| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MOUNTAIN TRACE REHABILITATION & NURSING CENTER | 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779 |

| (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 |
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| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview and staff interviews, the facility failed to continue self administration of medication for 1 of 1 residents (Resident #78) assessed as safe for this practice.<br><br>Findings included:<br><br>Resident #78 was admitted to the facility on 01/23/12 with a diagnosis of end stage renal disease. A review of her most recent Minimum Data Set dated 02/9/14 revealed the resident as being cognitively intact and receiving dialysis treatment. The care plan for Resident #78 dated 11/18/13 noted the resident at risk for nutritional complications with an intervention of providing her "meds/binders with meals as indicated." Another care plan problem noted Resident #78 as alert and oriented, able to make her needs known and able to plan and organize her day, with an intervention to "honor preferences as able, update MD [physician] with decline in cognition or AMS [altered mental status]."<br><br>Review of a care plan participation record dated 12/10/13 revealed Resident #78 wanting "to know if she can administer Phoslo [brand of phosphate binder] per self d/t [due to] needs to take with food" and "suggest her own lock box per niece." | F 176 | **THIS PLAN OF CORRECTION IS BEING SUBMITTED IN COMPLIANCE WITH SPECIFIC REGULATORY REQUIREMENTS AND PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES.**<br><br>**This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.**<br><br>**F- 176**<br><br>**To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**1. Resident # 78 was reassessed for safety in self- administration of medication and care plan updated.**<br><br>**2. All resident who self-administer medication have the potential to be affected.**<br><br>**3. Licensed Nurses were re-in-serviced on safety and self administration of medication process.** | 5/8/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Morrow — TITLE: Administrator — (X6) DATE: 5/14/14

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

Original Signature Date: 5-5-14

DHSR Received Black Mountain WRO MAY 14 2014 by: SKH

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| F 176 | Continued From page 1<br>A verbal order from the physician dated 12/12/13 revealed the resident was permitted to have binders at her bedside to self administer with meals during a 2 week trial, nursing was to check after meals that the resident had taken the binders and with any acute symptoms nursing would continue to administer the binder. A physician progress note dated 01/02/14 revealed the resident requesting use of phosphate binders by herself in the dining room with meals as administration time would be better for her, the medication was best used with meals and she had demonstrated favorable response to this with no problems on a trial basis. A physician order dated 01/02/14 directed Resident #78 could have and take phosphate binders with her meals. A self-administration of drugs form dated 01/20/14 and completed for Resident #78 revealed a checked box next to the statement "yes, I wish to administer my own medications. Proceed with your assessment of my ability to do so safely." An assessment by Nurse #1 on this form revealed the resident to be "alert, oriented, knows meds and can keep locked" with the form signed by both Resident #78 and Nurse #1. A copy of an untitled and undated document with blocks labeled "Bed Hold Policy", "Medication Administration" and "Sitter Policy", with respective lines for initials, revealed in the "Medication Administration" block the checked statement "The Resident should be considered a candidate to administer his or her own medications, which will be stored in a locked area. Such medications must be recorded by a licensed nurse as they are taken by the Resident." The initials placed on this form matched the initials placed on the self-administration of drugs form dated 01/20/14. Review of a care plan dated 01/20/14 revealed the resident "wants to keep and administer (self)" | F 176 | **Residents who would like to self administer medication will be assessed on admission, quarterly and with significant change for ability to safely self- administer medication.**<br><br>**Care plan will be developed and will include how medication will be stored and who will document the administration of the medication.**<br><br>**4. DON or designee will conduct random audits on residents who self administer medication for compliance weekly x 4, then monthly x 3.**<br><br>**5. Findings of the audit will be reported to Quality Insurance monthly x 3 , and action if needed.** | |

