STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27536

(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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and family and staff interviews, the facility failed to encourage and provide an ongoing program of activities for 1 of 1 cognitively impaired resident reviewed for activity program participation. Resident #34. Findings included: Resident #34 was admitted to the facility on 7/23/13 with diagnoses which included: Alzheimer's dementia, chronic anemia, hyperkalemia, dehydration, and a history of chronic kidney disease. The review of the Initial Activity Pursuit Patterns/Activity Assessment dated 7/24/13 indicated Resident #34's Responsible Party (a family member) answered the facility staff's questions concerning the resident's previous activity preferences which included: spiritual/gospel music; church member; outdoors when weather permitting; television on just for noise; flower gardening; enjoyed socializing with others. The family member also reported that during the day; unless someone got the resident out of bed, she would sleep most of the day.	F 248	One on one visits and /or group activities have been scheduled for Resident #34. It has also been placed on the C.N.A. assignment sheets to have resident up in Geri chair per schedule. Residents will be provided with a group activity and/or 1 on 1 visits. On a weekly basis, for 60 days, the Administrator will audit the Activity Participation Record by completing the Activity QA form. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	5-30-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wendy Owen	Administrator	5-29-14

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

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F 248	Continued From page 1 Once up, the resident might watch/listen to the television or sit on the porch if the weather was nice. The resident would sometimes listen to spiritual music tapes her family member made for her. Resident #34 was hospitalized on 1/16/14 through 1/31/14. Review of the Significant Change MDS (Minimum Data Set) dated 2/6/14 indicated Resident #34 had short and long term memory problems with severely impaired decision-making skills; required extensive assistance of one person for bed mobility and transfers; and was totally dependent on staff for locomotion on and off the unit. The Interview for Activity Preferences section of the MDS was conducted with the resident's family. This interview indicated that it was very important to the resident to listen to music; do things with groups of people; do favorite activities; go outside; and religious services. A review of Resident #34's CAA (Care Area Assessment) Summary dated 2/10/14 revealed Activities and Psychosocial Well-being did not trigger and was not documented in the CAA and, was not addressed in the resident's Care Plan. Resident #34's Activity Participation Record dated 4/17/14 with the data collection period from January 2014 through March 2014 indicated the resident attended one musical activity. The resident was noted to be alert but confused at times with passive participation. Activity staff summarized that Resident #34 attended activities of choice as desired; and, that a family member/sitter would spend most of the morning with the resident.	F 248		

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F 248	Continued From page 2 The Monthly Activities Participation Record indicated there were no activities offered or provided for Resident #34 for the months of January 2014 (in hospital on 1/16/14-1/31/14), March 2014, April 2014, and May 1-2, 2014. During the month of February 2014, the Participation Record indicated the resident attended a movie on February 21, 2014. There was no available documentation indicating the resident refused to participate in the facility's activity programs or that she received any one to one visits from the facility's Activity staff. During an observation on 4/28/14 at 1:27pm, Resident #34 was awake and alert reclining in bed with the head of the bed up at a 45 degree angle. The resident was receiving continuous tube feeding. The resident appeared confused when questioned; but, would speak out from time to time. A family member was visiting with the resident. The television was on and a geri-chair was observed next to the resident's bed. During an interview in Resident #34's room on 4/28/14 at 1:34pm, the family member revealed that she visited the resident everyday, except on weekends. The family member stated that she never observed the resident attend or any of the staff ask the resident if she wanted to attend activities in at least a year. The family member also revealed that there was only one nursing assistant (on day shift) who would take the time to get the resident out of bed into the geri-chair in her room; but, the nursing assistant was not always assigned to work with the resident. During an observation and interview on 5/1/14 at 4:06pm, Resident #34 was awake and alert	F 248		

