STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	**430 BROOKWOOD AVENUE NE CONCORD, NC 28025**

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F 000	INITIAL COMMENTS SQC was identified under F242 (H). Team conducted the extended survey on 3/11/14.	F 000		
F 242 SS=H	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to honor resident's choice for not having the indwelling catheter for 1 of 1 sampled resident with an indwelling catheter.(Resident # 24) Findings included: Resident #24 was admitted to the facility on 5/29/03 and was readmitted on 5/29/13 with multiple diagnoses including Schizophrenia, Schizo affective disorder, Mental Retardation, Depression, Joint contracture and Urinary Tract Infection (UTI). The annual Minimum Data Set (MDS) assessment dated 2/19/14 indicated that Resident #24 had severe cognitive impairment, had a stage IV pressure ulcer (not present on admission) and had an indwelling catheter. The	F 242	Criteria #1 On 2/28/14, Administrator and Director of Nursing (DON) spoke to resident #24 about her choice regarding the foley catheter. Resident #24 stated regarding the foley catheter, "It holds my pee pee and helps make my bottom better." Order received on 3/1/14 by Medical Director saying "may leave foley catheter out." Criteria #2 All residents have the potential to be affected by the alleged deficient practice. All residents were interviewed by designated staff(Unit Coordinators, medical records clerk, scheduler, rehab tech, restorative nursing staff) to ensure choices are being honored. Interviews indicate no other residents were found to be affected. Administrator attended the Resident Council meeting held on 3/28/14	4/4/14

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

Electronically Signed | 03/11/2014

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F 242	Continued From page 1 assessment indicated that Resident #24 had no behavioral symptoms. The care plan dated 12/11/13 was reviewed. One of the care plan problems was " at risk for loss of skin integrity and UTI related to impaired mobility and incontinence of bowel and bladder. Has stage III area to sacrum and using Foley to aid in healing. " On 1/14/14, a statement was added at the bottom of the care plan problem which read " noted to be pulling at Foley related to anxiety. " The nurse's notes were reviewed. The notes indicated that Resident #24 had multiple episodes of pulling out the indwelling catheter. She had pulled her catheter out 16 times in the last 2 months. The nurse's notes revealed that Resident #24 had pulled the indwelling catheter out on 1/3/14, 1/9/14, 1/12/14 (2 times), 1/14/14, 1/19/14, 1/20/14, 1/24/14, 2/16/14, 2/19/14, 2/22/14 (2 times), 2/23/14 (2 times) and 2/24/14 (2 times). On 1/12/14 at 4:30 PM, the notes indicated that Resident #24 had pulled her catheter out. When the nurse asked her why she kept pulling out her catheter, she replied in tearful tones (name of doctor) discontinued this cause I told him I hated it. " The notes further indicated that the catheter was replaced and education was given to the resident about the importance of leaving the catheter in place. The resident voiced understanding but remains tearful. On 1/12/14 at 9:46 PM, the notes indicated that the nurse was alerted that Resident #24 had pulled out her catheter for the second time in the	F 242	to address residents rights related to choice/refusing prescribed medical treatment. All residents who answered, stated their choices were being honored. Criteria #3 DON and/or Assistant Director of Nursing (ADON) completed inservicing for licensed nursing staff on Prescribed Medical Treatment Refusal Notification form on 4/2/14. This form is used every shift by nursing staff following a patient's refusal for any prescribed treatment. This data includes: patient name, date, room #, and detail of the refused treatment or medication. Nurses will indicate time of documentation of education of patient, as well as notification of RN on call. The refusal forms will be reviewed Monday - Friday in department head morning meeting and by Unit Coordinators on Saturday - Sunday, to identify residents wishes related to choices. Designated personnel (Unit Coordinators, medical records clerk, scheduler, rehab tech, restorative nursing staff) will interview (5) residents per hall daily for (5) days, then (5) residents per hall weekly for (12) months to identify resident wishes related to choices. DON and/or ADON will review interviews weekly upon completion. Refusal forms will be reviewed by Medical Director upon each visit, which is normally Tuesday, Thursday, and Friday. Care plans will be adjusted accordingly. Criteria #4 DON and/or ADON will report results of audits in Quality Assessment and	

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F 242	Continued From page 2 shift. The nurse asked her why she pulled it out and she replied " cause it hurts and I don't want it in (G -D). " Resident #24 also told the nurse " if you put that thing back in me I will never talk to you again (D). " The notes revealed that the physician was informed of the resident's increased agitation with an order to give Ativan (antianxiety) 0.5 milligram (mgs) times 1 dose. Ativan was administered by mouth with little effect. The catheter was replaced and the resident had yelled obscenities at the nurse throughout the insertion. On 2/19/14 at 9:22 PM, the notes indicated that it was reported to the nurse that the catheter of Resident #24 was lying inside her brief. Resident #24 stated " I pulled it out on purpose cause I don't want it. " On 2/22/14 at 6:36 AM, the notes indicated that the nurse was informed that the catheter of Resident #24 was not in place. The nurse asked her what happened and she stated " it was hurting so I pulled it out. " On 2/22/14 at 9:37 PM, the notes revealed that the nurse was informed that the catheter of Resident #24 was lying inside the brief. The resident stated to the nurse " it hurts so I pulled it out. " The resident was crying while she was speaking to the nurse. Resident #24 was educated on the importance of leaving the catheter in place. The resident refused to voice understanding. The catheter was replaced and the resident was with severe anxiety/tearfulness. Ativan was administered as ordered. On 2/23/14 at 12:44 PM, the notes indicated that	F 242	Assurance (QA&A)monthly next (12) months at which time the QA&A committee will determine if further auditing is needed.	

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F 242	Continued From page 3	F 242		

that the catheter of Resident #24 was lying in bed with the bulb inflated. The resident stated " it hurts so I got it out. "

On 2/23/14 at 10:00 PM, the notes indicated that the catheter of Resident #24 was found lying in her brief with bulb inflated. The resident was crying and not speaking. The nurse attempted to calm the resident without success. The catheter was replaced and the resident was yelling " I'm sore. " This nurse explained to resident that soreness could be the result of pulling out of the catheter multiple times. Resident refused to acknowledge the nurse.

On 2/24/14 at 6:31 AM, the notes indicated that it was reported to the nurse that the catheter of Resident #24 was hanging out. The catheter was found inside the brief with the balloon inflated. Resident stated " I took it out. " When questioned why she pulled it out, the resident stated " because it was hurting. "

On 2/26/14 at 3:54 PM, Resident #24 was observed in bed with the indwelling catheter in place. When asked why she was pulling her catheter out, she replied " because I don't like it. "

The doctor's progress notes were reviewed. The notes dated 1/14/14 indicated that Resident #24 had the indwelling catheter to help sacral wound dry but she (resident) has been pulling the catheter and taking it out. She had pulled it out six times over the weekend and again today. The notes further indicated that the resident stated that she does not like the catheter.

