AMENDED

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

PRINTED: 02/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	C 01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 483.25 (F323) at K Immediate Jeopardy began on 11/15/13 when it was reported to the Assistant Administrator that the securement straps that secured wheelchairs in all 3 facility transportation vehicles were frayed and worn. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. 483.75 (F490) at K Immediate Jeopardy began on 11/15/13 when it was reported to the Business Office Manager/Assistant Administrator that the securement straps that secured wheelchairs in all 3 facility transportation vehicles were frayed and worn. The Administrator had not been informed the securement straps that secured wheelchairs to transport vans were slipping and no monitoring was implemented to ensure safety straps did not loosen during van transport. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. 483.75 (F520) at K Immediate Jeopardy began on 11/15/13 when it	F 000	There were Three Immediate Jeopardy imposed on the facility during the Recertification Survey from January 6th through January 12th. A creditable allegation of compliance was accepted on 1/12/2014 for the following: 1) Resident #85 - Immediate Jeopardy 2) Administration - Immediate Jeopardy 3) Quality Assurance - Immediate Jeopardy To address the requirements of the CMS Imposition Notice requirements the following Directed Plan of Correction was implemented: The facility will obtain the services of independent contractors (individuals or companies not having any personal or professional relationship with the facility, the owners, and/or the Management Company), to conduct the following items specified in the directed plan of correction. 1) The facility will engage the services of an independent contractor to provide " Compassionate and Person Centered Training to the facility's direct care Staff and the independent contractor shall submit a written report to CMS and the state providing the content of the training, documentation of objectives and attendees participating. 2) The facility shall utilize an independent contractor to evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care and shall submit a written report to CMS and the State summarizing outcomes the outcomes of competency skills evaluation of direct care staff. of particular importance is staff knowledge related to abuse, neglect, dignity, and activities of daily living.	3/5/2014 3/5/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dianne Parsons | TITLE: DON | (X6) DATE: 2/26/14

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.

Dianne Parsons

DHSR Mail Processing Unit Received FEB 27 2014 by: SKH

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F 000	Continued From page 1 was reported to the Business Office Manager/Assistant Administrator and Director of Nursing that the securement straps that secured wheelchairs in all 3 facility transportation vehicles were frayed and worn. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. There were no deficiencies cited as a result of the complaint investigation. Event ID #TM2M11.	F 000	3) The governing body, with the assistance of the independent contractor, shall conduct a root cause analysis regarding the facility's survey history beginning January 1st, 2011. The Root Cause Analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation 4) The facility shall specify in writing who will be responsible and accountable for the provision of quality care, treatment and services. A copy of the root cause analysis shall be provided to CMS and the State. 5) The governing body shall submit a written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports shall be provided to CMS and the State ,monthly x 5 months.	3/5/2014 3/5/2014
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	To address the cited deficiency for Personal Privacy/Confidentiality where the facility failed to close doors, privacy curtains and window blinds, during dressing changes of 3 of 4 wound observations and failure to knock on doors, close doors and privacy curtains of 2 of 4 residents observed during personal care and those residents having the potential to be affected by the same deficient practice the following action plan was implemented: 1) Wound Care Nurse was counseled in writing regarding failure to provide privacy to Resident #152, #59, and #83 2) Wound Care nurse was re-educated on the rationale and the method of providing privacy to Resident #153, #59 and #83 and by inservice 3) NA #9 was counseled in writing for failure to provide for resident #152 privacy while	1/29/2014 1/29/2014 2/5/2014

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F 164	Continued From page 2 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and family and staff interviews the facility failed to close doors, privacy curtains and window blinds during dressing changes in 3 of 4 wound observations and failed to knock on doors, close doors and privacy curtains for 2 of 4 residents observed during personal care. (Resident #153, #59, #83, #48 and #8). The findings included: 1. During an observation of dressing changes on 01/08/13 at 10:29 AM the wound care nurse placed dressing supplies on top of a treatment cart in Resident #153's room and washed her hands and put on gloves. The door of Resident #153's room was left open, the privacy curtain was open and was pushed back to the wall and the blinds on the window were open. Resident #153's roommate was sitting in a chair next to the privacy curtain and looked at the wound care nurse as she opened dressing supplies. While the wound care nurse removed a dressing from Resident #153's left heel and cleaned the wound residents and visitors walked by in the hallway and looked into Resident #153's room. The	F 164	assisting the Wound Nurse with wound care and exposing Resident #153's buttocks to roommate. 1/30/2014 4) All Nursing Staff with Resident #48 including Nurse Aide #5 and #6 were reeducated on the rationale and the method of providing privacy to Resident #48, Resident #48 roommate and Resident #8 while personal care is delivered by inservice 2/5/2014 5) Nurse Aid #5 and Nurse Aide #6 were counseled in writing regarding failure to provide privacy with personal care to resident #48 1/30/2014 6) Nurse Aide/Med Aide #7 was counseled in writing regarding failure to knock on Resident #8's door prior to entering Resident #8's room looking at the resident in the room, backed out of the room and closed the door. 1/30/2014 7) Nurse Aide/Med Aide #7 and Nurse Aide #9 attended an inservice to learn how to provide privacy to Resident #8, Resident #153 and Resident #153's roommate and to all other residents that could be affected by such a deficient practice of failing to knock on doors and failing to utilize privacy curtains to prevent resident's buttocks being exposed to Resident #153's roommate. 2/5/2014 8) In addition to all Nursing Staff, Housekeeping Laundry, Maintenance, Activities, Therapy and Restorative staff having job responsibilities in resident rooms were inserviced on patient rights for privacy. 2/6/2014 9) Daily Audits will be conducted by the Administrative Nurses assigned to Halls A, B, C, and D for 4 weeks, then weekly x 4 weeks, then monthly thereafter.	

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F 164	Continued From page 3 wound care nurse walked out of Resident #153's room after she finished the dressing change and came back into the room with 2 nurse aides. Nurse aide #9 closed the door of the room but the privacy curtain and window blinds were still open and Resident #153's roommate was still sitting in a chair next to the privacy curtain watching the wound care nurse as she opened dressing supplies. NA #9 turned Resident #153 onto her right side and exposed Resident #153's buttocks to the roommate. The wound care nurse removed a dressing from Resident #153's buttocks and cleaned the wound and re-applied a dressing. During an interview on 01/10/14 at 5:08 PM the wound care nurse stated the privacy curtain was supposed to be closed when she provided wound care to Resident #153 but she had just missed that because she was focused on doing the wound treatments. She stated it was her normal practice to leave the door open but she usually closed the privacy curtain and turned the resident away from the door. She further stated she should have provided privacy to Resident #153 during the dressing changes and should have closed the privacy curtain since Resident #153's roommate was sitting next to her and watched during the dressing changes. During an interview on 01/10/14 at 5:27 PM the Director of Nursing stated it was her expectation for dressing changes to be done in a private setting. She explained the privacy curtains should be pulled between residents and the door and window blinds should be closed. 2. During an observation of a dressing change	F 164	10)The Audits will be conducted and documented on a Hall Rounds sheet by the LPN MDS Nurse for A Hall; by the RN MDS Coordinator on Hall B, Nursing Supervisor or designee for C Hall; and by the RN Staff Development Coordinator assigned to D.Hall. 11)The audits will document any privacy issues identified or concerns voiced by any resident or family member/responsible party. 12) Concerns will be documented on a Grievance Form and forwarded to the Director of Nursing for review in the Daily Stand-Up Meeting. 13) The Director of Nursing will forward all written privacy grievance concerns to the facility Social Worker. 14) The Director of Nursing will make hall rounds in the afternoon to follow-up on any findings from the Administrative Nursing rounds. 15) The Director of Nursing will report follow-up on concerns and interventions on any privacy issue in the Daily Stand-up Meeting. 16) The Daily Stand-up Meeting participants will make recommendations for any further follow-up or action needed which will be documented in the minutes of the meeting. 17) The QA/PI Coordinator will forward all minutes of the Daily Stand-Up Meeting to the Administrator for review for any further action that might be needed. 18) The results of the audits will be compiled by the Director of Nursing and presented to the monthly QA/PI Committee for trending, effectiveness of systemic interventions and ongoing process analysis.	

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F 164	Continued From page 4 on 01/08/14 at 10:50 AM Resident #59 was seated in a wheelchair next to his bed and the door of the room, and the privacy curtains and window blinds were open. The wound care nurse removed Resident #59's sock from his right (R) foot and held his foot up in the air facing the open door of his room. Residents and visitors were standing in the hallway outside of Resident #59's room. The wound care nurse then sat down on a small stool and cleaned the wound and applied a new dressing while residents and visitors remained in the hallway and looked into Resident #59's room. During an interview on 01/10/14 at 5:08 PM the wound care nurse stated she left the door open when she changed the dressing on Resident #59's foot and didn't think about closing it because she was so focused on doing the treatment. She stated she should have provided privacy to the resident during the dressing change and it was her usual practice to close the privacy curtain and leave the door open when she changed the dressing. During an interview on 01/10/14 at 5:27 PM the Director of Nursing stated it was her expectation for dressing changes to be done in a private setting. She explained the privacy curtains should be pulled between residents and the door and window blinds should be closed. 3. During an observation on 01/08/13 at 1:52 PM the wound care nurse walked into Resident #83's room and stated to Resident #83 she wanted to look at his back. She assisted him to lean forward in his wheelchair and raised his shirt up and exposed his back up to his shoulders toward the open door. The door of the room was open	F 164	19) The Facility Social Worker will compile all grievances and present a report to the Monthly QA/PI Committee. 20) The evaluation of the interventions will be measured by the results of audits completed on Hall Rounds on a daily basis by designated Administrative Nursing Staff. 21) Director of Nursing will review the effectiveness of the audits and action taken in the Daily Stand-up Committee and will be documented in the minutes of the meeting. 22) QA/PI Coordinator will e-mail minutes from the Daily Stand-Up Meeting to the Administrator for review and follow-up as indicated. 23) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency. 24) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	

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and the privacy curtain was pushed all the way back and window blinds were open and were pulled halfway up the window. Resident #83's roommate was lying on his bed and visitors and residents walked by the room and looked inside while the wound care nurse applied cream to a large reddened area on Resident #83's right shoulder.

During an interview on 01/10/14 at 5:08 PM the wound care nurse stated she left the door, privacy curtain and blinds of the window open because she was so focused on doing the treatment and just missed it. She stated she should have provided privacy to Resident #83 when she assessed and applied cream to his shoulder.

During an interview on 01/10/14 at 5:27 PM the Director of Nursing stated it was her expectation for dressing changes to be done in a private setting. She explained the privacy curtains should be pulled between residents and the door and window blinds should be closed.

4. Resident #48's most recent annual Minimum Data Set (MDS) dated 10/18/13 assessed her as being cognitively intact.

During an interview on 01/06/14 at 3:51 PM Resident #48 stated that when staff provided her with incontinence or hygiene care, they either closed her door but left the curtain open or closed the curtain but left the door open. Resident #48 stated she did not like being exposed to the hallway or to her roommate when staff came and left during care. Resident #48 stated she reminded staff daily to close her door and to pull her curtain all the way around and when they did,

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it was only after she reminded them and sometimes was not done right away. Resident #48 also stated she had complained to staff about leaving her privacy curtain open when her roommate received personal care, and had been told by staff that her roommate wasn't paying attention and she shouldn't be worried about being seen by her roommate.

Interview with the Director of Nursing (DON) on 01/10/14 at 10:02 AM revealed her expectation that any time staff provided care to any part of any resident's body, they first closed the resident's door, pulled the resident's curtains all the way around, and closed the resident's blinds. The DON stated there was no excuse for any nurse aide or nurse leaving a privacy curtain not pulled all the way around, not shutting the door or not pulling the blinds

Interview with resident on 01/10/14 at 11:58 AM revealed staff had changed her that morning with the curtain around her bed partially closed but the door to the hall was left open. Resident #48 stated she could hear people going up and down the hall while care was being provided, and was afraid someone would come in and see her. Resident #48 stated she had asked the staff to close her door, and they had said they would in just a minute, but did not until her care was completed.

Observation on 01/11/14 at 9:35 AM of Nurse Aide #5 and Nurse Aide #6 provided hygiene care with Resident #48 and incontinence care with Resident #48's roommate the privacy curtain between residents was drawn halfway back and exposed each resident to the other during care. During the observation, NA #6 left the room and

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F 164	Continued From page 7 came back with additional supplies and each time opened the door to the hallway and briefly exposed the residents to anyone in the hall. Interview with NA #5 on 01/11/14 at 9:40 AM revealed NA did not typically draw curtain between residents when residents sleeping or received personal care. NA #5 stated she felt the residents' privacy was protected sufficiently with the curtains pulled part way between the beds, as long as both residents were of the same gender. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed he had been trying to monitor nurses and nurse aides to provide care for residents in a way that preserved their dignity and personal privacy. Nurse #2 stated he was aware that staff in the facility did not consistently pull the privacy curtain all the way around the resident, close the door, and close the blinds before initiating care. Nurse #2 stated staff had all been trained, but it was an ongoing problem in the facility. 5. Resident #8 was admitted to the facility on 04/19/12 with diagnoses which included generalized pain, heart disease and type 2 diabetes. Resident #8's most recent quarterly Minimum Data Set (MDS) dated 10/25/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #8 needed extensive assistance of two or more persons for personal hygiene. During an interview with Resident #8 on 01/07/14 at 2:54 PM, NA #7 was observed to open the door to Resident #8's room and to enter the room without knocking. After NA #7 entered the room she looked at the residents in the room, backed out of room and closed the door.	F 164		

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F 164	Continued From page 8 During interview with Resident #8 on 01/07/14 at 2:54 PM, she stated she felt violated by staff when they came into her room without knocking. Resident #8 stated staff frequently entered her room without knocking and she had complained to nurses about it on more than one occasion. During interview with Resident #8 on 01/07/14 at 3:15 PM, NA #7 knocked on the door to the resident's room and then without waiting for permission to enter, she stepped into the room and asked for Resident #8 to let her know when the interview was complete so she could give her medications. Resident #8 stated she was very frustrated with staff interrupting her privacy at all times and felt embarrassed when they came in without knocking. Interview with the Director of Nursing (DON) on 01/10/14 at 10:02 AM revealed her expectation that any time staff entered a resident's room to provide any type of care staff would first knock on the door, wait for a response, and then let the resident know who they are and the reason for their visit. The DON stated there was no excuse for any nurse aide or nurse to enter a resident's room without knocking. Interview with NA #7 on 01/11/14 at 11:40 AM revealed she was aware of the need to knock on doors to resident rooms before entering their room, but she sometimes forgot to knock because she was trying to provide resident care in a timely manner. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed he had been trying to monitor nurses and nurse aides providing care for residents in a	F 164		

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F 164	Continued From page 9 way that preserved their dignity and personal privacy. Nurse #2 stated he was aware that staff in the facility did not consistently knock on resident doors before entering. Nurse #2 stated all staff were trained, but it was an ongoing problem in the facility.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to cover a catheter bag to provide dignity in 1 of 1 resident with a catheter. (Resident #153). The findings included: Resident #153 was admitted to the facility on 01/03/14 with diagnoses which included diabetes and wounds. There was no admission Minimum Data Set available but a nursing admission assessment dated 01/04/14 indicated Resident #153 had short term memory problems and had modified independence with daily decision making with some difficulty in new situations only. The nursing admission assessment also indicated Resident #153 required assistance with activities of daily living and had a urinary catheter. During an observation on 01/06/14 at 12:30 PM the door of Resident #153's room was open and	F 241	To address the cited deficiency of the facility failing to cover catheter bag to provide dignity in 1 of 1 resident with a catheter Resident #153) and for those residents having potential to be affected by the same deficient practice, the following action plan was implemented. 1) A dignity bag was placed on Resident #153 catheter bag. 1/11/2014 2) Catheter was discontinued for Resident #153 1/28/2014 3) All Nursing staff in-serviced on dignity bag for urinary catheters. 2/5/2014 4) The Administrative Staff Nurse assigned to each hall will be responsible for daily monitoring for ongoing compliance for dignity bags for urinary catheters.	

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F 241	Continued From page 10 a urinary catheter bag was hanging from the bed frame near the foot of the bed and was not covered with a dignity bag (a bag used to cover the catheter bag). The catheter bag was visible from the hallway and residents and visitors were in the hallway outside of Resident #153's door. During an observation on 01/06/14 at 2:45 PM the door of Resident #153's room was open and a urinary catheter bag was hanging from the bed frame near the foot of the bed and was not covered with a dignity bag. The catheter bag was visible from the hallway and a visitor walked into Resident #153's room and stood next to the urinary catheter bag as she talked with the resident. During an observation on 01/07/13 at 10:04 AM the door of Resident #153's room was open and a urinary catheter bag was hanging from the bed frame near the foot of the bed and was not covered with a dignity bag. The catheter bag was visible from the hallway and residents and staff were in the hallway in front of the door to Resident #153's room. During an observation on 01/07/13 at 3:30 PM the door of Resident #153's room was open and a urinary catheter bag was hanging from the bed frame near the foot of the bed and was not covered with a dignity bag. The catheter bag was visible from the hallway and residents and visitors were in the hallway in front of the door to Resident 153's room. During an interview on 01/09/14 at 3:20 PM Nurse Aide #9 stated residents who had urinary catheters were supposed to have them covered with a dignity bag at all times. She further stated	F 241	5) A Hall monitored by the LPN Care Plan Nurse, B Hall monitored by the RN MDS Coordinator C Hall monitored by the D.O.N. or designee, D. Hall monitored by the RN Staff Development Coordinator 6) Results of the Hall rounds by the Administrative Nursing Staff will be forwarded to the Director of Nursing 7) In the absence of the assigned Administrative Nurse Monitor, the Charge Nurse will monitor or will designate a replacement monitor. 8) The Director of Nursing will make a round on all halls in the afternoon to follow-up on findings from the Administrative Nurse Hall Rounds 9) The Director of Nursing will then take results obtained by hall rounds with interventions to the Daily Stand-Up Meeting. 10) Director of Nursing will review results from Hall Rounds in the Daily Stand-Up Meeting with results entered in the minutes of the meeting. 11) QA/PI Coordinator will e-mail minutes of the Daily Stand-Up Meeting to the Administrator. 12) Results of the monitoring of dignity bag compliance will be made a part of the Nursing QA/PI report to the monthly QA/PI Committee for review and any further action needed until substantial compliance is maintained.	

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	345246	A. BUILDING _____ B. WING _____	C 01/12/2014

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F 241	Continued From page 11 she was not sure why Resident #153 did not have a dignity bag over her catheter but someone must have forgotten to put it on when she was admitted to the facility. During an interview on 01/10/13 at 2:32 PM Nurse #11 who was the nurse assigned to the care of Resident #153 stated all residents who had urinary catheters were supposed to have the catheter bag covered with a dignity bag. She stated Resident # 153 had only been in the facility for a few days and the dignity bag for her catheter was probably overlooked. During an interview on 01/11/14 at 10:15 AM Resident #153 stated she was a very private person and if the catheter bag was supposed to be covered then it should be covered. She stated she did not want visitors or other residents to see her catheter bag but she expected staff to be aware of it and take care of it. During an interview on 01/11/14 at 3:07 PM the Director of Nursing stated it was her expectation for all urinary catheter bags to be covered to maintain residents' dignity. She further stated nursing staff should check to see if the dignity bag was in place when they made their rounds and if there wasn't one they should get one and put it on.	F 241	13) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency. 14) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	
F 242 SS=E	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	F 242	To correct the cited deficiency for the facility's failure to honor resident's choices for frequent showers and/or choice of tub bath for 4 of 6 residents reviewed for choices (Resident #2, #8, #31 and #48) To also correct the cited deficiency for those residents having potential to be affected by the same deficient practice.	