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F 248	Continued From page 3 reclining in bed with the head of the bed up at a 45 degree angle. The resident was receiving continuous tube feeding. The family member was visiting with the resident and NA#1 (nursing assistant) was leaving the room. NA#1 revealed that the first shift nursing assistant would transfer the resident from her bed to her geri-chair in her room for two hours; but, none of the staff offered in room activities or offered to take the resident to any out of room activities. During an interview on 5/2/14 at 10:50am, the MDS Coordinator revealed that when data was recorded on the MDS, the computer determined which care areas triggered for review. The SDC (Staff Development Coordinator) was responsible for conducting the interviews for the Activity Section of the MDS. During an interview on 5/2/14 at 12:31pm, the SDC revealed she was responsible for the Initial Activity Assessments, quarterly progress notes, and the interviews for the Activity Section of the MDS. She stated that the Activity Assistant was responsible for planning the Activity Calendar; implementing the calendar activities which included seeing to residents' attendance; and, conducting one to one visits with residents. The Activity Assistant's responsibility also included documenting each resident's participation (group and one to one visits). She revealed that the facility's Activity Assistant was currently on approved leave and that she (SDC) was substituting for her. After reviewing the Activity Assistant's records, the SDC acknowledged there was no documentation of any one to one visits with Resident #34.	F 248		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 4 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 observations, record reviews, and family and staff interviews, the facility failed to develop an Activity Care Plan for 1 of 1 cognitively impaired resident reviewed for activity program participation. Resident #34. Findings included: Resident #34 was admitted to the facility on 7/23/13 with diagnoses which included: Alzheimer's dementia, chronic anemia, hyperkalemia, dehydration, and a history of	F 279	Resident #34 has an activity care plan. All residents will be audited for an Activity care plan. On a monthly basis, for 2 months, the Administrator will check to ensure residents have an activity care plan by completing the Care Plan QA form. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	5-30-14

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F 279	Continued From page 5 chronic kidney disease. The review of the Initial Activity Pursuit Patterns/Activity Assessment dated 7/24/13 indicated Resident #34's Responsible Party (a family member) answered the facility staff's questions concerning the resident's previous activity preferences which included: spiritual/gospel music; church member; outdoors when weather permitting; television on just for noise; flower gardening; enjoyed socializing with others. The family member also reported that during the day; unless someone got the resident out of bed, she would sleep most of the day. Once up, the resident might watch/listen to the television or sit on the porch if the weather was nice. The resident would sometimes listen to spiritual music tapes her family member made for her. Resident #34 was hospitalized on 1/16/14 through 1/31/14 for PEG (percutaneous endoscopic gastrostomy) placement. Review of the Significant Change MDS (Minimum Data Set) dated 2/6/14 indicated Resident #34 had short and long term memory problems with severely impaired decision-making skills; required extensive assistance of one person for bed mobility and transfers; and was totally dependent on staff for locomotion on and off the unit. The Interview for Activity Preferences section of the MDS was conducted with the resident's family. This interview indicated that it was very important to the resident to listen to music; do things with groups of people; do favorite activities; go outside; and religious services. A review of Resident #34's CAA (Care Area	F 279		

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F 279	Continued From page 6 Assessment) Summary dated 2/10/14 revealed Activities and Psychosocial Well-being did not trigger and was not documented in the CAA and, was not addressed in the resident's Care Plan. The Monthly Activities Participation Record indicated there were no activities offered or provided for Resident #34 for the months of January 2014 (in hospital on 1/16/14-1/31/14), March 2014, April 2014, and May 1-2, 2014. During the month of February 2014, the Participation Record indicated the resident attended a movie on February 21, 2014. There was no available documentation indicating the resident refused to participate in the facility's activity programs or that she received any one to one visits from the facility's Activity staff. During an observation on 4/28/14 at 1:27pm, Resident #34 was awake and alert reclining in bed with the head of the bed up at a 45 degree angle. The resident was receiving continuous tube feeding. The resident appeared confused when questioned; but, would speak out from time to time. A family member was visiting with the resident. The television was on and a geri-chair was observed next to the resident's bed. During an interview in Resident #34's room on 4/28/14 at 1:34pm, the family member revealed that she visited the resident everyday, except on weekends. The family member stated that she never observed the resident attend or any of the staff ask the resident if she wanted to attend activities in at least a year. The family member also revealed that there was only one nursing assistant (on day shift) who would take the time to get the resident out of bed into the geri-chair in her room; but, the nursing assistant was not	F 279		