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| F 176 | Continued From page 2<br>her phosphate binder. A dietary progress note dated 01/28/14 revealed Resident #78 "tolerates phosphate binders; likes to administer them herself in dining room." Review of her care plan dated 02/14/14 revealed "res. cont to administer own binders with lock box in room."<br><br>Review of the monthly physician orders for April 2014 revealed the order "NURSING NOTES- may leave binders at bedside for resident to self administer with meals, nursing to check after meals that resident has taken binders, any AMS noted nursing will contact MD." A review of medical orders dated 04/07/14 revealed a new order to stop the phosphate binder Fosrenol and to start Phoslo 667 milligrams, 4 with meals and 3 with snacks.<br><br>An interview with Resident #78 on 04/08/14 at 10:25 AM revealed her need to take a binder with all meals and snacks to help keep her phosphorus level at an acceptable level. She stated sometimes the nurse did not bring her binder until after her meal or snack had been eaten.<br><br>An observation on 04/08/14 at 11:30 PM revealed Resident #78 approaching Nurse #6 and asking for her binder to take to the dining room to take with her meal. Nurse #6 was heard telling Resident #78 she had to watch the resident take them. Resident #78 was heard replying to Nurse #6 that she would go eat something and come back and get it.<br><br>An observation on 04/08/14 at 4:10 PM revealed Resident #78 telling Nurse #7 she had to take her meal in her room so that she could take her binder with her meal and Nurse #7 replied he | F 176 | | |

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| F 176 | Continued From page 3<br>would come by and give them at meal time.<br><br>An interview with Resident #78 on 04/10/14 at 11:40 AM revealed that until 3 weeks prior she was able to keep her binder in a black lock box with a key, at which time staff removed the box and they had not returned it. She stated since staff removed the lock box, she had planned to eat her meals in her room so she was available when the nurse came to the room with the medication cart. Resident #78 stated nurses had not been consistent with this practice. She stated the lock box was last seen at the nursing station and she was never given a reason why she could no longer take the binder herself.<br><br>An interview on 04/10/14 at 11:50 AM with Nurse #6 revealed she never had Resident #78 self administer medications and if she were allowed to do so, no one told her nor was she aware this could happen. She stated the binder recently changed from Fosrenol to Phoslo and that a week prior an empty lock box was removed from the resident's room. Nurse #6 stated if she were told self administration of medication were possible for this resident, she would comply but in the absence of direction she was required to observe all medications being taken by residents.<br><br>An interview on 04/10/14 at 5:27 PM Nurse #1 revealed residents were allowed self administration of medications but they had to be assessed, have a locked box, know to lock the box after they obtained their medications and had to understand their medications. She stated Resident #78 should be allowed to take her phosphorus binder as she was assessed, care planned and provider orders were obtained for this practice. | F 176 | | |

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| F 242 SS=D | 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews with residents and staff and record review, the facility failed to provide showers to residents per the residents' choice of how frequently and what time of day for 3 of 3 residents (Residents #2, #30 and #81).<br><br>Findings included:<br><br>1. Resident #81 was admitted on 04/30/12 with diagnoses including advanced Parkinson's disease, coronary artery disease and hypertension. An annual Minimum Data Set (MDS) assessment indicated Resident #81 was cognitively intact for daily decision making and was able to understand and could make himself understood. The MDS indicated he had no rejection of care during the observation period.<br><br>During an interview with Resident #81 on 04/07/14 at 4:09 PM, Resident #81 stated he had not been asked how often he would like a bath or shower. He stated he was told he would get 2 showers a week. He stated he would like to have a shower every day because it helped his muscles relax. He stated if it wasn't possible to get a shower every day that he would like at least | F 242 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F-242**<br><br>**1. Residents #2, #30, #81, will be interviewed and bathing preferences will be care planned and honored.**<br><br>**2. All residents have the potential to be affected. The Social Worker will interview all residents on bathing preferences and update care plan and kardex developed accordingly.**<br><br>**3. Residents will be interviewed on admission, quarterly and with significant change on bathing preferences by Social Services. Bathing preferences will be scheduled and care plan and kardex developed.**<br><br>**4. The Interdisciplinary Team (IDT) will conduct random daily audits for honoring resident preferences during Care Keeper rounds x 4 weeks.**<br><br>**5. Results of findings will be reported to QAPI Committee monthly for review and action if needed.** | 5/8/14 |