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F 242	Continued From page 12 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 observations, record review and resident and staff interviews the facility failed to honor residents' choices for frequency of showers and/or choice of tub bath for 4 of 6 residents reviewed for choices. (Resident #2, #8, #31 and #48). The findings included: Review of Resident #2's Admission Nursing Assessment dated 10/26/13 signed by Nurse #1 revealed two showers per week was checked for the question regarding resident's preference for frequency of showers. Resident #2 was admitted to the facility with diagnoses which included arthritis and depression. Resident #2's most recent Admission Minimum Data Set (MDS) dated 11/03/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #2 needed total assistance of one person for bathing. During an interview on 01/06/14 at 3:11 PM Resident #2 stated she did not get to choose how many showers she receives each week. She stated she receives 2 showers per week. She stated she had asked if she could have a shower more frequently but staff told her she could if they could work her in. She stated she did not get extra shower's. On 01/08/14 at 8:34 AM an interview was	F 242	To correct the cited deficiencies, the following correction plans were implemented. 1) Resident #2 shower schedule changed to 3 times a week per her request 2) Resident #8 shower schedule changed to 3 times per week, per her request 3) Resident #31's shower schedule changed to 3 times a week per her request. 4) Resident #48's shower schedule changed to 3 times a week after speaking with resident. 5) In-service provided to all Nursing Staff which includes RN's, LPN's, Nursing Assistants and Medication Aides, on the rights of residents to make choices about his/her care. This included the right to decide how many tub baths or showers residents want each week. 6) All whirlpool tubs were checked for operability and all were deemed operable by maintenance. 7) Nursing staff will notify Maintenance of any issues with the Whirlpool Tubs by documenting on a Maintenance Work Order and forwarding to the Maintenance Department for any issues to be corrected. 8) Administrative Assistant and Director of Environmental Services/Safety will review all Maintenance Work Orders weekly to ensure work is completed 9) Director of Environmental Services Safety presents reports to the Safety Committee and the QA/PI Committee on a monthly basis to review for action taken for resolvement of any maintenance issues identified.	2/3/2014 2/3/2014 2/3/2014 2/3/2014 2/6/2014 1/30/2014 2/14/2014

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F 242	Continued From page 13 conducted with Resident #2. She stated earlier in the week she was not feeling well and missed her shower. The next day she requested a shower and was told it was not her day. On 01/10/14 at 3:50 PM an interview was conducted with Resident #2. Resident #2 stated she would like to have a shower at least 3 times per week or every other day if she could. She stated when she was admitted she was not asked how frequently she wanted a shower. An interview was conducted on 01/11/14 at 10:04 PM with Nurse #1. Nurse #1 stated she did the nursing admission assessment for Resident #2. She stated as a rule showers are given twice per week unless a resident wants more. She further explained the resident has to ask for more showers if they want more than two showers per week. She stated the shower schedule is set up based on room numbers. The time of day the showers are given also depends upon the resident's room number. She stated she told Resident #2 that showers are offered twice per week but she did not ask Resident #2 how many showers she wanted per week. On 01/11/14 at 4:46 PM an interview was conducted with the Director of Nursing (DON). The DON stated we have a very strong system in place to make sure residents get the number of showers they would like per week. She stated when the Admission Nursing Assessment is completed it was asked and documented how many showers a resident would like to have per week. She stated she talks to the residents and asks them if they are receiving their showers. The DON stated her expectation was for nurses doing the assessments to ask the residents how	F 242	10) An audit was completed on all current residents that have the capacity to make decisions. They were asked about their shower preferences for type of bath/ shower and frequency. 1/31/2014 11) The shower schedule was updated based on resident preferences from the audit. 2/3/2014 12) The Admission Assessment reviewed for adequacy to ask each resident for shower/bath preference and frequency. 1/31/2014 13) The MDS staff update the care plan to reflect the resident preference. The Daily Nursing Worksheet is then updated to reflect resident preferences of shower/bath type, frequency and time of day. 14) The Care Plan team meets with the resident, family and/or responsible party within 14 days of admission to discuss the plan of care and any issues identified. 15) Resident preferences are continually reviewed and documented on the interdisciplinary care plan meeting form as part of the quarterly care planning meeting schedule. 16) The facility will monitor its performance weekly by review of each admission/ readmission, in the Daily Stand-Up Meeting and the Care Plan Nurse follow-up on the 7th day following admission/readmission.	

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F 242	Continued From page 14 many showers they would like to have per week and for nurses to make sure the showers are being provided for the residents. 2. Resident #8 was admitted to the facility on 04/19/12 with diagnoses which included generalized pain, cardiac dysrhythmia, and type 2 diabetes. Resident #8's most recent quarterly Minimum Data Set (MDS) dated 10/25/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #8 needed extensive assistance of two or more persons for bathing. During an interview on 01/07/14 at 2:54 PM Resident #8 stated she preferred baths to showers and wanted baths to be provided at least every other day. Resident #8 stated she was told during admission each resident was provided 2 showers each week. Resident #8 stated when she asked for baths or more frequent showers she was reminded by nurse aides and nurses of the 2 days a week that her showers were scheduled. Resident #8 stated she had never been asked if she would prefer baths or how many baths she would like each week. Resident #8 stated she spent a lot of time each day completing physical exercise to strengthen her muscles, and as a result she felt sweaty and dirty without frequent baths. Interview with Nurse Aide #3 (NA) on 01/10/14 at 6:53 AM revealed residents get showers twice a week depending on their room number. NA #3 stated when residents change rooms, their shower days are changed to the days assigned to their new room number. NA #3 stated she understood the facility bath tub to be broken, and	F 242	17) The Charge Nurse or designee will document any deviations from the plan of care in the medical record. 18) The Administrative Nursing Hall Rounds team will document the shower/bath preference on the hall rounds form. 19)The Administrative Nursing Hall Rounds form will be forwarded to the Director of Nursing each day. 20) The Director of Nursing will follow-up on Hall Rounds with an afternoon facility round and will report findings to the Daily Stand-Up Meeting. 21) The QA/PI Coordinator will e-mail minutes from the Daily Stand-up Meeting to the Administrator. 22) The Administrator and/or designee will oversee the systemic process to ensure that the deficit practice of not allowing residents to choose type, number and time of bath/shower does not reoccur. 23) A report on bath/shower preferences and compliance with the cited deficiency will be made a part of the Nursing QA/PI report to the monthly QA/PI Committee until substantial compliance is maintained. 24) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency.	

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F 242	Continued From page 15 told residents that if they requested a bath. NA #3 stated it had been over a year since she had seen a resident getting a bath in the facility. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed the charge nurse was assigned the initial nursing assessment on resident admission, which included bath/shower preferences, but many times the responsibility was passed to a hall nurse. Nurse #2 stated he was unaware of the method other nurses used when assessing preferences. On 01/11/14 at 4:46 PM an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a very strong system in place. She stated when the Admission Nursing Assessment was completed it was asked and documented how may showers a resident would like to have per week. She stated she talked to the residents and asked them if they were receiving their showers. The DON stated the facility had 2 functioning whirlpool tubs that were available for use by residents who preferred baths to showers. The DON stated her expectation was for nurses doing the assessments to ask the residents how many showers or baths they would like to have per week and for nurses to make sure the showers or baths are being provided for the residents 3. Review of Resident #31's Admission Nursing Assessment dated 05/07/13 signed by Nurse #1 revealed two showers per week was checked for the question regarding residents' preference for frequency of showers. Resident #31 was admitted to the facility on 05/07/13 with diagnoses which included	F 242		

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F 242	Continued From page 16 osteoarthritis, depressive disorder, and generalized pain. Resident #31's most recent quarterly Minimum Data Set (MDS) dated 11/15/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #31 needed total assistance of one person for bathing. During an interview on 01/06/14 at 3:11 PM Resident #31 stated she would prefer to have baths instead of showers because she stayed uncomfortably cold during showers. Regarding frequency, Resident #31 stated if showers were her only option, she would prefer to have bed baths only. Resident #31 stated if baths were offered as an option, she'd prefer to take them every other day or so. Resident #31 stated she knew it was her shower day when staff walked into her room twice a week and told her. Resident #31 stated she had asked for baths and had been told she was to be given 2 showers each week and there was no bathtub available. Interview with NA #3 on 01/10/14 at 6:53 AM revealed residents got showers twice a week depending on their room number. NA #3 stated when residents change rooms, their shower days were changed to the days assigned to their new room number. NA #3 stated she understood the facility bath tub to be broken, and told residents that if they requested a bath. NA #3 stated it had been over a year since she had seen a resident getting a bath in the facility. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed the charge nurse was assigned the initial nursing assessment on resident admission, which included bath/shower preferences, but many times the responsibility was passed to a	F 242		

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F 242	Continued From page 17	F 242		

hall nurse. Nurse #2 stated he was unaware of the method other nurses use when assessing preferences.

On 01/11/14 at 4:46 PM an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a very strong system in place. She stated when the Admission Nursing Assessment was completed it was asked and documented how may showers a resident would like to have per week. She stated she talked to the residents and asked them if they were receiving their showers. The DON stated the facility had 2 functioning whirlpool tubs that were available for use by residents who preferred baths to showers. The DON stated her expectation was for nurses doing the assessments to ask the residents how many showers or baths they would like to have per week and for nurses to make sure the showers or baths were being provided for the residents

4. Review of Resident #48's Admission Nursing Assessment dated 10/09/09 revealed Resident #48 had not been assessed for frequency of showers.

Resident #48 was admitted to the facility on 10/09/09 with diagnoses which included kidney disease, generalized muscle weakness, and depressive disorder. Resident #48's most recent annual Minimum Data Set (MDS) dated 10/18/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #48 was dependent on staff for bathing and needed the assistance of 2 or more persons for bathing. The annual MDS assessed her preferences for choice of type of bath/shower was "very important."

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F 242	Continued From page 18 During an interview on 01/06/14 at 3:51 PM Resident #48 stated that although she was never asked about her shower preferences, she was told by staff that each resident could only get 2 showers per week on assigned days. Resident #48 stated her assigned shower days were Wednesdays and Saturdays. Resident #48 stated she would prefer to be showered every day, but since that seemed like an unreasonable request, she'd be happy to get a shower every other day, if she had a choice. Interview with NA #3 on 01/10/14 at 6:53 AM revealed residents get showers twice a week depending on their room number. NA #3 stated when residents change rooms, their shower days are changed to the days assigned to their new room number. Interview with nurse aide (NA) #4 on 01/10/14 at 4:06 PM revealed residents were given 2 showers per week based on their room number. NA #4 stated that residents needed to ask for more if they wanted more showers per week. NA #4 explained the shower scheduled was set up by sections of the hall: the first part of rooms were assigned to showers on Mondays and Thursdays, the second part were assigned to showers on Tuesdays and Fridays, and the third part were assigned showers on Wednesdays and Saturdays. NA #4 stated on Sundays NAs were to do nail care and shaving for residents and no showers. NA #4 stated Resident #48 was assigned showers on Wednesday and Saturday, due to the location of her room. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed if residents stated their preferences, staff was obligated to provide their showers	F 242		

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F 242	Continued From page 19 accordingly. Nurse #2 stated most residents defaulted to getting showers twice a week. Nurse #2 stated the charge nurse was assigned the initial nursing assessment on resident admission, which includes bath/shower preferences, but many times the responsibility was passed to a hall nurse. Nurse #2 stated he was unaware of the method other nurses use when assessing preferences. On 01/11/14 at 4:46 PM an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a very strong system in place. She stated when the Admission Nursing Assessment was completed it was asked and documented how many showers a resident would like to have per week. She stated she talked to the residents and asked them if they are receiving their showers. The DON stated her expectation was for nurses doing the assessments to ask the residents how many showers they would like to have per week and for nurses to make sure the showers were being provided for the residents. Interview with Nurse #9 on 01/12/14 at 12:04 PM revealed showers were given twice weekly to residents according to the location of their bedroom. Nurse #9 stated if staff noticed a resident had excessive body odor they would increase the resident's shower frequency.	F 242		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and	F 244	To address the cited deficiency of facility failure to act upon concern raised by the Resident Council on 3 of 3 residents (Resident #68, #31 and #104) and to take corrective action for those residents having potential to be affected by the same deficient practice, the following action plan was implemented.	

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F 244	Continued From page 20 operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to act upon concerns raised by the resident council, specifically 3 of 3 interviewable residents (Residents #68, #31, and #104). Findings included: Record review of the Resident Council minutes dated 08/12/13 revealed concerns including laundry not being returned to the correct resident, poor food taste and too much seasoning in food. There was no documented response to the concerns in the minutes. Record review of the Resident Council minutes dated 09/23/13 revealed concerns including laundry not being returned to the correct resident, the behavior of 2 specific nurse aides, poor food taste, and food trays not including needed items. There was no documented response to the concerns in the minutes. Record review of the Resident Council minutes dated 10/07/13 revealed concerns including poor food taste, poor cooking of food, call bell response, and nurse aides taking too long to put residents to bed at night and get residents up in the morning. There was no documented response to the concerns in the minutes. Record review of the Resident Council minutes dated 11/06/13 revealed concerns including call	F 244		

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F 244	Continued From page 21 bell response, laundry not being returned to the correct resident, nursing taking too long to give out medications, poor food taste and poor cooking of food. There was no documented response to the concerns in the minutes. Record review of the Resident Council minutes dated 12/09/13 revealed concerns including call bell response, staff taking too long to provide care, and poor food taste. There was no documented response to the concerns in the minutes. When asked for the name of interviewable residents who regularly attended the facility's resident council meetings, the Director of Nursing (DON) provided the names of Residents #31, #68, and #104. Interview with Resident #68 on 01/10/14 at 11:31 AM revealed she felt the same concerns were discussed at every resident council meeting and nothing changed. Resident #68 stated she was never given anything in writing about the concerns she had expressed and no staff member had ever come to her to discuss her concerns. Resident #68 stated she had stopped attending the Resident Council meetings because she felt it didn't help to express concerns and the facility staff wasn't going to make changes. Interview with Resident #31 on 01/10/14 at 11:50 AM revealed she had complained at every resident council meeting about how long it took for the nurses to come help when she called for help. When asked if her concerns had been responded to, she stated at each meeting she was asked again if nurses were taking too long and sometimes she told them "yes" and	F 244	Resident #68 was at the last resident council meeting in January 2014. Resident's concerns were discussed with her about her bedpan use. 1) Response was written on the Resident Council Meeting notes. 2) Administrative Nurse assigned to Hall Rounds will follow-up with resident about concerns. Resident #31 was spoken to about her concerns and the lack of timely response when she called for help. 1) The Charge Nurses are speaking with resident daily asking her if she has had the response to her needs that she expects. 2) Response to her needs are documented in the Nursing Notes. 3) Administrative Nurse assigned to Hall Rounds will check daily response time	2/6/2014

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	345246	A. BUILDING _____ B. WING _____	C 01/12/2014

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F 244	Continued From page 22 sometimes she told them "no" . Resident #31 stated no staff had ever come to talk to her about how long the nurses were taking or what they were going to do about it. Resident #31 stated she had also complained about food at almost every Resident Council meeting and the Dietary Manager (DM) said she would make changes but never did. Interview with Resident #104 on 01/07/14 at 2:40 PM revealed she felt angry because the activity director that used to work at the facility would listen to the resident council's concerns and would come back to the residents and tell them what was being done about them. Resident #104 said since the new activity director came, the residents complained and nothing was done. Resident #104 stated she had stopped attending the resident council meetings because she felt being a resident who was willing to talk about her concerns didn't fit in that facility anymore. When asked if any staff had come to talk to her about not attending the Resident Council meetings anymore, Resident #104 stated she didn't think anyone had noticed she had stopped going. Interview with the Activities Director (AD) on 01/08/14 at 10:45 AM revealed at each Resident Council meeting, she asked the residents if the issues from the previous meeting had been resolved. The AD stated she wrote notes to department heads to notify them of concerns that had been brought up during the meeting. The AD stated she did not document concerns from the residents on grievance forms and she did not document responses to the concerns from the department heads. The AD further stated she was aware that some of the residents felt the issues they had concerns about had not changed	F 244	to resident needs and will document on Hall Rounds sheets daily.	2/6/2014
			Resident #104 was discharged home To correct the deficient practice of facility failure to act upon concerns raised by the Resident Council the following action plan was implemented: 1) The Activities Director will document on Grievance Forms any concerns voiced in the Resident Council Meeting. 2) Minutes of the Resident Council meeting will be distributed to the Administrator, Assistant Administrator, Director of Nursing and all Department Managers. 3) Grievance Forms will be forwarded to the pertinent Department Manager for follow-up of resident concerns. 4) The Department Manager will discuss residents concerns with them and document findings and action taken on the Grievance Form. 5) The Department Managers will forward the completed Grievance Form to the facility Social Worker to check response and any further follow-up needed. 6) Grievance Forms will be kept on file in the Social Workers Office.	1/24/2014

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F 244	Continued From page 23 and some residents had stopped attending the Resident Council meeting because they felt it wasn't helping to express their concerns. Interview with the Social Worker (SW) on 01/08/14 at 2:15 PM revealed she was verbally told about concerns from the activity director after resident council meetings but she did not document the concerns as grievances or document any responses she made to them. SW stated she met with the administrator and other department heads each morning to discuss resident concerns that had been brought to their attention. SW stated when she was made aware of a resident concern that involved social work, she met with the resident or resident's family directly to resolve the concerns. SW stated she was not routinely given a copy of the Resident Council minutes but felt certain she was aware of resident concerns in the facility, as the administrative team met on them daily. Regarding the specific concerns from the resident council minutes reviewed, SW stated she was aware of some of the concerns and was under the impression the residents making the concerns had been met with to resolve the issues. SW stated she did not have documentation that the issues had been resolved. Interview with the Director of Nursing (DON) on 01/10/14 at 10:02 AM revealed she had been verbally told of the concerns from resident council meetings and had been doing her best to hold staff trainings regarding the concerns to educate the staff in those areas. The DON said she felt it was more efficient to train all staff on issues the residents were concerned about rather than try to resolve these issues one staff person at a time. The DON stated she did not document concerns	F 244	7) Grievance Reports will be discussed in the Daily Stand-Up Meeting for any further follow-up or action needed and documented in the minutes of the meeting. 8) The procedure for follow-up of Grievances from the Resident Council was inserviced to all Department Heads in the Daily Stand-Up Meeting 9) QA/PI Coordinator will forward the minutes of the meeting to the Administrator, Assistant Administrator and Administrative Team by e-mail daily 10)The facility Social Worker will compile report and present to the monthly QA/PI Committee for compliance and trending related to resident concerns voiced. 11) The facility Administrator and/or designee will oversee the QA process to ensure deficient practice does not reoccur.	1/17/2014 2/6/2014

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F 244	Continued From page 24 from the resident council on a grievance form nor did she document her responses to the concerns on a grievance form. The DON showed staff meeting attendance sheet for the October 25, 2013, where it was documented she discussed the following concern item from resident council: call bell response time. The DON stated she understood the DM resolved the food issues brought up at the Resident Council meetings at the meetings. DON also stated the laundry concerns would be resolved by the maintenance director, but he was also not documenting the responses to concerns. The DON stated that the facility did not currently have a system to ensure each resident concern was documented, assigned to the appropriate person, and responded to in a timely manner. Interview with the Dietary Manager (DM) on 01/11/14 at 9:02 AM revealed she attended most resident council meetings and spoke directly with residents about their food concerns at the meeting or met with the residents later to resolve the food issues. The DM stated she did not get a copy of resident council minutes. The DM further stated she did not have a system in place to document the responses to the residents' food concerns. When shown the specific food concerns documented in the resident council minutes reviewed, the DM stated she had not been made aware of those specific concerns and had not followed up with the residents regarding those concerns.	F 244		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246	To address the cited deficient practice that the facility failed to make drinking water accessible for 2 of 2 residents and failed to provide a raised toilet seat wide enough for the resident's hips for 1 of 1 resident.	