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F 279	Continued From page 7 always assigned to work with the resident. During an observation and interview on 5/1/14 at 4:06pm, Resident #34 was awake and alert reclining in bed with the head of the bed up at a 45 degree angle. The resident was receiving continuous tube feeding. The family member was visiting with the resident and a nursing assistant was leaving the room. The Nursing Assistant revealed that the first shift nursing assistant would transfer the resident from her bed to her geri-chair in her room for two hours; but, none of the staff offered in room activities or offered to take the resident to any out of room activities. During an interview on 5/2/14 at 10:50am, the MDS Coordinator revealed that when data was recorded on the MDS, the computer determined which care areas triggered for review. The SDC (Staff Development Coordinator) was responsible for conducting the interviews for the Activity Section of the MDS. During an interview on 5/2/14 at 12:31pm, the SDC revealed she was responsible for the Initial Activity Assessments, quarterly progress notes, and the interviews for the Activity Section of the MDS. She stated that the Activity Assistant was responsible for planning the Activity Calendar; implementing the calendar activities which included seeing to residents' attendance; and, conducting one to one visits with residents. The Activity Assistant's responsibility also included documenting each resident's participation (group and one to one visits). She revealed that the facility's Activity Assistant was currently on approved leave and that she (SDC) was substituting for her. After reviewing the Activity Assistant's records, the SDC acknowledged there	F 279		

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F 279	Continued From page 8 was no documentation of any one to one visits with Resident #34.	F 279		
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: Based on observations, facility staff and sitter interviews, and record reviews the facility failed to ensure proper respiratory services were rendered for 1 of 1 residents (# 63) receiving respiratory care. A review of the facility's policy and procedure dated 01/21/2004 entitled - "Medication Administration, Documentation of Medications," reads in part on page 32 under Policy - All medications shall be administered and documented by physician's , registered nurses, licensed practical nurses, or physician's assistants if in accordance with the assistant's approved practice. Paragraph 5 - Medications will be administered by the same licensed personnel who prepared the dose for administration.	F 328	Staff has been in-serviced that only nurses and med aides are allowed to turn off and remove nebulizer treatments. A sticker which says "STOP! ONLY NURSES/MED AIDES MAY TURN MACHINE ON/OFF" has been placed on Resident #63s nebulizer machine. Al l nebulizers now have a sticker that says "STOP! ONLY NURSES/MED AIDES MAY TURN MACHINE ON/OFF". On a weekly basis, for 60 days, the D.O.N. will watch one nebulizer tx to ensure only a nurse or med aide is turning off the nebulizer machine. The D.O.N. will complete the form called Nebulizer QA when watching a nebulizer treatment. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for resolution.	5-30-14

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F 328	Continued From page 9 A review of the facility's policies and procedures entitled - "Special Duty Nursing (Sitters)," dated 08/05/1992 with update on 06/20/2000 (page 1 of 1) reads in part: It is the policy of this facility to regulate the presence of and conduct of private sitters while in the facility. Paragraph 1 - Special duty nurses (sitters) will be treated as "non-nursing" personnel by the facility's nursing staff who are responsible for providing the required level of resident care Paragraph 2 - Special duty nurses (sitters) are not employees of this facility. They will, however, be required to abide by all policies and procedures of this facility Resident # 63 was initially admitted to the facility on 08/05/2013 and re-admitted on 04/22/2014 after a hospitalization and treatment for aspiration pneumonia, pleural effusion, and chronic obstructive pulmonary disease (COPD). Resident # 63's diagnoses included a history of pleural effusion, quadriplegia, a history of hypoxemia, and COPD. Resident # 63's physician's orders and medications included oxygen (O2) at 2Liters/minute via a nasal cannula (continuous oxygen) and to monitor. The orders also included Duo-Nebulizer (Albuterol 3milligrams/3milliliters of fluid) breathing treatments 6 times daily. Resident #63's Minimum Data Set (MDS) dated 02/23/2014 indicated the resident to be moderately cognitively impaired and having a basic interview for mental status (BIMIS) of 8 out of 15. The MDS also indicated resident # 63 to be a quadriplegic and needing total assistance of 1-2 staff for all activities of daily living (ADLs).	F 328		