On 2/26/14 at 9:45 AM, administrative staff #2

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F 242	Continued From page 4	F 242		

was interviewed. She stated that the pulling out of the catheter by Resident #24 was a behavioral issue.

On 2/26/14 at 1:41 PM, Nurse #5 was interviewed. She stated that Resident #24 had pulled her catheter out several times with the bulb inflated. She added that the physician was aware of her behavior of pulling out her catheter and he ordered to reinsert the catheter. She also stated that Resident #24 had an order for scheduled and PRN (as needed) ativan and she had to administer the PRN dose of ativan whenever she pulled her catheter out.

On 2/27/14 at 8:23 AM, administrative staff #5 was interviewed. She stated that she was aware that Resident #24 had been pulling her catheter out because she did not like it. She indicated that she had informed the physician about it but he preferred to leave the catheter in to help the sacral wound to heal.

On 2/27/14 at 8:45 AM, administrative staff #2 was interviewed. She stated that the physician was informed of resident's pulling the catheter out and he ordered to start ativan to minimize her behavior and anxiety. She added that the physician was also informed that the resident preferred not to have the catheter but he said to leave the catheter in because of the pressure ulcer.

On 2/27/14 at 8:45 AM, the physician was interviewed. The physician stated that he was aware that Resident #24 had been pulling her catheter out for the past 2 months now. He stated that it was attention seeking behavior and he discussed it with the resident and the resident

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F 242	Continued From page 5 stated that she did not like the catheter. He further stated that he added a scheduled ativan to calm her down and to reduce her anxiety.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan with goal and approaches for a resident who had been pulling out the indwelling catheter for 1 of 1 sampled resident with an indwelling catheter (Resident #24). The findings included: Resident #24 was admitted to the facility on	F 279	Criteria #1 Minimum Data Set (MDS) Nurse updated the care plan for resident #24 on 3/5/14 to address goals and approaches for resident pulling out catheter. Criteria #2 All residents identified as refusing a	4/11/14

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F 279	Continued From page 6 5/29/03 and was readmitted on 5/29/13 with multiple diagnoses including Schizophrenia, Schizo affective disorder, Mental Retardation, Depression, Joint contracture and Urinary Tract Infection (UTI). The annual Minimum Data Set (MDS) assessment dated 2/19/14 indicated that Resident #24 had severe cognitive impairment, had a stage IV pressure ulcer (not present on admission) and had an indwelling catheter. The care plan dated 12/11/13 was reviewed. There was no care plan developed which included goals and approaches to address the resident's behavior of pulling the indwelling catheter out. One of the care plan problems was " at risk for loss of skin integrity and UTI related to impaired mobility and incontinence of bowel and bladder. Has stage III area to sacrum and using Foley to aid in healing. " On 1/14/14, a statement was added at the bottom of the care plan problem which read " noted to be pulling at Foley related to anxiety. " On 1/14/14, a statement was also added under approaches which read " antianxiety medication (med) related to behavior with Foley (pulling out), staff to observe/document effectiveness, notify physician as needed. " The nurse's notes were reviewed. The notes indicated that Resident #24 had multiple episodes of pulling out the indwelling catheter. She had pulled her catheter out 16 times in the last 2 months. On 2/27/14 at 8:23 AM, administrative staff # 5 was interviewed. She stated that she addressed the resident's behavior of pulling out the catheter	F 279	prescribed medical treatment has the potential to be affected by the alleged deficient practice. Nursing documentation for all residents will be reviewed for (2) months (February - March 2014) to identify any other refusal of treatment by 4/11/14 to ensure goals and approaches for refusals are being care planned. Care plans will be updated accordingly. Criteria #3 Inservicing for all licensed nursing staff was completed by Director of Nursing (DON)and/or Assistant Director of Nursing (ADON) on 4/2/14 for using the Prescribed Medical Treatment Refusal Notification form. The completed form will be reviewed in department head meetings Monday - Friday and reviewed by Unit Coordinators on Saturday - Sunday. All resident care plans were audited by DON and/or MDS Coordinator by 4/11/14 for appropriate interventions related to refusals. Care plans will be updated accordingly. DON inserviced the Care Plan team (Social Worker, Activities Director, Certified Dietary Manager, Care Plan Nurse) on 3/27/14 on Prescribed Medical Treatment Refusal Notification form who will also review the forms during quarterly care plans weekly. This review will be on an ongoing basis in morning meetings and during the care plan meetings weekly to ensure goals and approaches for refusals are being care planned. Medical Director will review refusal notification forms upon his visits, which is normally Tuesday, Thursday, and Friday. Upon continued objection to the	

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F 279	Continued From page 7 under the use of the antianxiety medication.	F 279	prescribed course of treatment, the physician and/or the nursing staff will meet with the resident and/or the Responsible Party to review alternate treatment, and come to an agreed course of treatment. Criteria #4 DON and/or ADON will report results of notifications during the Quality Assessment and Assurance (QA&A) monthly for (12) months to ensure continued compliance of process change and updating of care plans, at which time the QA&A committee will determine if further auditing is needed.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide nail care for one (1) of four (4) sampled residents who needed extensive assistance with personal hygiene (Resident #43). The findings included: Resident #43 was readmitted to the facility 10/4/2011. Cumulative diagnoses included: Dementia, Depression and history of CVA (cerebrovascular accident).	F 312	Criteria #1 Nail care was provided for resident #43 on 2/26/14 by a Certified Nursing Assistant (CNA). Criteria #2 All residents have the potential to be affected by the alleged deficient practice. 2 CNAs completed an audit of all residents nails on 2/26/14. Nail care was	4/4/14

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F 312	Continued From page 8 An Annual Minimum Data Set (MDS) dated 12/10/13 indicated Resident #43 had short term and long term memory impairment and was moderately impaired in decision-making. Extensive assistance was required with dressing, eating and personal hygiene. Range of motion was limited for the upper extremities on one side. A care plan dated 12/21/13 indicated Resident #43 had refused care and showers on occasion. Approaches included: staff to offer alternative time or caregiver when care was refused. Offer a bed bath on shower days if she refused and notify charge nurse if she refused both. Talk with her and get her reasons for refusal. Involve family for problem-solving for continued refusals. On 2/24/14 at 4:09 PM, an observation of Resident #43 revealed brown material was noted under the nail beds of the two middle fingers of her left hand and under all of the nails of the right hand. Nails were slightly elongated. Resident #43 stated she liked her nails at the present length but said she needed to have her nails cleaned because she was bad to put her fingers in her mouth and her nails were dirty. Resident #43 said she could not clean her nails herself On 2/25/14 at approximately 11:00 AM, Resident #43 was observed and continued to have brown material under all of the nails of her right hand. Her left hand was under the covers and could not be visualized. On 2/26/14 at 9:45AM, ADL (activities of daily living) was observed. NA#1 performed bathing and dressing. She assisted resident with oral hygiene and provided hair care. NA#1 stated	F 312	provided for any resident who needed nail care during the audit. Criteria #3 Director of Nursing (DON)and/or Assistant Director of Nursing (ADON)completed inservicing nursing staff, including licensed nursing staff and CNAs, on the proper care of fingernails for all residents on 3/6/14. Charge nurses will audit nail care for all residents on their assigned hall daily for (7) days, then weekly for (3) months. Nail care will be provided for any resident needing nail care during audits. DON and/or ADON will review audits weekly for compliance. Criteria #4 DON and/or ADON will report results on audits during Quality Assessment and Assurance (QA&A) to ensure compliance for (3) months, at which time the QA&A committee will determine if further auditing is needed.	