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F 246	Continued From page 25 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews the facility failed to make drinking water accessible for 2 of 2 residents and failed to provide a raised toilet seat wide enough for the resident's hips for 1 of 1 resident reviewed for accommodation of needs. (Residents #156, #96, and #152). The findings included: 1. Resident #156 was admitted to the facility on 12/17/13 which included lung disease, kidney disease, dementia, malnutrition, depression, heart disease and a history of urinary tract infections. The admission Minimum Data Set dated 12/24/13 indicated Resident #156 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #156 required extensive assistance by staff for activities of daily living including transfers and ambulation and extensive assistance with 2 plus staff for eating. During an observation on 01/09/13 at 11:08 AM Resident #156 was sitting in a wheelchair next to the right side of his bed and there was no water pitcher or cups observed in his room.	F 246	Corrective action was taken for the residents affected and for those residents having potential to be affected by the same deficient practice Residents reviewed for accommodation of needs were #156, #96, #152 Resident #156 deficiency was immediately corrected with accessibility of water, cup and straws on bedside table within reach Resident #156 was discharged home with daughter on 1/14/2014	1/9/2014

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F 246	Continued From page 26 During an observation on 01/09/14 at 2:26 PM Resident #156 was lying on top of his bed and the overbed table was pushed up against the wall across from the foot of his bed and was not within reach. A water pitcher was sitting on top of overbed table partially filled with water but there were no cups or straws. During an interview on 01/09/14 at 2:30 PM Resident #156 stated he could not get up out of bed to get to his water pitcher because it was over next to the wall and he couldn't walk without help. He further stated sometimes his mouth was dry and he was thirsty and he would like to have a drink of water if he could get to it. Resident #156 also stated he could hold a cup and drink from it without any problems and did not need for anyone to help him do that. During an observation on 01/10/14 at 2:29 PM Resident #156 was sitting in his wheelchair on the right side of his bed and a water pitcher was sitting on the overbed table at the foot of his bed but was not within his reach. There were no cups or straws observed in the resident's room. During an interview on 01/11/14 at 9:06 AM Nurse Aide (NA) #8 explained residents were supposed to have a water pitcher and the pitchers were filled with ice and water a couple of times a day unless a resident did not want water or ice. She stated they had plastic cups available and they got straws from the nurse or from the nutrition room. She further stated she did not know why Resident #156 did not have cups or straws on the overbed table with his water pitcher and the overbed table should be placed where he could reach it but staff probably got busy and just forgot. She explained Resident #156 ate and	F 246		

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F 246	Continued From page 27 drank fluids good and could drink from a cup or could drink from a straw without any staff assistance if it was within his reach. During an interview on 01/11/14 at 9:41 AM Nurse #10 explained nursing staff filled water pitchers with ice and water twice a day and the water pitcher was supposed to be next to the bed so the resident could get to it. She stated she had noticed Resident #156's overbed table was usually located at the foot of the bed or against the wall and confirmed Resident #156 could not reach it if it was not next to him. She further stated and cups and straws should be placed next to the water pitcher because Resident #156 was able to drink from a cup if he could reach it. During an interview on 01/10/14 at 9:47 AM the Director of Nursing (DON) stated there had to be cups available for residents to be able to pour water into a cup from the water pitcher. She stated straws did not work in the water pitchers as the large plastic straws molded and a regular straw was too short. She stated it was her expectation for staff to pour water into cups and offer fluids to residents anytime the staff was in the residents' rooms. The DON reiterated there should be a cup for the residents to drink from. 2. Resident #152 was admitted to the facility on 12/29/13 with diagnoses which included Alzheimer's disease. Resident #152's Admission Minimum Data Set (MDS) dated 01/09/14 assessed her as having severe cognitive impairment. The MDS further assessed Resident #152 as needing extensive assistance for transfers and needing limited assistance of two people for eating.	F 246	Resident #152 being observed on a daily basis by the Administrative Hall Rounds Nurse for C Hall, to ensure water pitcher is available and accessible. Resident #152 is offered fluids during meal and snack times as she roams around the facility following meals and in-between rest periods.	

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F 246	Continued From page 28 An observation was made on 01/09/14 at 9:35 AM of Resident #152 lying in bed. Resident #152 was in a low bed with a bed alarm clipped to her shirt. Resident #152 did not have any fluids within her reach and her water pitcher was observed across the room on the television table. There was not an over the bed table in Resident #152's room. On 01/09/14 at 9:35 AM Resident #152 stated "I am so thirsty. My mouth is so dry." During this interview with much encouragement Resident #152 rang her call bell. On 01/09/14 at 9:40 AM an observation was made of Nursing Assistant (NA) #1 coming into Resident #152's room. Resident #152 stated to NA #1, "I am so thirsty can you get me some water?" NA#1 waked across the room and picked up the water pitcher from the television table and brought it to the resident. The water pitcher of approximately 32 ounces was full with ice and water. She attempted to hand it to the resident but the water pitcher did not have a straw just a slit in the top. NA #1 left the room and returned with a small plastic cup and poured some water for the resident. Resident #152 was observed to drink water from the small plastic cup and stated, "Oh that is so good." On 01/09/14 at 9:44 AM an interview was conducted with NA #1. NA #1 stated Resident #152 could not have reached her water pitcher. She stated the water pitchers are filled by 3rd shift nursing assistants. She stated Resident #152 had not had a bedside table since she was admitted and therefore had not had access to her water since admission. She further stated the reason there was not a bedside table in her room	F 246		

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F 246	Continued From page 29 was because there had not been a resident in that bed prior to her admission. On 01/09/14 at 5:12 PM a telephone interview was conducted with NA #3 who had worked 3rd shift and had filled the water pitchers. NA #3 stated he did recall filling Resident #152's water pitcher that morning. He stated he usually puts water pitchers on residents' over the bed table. He stated that Resident #152 did not have one which in that case he tries to sit the water pitcher on the resident's night stand. He stated he could not remember where he had sat Resident #152's water pitcher. On 01/10/14 at 9:47 AM an interview was conducted with the Director of Nursing (DON). The DON stated there has to be cups for the residents to be able to pour water into a cup. She stated straws do not work in the water pitchers as the large plastic straws become molded and a regular straw is too short. She stated staff should be pouring water into cups and offering fluids to residents anytime the staff is in the residents' rooms. The DON reiterated there should be a cup for the residents to drink from. 3. Resident #96 was admitted to the facility 05/13/13 with diagnoses which included hypertension, diabetes and dementia. Review of Resident #96's most recent Minimum Data Set (MDS) dated 11/18/13 assessed him as having severe cognitive impairment. The MDS further assessed Resident #96 as needing extensive assistance with transfers and toileting. On 01/09/14 at 11:04 AM an interview was conducted with Resident #96. He stated sharing	F 246	Resident #96 was discharged to hospital on1/24/2014 with anticipated return to the facility. The toilet seat in place was evaluated for appropriate size by the Charge Nurse. Maintenance installed a raised toilet seat to accommodate resident #96. 1) Inservice was held for all Nursing Staff which included RN's, LPN's, C.N.A.'s and Medication Aides on Accommodation of Needs with a focus on staff to ensure accessibility of water pitchers and cups and straws available for water consumption.	1/12/2014 2/5/2014

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F 246	Continued From page 30 the bathroom with women was not a problem for him but the toilet seat was too small and he had to squeeze down on it which was uncomfortable. On 01/09/14 at 11:10 AM an observation was made of Resident #96 being toileted by Nursing Assistant (NA) #2. She assisted Resident #96 to the toilet in his bathroom. Resident #96 was seated on the toilet seat and he was squeezed between the hand rails of the toilet seat as the hand rails pressed into the side of his hips. On 01/09/14 at 11:10 AM an interview was conducted with Nursing Assistant (NA) #2. She stated staff provided Resident #96 with toileting assistance but the toilet seat was too small for Resident #96. NA #2 had not reported this to anyone. On 01/09/14 at 4:22 PM an interview was conducted with Nurse #2 who was the charge nurse. Nurse #2 stated the resident should have had a toilet seat that fit him. He stated he was not aware the toilet seat was too small. He stated if staff made a request for a raised toilet seat then maintenance would have provided the seat. He stated after the raised seat was provided it should have been assessed by nursing staff to see if it was appropriate. An interview was conducted on 01/10/14 at 9:47 AM with the Director of Nursing (DON). She stated the toilet seat in Resident #96's bathroom was put in for a female resident who shared the bathroom. She stated the seat should have been assessed to make sure it was an appropriate fit for Resident #96.	F 246	2) Daily Hall rounds will be completed by the Administrative Nursing Hall Rounds Team or designee in absence of a team member with reports for each hall given to the Hall Nurses, Charge Nurse and Director of Nursing for follow-up as evidenced by completion of Daily Nursing Round Sheets. 3) The Director of Nursing will make daily rounds in the afternoon hours and follow-up on reports. 4)To ensure the standard is monitored and action taken as indicated, daily audits x 4 weeks; weekly audits x 4 weeks and then monthly thereafter by the Administrative Nursing Hall Rounds Team. 5)Reports of rounds will be discussed in the Daily Stand-up Meeting if further issues of non-compliance is identified. 6)Results of Audits will be made a part of the Nursing QA/PI monthly report to the QA/PI Committee. Plans of Action will be approved or modified following presentation the QA/PI Committee with follow-up to ensure the interventions are effective and substantial compliance is maintained. 7) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency. 8) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE	F 247		

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F 247 SS=E	Continued From page 31 ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to notify two of three residents of a room or roommate change (Residents #60 and #31). The findings include: 1. The latest Minimum Data Set (MDS) for Resident #60 dated 11/01/13 assessed the resident as moderately cognitively impaired with signs of delirium, able to understand and make himself understood. Interview with family member of Resident #60 on 01/07/14 at 12:17 PM revealed they had been told by staff after Resident #60 was moved that he had to be moved because he needed a different kind of bed. The family member stated they had been confused about the move, however, because the resident had been moved with the same bed he had had in the previous room. The family member stated they didn't understand why the resident had to be moved at all when he was already easily confused and why the resident or family had not been told so they could assist Resident #60 with the change. Interview with Social Worker (SW) on 01/10/14 at 12:19 PM revealed she recalled speaking to Resident #60's family regarding his need to move	F 247	To address cited deficiency of failure to notify two of three residents of a room or roommate change and the potential for other residents to be affected by the same deficient practice, the following corrective plan was implemented: 1) Social Worker implemented further discussions with resident #60 family member to address concerns about the residents room change. 2) The family member voiced understanding and had no further questions or concerns.	1/14/2014

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F 247	Continued From page 32 because Resident #60 had had several falls, needed a high-low bed, and high-low beds were only on other units. SW stated he had to be moved to be able to be on a safer bed that would prevent falls. SW stated she was unaware that the family of Resident #60 was confused regarding the reason for his move. Interview with the Director of Nursing (DON) on 01/10/14 at 10:02 AM revealed she was aware that Resident #60 had the same type of bed in his previous room as he had in his new room. The DON stated although the Administrator had made a rule that all residents with high-low beds had to reside on the A, B, or C hall, the DON had gotten special permission for Resident #60 to stay on the D hall with his high-low bed. The DON said she didn't know why Resident #60 had been moved, but her expectation was that any resident experiencing a room change for any reason would receive advance notification of the upcoming change and residents involved in changes would have notifications documented in their medical records. 2. The latest Minimum Data Set (MDS) for Resident #31 dated 11/15/13 assessed the resident as cognitively intact and able to understand and make herself understood. Interview with Resident #31 on 01/07/14 at 2:32 PM revealed she found out she was getting a new roommate when staff wheeled the woman into her room in her wheelchair. Resident #31 stated she felt very angry because she wanted to feel she had a little control over her living situation and with the staff not telling her about getting a new roommate, she felt they could make changes without telling her anytime they wanted. Resident	F 247	Social Worker met with resident #31 to discuss her concerns and resident #31 stated that she gets along well with this new roommate and has no further complaints. Resident #31 will notify the Social Worker if any problems or issues arise.	1/14/2014

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F 247	Continued From page 33 #31 stated her previous roommate had told her she was thinking of moving to another room, but no one had told her when and if it was going to happen until she returned to her room and found her roommate and belongings gone. Review of Resident #31's medical record revealed no notification of roommate change regarding her current roommate. Interview with Social Worker (SW) on 01/10/14 at 12:19 PM revealed she tried to have new roommates meet each other whenever possible but she cannot always speak for specific situations. SW stated she does not have documentation of resident acknowledgement of notification of roommate change. Interview with the Director of Nursing on 01/10/14 at 10:02 AM revealed she expected residents experiencing a room change or roommate change for any reason will receive advance notification of the upcoming change and residents involved in changes will have notifications documented in their medical records.	F 247	To resolve the cited deficiency of notification of room or roommate change the following action was taken: 1) A Room Change Analysis sheet has been put in place. 2) This will be completed when a room change and/or roommate change is to take place. 3) The Room Change Analysis sheet includes a check list of notifications made to residents involved and their family members/responsible party. 4) Notification will be documented on the Room Change Analysis form and in the resident's medical record. 2/1/2014 5) Any issues and/or problems expressed by the residents will be discussed in the Daily Stand-Up Meeting and action taken to resolve any issues or problems identified and reflected in the Minutes of the Daily Stand-up Meeting. 2/10/2014 6) Minutes of the Daily Stand-up meeting are e-mailed to the Administrator and Administrative Staff on a daily basis for any further follow-up or action needed. 7) Social Worker will discuss resolvement of issues and/or problems with the resident and/or family member or responsible party and document in the residents medical record on a weekly basis. 8) A report of Room/Roommate changes will be presented to the QA/PI Committee on a monthly basis to ensure substantial compliance is maintained and any further action to resolve any system or procedural issues is identified.	
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 resident observation, record review	F 248 F248		

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F 248	Continued From page 34 and staff interviews the facility failed to provide one on one activities as indicated by the care plan to a resident (Resident #66) that was dependent on staff for 1 out of 3 residents reviewed for activities. Findings included: Resident #66 was admitted to the facility on 03/04/13 with diagnosis including heart disease, diabetes, and Alzheimer's disease. Resident #66's most recent quarterly Minimum Data Set (MDS) dated 12/11/13 assessed him as being severely cognitively impaired. Further review of the MDS revealed Resident #66 was understood, understood others, and was dependent on staff for bed mobility and transferring. The care plan most recently dated 09/12/13 indicated resident was to have frequent in room visits for socialization and to be escorted to and from activities of interest. Record review of assessment by activities director 03/13/13 indicated resident enjoyed sports, music, spiritual and religious activities, going outdoors, watching TV. The assessment also indicated Resident #66 preferred to participate in scheduled activities in the afternoon. Activity director also documented Resident #66 enjoyed having food brought in from activities he chose to not participate in physically. Review of activity progress note dated 12/09/13 revealed resident did not attend activities at this time. Resident's chart revealed no documentation that	F 248	The cited deficiency of Activities meeting the interests/needs of each resident and failure to provide one-on-one activities as indicated by the care plan for 1 out of 3 residents and having the potential for those residents to be affected by the same deficient practice the following action plan was implemented. Resident #66 will receive in room visits daily by the Activity Director or Assistant Activity Director who will encourage the resident to participate in activities daily. 1) If the resident wishes not to attend, he will be offered in-room activities that he is able to self-direct. 2) Activity Director will train activity staff to document in the medical record correctly. 3) Activity Director will be trained on accessing activity participation data sheets by the I.T. Manager 4)All residents will be offered in-room activities such as music, reading material, crafts, writing material, cards, coloring books, movies, TV and any other activities if they are able to self-direct for in-room activities and if they are unable to attend activities or wish to stay in their room. 5) Activity Staff will document a weekly note for residents who have been provided with self-directed activities in their room. 6) Activity Staff will document on the Activity Flow sheet on a daily basis if resident received in-room visit, any self-directed activities and and any schedules activities they attended. 7) Audits will be completed by the Medical Record Clerk daily x 1 week, weekly x 4 weeks and monthly thereafter 8} Any issues/problems identified will be discussed at the Daily stand-Up Meeting for any action needed.	2/6/2014 2/6/2014 2/6/2014 2/6/2014

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F 248	Continued From page 35 resident was receiving in room visits or escorted to and from activities of interest as indicated in the plan of care. A five-minute resident observation on 01/06/14 at 3:59 PM revealed resident #66 lying in bed, alone in room. Lights and television were off in room. Interview with family member of Resident #66 on 01/07/14 at 10:52 AM revealed he was always laying in bed alone when she arrived weekly to visit with him at various times of day. Resident #66's family member stated she had asked staff repeatedly to get him up into his wheelchair at least one a day and to assist him in engaging with other people but it hadn't happened. Resident #66's family member said she visited Resident #66 at least once a week and hadn't seen Resident #66 out of bed in over 2 months. The family member stated she was very worried he had lost the ability to sit up comfortably and to enjoy being around other people. A five-minute resident observation on 01/07/14 at 11:30 AM revealed resident #66 lying in bed, alone in room. Lights were on but television was off in room. A five-minute resident observation on 01/07/14 at 3:26 PM revealed resident #66 lying in bed. Resident's roommate was also in bed in room, but they were not observed talking during the observation. The lights were on but television was off in room. A five-minute resident observation on 01/08/14 at 9:45 AM revealed resident #66 lying in bed, alone in room. The lights and television were off in room.	F 248	Minutes of the meeting will be e-mailed to the Administrator and Administrative staff for any further recommendations or action needed. 9) Audit results will be given to the Activities Director for tracking and trending and will be made a part of the Activities QA/PI Report to the monthly QA/PI Committee. 10) Report on in-room activities will be made a part of the Activities QA/PI Report to the monthly QA/PI Committee until substantial compliance is maintained. 11)The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	

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Interview with Activity Director (AD) on 01/08/14 at 10:45 AM revealed attendance was taken at each activity by checking off resident's name from list of residents. AD stated data was entered into computer each day showing activities each resident participated in. When asked how she assessed decline in specific resident's activity participation, AD stated she knew the residents in the facility and noticed when one stopped participating in activities as much. AD stated she did not know how to print out activity participation data by resident, showing the participation amount for a specific resident; she completed that task subjectively from memory. When asked about Resident #66, AD stated either she or the assistant activities director conducted in-room activities every day for each resident who didn't like to engage in out of room activities, including Resident #66. AD stated she didn't have data showing the daily in-room activities. AD stated she could not tell me which days she conducted the activities with Resident #66 and which days the assistant AD conducted the activities with Resident #66. AD also stated she had not conducted any in-room activities with Resident #66 during the week of the survey.

A seven-minute resident observation on 01/08/14 at 2:30 PM revealed resident #66 lying in bed. Lights and television in room was observed on but resident was not facing TV.

A five-minute resident observation on 01/09/14 at 9:10 AM revealed resident #66 lying in bed, alone in room. The lights and television were off in room.

A five-minute resident observation on 01/09/14 at

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F 248	Continued From page 37 4:45 PM revealed resident #66 lying in bed, alone in room. The lights were on in room but television was off in room. Interview with nurse aide #3 NA) on 01/10/14 at 6:53 AM revealed although she had worked with Resident #66 a lot since his admission to the facility in March of 2013, she had only seen him out of bed just after showers had been given to him. NA #3 stated she had never seen him participate in any activity in or out of his room. A seven-minute resident observation on 01/10/14 at 8:45 AM revealed Resident #66 lying in bed, alone in room. The lights were on in the room and the television was off in the room. Interview with Director of Nursing on 01/10/14 at 10:02 AM revealed her expectation that the activity director would record all activities attempted or refused with dates and times as well as monitor changes in participation over time for each resident. The DON further stated she expected the AD to notify her in writing when a resident had a pattern of refusing activities. The DON stated she did not know how to access activity data by resident but knew the assistant DON knew how to do this task. Interview with Nurse #5 on 01/10/14 at 10:30 AM revealed she had never seen Resident #66 engaging in any activity. Nurse #5 stated she had never seen an activity staff person involving Resident #66 in an in-room activity. Nurse #5 stated she had rarely seen Resident #66 out of his bed. A five-minute resident observation on 01/10/14 at 11:58 AM revealed Resident #66 sitting in	F 248		

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F 248	Continued From page 38	F 248		

wheelchair beside bed, alone. No TV or radio was observed to be playing.

Interview with Assistant Director of Nursing (ADON) on 01/10/14 at 2:15 PM revealed one form of activity data showed Resident #66 had participated in multiple activities each day, many conflicting with each other. When asked to explain, the ADON produced a separate activity data sheet that indicated Resident #66 had actively participated in an in-room visit with verbal response every day during the past 30 days, including the week of 01/06/14 - 01/10/14. The ADON stated she had no explanation for the inconsistency in the data. The ADON also stated there was no activity data showing the times or duration of the in-room visits, or the activity completed with the resident during the in-room visit.

A five-minute resident observation on 01/10/14 at 3:28 PM revealed Resident #66 lying in bed. Lights were on in room and television was observed on but resident was not facing television.

Interview with NA #4 on 01/10/14 at 4:06 PM revealed she had worked with Resident #66 a lot since his admission in March of 2013 and felt she knew him very well. NA #4 stated he was very easy to work with and when she asked if he wanted to do something, he was always willing to try. NA #4 stated she had never seen an activity staff person in his room or him engaging in any structured facility activity. NA #4 stated he usually is alone in his room, lying in his bed.

Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed he had never seen an activity staff

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F 248	Continued From page 39 member in Resident #66's room to do an in-room activity. Nurse #2 stated he had never observed Resident #66 engaged in any activity except for having the TV on in his room. Interview with Nurse #9 on 01/12/14 at 12:04 PM revealed she had seen Resident #66 out of bed only one time since she had started working in facility in October of 2013. Nurse #9 stated that although Resident #66 didn't appear to be motivated to participate in activities, she had found him to be easily encouraged and not argumentative when she worked with him. Nurse #9 stated she had never observed any activity staff in Resident #66's room providing in-room activities for him.	F 248		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to administer the correct dose of Valium, give Ativan as ordered prior to administering the Valium and to remain with a resident during medication administration for 2 of 2 residents reviewed for medication administration practices. (Resident #104 and #117). The findings included: 1. Resident #117 was admitted to the facility on 02/21/13 with diagnoses which included traumatic	F 281	To address the cited deficient practice of the facility failing to administer the correct dose of Valium, give Ativan as ordered prior to administering the Valium and to remain with residents during medication administration for 2 of 2 residents reviewed for medication administration practices (Resident #104 and #117), and to address any corrective action for those residents who have potential to be affected by the deficit practice, the following action plan was implemented: 1) Resident #117 was assessed for any adverse reaction from receiving the Valium before the Ativan was given. The seizure subsided without an adverse reaction and the resident returned to baseline	1/5/2014

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F 281	Continued From page 40 brain injury and convulsions. Resident #117's most recent quarterly Minimum Data Set (MDS) dated 12/02/13 assessed him as having long and short term memory loss with severe impairment for daily decision making. Review of Resident #117's care plan dated 12/2013 for potential for seizures revealed a goal of no seizure activity for the next 90 days with an intervention to administer meds as ordered. Physician orders dated January 2014, with a start date of 04/29/13, revealed an order for Ativan (a drug used for initial treatment of a prolonged seizure) 2 milligrams (mg)/ milliliter (ml) vial - give 2 mg intramuscularly as needed for seizure activity (administer once, if no relief in 20 minutes, give Valium as ordered). Physician orders dated January 2014, with a start date of 04/29/13, revealed an order for Valium (a drug used to treat a prolonged seizure) 5 mg/ml vial- if no relief from Ativan give 5 mg intramuscularly as needed for seizure if no relief from Ativan after 20 minutes. Review of the Medication Administration Record (MAR) on 01/05/14 at 8:23 AM Valium 5 mg/ml was signed as being given by Nurse #4. There was no indication on the MAR that the Ativan was administered prior to the Valium. A telephone interview was conducted on 01/11/14 at 4:10 PM with Nurse #4. Nurse #4 stated she administered the full vile of Valium to Resident #117 on 01/05/14. She stated she was sure she administered the full vile because she would have remembered wasting the other half of the vile as she would have had to have another nurse's	F 281	2) Nurse #4 was counseled in writing and reeducated on slowing down during the an emergency and taking the time to read the medication and follow the five steps of medication administration.	2/1/2014

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F 281	Continued From page 41 signature. She stated the resident was having a seizure that day. Nurse #4 stated she assumed the vile she gave was the correct amount the resident was to receive. Nurse #4 also stated she did not notice the vile contained 10 mg instead of 5 mg that was ordered. She stated the seizure was bad and it happened so fast. On 10/12/14 at 3:10 PM a later telephone interview was conducted with Nurse #4. Nurse #4 stated she should have given the Ativan intramuscularly prior to administering the Valium. Nurse #4 did not give an explanation for giving the Valium prior to the Ativan during Resident #117's seizure. An interview was conducted on 01/11/14 at 4:35 PM with the Assistant Director of Nursing. She stated Nurse #4 should have administered the correct dose. On 01/12/14 at 12:50 PM an interview was conducted with Nurse #5 who is a charge nurse. Nurse #5 stated the Ativan should have been administered prior Nurse #4 giving the Valium. An interview was conducted on 01/11/14 at 4:40 PM with the Director of Nursing (DON). The DON stated her expectation was for Nurse #4 to have given the correct dose prior to administering the medication. On 01/12/14 at 12:58 PM a later interview was conducted with the DON. She stated Nurse #4 should have administered the Ativan and waited 20 minutes to see if the seizure would stop prior to administering the Valium. 2. A review of a facility policy titled "Medications - Administration" with a revised date of 2012 indicated in part to administer oral medications and remain with resident while he/she takes the medication. Never leave a drug in resident's room.	F 281		

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F 281	Continued From page 42 Resident #104 was admitted to the facility on 06/29/12 with diagnoses which included diabetes and generalized pain. The most recent quarterly Minimum Data Set (MDS) dated 10/07/13 indicated Resident #104 had no short term or long term memory problems and was cognitively intact for daily decision making. A review of monthly physician's orders dated 01/01/14 through 01/31/14 indicated Neurontin 100 milligram (mg) capsule by mouth 3 times a day (for treatment of nerve pain associated with diabetes). A review of a medication administration record dated 01/01/14 through 01/31/14 indicated Neurontin 100 mg capsule by mouth 3 times a day at 9:00 AM; 3:00 PM and 9:00 PM. During an observation on 01/07/14 at 2:14 PM Nurse #6 walked into Resident #104's room with 1 capsule of Neurontin 100 mg in a small plastic cup and set the cup on the overbed table in front of Resident #104 and stated "now take your medication" and turned and walked to the doorway of the room. Resident #104 looked at the cup and replied "what did she say" as Nurse #6 walked through the doorway, turned to her right and walked down the hallway to a medication cart that was parked 2 doors down from Resident #104's room. Nurse #6 did not walk back to Resident #104's room to see if Resident #104 had taken the medication and continued with her medication pass to other residents. During an interview on 01/09/14 at 3:40 PM Resident #104 stated she remembered when	F 281	Resident #104 was discharged home Nurse #6 was counseled in writing and re-educated on basic medication administration of medications and review of facility policy on medication administration. To correct the identified deficit practice the following corrective plan was implemented: 1) A medication administration audit will be conducted on all halls with all nurses daily x 1 week, weekly x 4 weeks, then monthly until full compliance is maintained by the Staff Development Coordinator or designee in absence of Staff Development Coordinator 2) The Staff Development Coordinator will give a copy of all audits to the Director of Nursing and Assistant Administrator. 3) The Medication Administration audit results will be discussed in the Daily Stand-Up Meeting. 4) Deficiencies brought to the attention of the Director of Nursing will be acted on immediately and a sustainable process will be implemented with input from the Daily Stand-up Meeting participants. 5) An Inservice was given to all RN's, LPN's Medication Aides on Medication Administration by the Director of Nursing 6) The Medication Administration Accuracy Audit Report will be presented to the monthly QA/PI Committee for review until accuracy is substantially maintained. 7) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency.	1/24/2014 1/29/2014 2/6/2014

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F 281	Continued From page 43 Nurse #6 left the medication on her overbed table and confirmed she took the medication after the nurse had left the room. She explained different nursing staff had left medication on her overbed table at different times on several occasions but she could specifically remember which nursing staff had done it. She further stated she did not think it was safe for nursing staff to leave her room before she took her medications. During a telephone call on 01/10/14 at 10:47 AM Nurse #6 confirmed she left the medication in a cup on Resident #104's overbed table on 01/07/14 and walked out of the room and went back to her medication cart. She stated Resident #104 was alert and oriented and she knew Resident #104 would take the medication. She further stated since she was just in the hallway at her medication cart she didn't think it was a problem to leave the medication on Resident #104's overbed table. During an interview on 01/10/14 at 11:09 AM the Director of Nursing stated medication should never be left in a resident's room and it was her expectation when medication was administered the nurse or medication aide should stay at the bedside until the medication was swallowed. She explained medications should never be left on the overbed table and if a resident couldn't take the medication it should be taken out of the room and locked in the medication cart until the nurse or medication aide could attempt to give the medication at a later time.	F 281	8) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	To correct the cited deficiency to provide ADL for residents who are unable to carry out activities of daily living by not providing oral care for 2 out of 2 residents	

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F 312	Continued From page 44 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 observations, family interviews, staff interviews, and medical record review, the facility failed to provide oral care for 2 of 2 residents requiring assistance for activities of daily living. (Residents #48 and #152) The findings included: 1. Resident #152 was admitted to the facility on 12/29/13 with diagnoses which included Alzheimer's disease. Resident #152's Admission Minimum Data Set (MDS) dated 01/09/14 assessed her as having severe cognitive impairment. The MDS further assessed Resident #152 as needing extensive assistance of two people for hygiene. An observation was made on 01/06/14 at 3:03 PM of Resident #152. Resident #152 had noticeable food debris in her bottom teeth. An observation was made on 01/08/14 at 5:35 PM of Resident #152. She was in the dining room waiting for diner to be served and was observed to have food debris and a white film on her teeth. An observation was made on 01/09/14 at 9:35 AM of Resident #152 lying in her bed. Resident #152 is observed to have food debris and a white coating on her bottom teeth.	F 312	requiring assistance for activities of daily living and to implement corrective action for those residents having potential to be affected by the same deficient practice, the following action plan was implemented 1) Resident #152 is being given oral care twice daily am and pm. and will be documented in nurse's notes. 2) Resident #152 has been placed on high alert for need for oral care due to her need for assistance with ADL's 3) The Administrative Nurse for C Hall rounds to check daily for oral care for Resident #152 4) In the absence of the Administrative Nurse for C Hall, the Charge Nurse will check for oral care for Resident #152 5) The documentation for the 1st week of daily checks will be placed on the Nursing Hall Rounds Sheets. For all other Residents that require assistance with ADLs/oral care, the Administrative Nurse for Hall Rounds will check each resident with needs for ADL's to ensure oral care is being completed twice daily: 1) The Director of Nursing will complete afternoon rounds and will follow up on any deviations from anticipated completion of oral care on residents that need assistance and are dependent on staff for oral care	2/6/2014 2/6/2014

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F 312	Continued From page 45 On 01/09/14 at 9:44 AM an interview was conducted with Nursing Assistant (NA) #1 who was working with Resident #152 that day. She stated 3rd shift provided morning care for Resident #152 that morning. She stated morning care consists of mouth care, nail care and hair care. NA #1 stated she provided incontinence care for Resident #152. On 01/09/14 at 10:20 AM an observation was made of Resident #152 who continued to have food debris and a white film on her lower teeth. On 01/09/14 at 4:22 PM an interview was conducted with Nurse #2 who was the charge nurse. Nurse #2 stated morning care before breakfast consists of making sure incontinence care is provided as well as face washed, hair combed and teeth brushed if there is an obvious need. He stated if morning care has not been provided by 3rd shift then morning care should be provided by 1st shift. He stated mouth care should be provided at least twice per day morning and night. A telephone interview was conducted on 01/09/14 at 5:12 PM with NA #3. NA #3 stated he had worked with resident #152 on 3rd shift but he stated he did not provide care for her as she was a 1/1 assist. An interview was conducted on 01/10/14 at 9:47 AM with the Director of Nursing (DON). The DON stated it was her expectation for mouth care to be done in the morning and at night. 2. Resident #48 was admitted to the facility on 10/09/09 with diagnoses which included kidney disease, generalized muscle weakness, and	F 312	2) An in-service for all Nursing staff will include information on oral care and the expectations for completion of ADL's. 3) An inservice for all Nursing Staff by the contracted Dental hygienist was given on resident oral hygiene 4) An audit outlining compliance with oral care will be completed daily x 4 weeks; weekly x 4 weeks and monthly thereafter with daily rounds. 5) The results will be compiled by the Director of Nursing or designee, and made a part of the Nursing QA/PI report to the monthly QA/PI Committee. 6) Nursing QA/PI report on oral care will continue to be presented to the QA/PI Committee on a monthly basis until substantial compliance is maintained. 7) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency. 8) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur. Resident #48 is being given oral care twice daily am and pm. and oral care is being documented in the nurse's notes.	2/5/2014 2/13/2014

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F 312	Continued From page 46 depressive disorder. Resident #48's most recent annual Minimum Data Set (MDS) dated 10/18/13 assessed her as being cognitively intact. Further review of the MDS revealed Resident #48 required extensive assistance from staff with two plus persons physical assistance needed for personal hygiene. During an interview on 01/06/14 at 3:51 PM Resident #48 stated that unless Nurse Aide #4 (NA) was assigned to work with her; she didn't receive assistance with oral care except once every week or two. Resident #48 stated she could brush her own teeth, but not without help from staff to sit her up and set up supplies. Resident #48 opened her mouth and revealed food debris on her upper and lower teeth as well as on her tongue. Interview with Resident #48 on 01/10/14 at 11:58 AM revealed staff had assisted her to brush her teeth the night before, which was the first time they'd been brushed since Monday, 1/06/14. Resident #48 stated the care was unusual because didn't usually get her oral care completed during the week. Resident #48 stated she had been vomiting all morning, however, and felt her mouth and teeth were extremely dirty and needed care this morning. When asked to call her nurse and request oral care, Resident #48 stated she did not want to upset the staff by making special requests. Resident #48 stated she would wait until care was offered even though the taste in her mouth was bad. Interview with NA #4 on 01/10/14 at 4:06 PM revealed she completed oral care on all residents she was assigned to work with at least once daily, in the afternoon. NA #4 stated she assisted	F 312	1) Resident #48 has been placed on high alert for need for oral care due to her need for set up with toothbrush and toothpaste. Resident can brush own teeth with set up from staff. 2) The Administrative Nurse is assigned to D. Hall for daily rounds and Staff Development Coordinator to check for oral care twice daily 3) In the absence of the Staff Development Coordinator, the Charge Nurse will check oral care for resident #48 2 times daily. 4) The documentation for the first week of daily checks will be placed on Nursing Hall Round Sheets. For all other Residents that require assistance with ADLs/oral care, the Administrative Nurse for Hall Rounds will check each resident with needs for ADL's to ensure oral care is being completed 2 times daily am and pm. 1) The Director of Nursing will complete afternoon rounds and will follow up on any deviations from anticipated completion of oral care on residents that need assistance who are dependent on staff for oral care 2) An in-service for all Nursing staff will include information on oral care and the expectations for completion of ADL's. 3) Any issues with oral hygiene will be discussed at the Daily Stand-up Meeting for any further action to be taken 4) Minutes the meeting will be e-mailed to the Administrator for any further recommendations or action needed. 5) An audit outlining compliance with oral care will be completed daily x 4 weeks, weekly x 4 weeks and monthly thereafter with daily rounds 6) The results will be compiled by the Director of Nursing or designee and make a part of the Nursing QA/PI to the monthly QA/PI Committee and will continue to be presented on a monthly basis until substantial compliance is maintained.	2/6/2014 2/6/2014 2/5/2014

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F 312	Continued From page 47 Resident #48 to clean her mouth and teeth frequently on days she was assigned to work with her and she understood it was very important to Resident #48 to have a clean mouth and clean teeth. NA #4 stated every time she set up the supplies for Resident #48 to brush her teeth, Resident #48 expressed her appreciation for the NA remembering, and told the NA she hadn't had oral care since the last time the NA was assigned to work with her. NA #4 stated she frequently encouraged Resident #48 to ask other staff to assist her with oral care but she didn't think Resident #48 ever did. NA #4 stated she could tell Resident #48's teeth were dirty because she had food debris on her teeth and tongue each time she was assigned to work with her. Interview with Director of Nursing (DON) on 01/10/14 at 10:02 AM revealed her expectation that residents receive oral care assistance at least twice daily: first thing in the morning and in the evening and as needed. Follow up interview with DON on 01/10/14 at 11:47 AM revealed she had addressed the need for staff to provide oral care at least three times daily: morning, after lunch, and in the evening, during a staff meeting on 10/25/14. DON stated instructing staff to provide oral care twice daily had not been enough to provide adequate oral care, and they needed to be instructed to provide the care three times each day for each resident. DON stated she was aware there had been reports of residents not getting adequate oral care. Observation of NA #6 providing morning care for Resident #48 on 01/11/14 at 9:30 AM revealed no oral care provided.	F 312	7) The Director of Nursing and/or designee will meet the requirements of the above correction plan for the cited deficiency. 8) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	

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F 312	Continued From page 48 Interview with NA #6 on 01/11/14 at 9:50 AM revealed NA had not provided oral care that day for Resident #48 and was unaware of the level of assistance required by Resident #48 to brush teeth. NA #6 stated she brushed teeth daily for all residents for which she provided care, but couldn't ' Ft remember when she had last provided oral care for Resident #48. NA #6 agreed that Resident #48 had food debris on teeth and gums and needed oral care. NA #6 had no explanation for why she had not yet provided oral care for Resident #48. Interview with Nurse #2 on 01/11/14 at 4:41 PM revealed he was aware that daily oral care had not been provided to residents in the facility and he was not happy with the lack of oral care that had been provided to residents by NAs and nurses. Nurse #2 stated he was trying to make changes so that residents would get daily oral care and had completed rounds that afternoon to remind NAs to provide oral care on each of their residents.	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.	F 315	To address the cited deficiency for the facility failure to have a medical justification for the use of urinary catheter for 1 of 1 sampled residents with a catheter for resident #153 and residents having potential to be affected by the same deficient practice, the following action plan was implemented.	

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F 315	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to have a medical justification for the use of a urinary catheter for 1 of 1 sampled resident with a catheter. (Resident # 153). The findings included: Resident #153 was admitted to the facility on 01/03/14 with diagnoses which included diabetes and wounds. There was no admission Minimum Data Set available but a nursing admission assessment dated 01/04/14 indicated Resident #153 had short term memory problems and had modified independence with daily decision making with some difficulty in new situations only. The nursing admission assessment also indicated Resident #153 required assistance with activities of daily living and had a urinary catheter. A review of physician's orders dated 01/03/14 indicated catheter care every shift and change catheter as needed. There was no documentation found in the resident's medical record to indicate a diagnosis for the use of a urinary catheter. During an observation on 01/06/14 at 12:30 PM Resident #153 was in bed and a urinary catheter bag was hanging from the bed frame near the foot of the resident's bed. During an observation on 01/07/14 at 10:04 AM Resident #153 was in bed and a urinary catheter bag was hanging from the bed frame near the foot of the resident's bed.	F 315	1) Resident #153 urinary catheter was removed after order obtained from PA to M.D. to remove catheter. No diagnosis was obtained by urologist to justify long-term use of urinary catheter. 1/28/2014 2) An audit of all resident's with catheters was completed by the Assistant Director of Nursing to ensure supporting diagnosis for residents catheter usage. 2/04/2014 3) All Nursing Staff in-serviced on reason to obtain diagnosis to support urinary catheters and the importance of obtaining a discontinuation order if there is no diagnosis to support long-term use of catheter. 2/05/2014 4) The Charge Nurse will evaluate each new admission and if an indwelling urinary catheter is present, the Charge Nurse will determine if there is a diagnosis to support the continued use of the catheter. If no justification is present, the M.D. will be contacted to discontinue catheter order.	