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SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27536

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F 328	Continued From page 10 Resident # 63's care plan initially dated 11/13/2013 and updated on 02/28/2014 and 04/30/2014 indicated the resident to need: Problem - Resident with self care deficit and Dx of aspiration pneumonia, pleural effusion, hypoxia, and history of COPD. The facility's Goals - Resident will have early interventions for S/S of respiratory distress through next review (90 days). The facility's interventions included - Continue aspiration precautions, Hold medications and feedings if resident can not swallow, Administer oxygen at 2 liters per minute via nasal cannula (continuous), Administer Nebulizer treatments as ordered, Notify MD of any changes in respiratory status, Transport to appointments as needed, Administer medications as ordered unless can not swallow, Notify MD if resident can not swallow. A review of resident # 63's medical record indicated the resident was receiving Duo-Nebulizer (Albuterol nebulizer) breathing treatments 6 times daily. On 04/30/2014 at 9:10 a.m. an observation of a medication pass was conducted by nurse #1 for resident # 63. The nurse was observed to administer all of the resident's oral (PO) medications to the resident then set up the resident's physician ordered respiratory Duo-Nebulizer (Albuterol) breathing treatment. The nurse was observed to appropriately initiate the respiratory treatment and indicated to the resident's private sitter seated in a chair in the room she would be back to finish the treatment. At 9:20 a.m. the nurse indicated she needed to check on resident # 63's breathing treatment and while walking to the resident's room indicated the resident's private sitter may have already finished the treatment and taken the treatment mask off of the resident. When entering the room the	F 328		

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F 328	Continued From page 11 resident was observed sitting in bed and having his breathing treatment mask off/removed and put away. The nurse asked the private sitter if the she had removed the resident's breathing treatment mask and the sitter indicated she had taken the mask off of the resident, turned off the machine, and placed the mask in the bag on the resident's night stand. On 04/30/2014 at 9:38 a.m. an interview was conducted with the private sitter. The private sitter indicated she had removed resident # 63's breathing treatment mask as she felt the treatment had been completed. The sitter was asked if she was a facility employee and the sitter indicated, "No." The sitter was asked if she was a nurse and/or was allowed to administer or assist with medication administration and/or treatments in the facility. The sitter indicated, "I am a CNA." The sitter then indicated she did all of the personal care for the resident between 8:00 a.m. and 4:30 p.m. and that she had also removed the resident's breathing treatment mask several times previously. On 04/30/2014 at 1:55 p.m. an interview was conducted with nurse # 1 who initiated the treatment. The nurse indicated there was no way to verify if the breathing treatment had been completed correctly. The nurse indicated there had been several times in the recent past where she had gone into resident # 63's room and the nebulizer treatment mask was no longer on the resident after she had initiated a breathing treatment. The nurse indicated either the resident or the sitter removed the breathing treatment mask on the days she returned to resident # 63's room and found the mask was not on the resident. The nurse indicated she always	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 12 signed off the medication administration as being fully administered even though she could not verify the treatments were properly completed on the days she found the resident's breathing mask had been removed. On 04/30/2014 at 3:25 p.m. an interview was conducted with the facility's administrator. The administrator indicated the facility had no policies or procedures that indicated what care and services an unlicensed private sitter employed by a resident's family was allowed to do or not do while privately sitting with a facility's resident (except as noted above). The administrator indicated the facility's staff was responsible for all care and services while the resident was in the facility. The administrator indicated the Social Worker (SW) may have more information as to any family instructions private sitters were to carry out while in the facility. On 04/30/2014 at 3:30 p.m. an interview was conducted with the facility's SW. The SW indicated the facility had no written or verbal contract or agreement between the facility and any resident's family as to what the family expected their private sitters to do or was allowed to do while sitting with a resident in the facility. On 05/02/2014 at 8:33 a.m. an interview was conducted with the facility's Director of Nursing (DON). The DON indicated it was her expectation that the medication nurse that initiated a breathing treatment would complete it according to the facility's policies and procedures and a private pay sitter (non-facility employee) should not be removing a breathing treatment mask.	F 328		