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F 312	Continued From page 9 ADL care had been completed. When asked regarding nail care, she stated nail care was usually part of the morning care and she should have cleaned Resident #43's nails. Observations of the resident's fingernails with NA#1 revealed the resident's fingernails should have been trimmed and cleaned as part of the resident's morning care and she would clean them now. On 2/26/14 at 10:45AM, Administrative staff #2 stated she expected nail care to be done with AM care (ADL care).	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to assess for consideration of the risk or benefits and potential complications resulting from the repeated pulling out of the indwelling catheter for 1 of 1 sampled resident with an indwelling catheter (Resident #24). The findings included:	F 315	Criteria #1 Order received from the Medical Director (MD) on 3/1/14 for resident #24 "may leave foley catheter out." Resident #24 has not been treated for Urinary Tract Infection since being readmitted from the hospital in March 2013. Criteria #2	4/11/14

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F 315	Continued From page 10 Resident #24 was admitted to the facility on 5/29/03 and was readmitted on 5/29/13 with multiple diagnoses including Schizophrenia, Schizo affective disorder, Mental Retardation, Depression, Joint contracture and Urinary Tract Infection (UTI). The annual Minimum Data Set (MDS) assessment dated 2/19/14 indicated that Resident #24 had severe cognitive impairment, had a stage IV pressure ulcer (not present on admission) and had an indwelling catheter. The care area assessment (CAAs) was not completed yet for this assessment. The weekly pressure ulcer assessments were reviewed. The assessment indicated that a stage IV pressure ulcer on the sacrum was first identified on 2/14/13. On 2/19/14, the measurements were 2.3 x 1.2 x 0.6 centimeter (cm), stage III. On 3/4/13, the physician had ordered " Foley catheter care daily and check placement of Foley catheter, dignity bag and leg strap every shift. " The care plan dated 12/11/13 was reviewed. One of the care plan problems was " at risk for loss of skin integrity and UTI related to impaired mobility and incontinence of bowel and bladder. Has stage III area to sacrum and using Foley to aid in healing. " The goal was " will have no signs of UTI thru next review. " On 1/14/14, a statement was added at the bottom of the care plan problem which read " noted to be pulling at Foley related to anxiety. " On 1/14/14, a statement was also added under approaches which read " antianxiety medication (med) related to behavior	F 315	All residents identified as having indwelling catheter have the potential to be affected by the alleged deficient practice. Resident with indwelling catheters have been re-assessed by MD on 3/27/14 and educated on the potential complications associated with indwelling catheters, including pulling out the catheter. One resident is being followed by the urologist for catheter maintenance. No residents were found to be negatively impacted. Criteria #3 Director of Nursing (DON) and/or Assistant Director of Nursing (ADON)will inservice licensed nursing staff by 4/11/14 on assessing residents with foley catheters for signs and symptoms of complications, including UTI and pulling out catheter, and reporting information to administrative nursing staff through 24 hour report and Prescribed Medical Treatment Refusal Notification form. DON and/or ADON will monitor signs and symptoms of complications, including UTI and pulling out catheter by reviewing the 24 hour report and Prescribed Medical Treatment Refusal Notification form, which will be discussed in department head morning meeting Monday - Friday, and reviewed by Unit Coordinators on Saturday - Sunday, with follow-up from MD as needed. This will be an ongoing process. DON will address appropriateness of catheter for each resident with MD monthly. Criteria#4	

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F 315	Continued From page 11 with Foley (pulling out), staff to observe/document effectiveness, notify physician as needed. " The nurse ' s notes were reviewed. The notes indicated that Resident #24 had multiple episodes of pulling out the indwelling catheter. She had pulled her catheter out 16 times in the last 2 months. The nurse's notes revealed that Resident #24 had pulled the indwelling catheter out on 1/3/14 at 11:07 AM, 1/9/14 at 12:10 PM, 1/12/14 at 4:39 PM, 1/12/14 at 9:46 PM, 1/14/14 at 2:35 PM, 1/19/14 at 2:53 PM, 1/20/14 at 12:06 PM, 1/24/14 at 10:36 PM, 2/16/14 at 12:22 PM, 2/19/14 at 9:22 PM, 2/22/14 at 6:36 AM, 2/22/14 at 9:37 PM, 2/23/14 at 12:44 PM, 2/23/14 at 10:00 PM, 2/24/14 at 6:31 AM, and 2/24/14 at 2:21 PM. The doctor's progress notes were reviewed. The notes dated 1/14/14 indicated that Resident #24 had the indwelling catheter to help sacral wound dry but she (resident) has been pulling the catheter and taking it out. She had pulled it out six times over the weekend and again today. The notes further indicated that the resident stated that she does not like the catheter. The notes dated 2/7/14 revealed that the resident had marked episodes of anxiety and behavioral disturbances in the past 2 months, she pulled out her catheter, " possible to get attention. " The notes dated 2/25/14 revealed that the resident had been pulling out her catheter multiple times, she had pulled it out 6 times in the past one week. It has been discussed with her multiple times that she needs it to help with wound healing. The notes further indicated that the resident needs the indwelling catheter to help with wound healing. " We ' ll start her on Ativan 0.5	F 315	DON and/or ADON will report results of audit during Quality Assessment & Assurance (QA&A) monthly for (12) months to ensure continued compliance of process change, at which time the QA&A committee will determine if further auditing is needed.	

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F 315	Continued From page 12 mgs by mouth twice a day on a scheduled basis for anxiety. " Resident #24 medical records were reviewed and there was no assessment that risk, benefit or potential complications were considered that might result in injury from the repeated pulling out of the catheter. On 2/26/14 at 9:45 AM, administrative staff #2 was interviewed. She stated that the pulling out of the catheter by Resident #24 was a behavioral issue. On 2/26/14 at 1:41 PM, Nurse #5 was interviewed. She stated that Resident #24 had pulled her catheter out several times with the bulb inflated. She added that the physician was aware of her behavior of pulling out her catheter and he ordered to reinsert the catheter. She also stated that Resident #24 had an order for scheduled and PRN (as needed) ativan and she had to administer the PRN dose of ativan whenever she pulled her catheter out. On 2/26/14 at 3:54 PM, Resident #24 was observed in bed with the indwelling catheter in place. When asked why she was pulling her catheter out, she replied " because I don't like it. " On 2/27/14 at 8:23 AM, administrative staff #5 was interviewed. She stated that she was aware that Resident #24 had been pulling her catheter out because she did not like it. She indicated that she had informed the physician about it but he preferred to leave the catheter in to help the	F 315		