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F 315	Continued From page 50 During an interview on 01/07/14 at 10:58 AM Nurse #12 stated Resident #153 was admitted on 01/03/14. She stated she thought the reason Resident #153 had a catheter was because of incontinence but she was not sure. Nurse #12 looked in Resident #153's medical record and stated she could not find a reason for the catheter documented but found a note that was not signed in the medical record that indicated to obtain a diagnosis for catheter. She stated she was not sure who wrote the note. During an observation on 01/08/14 at 10:04 AM Resident #153 was in bed and a urinary catheter bag was hanging from the bed frame near the foot of the resident's bed. During an observation on 01/09/13 at 3:20 PM Resident #153 was in bed and a urinary catheter bag was hanging from the bed frame near the foot of the resident's bed. During an observation on 01/10/14 at 2:26 PM Resident #153 was in bed and a urinary catheter bag was hanging from the bed frame near the foot of the resident's bed. During an interview on 01/10/13 at 2:32 PM Nurse #11 who was the nurse assigned to the care of Resident #153 stated she was not sure why Resident #153 had a urinary catheter but she knew she was admitted with it a couple of days ago. She confirmed she had not talked with a physician and had not asked for a diagnosis for the catheter. During an interview on 01/10/14 at 5:27 PM the Director of Nursing stated she thought nursing	F 315	5) The policy and procedure for indwelling urinary catheters will be revised to support process of eliminating unnecessary catheters on admission 6) The Administrative Nurses assigned to each hall will include indwelling catheter checks on their daily rounds in the am. 7) The Director of Nursing will complete rounds in the afternoon and follow-up on any issues identified from earlier rounds. 8) The Director of Nursing will include unnecessary indwelling catheters as a round item and will give report on findings to the Daily Stand-Up meeting 9) An audit will be conducted by the Charge Nurse weekly x 8 weeks and monthly thereafter to assess for unnecessary indwelling urinary catheters. 10) Director of Nursing or designee will present audit results to the monthly QA/PI Committee until compliance with this deficient practice is consistently maintained. 11) The Director of Nursing and/or designee will meet the requirements of the above correction plan or the cited deficiency. 12) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	2/6/2014

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F 315	Continued From page 51 staff were checking with the physician about getting Resident #153's catheter discontinued. She further stated it was her expectation for residents who had catheters to have a medical diagnosis for justification of the catheter and she usually had to do the follow up with the physician to either get the catheter discontinued or to get the medical justification for it.	F 315		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to provide a wheelchair securement system that would prevent a resident from turning over in her wheelchair during transport for 1 of 4 residents reviewed for accidents. (Resident #85) Immediate Jeopardy began on 11/15/13 when it was reported to the Assistant Administrator that the straps securing wheelchairs in all three facility transportation vehicles were frayed and worn. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with	F 323	The cited deficiency for the facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents was addressed and action plan implemented. Action Plan to correct the cited deficiency that the facility failed to provide a wheel-chair securement system that would prevent a resident from turning over in wheelchairs during transport was implemented: 1) Specialized Transport vehicles #2 White Van and #3 Grey Van were taken out of service for completion of the installation of the strapping and latching/rachet system. 2) The installation of the specialized Transport vehicle #2 - White van was completed. 3) The Specialized Transport vehicle #3 Grey Van remained out of service until the strapping and latching/rachet system was complete. 4) The #1 Specialized Transport Vehicle White Bus remained out of service until all transporters were educated on the	1/10/2014 1/16/2014

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F 323	Continued From page 52 potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. The findings included: Resident #85 was admitted to the facility on 10/09/13 with diagnoses of diabetes, kidney failure and non-Alzheimer's dementia. A review of the admission Minimum Data Set (MDS) dated 10/19/13 specified Resident #85 had short and long term memory impairment and was moderately impaired in cognitive skills for daily decision making. Resident #85 required extensive assistance with transfers, used wheelchair for mobility and received dialysis three times per week. Nursing note dated 11/15/13 at 10:50 AM revealed that the facility was notified by Transporter #1 that while en route to dialysis with Resident #85 in the facility van, her wheelchair tipped over due to a strap securing her wheelchair coming loose. Transporter advised the facility that Resident #85 denied any injury. The facility instructed the transporter to have the dialysis nurse assess the resident for any injuries and to follow up with the hall nurse upon return to facility. The transporter verbalized understanding. Review of nurse's note dated 11/15/13 at 12:30 PM revealed a call was received from the dialysis nurse stating that Resident #85 did not appear to have any injuries related to the fall in the van but Resident #85 did not want to complete dialysis and wished to return to the facility. The hall nurse was notified and the Transporter #1 was advised to pick resident up at approximately 2:00 PM.	F 323	correct usage of the wheelchair safety equipment. The SURE-LOK training video and worksheet pre-trip check list and return demonstration of competency was used for this training. 5) All Transporters were also inserviced on basic first aide and instructions on when to call 911. Transporters were issued with facility owned cell phones to facilitate emergency contact. 6) All Transporters will complete a safety check list before entering vehicles into daily service and Environmental/ Safety Director will monitor compliance with daily inspections evidenced by review of the safety check list with the transporters and will forward a copy of the safety check list to Administration. 7) All Transporters were not allowed to transport residents until they were all educated and demonstrated competency 8) Any identified issues with the specialized transportation vehicles will be discussed with Administration immediately and corrective action taken before allowing the specialized transportation vehicles to be put into service. 9) Any issues identified and corrective action taken will be discussed in the daily stand-up meeting. 10) All transportation issues will be reviewed by the Safety Committee members on an ongoing basis via memorandum and/ or e-mail and in the monthly Safety Committee Meeting and in called meetings as need arises 11)Transportation citation was reviewed in both Safety Committee Meeting and QA/PI Committee	1/12/2014 1/12/2014 1/12/2014 1/12/2014 1/12/2014 1/30/2014 1/31/2014 1/23/2014

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F 323	Continued From page 53 Review of the Resident Incident Report dated 11/15/13 at 10:50 AM revealed that while en route to dialysis in the facility van Resident #85 tipped over in wheelchair due to a strap securing her wheelchair coming loose. There were no injuries reported. Review of Camelot Manor Nursing & Rehab Facility Employee Verbal Consultation report dated 11/15/13 revealed handwritten notations from the Assistant Administrator regarding an explanation of circumstances related to the van incident. The report indicated Resident #85 tipped over in Bus #3 (facility transportation vehicle) when she rocked the wheelchair back and forth and caused the straps securing the wheelchair to the bottom of the van to loosen. The action taken was to have the mechanic order a more suitable latching system for all facility transportation vehicles. The plan of correction was for an employee to ride along with the transporter to ensure straps were secure until new straps/latching systems were installed. This document was signed by Transporter #1 and the Assistant Administrator on 11/15/13. During an interview with Resident #85 on 01/09/14 at 4:45 PM she stated she was en route to dialysis with Transporter #1. She stated Transporter #1 took the turn a little too fast and she turned over in her wheelchair in the van. Resident #85 reported she did not receive any injuries from the fall. Interview with Transporter #1 on 01/10/14 at 8:30 AM revealed he transported Resident #85 to dialysis on 11/15/13 and while en route he made a left turn and the resident's wheelchair tipped over. He stated he had informed the Assistant	F 323	12) All safety reports concerning the transportation of residents will be reviewed in the Safety Committee on a monthly basis to ensure action has been taken and any transportation issues have been resolved and monitoring is ongoing. 13) Environmental/Safety Director will present report on Safety Committee findings, action taken and resolvement of any issues on on transportation to the QA/PI Committee on a monthly basis. 14) The Administrator and/or designee, will oversee he systemic process to ensure that the deficit practice does not reoccur.	1/23/2014 1/23/2014

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Administrator that the straps securing the wheelchair to the bottom of all three facility transport vehicles would slip and loosen during transport in August 2013. Transporter #1 reported that after he informed the Assistant Administrator of the straps slipping in August 2013 the facility purchased new straps of the same type as the old frayed straps for the facility transportation vehicles. He stated there was no system put in place to monitor the wear of the replacement straps.

Transporter #2 was interviewed on 01/10/14 at 10:00 AM. He stated he had informed the Assistant Administrator of straps securing wheelchairs in all 3 of the facility transportation vehicles were worn and frayed and would become loose during transport in August 2013. Transporter #2 stated the facility used the 4 Point Wheelchair Tie-Downs that connect to the wheelchair and secure them to the floor of the wheelchair van or bus. A total of 4 points are required; two in the front and two in the back, and are positioned to provide front-to-back and side-to-side stability. Transporter #2 reported the facility purchased new straps of the same type of material to replace the worn straps for all 3 facility transport vehicles. He stated there was no system put in place to monitor the wear of the new straps that he was aware of.
During a follow up interview on 01/10/14 at 2:37 PM with Transporter #2, he stated that after the incident with Resident #85 on 11/15/13 a second staff member was assigned to ride along on all transports to observe for loosening straps that secured the wheelchair to the bottom of the van until a new latching system could be installed in all 3 facility transport vehicles. He explained if the straps became loose the second staff member

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should have the driver stop the van and readjust/tighten the straps to secure the wheelchair. Transporter #2 stated he was not aware of a time when the second staff rider had to have the van driver pull over to tighten the straps that secured the wheelchair to the bottom of the van. He stated the second staff member was assigned to ride in the facility transportation vehicles until White Bus #3 was installed with the new securement system on 11/21/13. He further stated all 3 facility transport vehicles remained in use after the incident on 11/15/13.

Observation on 01/10/14 at 4:30 PM revealed Transporter # 3 had Gray Van #1 running in front of the facility and was getting ready to leave the facility to pick up a resident at the hospital. Gray Van #1 was observed to have two new securement latching systems in the back of the van and two old strap latching systems which were worn and frayed in the front of the van. Transporter #3 stated the old worn and frayed straps were used to secure the front of the wheelchair and the new securement latching system was used to secure the back of the wheelchair.

Transporter #3 was observed on 01/10/14 at 4:45 PM as he demonstrated how to tighten and secure the old strap system in Gray Van #1 when the strap slipped as he tightened it to secure it to the bottom of the van causing him to stumble backwards in the van.

On 01/10/14 at 4:50 PM it was determined by the surveyors to have Transporter #3 called by the Business Office Manager/Assistant Administrator to return to the facility and not pick up the resident in Gray Van #1 due to the van not being

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F 323	Continued From page 56 safe for resident transport. Observation of the facility transport vehicle on 01/10/14 at 5:05 PM with Transporter #2 and the Business Office Manager/Assistant Administrator revealed White Van #2 had two new securement straps/latching systems in the back and two old latching systems in the front which were worn and frayed. Observation of the facility transport vehicle on 01/10/14 at 5:15 PM with Transporter #2 and the Business Office Manager/Assistant Administrator revealed White Bus #3 had four new securement straps/latching systems. An interview with the Business Office Manager/Assistant Administrator on 01/11/14 at 10:10 AM revealed the facility transporters had no formal training on the proper use of the new securement latching system after it was installed in the White Bus #3 on 11/21/13 and the Gray Van #1 on 12/17/13. A follow up interview with the Business Office Manager/Assistant Administrator on 01/11/14 at 5:45 PM revealed she was informed on 08/23/13 by Transporter #1 the straps securing the wheelchairs in the facility transportation vehicles were becoming loose during transport due to being worn and frayed. She reported new straps of the same type as the straps that were worn and frayed were ordered to replace the old straps in the 3 facility transportation vehicles but she could not find the receipt or invoice for the order of the new straps. The Business Office Manager/Assistant Administrator stated no system was put in place to monitor the wear or safety of the new straps. She stated she had not	F 323		

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checked to see if the old worn frayed straps had been changed out to the new straps and that she relied on the transporters to notify her of any problems they were having with facility transportation vehicles. The Business Office Manager/Assistant Administrator reported that after the van accident on 11/15/13 she contacted a local mechanic regarding the straps slipping in the van and the wheelchair turning over to get advice on what needed to be done to keep the resident safe. She stated he informed her facility transportation vehicles needed to have a more secure latching system installed to prevent wheelchairs from becoming loose and turning over. The Business Office Manager/Assistant Administrator stated she told the mechanic to order the new securement system for all 3 facility transportation vehicles. She reported she thought all 3 facility transportation vehicles had been fitted with the new securement latching system by 12/21/13 and was not aware that Van #1 and #2 was still equipped with two of the old strap latching systems. She further stated she had not inspected the transportation vehicles herself after the new securement systems were installed nor had she questioned the completion of the work.

The Business Office Manager/Assistant Administrator and Director of Nursing were informed of Immediate Jeopardy on 01/10/14 at 5:50 PM for Resident #85. The facility provided a credible allegation of compliance on 01/12/14 at 12:05 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

CREDIBLE ALLEGATION OF COMPLIANCE
RESIDENT #85 - IMMEDIATE JEOPARDY

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F 323	Continued From page 58 INTRODUCTION: Resident situation: On Friday November 15th, 2013 when resident #85 was en-route to dialysis in the facility's White Bus #3, the resident's wheelchair tipped over sideways due to a strap securing her wheelchair to the White Bus #3 coming loose. Transporter reported the fall occurred when he was making a left turn and the wheelchair tipped over side-ways. Transporter stopped White Bus #3 and assisted the resident by placing the wheelchair upright and resident repositioned in wheelchair; resident denied injury. Transporter re-secured wheelchair safety belt system and transported to the Dialysis Center and the Dialysis Nurse assessed Resident #85 for any injuries and recommended follow-up upon return to the facility. Hall Nurse reassessed Resident #85 upon return to the facility with no injury identified. The facility's policy states "in the event of an accident or personal injury, insurance and registration information be kept in the vehicle at all times and the Transporter should contact the facility as soon as possible." **The Transporter contacted the facility upon arrival at the Dialysis Center which was approximately 5 minutes after the incident and spoke to the Assistant Director of Nursing. Then the Assistant Director of Nursing reported to Assistant Administrator. Due to reported concerns about wheel chair safety straps loosening during transport in August 2013 on White Bus #3, replacement straps of the same type were installed in August 23, 2013. The replacement of straps occurred before the	F 323	To address the Resident #85 Immediate Jeopardy the following action plan will be implemented: To address the requirements of the CMS Imposition Notice requirements the following Directed Plan of Correction was implemented: The facility will obtain the services of independent contractors (individuals or companies not having any personal or professional relationship with the facility, the owners, and/or the Management Company), to conduct the following items specified in the directed plan of correction. 1) The facility will engage the services of an independent contractor to provide " Compassionate and Person Centered Training to the facility's direct care Staff and the independent contractor shall submit a written report to CMS and the state providing the content of the training, documentation of objectives and attendees participating. 2) The facility shall utilize an independent contractor to evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care and shall submit a written report to CMS and the State summarizing outcomes the outcomes of competency skills evaluation of direct care staff. of particular importance is staff knowledge related to abuse, neglect, dignity, and and activities of daily living.	3/5/2014 3/5/2014

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F 323	Continued From page 59 incident of 11/15/2013. Due to the incident on 11/15/2013 a Root Cause Analysis was completed on 11/18/2013 by the Quality Assurance/Performance Improvement Coordinator and review of safety recommendations for wheelchair transportation by Rehabilitation Engineering and Assistive Technology Society of North America and National Highway Traffic Safety Administration was done. The installation of the new latching/ratchet system for the white bus #3, was ordered on 11/19/2013 and installation was completed on 11/21/2013 for safe resident transport. After the incident all three facility vans remained in service for resident transport. White bus #3 was in service except when it was in the auto repair shop from 11/19/2013 to 11/21/2013 1. On 1/10/14 all specialized transportation vehicles were taken out of service until training of all transporters is complete by January 12th, 2014. 2. At 5:45 p.m. on January 10th, 2014 all transporters were notified that specialized wheelchair transport vehicles which included Grey Van #1 and White Van #2 and white bus #3 were taken out of service. 3. On 1/10/14 a local Auto Services technician who was completing the work on the specialized transport vehicles strapping and latching/ratchet systems was contacted concerning completion of the work for the Grey Van #1 and White Van #2 specialized transport vehicles. 4. The Services Technician completed the	F 323	3)The governing body, with the assistance of the independent contractor, shall conduct a root cause analysis regarding the facility's survey history beginning January 1st, 2011. The Root Cause Analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation 4) The facility shall specify in writing who will be responsible and accountable for the provision of quality care, treatment and services. A copy of the root cause analysis shall be provided to CMS and the State. 5) The governing body shall submit a written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports shall be provided to CMS and the State ,monthly x 5 months.	3/5/2014 3/5/2014 3/5/2014

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F 323	Continued From page 60 installation of the strapping and latching/ratchet system for the White 2008 Ford Van #2 at 6:30 p.m. on January 10th, 2014. A Facility Administrative Services Staff was in attendance and observed the completion of the installation of the wheelchair safety seat belt system at 6:30 p.m., on January 10th, 2014. 5. Administrative Services Representative, Environmental/Safety Director and Lead Transporter will be using SURE-LOK "Doing it Right" Leader Preparation Guide to enable them to educate all transporters. To validate competency, educators will review each other for competency. 6. Transporters will be reeducated by Administrative Services Representative, on daily safety inspection requirements and proper usage of the wheelchair safety equipment system for secure resident transport for all specialized wheelchair transport vehicles prior to transporting residents. Transport staff reeducated on what to do when there is an accident/incident, including when to call 911. All transporters have cell phone availability. Completion by January 12th, 2014. 7. Components of education will include SURE-LOK Safe and Secure Work Sheet, Pre-trip SURE-LOK Check List, Glossary of Terms for SURE-LOK System, Return Demonstration of Competency, Securing a resident in each specialized transport vehicle, SURE-LOK Training Video, purchased 01/11/14, will be part of the training. Licensed Physical Therapy Assistant will inservice all transporters on safe resident transport and proper body mechanics by 1/12/2014.	F 323		

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F 323	Continued From page 61 8. Facility policies on van transport will be revised to include safety inspections and pre-trip SURE-LOK Check List of the specialized wheelchair transport vehicles. Revised policies will be completed by January 12th 2014. 9. Beginning on 1/12/14 the Environmental Safety Director or a designated maintenance staff member will monitor compliance with safety inspections of the specialized transport vehicles on a daily basis. 10. Annual training will be done with all facility transporters. Records will be kept in employee file to validate training competency yearly. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility provided evidence of additional in-service training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van by the Business Office Manager and Maintenance Director were completed. Interviews of transportation staff revealed each staff had been trained on securing wheelchair bound residents in the transportation vehicles appropriately.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, facility document reviews, record reviews, and staff interviews the	F 333	To address the cited deficiency of the facility failure to give the correct dose of Pancrealipase for 1 of 25 residents reviewed for medication errors for Resident #138 and to address corrective action for those residents having potential to be affected by the same deficient practice, the following action plan was implemented	

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F 333	Continued From page 62 facility failed to give the correct dose of Pancrealipase for 1 of 25 residents reviewed for medication errors. (Resident #138). The findings included: Resident #138 was admitted to the facility on 09/13/13 with diagnoses which included disease of the pancreas, malnutrition, anemia, depression and diabetes. The most recent quarterly Minimum Data Set (MDS) dated 12/23/13 indicated Resident #138 had no short term or long term memory problems and was cognitively intact for daily decision making. A review of monthly physician orders dated 01/01/14 through 01/31/14 indicated Pancrealipase 5,000 Delayed Release (DR) 2 capsules by mouth 3 times a day with meals (due to a lack of enzymes produced by the pancreas to improve digestion of food). A review of a medication administration record (MAR) indicated Resident #138 received Pancrealipase 5,000 DR (1) capsule by mouth on the following dates and times: 01/07/14 at 8:00 AM 01/07/14 at 12:00 PM 01/07/14 at 5:00 PM 01/08/13 at 8:00 AM 01/08/14 at 12:00 PM During an observation of a medication pass on 01/08/13 at 4:35 PM Medication Aide #1 pulled a medication box labeled Pancrealipase for Resident #138 out of a medication cart and compared the label on the box to the (MAR) and stated something didn't look right because the MAR indicated to give 1 capsule and the label on	F 333	Resident #138's electronic medication record was corrected to state two capsules instead of one capsule of the Pancrealipase 5,000 Delayed Release (DR Nurse #5 was counseled in writing regarding incorrectly entering the Pancrealipase 5,000 DR, one capsule instead of two in the order entry system. The five-step order entry system is in place to identify inaccuracy of order entry and correct order entry errors prior to the error reaching the resident: 1) An order is entered by either order entry designated person and/or Charge Nurse. 2) The Charge Nurse checks the order when the entry designated person has entered order. In the event the Charge Nurse enters the order, the Charge Nurse designates another nurse to check all entries after the initial entry. 3) The Hall Nurse that has the resident that the order is written for completes the third check 4) The fourth check is completed by the third shift nurse that is assigned to the resident the orders are written for. 5) The fifth check is completed in the Daily Stand-Up meeting by the ADON or designated person in ADON's absence.	1/8/2014