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| F 242 | Continued From page 5<br>5 showers a week.<br><br>An interview with MDS Nurse #1 on 04/08/14 at 3:22 PM revealed no one on the Interdisciplinary Team (IDT) asked residents about their preferences for frequency of baths or showers as part of the assessment process. She stated residents can make specific requests and the facility will accommodate those requests. She stated she wasn't aware of any resident currently in the facility who had made any special requests.<br><br>An interview with the Social Worker (SW) on 04/08/14 at 3:35 PM revealed she did not ask residents about their preferences for frequency of baths or showers. She stated she wasn't aware of any current resident who had requested more frequent showers.<br><br>During a follow-up interview with Resident #81 on 04/09/14 at 8:58 AM, Resident #81 stated he would really like to get a shower every day and stated "it would make me very happy." He stated he was not aware it was an option to get a shower more than twice a week.<br><br>An interview with the Admissions Director on 04/09/14 at 10:23 AM revealed she had been responsible for doing admissions at the facility since mid January 2014. She stated she scheduled a meeting for 72 hours after the resident was admitted when the family and/or resident met with all the members of the IDT and they could share any personal preferences at that time.<br><br>An interview with the Activity Director on 04/09/14 at 11:40 AM revealed she completes Section F of the MDS which is a scripted interview. She | F 242 | | |

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| F 242 | Continued From page 6<br>stated she asked about their preference between a bath or shower but didn't ask about their preference for the time of day the shower is given or the frequency of showers.<br><br>An interview with Nurse Aide (NA) #1 on 04/09/14 at 3:15 PM revealed she was familiar with Resident #81. She stated his assigned shower days were Monday and Thursday on the 7-3 shift. NA #1 stated she thought Resident #81 seemed to want a shower more often because he would ask if it was his shower day when it wasn't. She stated Resident #81 had not specifically asked for more frequent showers.<br><br>An interview with Nurse #1 on 04/09/14 at 3:44 PM about the shower schedule revealed showers were scheduled based on the resident's room number so the showers were divided between the day and evening shifts. She stated residents could change the time of their shower based on their preference and could get more frequent showers if they requested them. She stated she wasn't aware of any current resident who had made any specific requests. She stated she adjusted the shower schedule to accommodate any specific resident requests. She stated she didn't specifically ask residents about their preferences for frequency of showers.<br><br>An interview with the Director of Nursing (DON) on 04/10/14 at 5:03 PM revealed she attends some of the 72 hour meetings with newly admitted residents. She stated she usually tells the resident and/or family member that the resident will get 2 showers a week unless they want more frequent showers. The DON stated she tells them they can have a shower every day if they want one. She was not aware of any other | F 242 | | |

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| F 242 | Continued From page 7<br>time when residents were asked about their choice for frequency of showers or their preference for the time of day of their shower.<br><br>Review of the documentation of Resident #81's showers for the past month revealed he had received 2 showers a week on Monday and Thursday.<br><br>Review of the facility's admission packet did not reveal any information regarding resident preferences for frequency of showers.<br><br>2. Resident #30 was admitted to the facility on 01/28/14 with diagnoses including uncontrolled diabetes mellitus type 2, hypertension and depression. An admission Minimum Data Set (MDS) assessment dated 02/03/14 indicated Resident #30 was cognitively intact for daily decision making and was able to understand and could make herself understood. The MDS indicated she had no rejection of care during the observation period.<br><br>During an interview with Resident #30 on 04/07/14 at 12:21 PM, Resident #30 stated no one had asked her how often she wanted a bath or shower. She stated she was told when she was admitted that she would get 2 showers a week. She stated she would like to have more than 2 showers a week and that she would prefer to have her showers on the day shift instead of the evening shift.<br><br>An interview with MDS Nurse #1 on 04/08/14 at 3:22 PM revealed no one on the Interdisciplinary Team (IDT) asked residents about their preferences for frequency of baths or showers as part of the assessment process. She stated | F 242 | | |