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F 315	Continued From page 13 sacral wound to heal. On 2/27/14 at 8:45 AM, administrative staff #2 was interviewed. She stated that the physician was informed of resident's pulling the catheter out and he ordered to start ativan to minimize her behavior and anxiety. She added that the physician was also informed that the resident preferred not to have the catheter but he said to leave the catheter in because of the pressure ulcer. On 2/27/14 at 8:45 AM, the physician was interviewed. The physician stated that he was aware that Resident #24 had been pulling her catheter out for the past 2 months now. He stated that it was attention seeking behavior and he discussed it with the resident and the resident stated that she did not like the catheter. He further stated that he added a scheduled ativan to calm her down and to reduce her anxiety.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		4/18/14

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F 329	Continued From page 14 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that non pharmacological interventions were considered prior to using the psychotropic medication for 1 of 1 sampled resident (Resident # 24) with a behavior of pulling out the catheter. Findings included: Resident #24 was admitted to the facility on 5/29/03 and was readmitted on 5/29/13 with multiple diagnoses including Schizophrenia, Schizo affective disorder, Mental Retardation, Depression, Joint contracture and Urinary Tract Infection (UTI). The annual Minimum Data Set (MDS) assessment dated 2/19/14 indicated that Resident #24 had severe cognitive impairment and was on antipsychotic, antianxiety and antidepressant medications. The assessment also indicated that Resident #24 had an indwelling catheter and had no behavioral symptoms. The care plan dated 12/11/13 was reviewed.	F 329	Criteria #1 Non-pharmacological interventions for resident #24 were reviewed by the Administrator and Director of Nursing (DON) on 3/11/14. Review of records showed that resident #24 participated in activities of interest which included Bingo, Music activities, radio, writing in personal notepad, and interacting with personal doll, and religious activities form 1/1 -1/14/14. Ativan 0.5 mg. 1 by mouth every 6 hours as needed for anxiety was ordered on 1/14/14. Ativan 0.5 mg. by mouth twice a day (scheduled) for anxiety was ordered 2/25/14. Resident #24 care plan was updated with diversional activities on 3/5/14. Criteria #2 All residents identified as receiving a psychotropic medication have the potential to be affected by the alleged deficient practice. An audit was completed by Medical Director (MD) and Consultant Pharmacist on 4/17/14 of all residents	

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F 329	Continued From page 15 Resident #24 was care planned for the use of the psychotropic medications. There was no care plan with goal and approaches that addressed the behavior of pulling out the catheter. Review of the physician's orders for February, 2014 revealed that Resident #24 was on Zyprexa (antipsychotic drug) 2.5 milligrams (mgs) twice a day for psychosis, Paxil (antidepressant) 30 mgs daily for depression, Remeron 7.5 mgs at bedtime for appetite stimulant and ativan 0.5 mgs every 6 hours as needed for anxiety. The physician's orders also indicated that Resident #24 was on Depakote (used to treat seizure disorder and manic episodes) 625 mgs. at 10 AM, 500 mgs at 1 PM and 625 mgs at bedtime for bipolar disorder. The nurse's notes were reviewed. The notes indicated that Resident #24 had multiple episodes of pulling out the indwelling catheter. She had pulled her catheter out 16 times in the last 2 months. The nurse's notes revealed that Resident #24 had pulled the indwelling catheter out on 1/3/14, 1/9/14, 1/12/14 (2 times), 1/14/14, 1/19/14, 1/20/14, 1/24/14, 2/16/14, 2/19/14, 2/22/14 (2 times), 2/23/14 (2 times) and 2/24/14 (2 times). On 1/14/14, there was a physician's order for Ativan 0.5 mgs every 6 hours as needed for anxiety and on 2/25/14, ativan 0.5 mgs twice a day was added for anxiety. The Medication Administration Records (MARs) for the month of January and February, 2014 were reviewed. The MAR for January, 2014 revealed that Resident #24 had received ativan	F 329	receiving psychotropic medications to ensure no resident was receiving unnecessary medication. Residents receiving a psychotropic medication will have care plans reviewed by the DON and/or Minimum Data Set (MDS)nurse by 4/11/14 to ensure care plans have been updated with non-pharmacological approaches to identify other residents who have the potential to be affected by the alleged deficient practice. Criteria #3 Designated nursing staff (Unit Coordinators, and Care Plan Nurse) and Care Plan team (Social Worker, Activities Director, Certified Dietary manager, Care Plan Nurse) were inserviced on 4/2/14 by the DON on implementing non-pharmacological approaches and updating care plans accordingly. DON and/or ADON will complete inservice by 4/18/14 of all licensed nursing staff on the Non-Pharmacological Approach Form, which includes the specific approaches attempted prior to notifying MD for further direction. This form will be reviewed daily by DON and/or Assistant Director of Nursing(ADON)and/or Unit Coordinators, as well as by the MD upon his visits, which is normally Tuesday, Thursday, and Friday each week. Care plans will be audited weekly by the Care Plan team on an ongoing continuous basis with care plans revised as found necessary. Criteria #4 DON and/or ADON and/or MDS nurse will review weekly care conference summary	

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F 329	Continued From page 16 21 times for anxiety and 28 times in February for anxiety. On 2/26/14 at 1:41 PM, Nurse #5 was interviewed. She stated that Resident #24 had pulled her catheter out several times with the bulb inflated. She added that the physician was aware of her behavior of pulling out her catheter and he ordered to reinsert the catheter. She also stated that Resident #24 had an order for PRN (as needed) ativan and lately the physician had added the scheduled ativan 0.5 mgs twice a day due to her pulling out of catheter. Nurse # 5 further stated that she had to administer the PRN dose of ativan whenever the resident pulled her catheter out. On 2/27/14 at 8:23 AM, administrative staff #5 was interviewed. She stated that she was aware that Resident #24 had been pulling her catheter out because she did not like it. She indicated that she had informed the physician about it and he ordered a scheduled ativan to calm her down before trying something else. On 2/27/14 at 8:45 AM, administrative staff #2 was interviewed. She stated that the physician was informed of resident's pulling the catheter out and he ordered to start ativan to minimize her behavior and anxiety. On 2/27/14 at 8:45 AM, the physician was interviewed. The physician stated that he was aware that Resident #24 had been pulling her catheter out for the past 2 months now. He stated that it was attention seeking behavior and he discussed it with the resident and the resident stated that she did not like the catheter. He further stated that he added a scheduled ativan to	F 329	sheets from care plan review every month to ensure continued compliance. DON and/or ADON and/or MDS nurse will report reuslts during Quality Assessment & Assurance (QA&A) monthly for (12) months, at which point the QA&A committee will determine if further auditing is needed. MD, DON, and Pharmacy Consultant will meet every month to review all resident receiving psychotropic medications for appropriateness. These results will also be reviewed in QA&A monthly for (12) months.	