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F 333	Continued From page 63 the box indicated to give 2 capsules. She further stated she had to talk to a nurse to get clarification about the dosage of the medication before she gave it. During an interview with on 01/08/14 at 5:15 PM the Assistant Director of Nursing (ADON) stated Medication Aide #1 came to her and asked for clarification about Resident #138's Pancrealipase medication dosage. She explained she figured out that Resident #138 went to hospital on 12/30/13 and returned to facility on 12/31/13 and when Nurse #5 transcribed the physician's orders she entered Pancrealipase 1 capsule per dose but it should have been transcribed as 2 capsules per dose. The ADON verified Resident #138 was incorrectly given 1 capsule of Pancrealipase instead of 2 capsules for a total 5 doses on 01/07/14 and 01/08/14. During an interview on 01/09/14 at 5:45 PM the facility Pharmacist verified Resident #138 should have received 2 capsules of Pancrealipase 5,000 DR but instead he received one half of his dosage of medication for a total of 5 doses on 01/07/14 and 01/08/14. He explained the medication was used for digestion and if Resident #138 didn't get the proper dosage he didn't digest his food properly and that affected his overall nutrition. During an interview on 01/10/14 at 10:25 AM Nurse #5 explained nurses were expected to enter physician's orders into the computerized pharmacy system when residents were admitted or returned from the hospital. She explained she had incorrectly entered Pancrealipase 5,000 DR 1 capsule instead of 2 capsules for Resident #138 in the order entry system. She stated she did not	F 333	6) The LPN Care Plan Nurse will check for all five initials with dates on the green cop of the order prior to filing and storing for 6 months. 7) To correct the deficient practice, the five step order entry system will be audited by the LPN Care Plan Nurse weekly x 8 weeks, and monthly thereafter with monthly reports to the QA/PI Committee and will continued to be reviewed by the QAPI Committee on a monthly basis until substantial compliance is maintained. 8) All RN's, LPN's and Medication Aides were reeducated on the 5 step order entry process. 9)The Administrator and/or designee, will oversee he systemic process to ensure that the deficit practice does not reoccur.	2/5/2014

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F 333	Continued From page 64 know if she was distracted in the nurse's station when she entered the orders or what had happened but she put the order in wrong. Nurse #5 verified the MAR indicated 5 doses were given incorrectly as 1 capsule instead of 2 capsules on 01/07/14 and 01/08/14. During an interview on 01/10/14 at 5:27 PM the Director of Nursing explained when Resident #138 received 1 capsule of Pancrealipase 5,000 DR instead of 2 capsules it was a medication error that was caused by an order entry mistake when Nurse #5 entered the order incorrectly into the computerized pharmacy system. She stated it was her expectation that Nurse #5 should have entered the orders for Pancrealipase for Resident #138 correctly into the pharmacy system and expected for nurses or medication aides to compare the label on the medication box with the MAR and if there was a discrepancy to get clarification before they gave medication.	F 333		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to ensure food was palatable, seasoned, and heated to resident preference for 2 of 2 residents (Resident #48 and 85).	F 364	To correct the cited deficiency that the facility failed to ensure food was palatable, seasoned and heated to resident preference for 2 of 2 residents (Resident #48 and #85) and to ensure corrective action is accomplished for those residents having potential to be affected by the same deficient practice, the following corrective action was implemented: A) Corrective action for cited deficient practices for residents #48 and #85 was taken: 1) Dietary Manager or Assistant Dietary Manager will monitor one meal daily x 2 weeks, weekly x 1 month and monthly thereafter for correct temperature, palatable and correctly seasoned food. 2) For correct food temperature guidelines, a chart in a Notebook on the Cooks Table for staff to follow.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 65 The findings included: A review of Resident #48's annual Minimum Data Set (MDS) dated 10/18/13 specified the resident was cognitively intact, understood others, and was understood. A review of Resident #85's admission Minimum Data Set (MDS) dated 10/19/13 specified the resident had moderately impaired cognitive skills for daily decision making. Observation was made during lunch on 01/06/13 from 11:30 AM to 12:50 PM of multiple residents returning food trays from their bedrooms, requesting food be reheated and requesting alternate meals. Staff were also observed during this meal removing trays from the food cart, which was parked at the nurse's desk with the doors open. Interview with Resident #48 on 01/07/14 at 9:45 AM revealed she ate all meals in her room due to her mobility limitations and pain but the food was usually cold by the time it was brought to her room for each meal. Resident #48 stated the food was often either cooked too long and was soggy or not cooked enough was hard. Resident #48 stated the food was also too bland and the same food items were served too frequently. Resident #48 stated she had spoken to the nurses, nurse aides, and the social worker before about the food being cold and tasting bad, but she felt it hadn't helped to report her concerns because the temperature or the taste of the food had not improved. During an interview on 01/09/14 at 11:10 AM nurse aide #1 (NA) stated it took at least an hour to pass out trays on C Hall due to the food cart	F 364	3) A new plate warmer was ordered (Expected delivery 2/6/2014) 4) Dietary Manager or Assistant Dietary Manager will accompany trays to the Halls making sure doors are closed between deliveries until all trays are served. 5) Nursing staff will be paged to pass trays immediately upon Hall Food Cart arriving. 6) Correctness of preparation, cooking and palatability will be monitored by the Dietary Manager, Assistant Dietary Manager and Cooks at each meal serving. 7) Any preparation, cooking and palatability issues will be addressed by the Dietary Manager immediately with redirection education to Dietary Staff concerned. 8) Seasoning will be placed on resident trays with monitoring for dietary restriction orders for resident with placement of seasoning on trays adjusted accordingly. 9) Dietary Manager conducted an inservices with Dietary Staff on preparation, seasoning palatability and correct temperatures of food. 10) Nursing Staff will address any concerns/ issues raised by residents immediately and refer to the Dietary Manager or Assistant Dietary Manager who will resolve the issue or concern immediately. 11) If plate is not warm enough for residents preference, they may request to have the plate reheated and staff will respond immediately. A plan has been developed to monitor performance of cited areas and ensure ongoing corrective action is taken immediately to resolve any issues/concerns expressed by residents on Dietary Services. 1) Dietary Manager and Assistant Dietary Manager will monitor meals daily on an ongoing basis for warmth, palatability and seasoning as well as texture.	1/31/2014 1/28/2014

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F 364	Continued From page 66 being parked at the nurse's desk and having to walk back and forth for each tray one at a time. NA #1 further stated the doors of the food cart were left open while the trays were being passed to residents which let the heat escape faster. Interview with Resident #85 on 01/09/14 at 3:18 PM revealed Resident #85 enjoyed having her meals in her room but stated by the time she received her tray the food was cold. Resident #85 stated temperature of the food was about the same for all meals but breakfast was the worst. Resident #85 reported she had informed the NAs, nurses and the social worker on numerous occasions that her food was cold. Resident #85 reported the dietary manager had not spoken to her about her concern regarding cold food. Interview with NA#3 on 01/10/14 at 6:53 AM revealed she had observed almost every resident complain about the taste of the food. NA #3 stated she heard residents daily complain the food is not fit to eat, not cooked enough or burned. NA #3 stated when residents complained about the food, they were offered an alternative or to have the food heated if the complaint is that the food is cold. Interview with Nurse #8 on 01/10/14 at 7:05 AM revealed food is the issue she hears residents complain about most. Nurse #8 stated most residents have reported to her and to the nurse aides the food was not fit to eat and was frequently cold. During an interview with the Director of Nursing (DON) on 01/10/14 at 10:02 AM she reported she had received numerous complaints about the food but there were a lot of alternates such as hot	F 364	2) Test trays will be given to two Administrative staff each week x 1 month and then monthly thereafter to solicit comments/ feedback. 3) Dietary Manager or Assistant Dietary Manager and Cooks will monitor meals for warmth, palatability, texture, correct preparedness x2 weekly for thirty days and monthly thereafter. 4) Dietary Manager or Assistant Manager will then monitor 1 x weekly x thirty days for warmth, palatability, texture and correct preparedness. The cooks will monitor each meal continuously for same. 5) Dietary Manager or Assistant Dietary Manager will continue to monitor weekly as well as the Cooks daily per meal. 6) Trays will continue to be monitored on Hall by Dietary Manager for maintaining warmth as all trays are passed out x 1 each week x 1 month, then monthly thereafter. 7) Grievances pertaining to food will be addressed to Dietary and they will follow through to resolve complaint or concern immediately. 8) A record will be maintained by the Dietary Manager of all complaints/ grievances and action that was taken to resolve any issues or concerns from the residents. 9) Complaints from Resident Council regarding food will be documented on Grievance Forms and forwarded to the Dietary Manager for action to be taken. 10) Dietary Manager will maintain a record of any grievances from the Resident Council Issues/Concerns and action taken. 11) All grievances will be addressed in the Daily Stand-up Meeting and followed up to ensure resolvement of any issues/ concerns and any systematic/procedures put in place to resolve issues/concerns	

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F 364	Continued From page 67 dogs, hamburgers, soups and sandwiches for the residents to choose from. The DON stated her expectation was that if residents complained to staff about food, they would report those concerns to the dietary manager, who would follow up with the resident personally to improve food choices and document that meeting in a timely manner. DON stated she was aware that some residents complained almost daily about the taste and temperature of the food. Interview with nurse #5 on 01/10/14 at 10:30 AM revealed some residents, including Resident #48, complain about the food almost daily. Nurse #5 stated when residents complain about the food, they are offered an alternative but some residents get tired of the alternates too. Interview with NA #4 on 01/10/14 at 4:06 PM revealed residents complain to her every day that the food was not fit to eat, was not appetizing and did not look or taste good. NA #4 stated that Resident #48 complains about the food daily and usually eats just soup or some other alternate. Interview with the Dietary Manager (DM) on 01/11/14 at 9:30 AM revealed she was not aware Resident #48 had a problem with cold food or the flavor and seasoning of the food. The DM stated if a resident has a complaint about the food or temperature of the food it was reported to the social worker and she reported the problem to the DM. The DM stated she has had numerous complaints about the food getting cold on the halls as well as the taste of the food. The DM stated the facility purchased new food carts last year that were better insulated and she was under the impression the food was staying warm. The DM also stated she had tried to work with	F 364	12) All grievances, complaints or concerns will be made a part of the Dietary QA/PI report to the monthly QA/PI Committee and areas of concern will be monitored until substantial compliance has been maintained. 13) The Administrator and/or designee, will oversee he systemic process to ensure that the deficit practice does not reoccur.	2/6/2014

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F 364	Continued From page 68 each resident who had complained about the taste of the food to try other options for her but had been unaware of Resident #48's concerns. Interview with nurse #2 on 01/11/14 at 4:41 PM revealed he hears residents complain about food a lot. Nurse #2 stated residents who complain are offered alternates, but some residents complain every day. Interview with Nurse #9 on 01/12/14 at 12:04 PM revealed she hears complaints from residents daily about the taste of the food. Nurse #9 stated she doesn't personally report complaints to the dietary manager but makes sure the residents are offered the alternates for the meal they don't like. Review of minutes of Resident Council meetings for prior six months revealed complaints were made about food at almost every meeting. The minutes included responses that the activity director would pass the complaints on to the dietary manager.	F 364		
F 371 SS=E	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	F 371	To address the cited deficiency that the facility must prepare, distribute and serve food under sanitary conditions was not met as the facility failed to clean two of two ice scoop holders and that this deficient practice has the potential to affect all residents. A) Corrective action has been put in place to systematically clean the Blue Plastic ice scoop hold on (L) side of ice machine in the kitchen and the Blue Plastic Ice Scoop Holder in the Emergency Room	

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F 371	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean two of two ice scoop holders. The findings included: Observations made during initial tour on 01/06/14 at 10:35 AM revealed a blue plastic ice scoop holder was positioned vertically on the left side of the ice machine located in the facility kitchen. A blue plastic ice scoop was stored inside the ice scoop holder. The bottom portion of the container had a partially wet residue which was black in color. Observations made on 01/06/14 at 11:00 AM revealed a blue plastic ice scoop holder was positioned vertically on the wall beside the ice machine in a room labeled storage beside the Conference Room in the facility. A blue plastic ice scoop was stored inside the ice scoop holder. The bottom portion of the container had water pooled in the bottom that was light black in color. Interview with the Dietary Manager (DM) on 01/09/14 at 1:40 PM revealed the ice scoop holders were taken down once a week and cleaned in dishwasher. Upon observation of the ice scoop holders in the kitchen and storage rooms the DM stated the black substance in the bottom of the ice scoop holders was mold. The DM further stated the ice scoops in both ice scoop holders were used to fill glasses and ice chests for resident use.	F 371	The corrective action was implemented and cleaning schedule for the ice scoop holders is now in place: 1) Cleaning occurs at the end of 2nd Shift daily. 2) Supervisor retrieves ice scoop and holder from both places (ice machine in Kitchen and Emergency Room). 3) These will be placed in the Dish Machine and on completion of cleaning allowed to air dry. Once dry they are returned to their positions beside the ice machines. 4) Dietary Manager or Assistant Dietary Manager will monitor each morning x 1 month and then will monitor weekly x 2months and monthly thereafter. 5) Cleaning/Infection Control procedure monitoring for the ice scoop holders will be made a part of the Dietary QA/PI report to the monthly QA/PI Committee and will be monitored untilsubstantial compliance is maintained. 6) The Administrator and/or designee, will oversee he systemic process to ensure that the deficit practice does not reoccur.	1/12/2014
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	To correct the cited deficiency that the facility failed to discard 4 pre-drawn	

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F 431	Continued From page 70 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard 4 pre-drawn cartridges of	F 431	cartridges of Valium (an anti-anxiety drug) which expired July 20134 found in a medication cart and failed to label 3 syringes of oral Morphine Sulfate (a pain medication) with an expiration date and failed to discard one vial of single use lasix (a diuretic medication) after it was used, was opened and found in a medication storage room in 2 of 5 medication storage areas. The Cited deficiency will be addressed for all those residents that may be affected by the same deficient practice, the following action plan was implemented: Medication Audit protocol will be followed by the pharmacy staff. 1) The pharmacy staff will check expiration dates for medications stored in the Medication Room Refrigerator and the Emergency Locked Box. 2) Expiration dates will be checked every two weeks. 3) The Pharmacy Staff will remove all medications that are close to expiration. 4) The Pharmacist and Pharmacy Staff will be responsible for ensuring that all monthly audits will be completed by the first Monday of the month. 5) Medications that will expire 30 days from the date of audit will be entered on the Audit log. 6) Medications that are close to expiration will be removed for disposal per Pharmacy policy and procedure. 7) Medication Aides or Nurses will be responsible for auditing the medications for date of expiration on the medication cart weekly on Monday by 11-7 staff. 8) Medication audit will be conducted monthly and completed on the first Monday of the month.	

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F 431	Continued From page 71 Valium (an anti-anxiety drug) which expired July 2013 found in a medication cart, failed to label 3 syringes of oral Morphine sulfate (a pain medication) with an expiration date and failed to discard one vial of single use Lasix (a diuretic medication) after it used was opened found in a medication storage room and in 2 of 5 medication storage areas. The findings included: 1. On 01/11/14 at 3:41 PM an inspection of C Hall medication cart revealed the following: 4 pre-drawn injectable cartridges/vials of Valium 10 milligrams (mg)/2 milliliters (ml) with the expiration dated on July 2013. The medication was in a plastic bag with the dispensed date of 09/30/13 and the expiration date of 09/30/14. Review of the narcotic count sheet indicated 1 vial had been used on 01/05/13. A telephone interview was conducted 01/11/14 at 4:10 PM with Nurse #4 who had given the expired Valium on 01/05/14. Nurse #4 stated she did look at the vile of medication prior to giving the drug but she did not notice the medication was expired. An interview was conducted on 01/11/14 at 4:40 PM with the Director of Nursing (DON). The DON stated it was her expectation that expiration dates should have checked prior to the medication being administered and expired vials should have been discarded. 2.) On 01/11/14 at 5:17 PM an inspection on the medication room revealed the following: 3 pre-drawn oral syringes with Morphine sulfate 20 mg/ml. These syringes were in a plastic bag,	F 431	9) Any Medications that are close to expiration will be removed and sent to the pharmacy for disposal with completion of the Log for disposal of medications. 10) Original Medication Disposal Logs will be maintained by the Pharmacy 11) Copies of all completed medication disposal logs will be forwarded to the Administrator, Assistant Administrator and Director of Nursing for review and any action needed. 12) Review of Medication Audit Protocol and Pharmaceutical Services Policy and Procedure reviewed by the Medication Aides, Nurses and Pharmacy Staff. 13) Nurses will be in-serviced on disposal of open vial of liquid medication immediately after use of all partial or partial contents. 14) The Medication Audits completed by Pharmacy and the Nursing Staff will be brought to the Medication Management Meeting monthly and reviewed for areas for interventions and any action needed. 15) Pharmacist and ADON will report results of audits to the monthly QAPI meeting as part of the Pharmacy and Medication Error Reports to the Committee. 16) Reports on process of reviewing for Expired drugs will be reported to the QA/PI Committee as part of the Pharmacy and Nursing Medication Error report until substantial compliance is maintained.	2/10/2014 2/5/2014

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F 431	Continued From page 72 there was no date the syringes were dispensed nor was there an expiration date for the medication. An interview was conducted on 01/11/14 at 5:17 PM with Nurse #2 who was present during the inspection of the medication room. Nurse #2 stated there should have been a dispense date and an expiration date on the Morphine sulfate. An interview was conducted with the Pharmacist on 01/11/14 at 5:24 PM who stated there should have been expiration date printed on the Morphine sulfate. An interview was conducted with the Director of Nursing on 01/11/14 at 5:44 PM who stated there should be a dispensing date and an expiration date on the Morphine sulfate. 3.) On 01/11/14 at 5:28 PM during further inspection of the medication room an open vial of Lasix was found in an emergency back up medication box. An interview on 01/11/14 at 5:28 PM with Nurse #2 who was present during the inspection of the medication room stated the vial of Lasix should have been discarded as it was a single dose vial. He stated there was no way to know when it was opened or how many times it was used. On 01/11/14 at 5:44 PM an interview with the Director of Nursing was conducted. She stated the vial of Lasix should have been discarded after the single use.	F 431	The Administrator and/or designee, will oversee he systemic process to ensure that the deficit practice does not reoccur.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	To correct the cited deficiency for facility failure to disinfect a blood glucose meter after use of 1 of 1 residents during survey	

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F 441	Continued From page 73 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	observation of a finger stick blood sugar the facility also failed to place a resident on contact isolation precautions and post signage for instructions for isolation precautions on 1 of 1 residents. (Resident #53 and #158) To address these cited deficiencies and implement a correction plan for those residents having potential to be affected by the same deficient practice the following action plan was implemented:	

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F 441	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to disinfect a blood glucose meter after use on 1 of 1 resident during observation of a finger stick blood sugar. The facility also failed to place a resident on contact isolation precautions and post signage for instructions for isolation precautions in 1 of 1 resident for isolation precautions. (Resident #53 and #158). The findings included: 1. A review of a manufacturers instruction manual titled "Oracle Blood Glucose Monitoring System User Guide" and not dated indicated to always clean the blood glucose meter after use with a soft cloth that had been slightly dampened with mild detergent. During an observation on 01/08/14 at 4:09 PM Medication Aide #1 removed a blood glucose meter from a medication cart in the hallway and wiped all of the surfaces on the meter with an alcohol wipe. She picked up the blood glucose meter, alcohol wipes and lancet and took them into Resident #53's room. She washed her hands with hand sanitizer, put on gloves and performed a finger stick blood sugar on Resident #53. She removed her gloves, disposed them in the trash with the used alcohol wipes, and walked out of the resident's room with the blood glucose meter to the medication cart in the hallway and wiped all of the surfaces of the blood glucose meter with an alcohol wipe. She then picked up the blood glucose meter and carried it down the hall. During an interview on 01/08/14 at 4:17 PM	F 441	Resident #53's nurses and Medication Aides were given disinfectant wipes and instructions given to properly use them in-between each blood glucose check. 1) Disinfectant wipes were purchased to carry on their carts and were initiated The policy for blood glucose disinfection between resident blood glucose checks revised to include use of a disinfectant wipe between usages from resident to resident. The procedure for blood glucose disinfection reviewed with staff during inservice. 1) The Staff Development Coordinator will check blood glucose testing on each hall for proper disinfections of blood glucometers daily x 7 days; weekly x 8 weeks and monthly thereafter. 2) The Staff Development/Infection Control Coordinator will present a report to the monthly QA/PI Committee as part of the Infection Control QA/PI report. 3) Ongoing reports for infection control compliance will be presented to the monthly QA/PI Committee until substantial compliance is maintained for proper disinfection of blood glucometers. 4) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	1/11/2014 1/11/2014 2/6/2014 2/5/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 75 Medication Aide #1 confirmed she was on her way to do the next finger stick blood sugar. She stated she had been taught it was facility policy and procedure to clean blood glucose meters with alcohol wipes. She stated she had asked about using disinfectant wipes but was told the alcohol wipes were to be used instead. During an interview on 01/08/14 at 5:10 PM Nurse #2 stated the facility did not have blood glucose meters that were assigned to each resident. He explained nursing staff were expected to clean all surfaces of the blood glucose meter after each use and allow them to dry until the alcohol evaporated. He stated disinfectant wipes were kept at the nurse's station and medication room but were not on the medication carts. During an interview on 01/09/14 at 11:25 AM the Director of Nursing explained they had purchased new blood glucose meters in May 2013 and was told by the representative who did the in-services for nursing staff that alcohol wipes were acceptable to use because the alcohol had a faster drying time and would not slow nursing staff down when they were doing their medication pass. She confirmed they did have disinfectant wipes available in the medication room and at the nurse's station and they should have been using them to disinfect blood glucose meters instead of alcohol wipes. 2. During an observation on 01/10/14 at 9:40 AM Resident #158 was lying in bed with her eyes closed in a semi private room with a roommate in the bed next to her. There were no contact isolation signs or personal protective equipment in the hallway or on the door of the room.	F 441	To address the cited deficiency for Resident #158 not being placed on contact isolation procedures the following action plan was implemented:	