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	345316	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27536

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F 441 F 441 SS=D	Continued From page 13 483.65 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 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.	F 441 F 441	Resident # 47's padding on the bedrail has been changed. All bed rails with insulated foam padding have been checked and replaced if needed. On a monthly basis, for 60 days, the Administrator will check the insulated foam padding on bedrails to see if they need to be cleaned or removed by completing the form called bedrail QA. Staff has been in-serviced about filling out a repair/maintenance slip. The repair slips are located at the front desk. There is a small basket at front desk also to place a completed repair slip. Maintenance will get the slips and start on the repair that has been requested. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for resolution	5-30-14

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, resident, sitter, and facility staff interviews, and record reviews the facility failed to clean/replace resident bed frame tape/padding with disinfectant to prevent the spread of possible infection for 1 of 5 residents (#47) observed with taped and padded side rails. A review of the facility's infection control policy and procedures (Resident Care Policies) dated 11/19/2013, section 15, entitled Infection Control read in part: Paragraph 10 - Housekeeping has access to Clorox and Sanicare spray to clean areas to prevent the spread of infections. Housekeeping is responsible for sanitizing bed frames. On 04/28/2014 at 11:03 a.m. a tour of the facility was conducted. During the tour an observation of resident #47's room (27A) was observed. The resident's bed was observed to have padding taped with white tape to the bed rail on the right side (when in bed). The white tape and padding was observed to be extremely dark brown/dirty and there were multiple areas where a dark red substance was observed also on the white tape and over the brown dirty areas of the padding. On 04/29/2014 at 4:18 p.m. a second observation was made of the resident's padding, tape, and bedrails. The resident's bed was still observed to have the dirty white tape and padding being extremely dark brown and multiple areas where a dark red substance was observed also on the white tape and over the brown dirty areas of the padding.	F 441		

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F 441	Continued From page 15 On 04/30/2014 at 8:55 a.m. a third observation was made of the resident's bed. The resident's bed was still observed to have the dirty white tape and padding being extremely dark brown and multiple areas where a dark red substance was observed also on the white tape and over the brown dirty areas of the padding. On 05/01/2014 at 4:00 p.m. a fourth observation was made of the resident's bed. The resident's bed was still observed to have the dirty white tape and padding being extremely dark brown and multiple areas where a dark red substance was observed also on the white tape and over the brown dirty areas of the padding. On 05/02/2014 at 8:15 a.m. a fifth observation was made of the resident's taped and padded bed rails with another survey team member. The resident's bed rail was still observed to have the dirty white tape and padding being extremely dark brown in areas and also having multiple areas where a dark red substance was observed on the white tape/padding and over the brown dirty areas of the padding. On 05/02/2014 at 8:20 a.m. an interview was conducted with the resident's private pay sitter. The sitter indicated she had been the resident's sitter for over two years. The sitter indicated the dark brown areas on the bed rail tape and padding was dirt from the resident holding the rail and staff using their hands putting the railing up and down. The sitter also indicated the dark red areas on the tape and padding was blood from the resident were the resident's skin tear on her right elbow/arm was hitting the padded railing. The sitter indicated the multiple areas of blood	F 441		