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F 329	Continued From page 17 calm her down and to reduce her anxiety.	F 329		
F 364 SS=E	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 observation, staff interview and test tray evaluation, the facility failed to ensure hot food was served hot and cold food served cold to residents who received their food trays in their rooms. The findings included: On 2/24/2014 at 12:40PM, dining observation was conducted on the 100 hall. The cart contained the food trays for those residents who ate in their rooms and those residents who required staff assistance for eating. The cart arrived at 12:40PM and the last tray was removed from the cart at 1:45PM. Residents who could feed themselves received their trays first. The remaining trays were residents who required staff assistance to eat their meals. The last tray was served to Resident #43 and nursing staff was not noted to heat the food prior to feeding the meal to the resident. When asked, Resident #43 stated the food was ok. An annual Minimum Data Set (MDS) dated 12/10/13 indicated Resident #43 had short term and long term memory impairment and was moderately impaired in decision-making. Poor	F 364	Criteria #1 Resident #43 stated the food was ok. Resident was found to have a (1)lb weight gain since December. Criteria #2 All residents have the potential to be affected by the alleged deficient practice, though no residents were found to be affected as no complaints regarding food temperatures were noted from other residents. All residents were interviewed by designated staff (medical records clerk, scheduler, restorative staff, rehab tech) between 3/26 -3/30 regarding their food temperatures. Criteria #3 On 3/6/14, department heads were inserviced by Administrator on assisting with passing meal trays on the hall and reheating meal trays as needed. Other designated staff (medical records clerk, scheduler, central supply clerk, receptionist, rehab tech, Unit	4/11/14

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F 364	Continued From page 18 appetite was noted two to six days during the assessment period. Test trays for the regular, mechanical soft and pureed diets were requested on 2/26/14 at 11:45AM. The test rays left the kitchen at 12:41 PM and arrived on the 100 hall at 12:43 PM. The test trays were evaluated for palatability with the dietary manager at 1:25PM on the 100 unit after the last resident was served. The following foods were tasted for proper temperature and palatability: Apricot chicken, diced potatoes, broccoli casserole, pureed bread, tomato soup, ice tea (small amount of ice remained in the tea) and a chocolate delight dessert that contained cream cheese. The dietary manager indicated that the hot foods were cold and the cold foods were not at an appropriate temperature. The dietary manager stated the food items were not palatable for residents to eat and the food should have been reheated prior to serving the food tray to the resident. .	F 364	Coordinators) were inserviced by Administrator on 3/6/14 on assisting with passing trays on the hall and assisting residents with their meals as they have been trained, and offering to reheat meal trays according to resident preference. Inservice for licensed nursing staff and certified nursing assistants was completed by Administrator and/or Assistant Director of Nursing (ADON) on 4/2/14 regarding offering to reheat meal trays according to resident preference. Certified Dietary Manager (CDM) will monitor food trays being passed on the hall by taking temperatures of test trays to ensure hot foods are served hot and cold foods are served cold for all residents for (5) days, then weekly for (3) months. Administrator and/or Director of Nursing will interview Resident Council members during Resident Council meetings for (3) months to ensure food is being served at palatable temperatures. Designated staff(medical records clerk, restorative nursing staff, rehab tech, unit Coordinators)will interview (5)residents per hall per day for (5) days to ensure residents are being served palatable food. The interviews will continue for (5) residents per hall per week for (3) months. At any point should the CDM find that the temperature of the food on the hall is not within compliance, CDM will notify staff who are passing trays on the hall, for steps to be taken to ensure resident meals are served at appropriate temperatures. Interviews will be discussed in department head morning meeting weekly for (3) months with	

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F 364	Continued From page 19	F 364	interventions put in place as deemed necessary. Criteria #4 Findings from the interviews will be reviewed by the Administrator and/or DON as the interviews are completed and report to Quality Assessment & Assurance (QA&A) monthly for (3) months, at which time the QA&A committee will determine if further auditing is needed.	
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 observation, staff interview and review of facility document review, the facility failed to wash dishes at the required temperature when using a hot water dish washer. The findings included: A facility policy named "Warewashing Dishmachine" undated stated, in part "2. Record and document prior to warewashing for each meal: High temperature Dishwasher (heat sanitization) wash 150-165 degrees F	F 371	Criteria #1 The Maintenance Director (MD)adjusted the dishwasher until the machine reached proper temperatures on 2/26/14. Temperature recorded at 159 degrees on 2/26/14. Dishwasher temperatures were monitored and continued to maintain proper temperature range. On 3/7/14, MD replaced the element and the thermostat to ensure proper temperature ranges will be maintained. Temperature recorded at	4/4/14

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F 371	Continued From page 20 (Fahrenheit) wash." On 2/26/14 at 9:21 AM, an observation of the kitchen's dishwashing machine was conducted. Dietary staff were observed actively washing and storing dishes that were being washed in the machine. The temperature of the water for the machine's wash cycle was noted to be 146 degrees F. Dietary staff #1 stated she was responsible for checking and documenting the wash temperature and had not documented the temperature yet. She said she documented the temperatures after the machine had gone through a few cycles. The Dishwashing Temperature Sanitizer Records for January and February 2014 were reviewed and revealed the following: 1/29/14 (dinner) wash temperature documented as 140 degrees F; 2/4/14 (dinner) wash temperature-140 degrees F; 2/8/14 (dinner) wash temperature-145 degrees F; 2/9/14 (lunch) wash temperature-144 degrees F and (dinner) wash temperature 142 degrees F 2/10/14 (dinner) wash temperature-145 degrees F. On 2/26/14 at 11:00AM, the dietary manager stated if the temperature in the wash cycle was low, they kept running the machine without using it until the temperature came up to 150 degrees F. If the temperature stayed low, the dietary cook left him a note and he would verbally tell maintenance to check it. The dietary manager stated he knew that maintenance had changed the thermostat recently. On 2/26/14 at 11:40AM, Maintenance staff #1 stated he adjusted the dish machine ' s temperature this morning when it was noted to be	F 371	160 degrees on 3/7/14. Criteria #2 All residents have the potential to be affected by the alleged deficient practice, though no residents were found to be affected. Criteria #3 Administrator and/or Certified Dietary Manager (CDM) completed inservice for dietary staff on 4/1/14 to notify the CDM immediately if the dishwasher is not working properly and to complete a work order that should be given to MD and Administrator for repair. CDM and/or designated dietary aide will monitor documented dishwasher temperatures daily for (3) months to ensure the dishwasher is working properly and ensure work orders are being completed when needed. Criteria #4 CDM will report findings to Quality Assessment & Assurance (QA&A)committee for the next (4) months, at which time the QA&A committee will determine if further monitoring is needed.	