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	345246	A. BUILDING _____ B. WING _____	C 01/12/2014

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F 441	Continued From page 76 During an interview on 01/10/14 at 9:45 AM Nurse #7 explained Resident #158 was admitted on 01/09/14 and was placed in a semi private room with a roommate. She stated they did not realize until this morning Resident #158 had a diagnosis of Clostridium Difficile (C-Diff) and Vancomycin resistant Enterococcal (VRE) urinary tract infection and was on antibiotics by mouth to treat her infection. She explained staff was getting ready to move Resident #158 to a private room with contact isolation. Nurse #7 confirmed Resident #158 had not had not been on isolation precautions since she was admitted. During an observation on 01/12/14 at 11:56 AM Resident #158 was lying in bed in a private room with a large rack hanging on the outside of the door with gowns, gloves and masks. The door of the room was open but there was a sign taped to the door that was typed on a white sheet of paper which indicated: "Attention visitors please report to nurse's station before entering resident's room. Thank you." During an interview on 01/12/13 at 12:10 PM the Director of Nursing stated she did not know anything about Resident #158 but she expected nursing staff should have reviewed her admission paperwork and should have been aware of the diagnoses of C-Diff and VRE and Resident #158 should have been admitted to a private room with contact isolation. She explained they used a rack that hung on the door for isolation supplies and sometimes there was isolation sign on the door but she didn't generally like to use signs to protect the resident's privacy. She stated staff had been trained when they saw the isolation rack on the door it meant contact isolation and it	F 441	1) Resident #158 was continued on contact isolation precautions until her antibiotics were completed and there was no symptoms of infection assessed. 2) Contact precautions were discontinued. All resident's medical records prior to admission to the facility will be reviewed to determine need for contact precautions and contact precautions will be initiated on admission. A sign will be hung on the door of the resident room who is on contact precautions to give notice to any visitors to report to the Nursing Station before entering room. 1) The Admissions Coordinator will alert the Director of Nursing of any potential resident with possible Methicillin Resistant Staph-aureus (MRSA), Vancomycin Resistant Staph-aureus; and Clostridium Difficile (C-Diff). 2) The Admission team with check the pre-admission information prior to admission to screen for infection. 3) The Charge Nurse will ask the Nurse that is giving report from from the transferring facility, if there is any reason for contact isolation. 4) The Director of Nursing or Assistant Director of Nursing will ensure that the procedure on pre-admission assessment for resistant bacterial infection has been followed by reviewing pre-admission patient information prior to arrival to the facility. 5) Infection Control Nurse will compile a report on residents admitted with resistant bacterial infections and the contact precautions initiated immediately upon the admission of the new resident.	2/6/2014 2/6/2014

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F 441	Continued From page 77 was her expectation for nurses to explain isolation precautions to visitors and family members.	F 441	The report will be made a part of the Infection Control QA/PI report to the monthly QA/PI Committee until substantial compliance is maintained.	1/31/2014
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide an effective securement system in the 3 facility transportation vehicles. Administrative staff failed to follow up on the purchase and installation of a securement system. Following an incident when Resident #85 tipped over in the wheel chair during transport, administration continued to use the same system and permitted another unsafe intervention by assigning an attendant to the resident during transport until the new system was installed. The administrator was not aware the vehicle securement straps were not effective and that there was a problem. (Resident #85). Immediate Jeopardy began on 11/15/13 when it was reported to the Business Office Manager/Assistant Administrator that the securement straps that secured wheelchairs in all 3 facility transportation vehicles were frayed and worn. The Administrator had not been informed the securement straps that secured wheelchairs to transport vans were slipping and no monitoring	F 490	The cited deficiency that the facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident was addressed and action plan implemented 1) Environmental Services/Safety Director will conduct daily meetings with transporters to review daily safety check lists for each specialized transportation vehicle 2) Environmental Services/Safety Director will submit there report to the Administrator and/or Assistant Administrator. 3) Any problems identified with the specialized transportation vehicles will be immediately relayed to the Local Auto Mechanic and the specialized transportation vehicle will be taken out of service until problem is corrected. 4) A report will be filed on any safety issues identified and e-mailed to the Administrator, Assistant Administrator, Administrative Staff and pertinent Department Managers.	1/31/2014 1/31/2014 1/31/2014 1/31/2014

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F 490	Continued From page 78 was implemented to ensure safety straps did not loosen during van transport. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. The findings included: Resident #85 was admitted to the facility on 10/09/13 with diagnoses of diabetes, kidney failure and non-Alzheimer's dementia. A review of the admission Minimum Data Set (MDS) dated 10/19/13 indicated Resident #85 had short and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #85 required extensive assistance with transfers, used wheelchair for mobility and received dialysis 3 times per week. A review of a nurse's note dated 11/15/13 at 10:50 AM revealed the facility was notified by Transporter #1 that while en route to dialysis with Resident #85 in the facility van, her wheelchair tipped over when a strap that secured her wheelchair to the floor of the van came loose. A review of a facility document titled Review of Camelot Manor Nursing & Rehab Facility Employee Verbal Consultation report dated 11/15/13 revealed handwritten notes from the Assistant Administrator regarding an explanation of circumstances related to the van incident. The report indicated Resident #85 tipped over in Bus	F 490	5) Remedial actions will be determined and assessed for effectiveness in the Daily Stand-up meeting. 1/31/2014 6) A copy of any incident reports connected with the specialized transportation vehicles will be reviewed in daily stand-up meetings for any required interventions 1/31/2014 7) The Administrator, Assistant Administrator and Administrative staff will attend daily stand-up meetings to discuss reports to determine action and resolve issues. Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem resolved. 1/31/2014 8) If the Administrator is unable to attend, minutes of the daily stand-up meeting will be e-mailed and communication will occur via e-mail and/or telephone conference 1/31/2014 9) Administration citation was entered into the QA/PI minutes. 1/23/2014 10)Any transportation safety issues will be reported to th Daily Stand-up Meeting and action taken immediately to resolve any issues. 11) Any transportation safety issues/concerns action taken, and any follow-up required will be made a part of the monthly report to the Safety Committee and to the monthly QA/PI Committee to ensure any issues/ concerns have been addressed, action taken and issues/concerns resolved. 12) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur.	

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F 490	Continued From page 79 #3 (facility transportation vehicle) when she rocked the wheelchair back and forth and caused the straps that secured the wheelchair to the bottom of the van to loosen. The action taken was to have the mechanic order a more suitable latching system for all facility transportation vehicles. The plan of correction was for an employee to ride along with the transporter to ensure straps were secure until new straps/latching systems were installed and the document was signed by Transporter #1 and the Business Office Manager/Assistant Administrator on 11/15/13. During an interview on 01/10/14 at 8:30 AM Transporter #1 stated he transported Resident #85 to dialysis on 11/15/13 and while en route he made a left turn and the resident's wheelchair tipped over. He stated he had informed the Business Office Manager/Assistant Administrator that the straps that secured the wheelchair to the bottom of all three facility transport vehicles slipped and loosened during transport in August 2013 and the straps were replaced with the same type as the old frayed straps for the facility transportation vehicles. During an interview on 01/10/14 at 10:00 AM Transporter #2 stated he had informed the Business Office Manager/Assistant Administrator the securement straps that secured wheelchairs in all 3 of the facility transportation vehicles were worn and frayed and became loose during transport in August 2013. He explained the worn straps were replaced with new straps of the same type of material for all 3 facility transport vehicles and confirmed there was no system put in place to monitor the wear or slippage of the new securement straps that he was aware of.	F 490		

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F 490	Continued From page 80 During an interview with the Business Office Manager/Assistant Administrator on 01/11/14 at 5:45 PM she stated her primary responsibility was to run the business office and she was responsible for the finances and billing. She explained she reported directly to the Administrator and all decisions had to be approved by the Administrator. She stated the Administrator had given her the title of Assistant Administrator but stated she only had in-service training for billing and did not have any formal training to be an administrator or assistant administrator. She confirmed the Administrator had not been physically present in the facility since before December 19, 2013 and prior to that was only at the facility approximately 2 days a week for a couple of hours at a time. The Business Office Manager/Assistant Administrator stated she was informed on 08/23/13 by Transporter #1 the securement straps securing wheelchairs in the facility transportation vehicles were becoming loose during transport because they were worn and frayed so she ordered new securement straps that were the same type as the straps that were worn and frayed. She explained she thought all securement straps were replaced in the 3 facility transportation vehicles but she could not find the receipt or invoice for the order of the new straps. She confirmed she did not monitor the wear or safety of the new securement straps because when she purchased new straps she thought that fixed the problem and she relied on the transporters to notify her of any problems they were having with facility transportation vehicles. She stated she was not aware there was still a problem with the securement straps until the straps loosened and Resident #85 turned over in her wheelchair when	F 490		

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F 490	Continued From page 81 she was transported to dialysis on 11/15/13. She stated she should have made sure the securement straps were fixed in all transportation vans after new straps were ordered in August 2013. The Business Office Manager/Assistant Administrator reported that after the van accident on 11/15/13 she contacted a local mechanic to get advice on what needed to be done to the securement straps and was told the transportation vans needed to have a more secure latching system installed to prevent wheelchairs from becoming loose and turning over. The Business Office Manager/Assistant Administrator stated she told the mechanic to order the new securement system for all 3 facility transportation vehicles and thought all 3 facility transportation vehicles had been fitted with the new securement latching system by 12/21/13. She further stated she was not aware until 01/10/14 that Van #1 and #2 still did not have the securement latching system and were still equipped with 2 of the old securement strap latching systems that were worn and loosened. She further stated she had not inspected the transportation vehicles herself nor had she questioned the completion of the work but she should have made sure the mechanic who replaced the securement straps in the vans understood what needed to be fixed and she should have kept the Administrator informed. During a telephone interview on 01/11/14 at 6:22 PM the facility Administrator confirmed she was not physically present in the facility on a daily basis and had not been in the facility for several weeks. She stated she had never heard that the securement straps that secured wheelchairs in the facility transportation vans were slipping and she did not know it was an issue until she was	F 490		

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F 490	Continued From page 82 called about it yesterday on 01/10/14. She stated nobody had reported anything to her about any slippage or anything at all related to the securement straps loosening during transports but it was her expectation for staff to report safety concerns to her immediately. The Business Office Manager/Assistant Administrator and Director of Nursing were informed of Immediate Jeopardy on 01/10/14 at 5:50 PM for Resident #85. The facility provided a credible allegation of compliance on 01/12/14 at 12:05 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy. CREDIBLE ALLEGATION OF COMPLIANCE ADMINISTRATION IMMEDIATE JEOPARDY 1/12/14 On 8/23/13 replacement straps that held the wheelchair in place during transport were purchased for White Bus #3 due to frayed straps that loosened during resident transport and did not hold the wheelchair securely in place. On 08/23/13 the facility's Assistant Administrator or administrator was made aware of the need to replace the wheel chair restraint straps in all of the facility vans and approved the purchase of the straps for White Bus #3. On Friday November 15th, 2013 when resident #85 was en-route to dialysis in the facility's White Bus #3, the resident's wheelchair tipped over sideways due to the straps securing her wheelchair to the White Bus #3 coming loose. Transporter reported the fall occurred while he was making a left turn and the wheelchair tipped	F 490	Upon being notified of Immediate Jeopardy at 5:50 p.m. for Resident #85. A credible allegation of compliance on 1/12/2014 at 12:05 p.m. was accepted. The following action was implemented to address the immediate jeopardy 1) Specialized Transport vehicles #2 White Van and #3 Grey Van were taken out of service for completion of the installation of the strapping and latching/rachet system. 2) The installation of the specialized Transport vehicle #2 - White van was completed. 1/10/2014 3) The Specialized Transport vehicle #3 Grey Van remained out of service until the strapping and latching/rachet system was complete. 1/16/2014 4) The #1 Specialized Transport Vehicle White Bus remained out of service until the transporters were educated on the daily safety inspection requirements and the correct usage of the wheelchair safety equipment. The SURE-LOK training video and worksheet pre-trip check list and return demonstration of competency as used for this training. 1/12/2014	

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F 490	Continued From page 83 over side-ways. Transporter stopped White Bus #3 and assisted the resident by placing the wheelchair upright. The resident was repositioned in wheelchair and denied injury. Transporter re-secured wheelchair safety belt system and transported the resident to the Dialysis Center. The Dialysis Nurse assessed Resident #85 for any injuries and recommended follow-up upon return to the facility. The Hall Nurse reassessed Resident #85 upon return to the facility with no injury identified. The Assistant Director of Nursing (ADON) was notified who then notified Assistant Administrator. After the 11/15/13 incident all three facility vans remained in service for resident transport. White bus #3 was in service except when it was in the auto repair shop from 11/19/2013 to 11/21/2013 to replace the van's wheelchair restraint straps with SURE-LOK safety system. An attendant was designated to ride in the white bus #3 by the Assistant Administrator until the replacement SURE-LOK system was installed. On 01/11/14 the facility's Assistant Administrator verified that she had not made the Administrator aware that the wheelchair restraint straps in two of the facility's transport vans needed to be replaced and that all administrative decisions must be approved by the Administrator. On 01/11/14 the facility's Administrator verified that she had not been informed that the straps used to secure the wheelchairs in the vans had slipped or loosened during resident transport until 01/10/14. CORRECTIVE ACTION:	F 490	5) Transporters were also inserviced on basic first aide and instructions on when to call 911. Transporters were issued with facility owned cell phones to facilitate emergency contact. 6) Transporters will complete a safety check list before entering vehicles into daily service and Environmental/ Safety Director will monitor compliance with daily inspections evidenced by review of the safety check list with the transporters and will forward a copy of the safety check list to Administration. 7) Any identified issues with the specialized transportation vehicles will be discussed with Administration immediately and corrective action taken before allowing the specialized transportation vehicles to be put into service. 8) Any issues identified and corrective action taken will be discussed in the daily stand-up meeting. 9) All transportation issues will be reviewed by the Safety Committee members on an ongoing basis via memorandum and/ or e-mail. 10)Transportation citation was reviewed in both Safety Committee Meeting and QA/PI Committee. 11) All safety reports concerning the transportation of residents will be reviewed in the Safety Committee on a monthly basis to ensure action has been taken and any transportation issues have been resolved and monitoring is ongoing. 12) Environmental/Safety Director will present report on Safety Committee findings, action taken and resolvement of any issues on any issues on transportation to the monthly QA/PI Committee .	1/12/2014 1/12/2014 1/12/2014 1/30/2014 1/31/2014 1/23/2014 1/23/2014

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F 490	Continued From page 84 1. On 1/10/14 all specialized transportation vehicles were taken out of service until training of all transporters is complete by January 12th, 2014. 2. At 5:45 p.m. on January 10th, 2014 all transporters were notified that specialized wheelchair transport vehicles which included Grey Van #1 and White Van #2 and white bus #3 were taken out of service. 3. On 1/10/14 a local Auto Services technician who was completing the work on the specialized transport vehicles strapping and latching/ratchet systems was contacted concerning completion of the work for the Grey Van #1 and White Van #2 specialized transport vehicles. 4. The Services Technician completed the installation of the strapping and latching/ratchet system for the White 2008 Ford Van #2 at 6:30 p.m. on January 10th, 2014. A Facility Administrative Services Staff was in attendance and observed the completion of the installation of the wheelchair safety seat belt system at 6:30 p.m., on January 10th, 2014. 5. Administrative Services Representative, Environmental/Safety Director and Lead Transporter will be using SURE-LOK "Doing it Right" Leader Preparation Guide to enable them to educate all transporters. To validate competency, educators will review each other for competency. 6. Transporters will be reeducated by Administrative Services Representative, on daily safety inspection requirements and proper usage of the wheelchair safety equipment system for	F 490	13) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur. To address the requirements of the CMS Imposition Notice requirements the following Directed Plan of Correction was implemented: The facility will obtain the services of independent contractors (individuals or companies not having any personal or professional relationship with the facility, the owners, and/or the Management Company), to conduct the following items specified in the directed plan of correction. 1) The facility will engage the services of an independent contractor to provide " Compassionate and Person Centered Training to the facility's direct care Staff and the independent contractor shall submit a written report to CMS and the state providing the content of the training, documentation of objectives and attendees participating. 2) The facility shall utilize an independent contractor to evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care and shall submit a written report to CMS and the State summarizing outcomes the outcomes of competency skills evaluation of direct care staff. of particular importance is staff knowledge related to abuse, neglect, dignity, and activities of daily living.	3/5/2014 3/5/2014

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F 490	Continued From page 85 secure resident transport for all specialized wheelchair transport vehicles prior to transporting residents. Transport staff reeducated on what to do when there is an accident/incident, including when to call 911. All transporters have cell phone availability. Completion by January 12th, 2014. 7. Components of education will include SURE-LOK Safe and Secure Work Sheet, Pre-trip SURE-LOK Check List, Glossary of Terms for SURE-LOK System, Return Demonstration of Competency, Securing a resident in each specialized transport vehicle, SURE-LOK Training Video, purchased 01/11/14, will be part of the training. Licensed Physical Therapy Assistant will inservice all transporters on safe resident transport and proper body mechanics by 1/12/2014. 8. Facility policies on van transport will be revised to include safety inspections and pre-trip SURE-LOK Check List of the specialized wheelchair transport vehicles. Revised policies will be completed by January 12th 2014. 9. Beginning on 01/12/14 the Environmental Safety Director or a designated maintenance staff member will monitor compliance with safety inspections of the specialized transport vehicles on a daily basis. 10. Annual training will be done with all facility transporters. Records will be kept in employee file to validate training competency yearly. 11. Beginning on 01/12/14 the facility's Environmental Safety Director will conduct daily meetings with Transporters to review vehicle safety check lists and submit written report to	F 490	3) The governing body, with the assistance of the independent contractor, shall conduct a root cause analysis regarding the facility's survey history beginning January 1st, 2011. The Root Cause Analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation 4) The facility shall specify in writing who will be responsible and accountable for the provision of quality care, treatment and services. A copy of the root cause analysis shall be provided to CMS and the State. 5) The governing body shall submit a written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports shall be provided to CMS and the State ,monthly x 5 months	3/5/2014 3/5/2014 3/5/2014

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CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

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F 490	Continued From page 86	F 490		

Administration. The report will be scanned and e-mailed to all staff in Administration. Any problem identified will be immediately relayed to the Auto Mechanic. Any effected Vehicle will be taken out of service until problem resolved.

12. An incident report will be filed on any complaint and e-mailed to the Administrator, Administration Staff and pertinent Department Heads. Remedial actions will be determined and prior plans assessed for effectiveness in the daily stand-up meeting.

13. A copy of all incident reports will be e-mailed to Administrator and Administration Staff and reviewed in the daily stand-up meetings for any required interventions.

14. The Administrator and Administration staff will attend Daily Stand up meetings to discuss reports and determine action to resolve issues. Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem resolved. If the Administrator does not attend, minutes of the meeting will be e-mailed and communication will occur via email and/or telephone conference call.