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F 441	Continued From page 16 had been on the padding and tape for over two months. The sitter also indicated she had talked to both staff Nursing Assistants (NAs) and Nurses to try to get the facility to change the dirty and blood soaked tape and padding. The sitter indicated the most recent attempt to get the staff to change the dirty and blood soaked padding and tape two weeks ago. On 05/02/2014 at 8:30 a.m. a sixth observation was made of the resident's taped and padded bed rails with the facility's director of Nursing (DON). The resident's bed rail was still observed to have the white tape and padding being extremely dark brown in areas and also having multiple areas where a dark red substance was observed (resident and sitter indicating it was the resident's blood) also on the white tape/padding and over the brown/dirty areas on the padding. On 05/02/2014 at 8:33 a.m. an interview was conducted with the DON. The DON indicated the padding and tape should not have been on the bed and should have been changed by maintenance when the staff was initially notified by the sitter. The DON indicated it was her expectation that when blood or dirt is observed on a piece of resident's equipment such as this resident's bed it should be changed immediately. The DON also indicated that all facility staff was responsible to ensure this type of problem is corrected immediately when observed/found or staff are informed about the condition and all staff should ensure the problem is corrected immediately.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 17 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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 staff and sitter interviews and record review, the facility failed to maintain effective monitoring practices to identify and correct quality deficiencies in infection control by staff not reporting to the committee bloody handrails that stayed on a resident's bed (Resident #47) for over a two month time period. Findings included: Cross refer to citation F441.	F 520	Resident # 47's padding on the bedrail has been changed. All bed rails with insulated foam padding have been checked and replaced if needed. On a monthly basis, for 60 days, the Administrator will check the insulated foam padding on bedrails to see if they need to be cleaned or removed by completing the form called bedrail QA. Staff has been in-serviced about filling out a repair/maintenance slip. The	5-30-14

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F 520	Continued From page 18 The facility Quality Assurance (QA) policy dated January 6, 2009 stated, "Information will be reviewed by the committee on a quarterly basis and more often if the need arises." The policy indicated the objective of the program was to improve resident care and put into place changes the committee recommended and that information for review would be gathered through internal audits, routine monitoring, staff observations and complaints. On 05/02/2014 at 8:20 a.m. an interview was conducted with the Resident #47's private pay sitter. The sitter indicated multiple areas of dried blood had been on the resident's bedrail padding and tape for over two months. The sitter also indicated she had talked to both staff Nursing Assistants (NAs) and Nurses to try to get the facility to change the dirty and blood soaked tape and padding. The sitter indicated the most recent attempt to get the staff to change the dirty and blood soaked padding and tape two weeks ago. On 05/02/2014 at 8:33 a.m. an interview was conducted with the Director of Nursing (DON). The DON indicated the padding and tape should not have been on the bed and should have been changed by maintenance when the staff was initially notified by the sitter. The DON indicated it was her expectation that when blood or dirt is observed on a piece of resident's equipment such as this resident's bed it should be changed immediately. The DON also indicated that all facility staff was responsible to ensure this type of problem is corrected immediately when observed/found or staff are informed about the condition and all staff should ensure the problem is corrected immediately.	F 520	repair slips are located at the front desk. There is a small basket at front desk also to place a completed repair slip. Maintenance will get the slips and start on the repair that has been requested. The QA committee met on May 28th, 2014. Bedrails and infection control was a topic at the QA meeting. The QA committee will discuss infection control at least every six months. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for resolution	5-30-14

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F 520	Continued From page 19 During an interview on 5/2/14 at12:15 pm with the Administrator, he indicated he is a member of the QA committee, stated, "If an issue comes up in between [quarterly] meetings, depending on the severity, [the QA committee] would go ahead and meet." He indicated if staff was aware of an issue, they should bring it to the committee. During an interview on 5/2/14 at 12:35 pm with the Administrator, he indicated an issue that he became aware of during the recertification survey that should be addressed by the QA committee was "The bedrails being dirty." He further indicated infection control was not an issue addressed by the QA committee within the past 6 months. During an interview on 5/2/14 at 12:40 pm with the DON, she indicated was a member of the QA committee and could not identify any issues within the past 6 months that have been brought forth to the QA committee and have been or are being addressed. She further revealed she had not been made aware by staff of "the bloody bed rail issue" prior to 5/2/14, but the bloody/dirty rails were "something that should be brought forth to the QA committee by staff if they were aware." During an interview on 5/2/14 at 1:00 pm with the Staff Development Coordinator, she indicated staff should go to the Nurse Supervisor or the DON if there was an issue that should be addressed by the QA committee. She indicated communication could be in person or by leaving a note.	F 520		