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F 371	Continued From page 21 146 degrees F and the machine wash temperature was now operating at 150 degrees F or above. He said he changed the thermostat on the booster heater about a month ago but it was the thermostat for the rinse cycle and not for the wash cycle. He said when there were problems with the dishwashing machine's water temperatures, he was verbally told about the problem; on occasion, a work order was filled out. If there was a work order, he completed the work order and gave the completed order to the Administrator. Administrative staff #1 said he had no concerns voiced to him this month regarding the wash temperatures for the dishwasher and had not received any work orders from dietary for this month. On 2/26/14 at 3:00PM, the wash cycle was rechecked and the temperature was noted to be 152 degrees F. On 2/26/14 at 3:39 PM, dietary staff #2 stated she was the one who washed the dishes for the dinner meal. She said the temperature on the kitchen's dish machine fluctuated and if it was below 150 degrees F, she told the head cook and the head cook would leave a note for the dietary manager. She stated they would not use the dishwasher but would use the three (3) compartment sink and hand wash / dry the dishes.	F 371		
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	F 441		4/4/14

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F 441	Continued From page 22 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations, the facility failed to follow contact precautions for one of one sampled resident (#36) reviewed for isolation precautions.	F 441	Criteria #1 Resident #36 was discharged to home on 2/27/14.	

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F 441	Continued From page 23 The findings included: A record review of the Policy and Procedures for Contact Precautions dated 10/12/2007 for the facility was conducted. The review revealed that contact precautions were intended to prevent the spread of infectious agents by direct or indirect contact with the patient or the patient ' s environment. Healthcare personnel caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient ' s environment. Resident #36 was admitted to the facility on 5/9/13 with multiple diagnoses including a history of Methicillin-Resistant Staphylococcus Aureus (MRSA) infection. A MRSA infection is caused by a strain of staphylococcus bacteria that has become resistant to the antibiotics commonly used to treat ordinary staphylococcus infections. A record review of the Physician ' s Orders for resident #36 revealed an order dated 2/23/14 which read " Contact Isolation for Treatment of Skin Rash. Ivermectin 3 milligrams tablet take 3 tablets by mouth at 9 PM and again in one week on 3/2/14 for skin rash. " Ivermectin is a medication used to treat some parasitic skin diseases, including scabies. Scabies is a contagious skin infection caused by mites. A record review of the Physician ' s Orders for resident #36 revealed an order dated 2/23/14 which read " Permethrin 5% Topical Cream one application on the skin apply from neck down to feet x 1 dose and repeat on 3/2/14. " Permethrin	F 441	Criteria #2 All residents requiring isolation precautions have the potential to be affected by the alleged deficient practice. An audit was completed on 3/21/14 by unit coordinators for staff compliance. However, no other resident required isolation precaution. Criteria#3 Director of Nursing (DON)and/or Assistant Director of Nursing (ADON) completed inservice for all staff regarding isolation precaution compliance on 4/1/14. Unit Coordinators will audit isolation rooms for staff compliance daily for (7) days, then weekly for (3) months. DON and/or ADON will review audits weekly for compliance for (3) months. Criteria#4 DON and/or ADON will report results of audits during Quality Assessment & Assurance (QA&A) next (3) months at which time the QA&A committee will determine if further auditing is needed.	

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is a medication used to treat scabies.

A record review of the Nurse ' s Notes revealed a note dated 2/23/14 at 9:52 AM which read " Rash has not improved and the doctor made aware and has ordered Ivermectin and Permethrin. Contact Isolation for skin rash and Trimcinolone acetonide 0.1%. " Triamcinolone Acetonide is a corticosteroid used to treat various skin conditions.

A record review of the Nurse ' s Notes revealed a note dated 2/24/14 at 9:04 AM which read " This nurse called Dermatology to arrange appointment for skin rash. "

A record review of the Physician ' s Orders revealed an order dated 2/24/14 which read " Doxycycline 100 mg by mouth twice a day for 7 days, Discontinue after 3/3/14 for skin irritation. " Doxycycline is an antibiotic used to treat a variety of infections.

A record review of the Nurse ' s Notes revealed a note dated 2/24/14 at 10:50 PM which read " Returned from appointment with dermatology received new orders and processed. Resident started on antibiotic doxycyclyne 100mg by mouth twice a day for 7 days for possible staff infection per certified nursing assistant who accompanied resident to appointment. "

An observation was made on 2/25/14 at 8:27 AM of Nursing Assistant (NA) #2 in the room of resident #36. NA #2 was observed moving the resident ' s pillows, using the controls to adjust the bed and moving the bedside tray without wearing gloves or a gown. A sign which read " Enteric Contact Precautions " was observed

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F 441	Continued From page 25 outside of the resident ' s room. An interview was conducted with NA #2 on 2/25/14 at 8:28 AM. The NA stated he "wasn't told anything except when you clean her up to use gloves." An interview was conducted with Nurse #4 on 2/25/14 at 8:29 AM. The nurse stated resident #36 was thought to have scabies, but now was thought to have an infection of MRSA. She further stated the nursing assistants were expected to wear a gown and gloves when working in the resident ' s room. A record review of the Nurse ' s Notes revealed a note dated 2/26/14 at 5:58 PM which read " Resident continue contact precautions for possible staff infection-MRSA. " An interview was conducted with NA #2 on 2/27/14 at 10:22 AM. NA #2 stated he entered the resident ' s room on the morning of 2/25/14 without wearing a gown or gloves. He stated he touched the resident ' s pillows and the bedside table while setting up the breakfast tray without wearing gloves. NA #2 further stated he was expected to wear gloves and a gown if he was planning to have direct contact with the resident. He was expected to wear gloves if he was planning to touch items in the room without having direct contact with the resident. An interview was conducted with the Infection Control Nurse on 2/27/14 at 10:26 AM. She stated the staff was expected to follow the instructions on the contact precautions sign posted outside of the resident ' s room and to put on a gown and gloves before entering the room.	F 441		

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F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to consistently document the administration of sliding scale insulin (SSI) as ordered by the physician and failed to document the reasons for not administering insulin when the blood sugar check indicated a need for insulin administration for 2 of 2 sampled residents (resident #38 and resident #55) receiving SSI and reviewed for unnecessary medications. The findings included: 1. Resident #38 was admitted to the facility on 5/17/11 and readmitted on 1/30/12 with multiple diagnoses including Diabetes Mellitus. Diabetes Mellitus is a metabolic disease in which a person has high blood sugar. A record review of the physician ' s orders revealed an order dated 8/3/11 which read "	F 514	Criteria #1 Residents #38 and #55 were assessed by Director of Nursing (DON) on 2/27/14 for any signs and symptoms of diabetic distress. No acute issues were noted. Criteria #2 All residents who receive insulin have the potential to be affected by alleged deficient practice. Diabetic resident's Medication Administration Records (MARS) were audited by Director of Nursing(DON) on 3/7/14 for missing documentation. No other residents identified as being affected by the alleged deficient practice. Criteria #3 DON and/or Assistant Director of Nursing (ADON) completed inservices for	4/4/14