15. The Grey Van # 1 will remain out of service until the scheduled SURE-LOK system is installed on 1/16/14.

Immediate jeopardy was removed on 01/12/14 at 3:48 PM when the facility provided evidence of additional in-service training for all transportation staff. Interviews with the Maintenance Director revealed he had implemented vehicle safety check lists and had performed safety checks of the securement

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F 490	Continued From page 87 straps in the facility vans except for the Grey Van #1 which was out of service. Interviews with the Director of Nursing and Business Office Manager/Assistant Administrator revealed understanding to keep the Administrator informed regarding concerns and safety issues so that administrative services would be provided.	F 490		
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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	F 520	To address the cited deficiency for failure of the QA/PI Committee to evaluate or follow-up on safety concerns for slipping safety straps for wheelchair securement in the Specialized Transportation Vehicles. A Corrective Action Plan was immediately implemented and will all residents who may have the potential to be effected by the deficit practice. 1) Environmental/Safety Director will conduct daily meetings with transporters to review daily safety check lists for each specialized transportation vehicle 2) Environmental/Safety Director will submit the report to the Administrator. 3) Any problems identified with the specialized transportation vehicles will be immediately relayed to the Local Auto Mechanic and the specialized transportation vehicle taken out of service until problem is corrected. 4) A report will be filed on any safety issues identified and e-mailed to the Administrator, Assistant Administrator, Administrative Staff and pertinent Department Managers.	1/31/2014 1/31/2014 1/31/2014

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F 520	Continued From page 88 by: Based on record reviews and staff interviews the facility failed to develop and implement plans of action or include safety securement of wheel chairs in the 3 facility transportation vehicles as part of the quality assurance review process. The facility administration continued to use the same safety securement system and Resident #85 tipped over in the wheel chair during transport. The facility also permitted another unsafe intervention by assigning an attendant to the resident during transport until the new securement system was installed. (Resident #85). Immediate Jeopardy began on 11/15/13 when it was reported to the Business Office Manager/Assistant Administrator and Director of Nursing that the securement straps that secured wheelchairs in all 3 facility transportation vehicles were frayed and worn. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. The findings included: Resident #85 was admitted to the facility on 10/09/13 with diagnoses of diabetes, kidney failure and non-Alzheimer's dementia. A review of the admission Minimum Data Set (MDS) dated 10/19/13 indicated Resident #85 had short and long term memory problems and was moderately impaired in cognition for daily decision making.	F 520	5) Remedial actions will be determined and assessed for effectiveness in the daily stand-up meeting. 1/31/2014 6) A copy of reports will be reviewed in daily stand-up meetings for any required interventions 1/31/2014 7) The Administrator and/or Assistant Administrator and Administrative staff will attend daily stand-up meetings to discuss reports to determine action and resolve issues 8) Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem resolved. 1/31/2014 9) If the Administrator is unable to attend, minutes of the daily stand-up meeting will be e-mailed and communication will occur via e-mail and/or telephone conference 1/31/20 10) The Administrator, Assistant Administrator Director of Nursing and Administration Staff will attend QA/PI Meetings to discuss reports and determine action to resolve issues. 11) Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem is resolved. 12) If the Administrator does not attend, the QA/PI Coordinator will e-mail the minutes of the meeting and communication will occur via e-mail and/or telephone conference call.	

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F 520	Continued From page 89 The MDS also indicated Resident #85 required extensive assistance with transfers, used wheelchair for mobility and received dialysis 3 times per week. A review of a nurse's note dated 11/15/13 at 10:50 AM revealed the facility was notified by Transporter #1 that while en route to dialysis with Resident #85 in the facility van, her wheelchair tipped over when a strap that secured her wheelchair to the floor of the van came loose. A review of a facility document titled Review of Camelot Manor Nursing & Rehab Facility Employee Verbal Consultation report dated 11/15/13 revealed handwritten notes from the Assistant Administrator regarding an explanation of circumstances related to the van incident. The report indicated Resident #85 tipped over in Bus #3 (facility transportation vehicle) when she rocked the wheelchair back and forth and caused the straps that secured the wheelchair to the bottom of the van to loosen. The action taken was to have the mechanic order a more suitable latching system for all facility transportation vehicles. The plan of correction was for an employee to ride along with the transporter to ensure straps were secure until new straps/latching systems were installed and the document was signed by Transporter #1 and the Business Office Manager/Assistant Administrator on 11/15/13. During an interview on 01/10/14 at 8:30 AM Transporter #1 stated he transported Resident #85 to dialysis on 11/15/13 and while en route he made a left turn and the resident's wheelchair tipped over. He stated he had informed the Business Office Manager/Assistant Administrator	F 520	13) QA/PI Agenda with minutes of previous meeting will be sent to Administrator physician, pharmacist and all Department Managers who are to attend the monthly QA/PI Committee to ensure clear understanding of their responsibility to address any issues that has not been resolved and submit reports to the QA/PI Coordinator from their ongoing monitoring of significant issues being addressed. 14) Communication of issue(s) and plan of action will be sent to the QA/PI Coordinator prior to the QA/PI Meeting for approval and clear understanding of issues/concerns that need to be addressed by the QA/PI Committee. 15) QA/PI Coordinator will submit all Department QA/PI reports to the Administrator for review before the QA/PI Meeting 16) Any items recommended by the Administrator, Administrative Staff and Department Managers will be added to the Agenda for discussion at the monthly QA/PI Committee. 17) A plan of action will be developed for each issue presented presented to the QA/PI Committee with follow-up to ensure interventions are effective. 18) The issue will remain on the agenda of the QA/PI Committee for follow-up until the Committee determines that effectiveness of the interventions and plan of action has been established with substantial compliance evidenced by tracking and trending reports presented to the QA/PI Committee.	

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F 520	Continued From page 90 that the straps that secured the wheelchair to the bottom of all 3 facility transport vehicles slipped and loosened during transport in August 2013. He further stated the straps were replaced with the same type as the old frayed straps for the facility transportation vehicles and he was not aware of any monitoring of the safety straps to ensure they did not loosen during transport. During an interview on 01/10/14 at 10:00 AM Transporter #2 stated he had informed the Business Office Manager/Assistant Administrator the straps securing wheelchairs in all 3 of the facility transportation vehicles were worn and frayed and became loose during transport in August 2013. He explained the worn straps were replaced with new straps that were the same type of material for all 3 facility transport vehicles and confirmed there was no system put in place to monitor the wear of the new straps that he was aware of. During an interview on 01/11/14 at 5:44 PM the Director of Nursing (DON) explained the quality assurance (QA) committee met quarterly and membership included herself, the Medical Director and various department managers. She verified the Business Office Manager/Assistant Administrator attended some of the meetings but the facility Administrator was not usually present at the meetings. She explained the Medical Director conducted the meetings and any identified issues such as safety concerns should be brought to the committee for discussion of any trends or patterns and they evaluated different approaches to resolve concerns. The DON confirmed the last QA committee meeting was held on 10/24/13 and there was no discussion regarding replacement of worn or loose	F 520	19) The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur 20) Transportation citation was reviewed in both Safety Committee Meeting and QA/PI Committee and plan of correction was approved with recommendations that monitoring of transportation safety be ongoing with reports to the Safety Committee and QA/PI Committee on a monthly basis.	

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F 520	Continued From page 91	F 520		

securement straps to attach wheelchairs in transportation vans that had been identified on August 23, 2013. She further stated there had been no monitoring of securement straps in the facility vans and there were no plans of action to ensure the securement straps remained secure during resident transport.

During an interview with the Business Office Manager/Assistant Administrator on 01/11/14 at 5:45 PM she stated her primary responsibility was to run the business office and she was responsible for finances and billing. She explained the Administrator had given her the title of Assistant Administrator but stated she only had in-service training for billing and did not have any formal training to be an administrator or assistant administrator. She stated she attended the QA committee meetings most of the time because the Administrator did not attend the QA committee meetings. She further stated she had not presented any concerns to the QA committee about securement straps that secured wheelchairs to the vans that loosened during transport. She explained when it was reported to her that securement straps were loose and slipped because they were worn she ordered replacement straps of the same type and they were installed on August 23, 2013. She stated she did not present this information at the next Quality Assurance Committee that occurred on October 24, 2013 because she thought since the straps had been replaced that had resolved the problem. She further stated there was no evaluation or follow up to ensure the securement straps remained secure during resident transport in the transport vehicles or to evaluate other interventions which included training of staff, to ensure residents were secured in their

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F 520	Continued From page 92 wheelchairs during van transport. She stated she was not aware there was still a problem with the securement straps until the straps loosened and Resident #85 turned over in her wheelchair when she was transported to dialysis on 11/15/13. She stated after the van accident on 11/15/13 she contacted a local mechanic to get advice on what needed to be done to the safety straps and was told the transportation vans needed to have a more secure latching system installed to prevent wheelchairs from becoming loose and turning over. The Business Office Manager/Assistant Administrator stated she told the mechanic to order the securement system for all 3 facility transportation vehicles and thought all 3 facility transportation vehicles had been fitted with the new securement latching system by 12/21/13. She further stated she was not aware until 01/10/14 that Van #1 and #2 still did not have the securement latching system and were still equipped with 2 of the old strap latching systems that were worn and loosened. She further stated she had not inspected the transportation vehicles herself nor had she questioned the completion of the work but she should have made sure the mechanic who replaced the securement straps in the vans understood what needed to be fixed and she should have informed the QA committee about problems with the securement straps in the facility transportation vans. During a telephone interview on 01/11/14 at 6:22 PM the facility Administrator confirmed she had not attended QA committee meetings but she made recommendations for items to be put on the agenda before the meeting was held and facility staff sent her the minutes after the meetings. She stated she had never heard that the securement straps that secured wheelchairs	F 520		

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F 520	Continued From page 93 in the facility transportation vans were slipping and she did not know it was an issue until she was called about it yesterday on 01/10/14. She stated nobody had reported anything to her about any slippage or anything at all related to the securement straps loosening during transports but it was her expectation for staff to report safety concerns to her immediately and they should have presented the problems related to the safety straps to the QA committee. The Business Office Manager/Assistant Administrator and Director of Nursing were informed of Immediate Jeopardy on 01/10/14 at 5:50 PM for Resident #85. The facility provided a credible allegation of compliance on 01/12/14 at 12:05 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy. Allegation of Compliance Quality Assurance 1/12/14 During August 2013 concerns were reported by transporters to Administration about wheel chair safety straps loosening during transport of residents in facility vans and White Bus #3. Replacement straps of the same type were installed on August 23, 2013 but this information was not reported within the Quality Improvement process and was not presented at the next Quality Assurance Committee that occurred on October 24, 2013. There was no evaluation or follow up by the Quality Assurance Committee to ensure the straps remained secure during resident transport in white bus #3 and in the other	F 520	A Corrective Action Plan was immediately implemented and with all residents who may have the potential to be effected by the deficit practice. To address the Imminent Jeopardy of Quality Assurance	

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F 520	Continued From page 94 two transport vehicles or to evaluate other interventions, including training of staff, to ensure residents were secured in their wheelchairs during van transport. On Friday November 15th, 2013 when resident #85 was en-route to dialysis in the facility's White Bus #3, the resident's wheelchair tipped over sideways due to a strap securing her wheelchair to the White Bus #3 coming loose. Transporter reports the fall occurred when he was making a left turn and the wheelchair tipped over side-ways. Transporter stopped White Bus #3 and assisted the resident by placing the wheelchair upright and resident repositioned in wheelchair; resident denied injury. Transporter re-secured wheelchair safety belt system and transported to the Dialysis Center and the Dialysis Nurse assessed Resident #85 for any injuries and recommended follow-up upon return to the facility. Hall Nurse reassessed Resident #85 upon return to the facility with no injury identified. Transporter reported incident to ADON and ADON reported incident to Assistant Administrator. The Grey Van #1 is out of service until scheduled replacement of straps and the SURE-LOK system is installed on 1/16/14. The White Van #2 had new straps installed 1/10/14. The White Bus #3 had SURE-LOK system installed, which included new strap system on 11/21/14. Corrective Action: The facility will identify QA issues that are being brought to QA by review of incident and accident reports by Administration and any other issue that	F 520	1) Environmental/Safety Director will conduct daily meetings with transporters to review daily safety check lists for each specialized transportation vehicle 2) Environmental/Safety Director will submit the report to the Administrator. 3) Any problems identified with the specialized transportation vehicles will be immediately relayed to the Local Auto Mechanic and the specialized transportation vehicle taken out of service until problem is corrected. 4) A report will be filed on any safety issues identified and e-mailed to the Administrator, Assistant Administrator, Administrative Staff and pertinent Department Managers. 5)Remedial actions will be determined and assessed for effectiveness in the daily stand-up meeting. 6) A copy of incident reports and reviewed in daily stand-up meetings for any required interventions 7) The Administrator, Assistant Administrator and Administrative staff will attend daily stand-up meetings to discuss reports to determine action and resolve issues. 8) Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem resolved. 9) If the Administrator is unable to attend, minutes of the daily stand-up meeting will be e-mailed and communication will occur via e-mail and/or telephone conference 10) The Administrator, Assistant Administrator Director of Nursing and Administration Staff will attend QA/PI Meetings to discuss reports and determine action to resolve issues.	1/31/2014 1/31/2014 1/31/2014 1/31/2014 1/31/2014 1/31/2014 1/31/2014 1/31/20

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F 520	Continued From page 95 is brought to our attention in the daily morning meeting. 1. On 1/10/14 all specialized transportation vehicles were taken out of service until training of all transporters is complete by January 12th, 2014. 2. At 5:45 p.m. on January 10th, 2014 all transporters were notified that specialized wheelchair transport vehicles which included Grey Van #1 and White Van #2 and white bus #3 were taken out of service. 3. On 1/10/14 a local Auto Services technician who was completing the work on the specialized transport vehicles strapping and latching/ratchet systems was contacted concerning completion of the work for the Grey Van #1 and White Van #2 specialized transport vehicles. 4. The Services Technician completed the installation of the strapping and latching/ratchet system for the White 2008 Ford Van #2 at 6:30 p.m. on January 10th, 2014. A Facility Administrative Services Staff was in attendance and observed the completion of the installation of the wheelchair safety seat belt system at 6:30 p.m., on January 10th, 2014. 5. Administrative Services Representative, Environmental/Safety Director and Lead Transporter will be using SURE-LOK "Doing it Right" Leader Preparation Guide to enable them to educate all transporters. To validate competency, educators will review each other for competency. 6. Transporters will be reeducated by	F 520	11) Prior issues will be reviewed for effectiveness of action taken and revised as needed until problem is resolved. 12)If the Administrator does not attend QA/PI Coordinator will e-mail minutes of the meeting and communication will occur via e-mail and/or telephone conference call. 13) QA/PI Agenda with minutes of previous meeting will be sent to Administrator physician, pharmacist and all Department Managers who are to attend the monthly QA/PI Committee to ensure clear understanding of their responsibility to address any issues that has not been resolved and submit reports to the QA/PI Coordinator from their ongoing monitoring of significant issues being addressed. 14) Communication of issue(s) and plan of action will be sent to the QA/PI Coordinator prior to the QA/PI Meeting for approval and clear understanding of issues/concerns that need to be addressed by the QA/PI Committee. 15) QA/PI Coordinator will submit all Department QA/PI reports to the Administrator for review before the QA/PI Meeting 16) Any items recommended by the Administrator, Administrative Staff and Department Managers will be added to the Agenda for discussion at the monthly QA/PI Committee. 17) A plan of action will be developed for each issue resented to the QA/PI Committee with follow-up to ensure the interventions are effective. 18) The issues will remain on the agenda of the QA/PI Committee for follow-up until the Committee determines that	

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F 520	Continued From page 96 Administrative Services Representative, on daily safety inspection requirements and proper usage of the wheelchair safety equipment system for secure resident transport for all specialized wheelchair transport vehicles prior to transporting residents. Transport staff reeducated on what to do when there is an accident/incident, including when to call 911. All transporters have cell phone availability. Completion by January 12th, 2014. 7. Components of education will include SURE-LOK Safe and Secure Work Sheet, Pre-trip SURE-LOK Check List, Glossary of Terms for SURE-LOK System, Return Demonstration of Competency, Securing a resident in each specialized transport vehicle, SURE-LOK Training Video, purchased 01/11/14, will be part of the training. Licensed Physical Therapy Assistant will inservice all transporters on safe resident transport and proper body mechanics by 1/12/2014. 8. Facility policies on van transport will be revised to include safety inspections and pre-trip SURE-LOK Check List of the specialized wheelchair transport vehicles. Revised policies will be completed by January 12th 2014. 9. Beginning on 1/12/14 the Environmental Safety Director or a designated maintenance staff member will monitor compliance with safety inspections of the specialized transport vehicles on a daily basis. 10. Annual training will be done with all facility transporters. Records will be kept in employee file to validate training competency yearly. 11. An incident report will be filed on any	F 520	the effectiveness of the interventions and plan of action has been established with substantial compliance evidenced by tracking and trending reports presented to the QA/PI Committee. 20)The Administrator and/or designee, will oversee the systemic process to ensure that the deficit practice does not reoccur5 21) Transportation citation was reviewed in both Safety Committee Meeting and QA/PI Committee and plan of correction was approved with recommendations that monitoring of transportation safety be ongoing with reports to the Safety and QA/PI Committee on a monthly basis. The facility will obtain the services of independent contractors (individuals or companies not having any personal or professional relationship with the facility, the owners, and/or the Management Company), to conduct the following items specified in the directed plan of correction. 1) The facility will engage the services of an independent contractor to provide " Compassionate and Person Centered Training to the facility's direct care Staff and the independent contractor shall submit a written report to CMS and the state providing the content of the training, documentation of objectives and attendees participating. 2)The facility shall utilize an independent contractor to evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care and shall submit a written report to CMS and the State summarizing outcomes the outcomes of competency skills evaluation of direct care staff.	1/23/2014 3/5/2014 3/5/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 97 complaint and e-mailed to Administrator, Administration Staff and pertinent Department Heads. Remedial actions will be determined and prior plans assessed for effectiveness in the daily stand-up meeting. 12. A copy of all incident reports will be e-mailed to Administrator and Administration Staff and reviewed in the daily stand-up meetings for any required interventions. 13. The Administrator and Administration staff will attend Quality Assurance meetings to discuss reports and determine action to resolve issues. Prior issues will be reviewed for effectiveness of action taken and revised needed until problem resolved. If the Administrator does not attend, minutes of the meeting will be e-mailed and communication will occur via email and/or telephone conference call. 14. Communication of issue(s) and plan of action will be sent to Administrative staff prior to QA Meeting with approval and clear understanding by all Administrative staff. Staff will refer issues to the QA committee by verbal and written communication on Stop and watch forms. 15. All issues will be presented to the quality assurance committee by written and verbal form to all QA members present. 16. Plan of Action need to be approved or modified following presentation to QA Team members. A plan of action will be developed for each issue presented to the QA Committee with follow up to ensure the interventions are effective. The issue will remain on the agenda of the QA committee for follow up until the committee	F 520	3) The governing body, with the assistance of the independent contractor, shall conduct a root cause analysis regarding the facility's survey history beginning January 1st, 2011. The Root Cause Analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation 4) The facility shall specify in writing who will be responsible and accountable for the provision of quality care, treatment and services. A copy of the root cause analysis shall be provided to CMS and the State. 5) The governing body shall submit a written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports shall be provided to CMS and the State, monthly x 5 months.	3/5/2014 3/5/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	C 01/12/2014

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CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

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F 520	Continued From page 98 determines the issue has been resolved. 17. Individuals will be designated as the responsible party to follow up with action plans, give progress reports and provide a target completion date. All incident reports will be reviewed in the Daily Administrative Team Meetings and be referred to the next scheduled Quality Assurance Committee if indicated. One indication would be any issue that has the capacity to cause harm or has caused harm. Daily meetings will be held to review QA issue follow up and progress. Administrator will be notified of all incident and grievances following daily meetings. Immediate Jeopardy was removed on 01/12/14 at 3:48 PM when the facility provided provided evidence of additional in-service training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van by the Business Office Manager and Maintenance Director were completed. Interviews of transportation staff revealed each staff had been trained on securing wheelchair bound residents in the transportation vehicles appropriately. The Business Office Manager/Assistant Administrator and Director of Nursing also provided evidence of knowledge related to the QA system, function of the QA committee and how the QA system monitors for necessary follow up.	F 520		