaging.

During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated the facility ' s policy was to date anything that is opened, including Advair Diskus inhalers. She indicated the Advair Diskus inhaler would have a 30-day expiration date once opened.

4b) Observations of the 1-North Medication Cart #2 revealed the following medications were stored on the cart without being labeled with a resident ' s name and/or expiration date:

Medication # 1 Stored without a Labeled Expiration Date:
An observation of the 1-North Medication Cart #2 made during medication pass administration on 11/7/13 at 9:00 AM revealed an opened, undated vial of Novolog insulin labeled for Resident #7 was stored on the cart. It was noted the vial of insulin had been dispensed from the pharmacy on 8/29/13. A review of Resident #7's November 2013 Physician Orders revealed

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F 431	Continued From page 65	F 431		

there was a current order for Novolog insulin to be given twice daily as a scheduled medication and used on a sliding scale basis as needed.

Medication # 2 Stored without a Resident ' s Name or Labeled Expiration Date:
An observation of the 1-North Medication Cart #2 made on 11/8/13 at 1:20 PM revealed an opened, undated Advair Diskus sample inhaler was stored on the cart. The sample prescription inhaler was not labeled with either a resident ' s name or date as to when it had been opened.

An interview was conducted with the nurse assigned to the 1-North Medication Cart #2 on 11/7/13 at 9:00 AM. During the interview, Nurse #10 stated the insulin should have been labeled with the date it was opened and that Novolog insulin needed to be discarded 30 days after the date opened. Nurse #10 indicated that since the insulin had not been dated when opened, she would need to discard the remaining amount and order another vial from the pharmacy.

A follow-up interview was conducted with Nurse #10 on 11/8/13 at 1:20 PM. During the interview, Nurse #10 stated the sample Advair Diskus inhaler should have been labeled with the resident's name and date opened. She indicated the inhaler would need to be discarded.

During an interview with the Director of Nursing (DON) on 11/8/13 at 4:34 PM, the DON indicated her expectation was that all unopened vials insulin would be stored in the medication storeroom refrigerator until needed on the medication cart. Once a vial of insulin was opened, it should be dated. The DON specified

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F 431	Continued From page 66 that the facility's policy was to discard opened vials of insulin 30 days from the date opened. The DON further stated the facility's policy was to date anything that is opened, including Advair Diskus inhalers. She indicated the Advair Diskus inhaler would have a 30-day expiration date once opened. 4c) An observation of the 2-North Medication Cart #1 on 11/8/13 at 12:23 PM revealed a bottle of [brand name] nutritional supplement was being stored on the medication cart. The nutritional supplement was not labeled with either a resident's name or expiration date. An interview was conducted with Nurse #9 on 11/8/13 at 12:23 PM. During the interview, Nurse #9 stated the bottle of nutritional supplement was provided by the family of Resident #122 and approved by his physician. Upon review of the bottle, Nurse #9 confirmed there was not an expiration date on the bottle and indicated it should have been labeled with both the resident's name and an expiration date from the manufacturer or pharmacy. The nurse indicated that since there was no expiration date on the bottle, it would need to be discarded and replaced.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F441 1. Resident #170 had the glucose meter disinfected prior to completing the blood glucose tests.	

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F 441	Continued From page 67 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to clean and disinfect a shared glucometer (glucose meter used to measure a resident's blood sugar level) for 1 of 2 residents observed (Resident #170) receiving blood glucose monitoring.	F 441	2. Nurse #3 was in- serviced on 11-7-2013 by SDC, on the correct procedure of disinfecting the blood glucometer, wiping with a Clorox wipe prior to use, after use and waiting 2 minutes to dry, with repeat demonstration. Licensed nurses will be in-serviced on the disinfecting of the blood glucometer by SDC by 12/06/13. 3. New nurses hired will be oriented and checked off prior to starting their medication pass. Wiping the blood glucometer prior to use, after use and then wait 2 minutes to dry. Staff Development Coordinator will observe nurses on medication process and check off weekly for 2 months, then bi-weekly for 1 month. 4. The DNS will be responsible For the process and bring findings to the monthly PI meeting for the next 3 months.	12/06/13