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F 514	Continued From page 27 Glucose Blood Sugar Twice a Day at 6:30 AM and 4:30 PM on Monday and Thursday. " A record review of the physician ' s orders revealed an order dated 1/30/12 which read " Novolog SSI 61-39=0 Units, 140-200=2 Units, 201-250=4 Units, 251-300=6 Units, 301-350= 8 Units, 351-400=10 Units, 401 or Greater =12 Units and call Medical Doctor. " A record review of the Medication Administration Record (MAR) for the month of January 2014 and February 2014 was conducted. The review revealed the administration of SSI was not documented for a blood sugar level greater than 140 as indicated in the physician ' s order on 1/6/14 at 6:30 AM, 1/23/14 at 6:30 AM, 2/17/14 at 6:30 AM, 2/17/14 at 4:30 PM and on 2/24/14 at 4:30 PM. On 1/6/14 at 6:30 AM the blood sugar was 155. On 1/23/14 at 6:30 AM the blood sugar was 164. On 2/17/14 at 6:30 AM the blood sugar was 147. On 2/17/14 at 4:30 PM the blood sugar was 142. And on 2/24/14 at 4:30 PM the blood sugar was 144. An interview was conducted with Nurse #1 on 2/25/14 at 4:31 PM. She stated the nurses were expected to document the administration of SSI on the MAR. An interview was conducted with Administrative Staff #2 on 2/25/14 at 5:18 PM. She stated the nurses were expected to document the administration of SSI on the MAR. She further stated the nurses would document the administration of SSI in the Nurse ' s Notes on occasion. She stated she reviewed the Nurse ' s Notes for 1/6/14, 1/23/14, 2/17/14 and 2/24/14 did not find documentation of the administration of	F 514	Licensed Nursing staff on 4/1/14 on administration and documentation of insulin. MARS will now include separate documentation of Sliding Scale Insulin (SSI) and site of administration. SSI administration and documentation audit was completed by Unit Coordinators daily for (7) days, and will continue weekly for (3) months with results presented to DON and/or ADON weekly as audits are completed for assessment of further staff education. Medical Director is to be notified by Unit Coordinators of any missing documentation and patient condition. Criteria #4 DON and/or ADON will report results of audit during Quality Assurance and Assessment (QA&A) monthly for (12) months to ensure continued compliance of Insulin administration and documentation. At which time the QA&A Committee will determine if further auditing is needed.	

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F 514	Continued From page 28 SSI for resident #38. An interview was conducted with Nurse #2 on 2/26/14 at 10:45 AM. The nurse stated she was the nurse assigned to resident #38 on 2/17/14 and 2/24/14 for the 3:00 PM to 11:00 PM shift. She stated she did not administer SSI to the resident on 2/17/14 at 4:30 PM and on 2/24/14 at 4:30 PM. Nurse #2 did not state the reason she did not administer the SSI as ordered by the physician. On 2/17/14 at 4:30 PM the blood sugar was 142 and the resident should have been administered 2 units of insulin per the physician ' s order. On 2/24/14 at 4:30 PM the blood sugar was 144 and the resident should have been administered 2 units of insulin per the physician ' s order. An interview was conducted with Administrative Staff #3 on 2/26/14 at 10:51 AM. She stated the nurses were expected to document the administration of SSI on the MAR. An interview was conducted with Nurse #3 on 2/26/14 at 11:57 AM. The nurse stated she administered SSI to resident #38 as ordered by the physician on 1/6/14 at 6:30 AM, 1/23/14 at 6:30 AM and 2/17/14 at 6:30 AM. On 1/6/14 at 6:30 AM the blood sugar was 155. On 1/23/14 at 6:30 AM the blood sugar was 164. On 2/17/14 at 6:30 AM the blood sugar was 147. She also stated she did not document the administration of SSI to the resident as ordered by the physician on 1/6/14 at 6:30 AM, 1/23/14 at 6:30 AM and 2/17/14 at 6:30 AM on the MAR. The nurse stated she forgot to document the administration of the SSI on those dates.	F 514		

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2) Resident #55 was admitted to the facility on 10/19/12 from a hospital. Her cumulative diagnoses included Type 2 diabetes. The most recent quarterly Minimum Data Set (MDS) dated 12/11/13 indicated the resident had moderately impaired cognitive skills for daily decision making. She required limited to extensive assistance with most of her Activities of Daily Living (ADLs) with the exceptions of being independent with locomotion on/off the unit and requiring set-up assistance only for eating.

A review of Resident #55 ' s December 2013 Monthly Physician ' s Orders revealed she was prescribed a Regular, Restricted Concentrated Sweets, No Added Salt diet with fruit only for dessert. Blood sugar (also referred to as Blood Glucose or BG) checks were ordered once daily at 4:30 PM. The list of medication orders for Resident #55 included an order initially dated 7/26/11 for Sliding Scale Insulin (SSI) using Novolog 100 Units/milliliters (ml) insulin injected subcutaneously (under the skin). SSI coverage indicated that the dose of insulin administered was dependent on the resident ' s BG result. The SSI ordered utilized the following parameters:
For BG 140-200 = 2 units insulin;
For BG 201-250 = 4 units insulin;
For BG 251-300 = 6 units insulin;
For BG 301-350 = 8 units insulin;
For BG 351-400 = 10 units insulin;
For BG >400 = 12 units insulin and call MD (Medical Doctor).

A review of the Resident #55 ' s Medication Administration Record (MAR) for December 2013 revealed the BG checks and sliding scale insulin coverage were scheduled at 4:30 PM each day

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F 514	Continued From page 30 and included the following: 1) On three occasions (12/2, 12/8, and 12/22) neither a notation of the resident ' s BG result nor an indication of whether or not insulin was administered was made on the MAR; 2) On one occasion (12/5) the resident ' s BG result was 143 and warranted insulin coverage with 2 Units of Novolog in accordance with the physician ' s orders. No notation was made on the MAR as to whether or not insulin was given; 3) The resident ' s BG results were recorded on the MAR and the appropriate SSI dose was documented as given on 13 days during the month of December 2013. On each of the remaining days of the month, the resident ' s BG checks were appropriately documented and no SSI coverage was required. A review of the Medication Administration Record (MAR) for January 2014 revealed the BG checks and sliding scale insulin coverage were scheduled at 4:30 PM each day and included the following: 1) On three occasions (1/5/14 BG = 173, 1/6/14 BG = 168, and 1/13/14 BG=156) the resident ' s BG result was documented and warranted insulin coverage in accordance with the physician ' s orders. No notation was made on the MAR as to whether or not insulin was given; 2) The resident ' s BG results were recorded on the MAR and the appropriate SSI dose was documented as given on 18 days during the month of January 2014. On each of the remaining days of the month, the resident ' s BG checks were appropriately documented and no SSI coverage was required. A review of the Medication Administration Record (MAR) for February 2014 through the date of	F 514		

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review revealed the resident ' s BG results were recorded on the MAR for each day. The appropriate SSI dose was documented as given on 22 days during the month of February 2014. On each of the remaining days of the month, BG checks were appropriately documented and no SSI coverage was required.