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F 441	Continued From page 68 The findings included: According to the Center for Disease Control (CDC) guidelines, shared glucometer devices should be cleaned and disinfected between each patient use. The CDC references additional guidance provided by the Food and Drug Administration (FDA) for manufacturers regarding appropriate products and procedures for cleaning and disinfection of blood glucose meters. The disinfection solvent chosen should be effective against human immunodeficiency virus (HIV), Hepatitis C, and Hepatitis B virus. It is recommended that healthcare personnel consult the manufacturers of blood glucose meters in use at their facilities to determine what products, meeting the criteria specified by the FDA, are compatible with their meter prior to using any EPA (Environmental Protection Agency)-registered disinfectant for disinfection purposes. The facility's procedure entitled, Glucose Meter dated 6/1/96 and revised on 10/1/12 was reviewed. This procedure indicated, " Disinfect meter before patient use " using an " appropriate disinfectant. " Information from the [brand name] glucose meter manufacturer ' s website revealed a letter to customers dated 12/19/12 that addressed the issue of cleaning and disinfecting guidelines for the glucose meter. The guidelines provided in the letter included the following: "Cleaning Guidelines: Use a moist (NOT WET) lint-free cloth dampened with a mild detergent. " "Disinfecting Guidelines: To disinfect your meter, clean the meter surface with [brand name] Disinfectant Towels with Bleach or [brand name]	F 441		

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F 441	Continued From page 69 Bleach Germicidal Wipes. " The two disinfectant products recommended by the manufacturer were EPA-registered disinfectants meeting the criteria specified by the FDA. Additional notes from the product manufacturer indicated other formules containing a 1:10 bleach dilution were in the process of being tested. The manufacturer also indicated, " Per the CDC, if shared, blood glucose meters should be cleaned and disinfected after every use. " During a medication administration pass observation on 11/7/13 at 4:16 PM, Nurse #3 used a [brand name] glucometer to obtain a blood glucose reading for Resident #31. After the reading was taken, the nurse set the glucometer on top of the medication cart. Nurse #3 was continually observed during the medication administration pass as this glucometer remained on top of the medication cart. At 4:20 PM, Nurse #3 was observed as she used a [brand name] hand wipe to clean the shared glucose meter in preparation to obtain a blood sample from Resident #170. The wipe was labeled for hand hygiene use and was not an EPA-registered disinfectant. The nurse then gathered the blood glucose monitoring supplies and the glucometer which had been previously used for Resident #31. Nurse #3 knocked on Resident #170 ' s door and entered her room. At this time, a request was made for the nurse to step out of the resident ' s room when inquiry was made as to whether anything else was available for use for disinfecting a shared glucometer between residents. Nurse #3 stated there was one other alternative and pulled a container of [brand name] Bleach Germicidal Wipes from her medication	F 441		

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F 441	Continued From page 70 cart. At that time, Nurse #3 indicated she did not initially use these wipes to clean the glucometer because they could not be used on hands. Nurse #3 then used one of the [brand name] Bleach Germicidal Wipes to disinfect the shared glucometer prior to completing a blood glucose test for Resident #170. The [brand name] Bleach Germicidal Wipes were an EPA-registered disinfectant meeting the criteria specified by the FDA. An interview was conducted with the Director of Nursing (DON) on 11/7/13 at 4:36 PM regarding the cleaning and disinfection of shared glucometers. The DON indicated her expectation was for the shared glucometer to be disinfected before and after each of the resident ' s blood glucose tests. She indicated the glucometers were wiped with a bleach cleaning wipe and allowed to air dry for at least two minutes prior to re-use. When asked if it was acceptable to use a hand wipe (labeled for hand hygiene use) to clean the glucose meter, the DON indicated it was not and stated, " It ' s supposed to be bleach. " She further indicated the nurse observed cleaning a glucose meter with a hand wipe would need to be in-serviced to insure the correct wipes were used to disinfect a shared glucometer.	F 441		

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

PRINTED: 12/02/2013
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
	345172	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/27/2013

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 11 (222) construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Triad Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2013 the	K 018	**K 018** 1. The Maintenance Director & Maintenance Assistant repaired the latch on rooms 106, 109, 116, 117, 122; 141and replaced the clean linen door with an automatic closure on 12/10/13. A new door for 109 was ordered and will be installed on 12/11/13. 2. The Maintenance Assistant audited all latching doors in the facility on 12/10/13 with repairs made as needed. Monitoring of door latches will be put on the Preventative Maintenance Program or the TELS System. 3. The Maintenance Director & Maintenance Assistant was educated by Kevin Wright, Regional Property Manager on 12/10/13 related to requirements of door latches. 4. The Maintenance Director or designee will audit all latching doors in the facility weekly for 1 month and monthly for 2 months. Results of the audit will be reported during the monthly Performance Improvement meeting for 3 months.	12/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm (X6) DATE: 12/12/13

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

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K 018	Continued From page 1 following failed to latch when closed 106,109,116,117,122,141 and the clean linen room near room113. 42 CFr r83.70 (a)	K 018		
K 029 SS=D	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: A. The door to the soiled linen side of the laundry failed to close and latch. B. Second floor soiled linen near room 227 failed to close and latch. 42 CFR 483.70 (a)	K 029	K 029 1. The doors to the soiled side to the laundry room and the second floor soiled linen near room 227 were repaired by the Maintenance Director on 12/10/13. 2. An audit was completed by the Maintenance Director on 12/10/13 related to corridor doors and latching with repairs made as needed. Monitoring of doors will be put on the Preventative Maintenance Program or the TELS System. 3. The Maintenance Director was educated by Kevin Wright, Regional Property Manager on 12/10/13 related to the requirements of doors self closing and latching. 4. The Maintenance Director or designee will audit all latching doors in the facility weekly for 1 month and monthly for 2 months. Results of the audit will be reported during the monthly Performance Improvement meeting for 3 months.	12/20/13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

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K 038	Continued From page 2 Based on observation on11/27/2013 there were (3) three rooms on the baock that has hasp and locks A. Main storage room , Boiler room and the small storage room across from the Main Storage room.. B. Staff did not know about the master door release switch at the nurses station. C. The med. storage room at the lounge requires more than one motion of the hand to exit the room. D. There is no master switch for the door release at Nurses Station # 2 North. 42 CFR 483.70 (a)	K 038	K038 1.) The three rooms identified as the main storage room, boiler room and the small storage room in the back that had the hasp and locks were removed. The locks were removed on 11/27/13 by the Maintenance Assistant. The remaining hardware was removed on 12/06/13 by the Maintenance Director. Staff Development Coordinator (SDC) began in-servicing all staff on the master door (Mag Lock) release switches on 11/27/13. The Maintenance Assistant removed the deadbolt lock and covered with metal plate on the med. storage room (central supply) on 12/09/13. Protection Services, Inc. installed a master switch for the door release at Nurses Station #2 North on 12/10/13. 2.) An audit of all doors with exit access was completed by Maintenance Assistant; on 12/10/13 to ensure that exits are readily accessible at all times. 3.) SDC re-educated all employees on 11/27/13 related to the master door (Mag Lock) release switches. 4.) Maintenance Director/SDC or designee will complete interviews with random employee sample weekly for four weeks, monthly for two months and during orientation for all new hire to ensure understanding and proper usage of master switch for the door release. Results of the interviews will be reported during the monthly Performance Improvement meeting for 3 months.	12/20/13
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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K 051	Continued From page 3 This STANDARD is not met as evidenced by: A. The phone connection for the FACP could not be tested as they could be located. 42 CFR 483.70 (a)	K 051	**K051** 1.) Protection Systems, Inc. was contacted and came out to the facility to inspect the Fire Alarm Control Panel (FACP) on 12/12/13. Protection Systems informed the Maintenance Director that an independent phone line needed to be installed to have the proper connection for the FACP. 2.) The Maintenance Director contacted Genesis HealthCare IT department to install an independent phone line for the FACP on 12/12/13. North State Phone Company will install the independent phone line from the existing phone board to the FACP. Once this is complete, Protection Services, Inc. will install a quick connect to the independent potts line for the FACP. Installation is to be completed by 12/17/13. 3.) Maintenance Director in-serviced all department heads on the location of quick connect line and the procedure to test the FAPC system. 4.) The results of the monthly tests will be reported during the monthly Performance Improvement meeting for 3 months	12/20/13
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2013 the inspection on the Ansul for the range hood was out of date.	K 069		

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K 051	Continued From page 3 This STANDARD is not met as evidenced by: A. The phone connection for the FACP could not be tested as they could be located. 42 CFR 483.70 (a)	K 051		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2013 the inspection on the Ansul for the range hood was out of date.	K 069	**K069** 1.) Triad Pressure Wash, made a service call to inspect the Ansul system for the range hood in the kitchen. Ansul system was brought back in compliance on 12/11/13. 2) The Maintenance Director will ensure that Ansul system is inspected every six months and is on the Preventive Maintenance Program/TELS System. 3) The Maintenance Director was educated by Kevin Wright, Regional Property Manager related to the requirements of the Ansul system inspection on 12/10/13. 4) The results of the inspections will be reported during the monthly Performance Improvement meeting for 3 months.	12/20/13