An interview was conducted with Administrative Staff member #2 and Administrative Staff member #3 on 2/27/14 at 8:58 AM regarding the documentation of BG checks and SSI coverage for elevated BG results. Administrative Staff member #2 reviewed Resident #55 ' s 12/2013, 1/2014, and 2/2014 monthly MARs. Upon their review, Administrative Staff member #2 provided the identity and contact information for the nurses who worked on Resident #55 ' s hall during the dates in question. Administrative Staff member #2 stated, " My expectation is that you (as a nurse) document insulin when you give it. " Administrative Staff member #2 reported that steps would be taken to ensure nurses documented BG checks and SSI coverage appropriately. She indicated that BG results should always be documented. Additionally, she stated that the dose of insulin administered should be noted on the MAR and if no SSI coverage was required, the nurse needed to indicate this with a 0 (zero) on the MAR.

A telephone interview was conducted on 2/27/14 at 11:04 AM with Nurse #6 regarding the documentation of SSI coverage for elevated blood sugar levels. Nurse #6 was identified as the nurse working on Resident #55 ' s hall on 12/5/13. Nurse #6 stated she was 100% certain that she gave SSI to Resident #55 if her BG warranted it on the date in question. The nurse

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indicated that she likely got distracted or pulled away and did not write down the units of insulin given even though she was sure she did give the insulin according to the resident ' s SSI protocol.

A telephone interview was conducted on 2/27/14 at 11:55 AM with Nurse #7 regarding the documentation of SSI coverage for elevated blood sugar levels. Nurse #7 was identified as the nurse working on Resident #55 ' s hall on 12/2/13, 12/8/13, 12/22/13, 1/5/14, and 1/6/14. Nurse #7 reviewed the process she followed when checking a resident ' s BG level. She stated the BG checks were completed as she worked on her medication pass. Nurse #7 reported that she would check the resident ' s BG, then go to the MAR and check the SSI orders to see if the resident required insulin administration. If the resident did require insulin per the SSI orders, the nurse stated she would draw up the insulin dose, give the injection, and then document the dose of insulin given on the MAR. In regards to the missing BG values for 12/2, 12/8, and 12/22, Nurse #7 stated, " I believe I would have taken the blood sugar and written them on my sheet (referring to a note sheet the nurse routinely uses to record info) ....I don ' t know why I didn't write it in the MAR. Normally I go back and check. More than likely I took her blood sugar and gave the insulin according to the SSI orders. " Nurse #7 indicated that both BG results and the dosage of any insulin given to a resident needed to be recorded on the MAR.

A telephone interview was conducted on 2/27/14 at 12:15 PM with Nurse #8 regarding the documentation of SSI coverage for elevated blood sugar levels. Nurse #8 was identified as the nurse working on Resident #55 ' s hall on

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F 514	Continued From page 33 1/13/14. Nurse #8 reviewed the process she followed when checking a resident ' s BG level and SSI coverage. The nurse reported that she would check the resident ' s BG, record the results, and then check the resident ' s SSI protocol to see if insulin was required. At that point, Nurse #8 stated she would draw up the insulin dose and go ahead and give it right then. Upon inquiry, the nurse stated she would document the dosage given when the insulin was drawn up. After the insulin was given, she would go back to the MAR and document the site of the injection. Nurse #8 reported she would normally document a resident ' s BG results, number of insulin units given, the injection site, and her initials on the MAR. She was unsure as to why she did not do so on this occasion.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		4/11/14

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F 520	Continued From page 34 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to identify that the facility was noncompliant with residents' right to choices and implement an action plan. The facility continued to utilize a urinary catheter for Resident #24 even after Resident #24 repeatedly removed the urinary catheter and stated she did not want it. The findings included: Cross refer F242. Based on record review, observation and staff and resident interview, the facility failed to honor resident's choice for not having the indwelling catheter for 1 of 1 sampled resident with an indwelling catheter.(Resident # 24). On 3/11/14 at 3:53 PM, Administrative staff #2 stated the facility did not have a specific policy that addressed choices. She stated, last year, when the facility was cited for choices (F242), staff training was conducted regarding nonverbal refusal of care. No further concerns had been identified by the facility. Administrative staff #2 said training was ongoing with new hires during orientation. Also, resident rights were reviewed annually, on orientation and as needed. On 3/11/14 at 5:20PM, Administrative staff #3 stated the QAA (quality assurance and	F 520	Criteria #1 A Quality Assessment and Assurance (QA&A)committee met on March 25, 2014. Resident rights related to choices for resident#24 pulling out her foley catheter was addressed. Also discussed physician order that was written 3/1/14 "may leave foley out" for resident #24. Resident right regarding choices for all residents was addressed. Criteria #2 All residents have the potential to be affected by the alleged deficient practice. Resident interviews for all residents regarding resident choices were completed by designated personnel (Unit Coordinators, medical records clerk, scheduler, rehab tech, restorative nursing staff) on 3/30/12 with no residents identified as being affected by the alleged deficient practice. Criteria#3 The QA&A committee will meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary, and will develop and implement appropriate plans of action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 35 assessment) committee met monthly. Attendees included the Administrator, Director of Nursing, Minimum Data Set (MDS) coordinator, rehabilitation director, medical records director, social worker, medical director and dietary. The pharmacist attended quarterly. She stated, when any staff person identified any type of problem, a member of the QAA team was notified. An audit would be done, a determination of the length of time for monitoring, who needed to do the monitoring which was dependent upon the area of concern. The results would be brought back to QAA, adjustments to the plan of action would be done if necessary and monitoring would be continued until the problem was resolved. On 3/11/14 at 5:20PM, Administrative staff #2 and Administrative staff #3 stated the facility also educated all staff using the Hand in Hand program (a training series developed by CMS (Center for Medicare and Medicaid Services) that emphasizes person-centered care in the care of persons with dementia and prevention of abuse). Both Administrative staff #2 and Administrative staff #3 stated they did not identify that Resident #24 pulling the urinary catheter out and stating she did not want it was noncompliance with resident's right to choices due to the fact that Resident #24 was mentally incompetent and the use of the catheter was part of the treatment to resolve a pressure ulcer on the sacrum.	F 520	to correct identified quality deficiencies. All staff, including licensed and non-licensed personnel, were in-serviced on identifying concerns related to residents' right to choices completed on March 31, 2014 by Administrator and Assistant Director of Nursing(ADON). An inservice on Quality Assurance Notification form for all staff will be completed by April 11, 2014 by Administrator and/or Director of Nursing (DON) and/or ADON. A member of the QA&A and Administrator will be notified by staff using the Quality Assurance Notification form for potential care deficiencies, which could include, but not limited to, resident choice concerns. An audit will then be implemented with a determination of length of time for monitoring, and who will be responsible for monitoring. The results will be presented to QA&A at which time, adjustments to the plan of action will be implemented, and monitoring continued until the problem is resolved. Criteria#4 Administrator will collect and analyze data from the Quality Assurance Notification form monthly for (12) months which will be reviewed monthly by the Medical Director for further direction. Upon completion of 12 months reviews, the QA&A committee, along with the Administrator and Medical Director will then determine if further audits are deemed necessary.	