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| F 242 | Continued From page 8<br>residents can make specific requests and the facility will accommodate those requests. She stated she wasn't aware of any resident currently in the facility who had made any special requests.<br><br>An interview with the Social Worker (SW) on 04/08/14 at 3:35 PM revealed she did not ask residents about their preferences for frequency of baths or showers. She stated she wasn't aware of any current resident who had requested more frequent showers.<br><br>A follow-up interview with Resident #30 on 04/08/14 at 4:00 PM revealed she had told a staff member she wanted more than 2 showers a week but she was unable to remember who she told. Resident #30 stated she didn't like to take a shower at 9:30 PM because it wakes her up and she can't go to sleep. She stated she would like to get her shower earlier in the day on Saturdays before her family visits.<br><br>During an additional interview with Resident #30 on 04/09/14 at 9:15 AM, Resident #30 stated: "I would really like to have a shower but I'm not supposed to get it until the 3-11 shift. "When asked if she had told staff she would like to get her shower this morning, she stated: "I've told them in the past but the Nurse Aides (NAs) tell me they don't have time because they have 2 meals to serve and already have a lot of showers to give."<br><br>An interview with the Admissions Director on 04/09/14 at 10:23 AM revealed she had been responsible for doing admissions at the facility since mid January 2014. She stated she scheduled a meeting for 72 hours after the resident was admitted when the family and/or | F 242 | | |

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| F 242 | Continued From page 9<br>resident met with all the members of the IDT and they can share any personal preferences at that time.<br><br>An interview with the Activity Director on 04/09/14 at 11:40 AM revealed she completes Section F of the MDS which is a scripted interview. She stated she asked about their preference between a bath or shower but didn't ask about their preference for the time of day the shower is given or the frequency of showers.<br><br>An interview with Nurse #1 on 04/09/14 at 3:44 PM about the shower schedule revealed showers were scheduled based on the resident's room number so the showers were divided between the day and evening shifts. She stated residents could change the time of their shower based on their preference and could get more frequent showers if they requested them. She stated she wasn't aware of any current resident who had made any specific requests. She stated she adjusted the shower schedule to accommodate any specific resident requests. She stated she didn't specifically ask residents about their preferences for frequency of showers.<br><br>An interview with NA #2 on 04/09/14 at 6:00 PM revealed she was familiar with Resident #30. She stated Resident #30's assigned shower days were Wednesday and Saturday on the 3-11 shift. NA #2 stated the last time she gave Resident #30 her shower, Resident #30 told her she would prefer to have her showers on the 7-3 shift but she forgot to tell the nurse so the shower schedule could be changed. She stated Resident #30 had not told her she would like to have more than 2 showers a week. | F 242 | | |

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| F 242 | Continued From page 10<br>An interview with the Director of Nursing (DON) on 04/10/14 at 5:03 PM revealed she attends some of the 72 hour meetings with newly admitted residents. She stated she usually tells the resident and/or family member that the resident will get 2 showers a week unless they want more frequent showers. The DON stated she tells them they can have a shower every day if they want one. She was not aware of any other time when residents were asked about their choice for frequency of showers or their preference for the time of day of their shower.<br><br>Review of the documentation of Resident #30's shower for the past month revealed she had received 2 showers a week on Wednesday and Saturday on the 3-11 shift.<br><br>Review of the facility's admission packet did not reveal any information regarding resident preferences for frequency of showers.<br><br>3. Resident #2 was admitted to the facility on 05/24/12 with diagnoses including cerebral vascular accident with hemiplegia affecting her non dominant side, colostomy related to rectal prolapse, contracture of hand joint and contracture of ankle and foot joints. A quarterly Minimum Data Set (MDS) assessment indicated Resident #2 was cognitively intact for daily decision making and was able to understand and could make herself understood. The MDS indicated she had no rejection of care during the observation period.<br><br>During an interview with Resident #2 on 04/07/14 | F 242 | | |

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| F 242 | Continued From page 11<br>at 4:00 PM she confirmed she was not given a choice as to how often she wanted a shower or a bed bath. She stated the staff told her she would have two showers a week and bed baths on the other days. Resident reported she loves to get cleaned up daily.<br><br>An interview with the Social Worker (SW) on 04/08/14 at 3:35 PM revealed she did not ask residents about their preferences for frequency of baths or showers. She stated she wasn't aware of any current resident who had requested more frequent showers.<br><br>An interview with the Admissions Director on 04/09/14 at 10:23 AM revealed she had been responsible for doing admissions at the facility since mid-January 2014. She stated she scheduled a meeting for 72 hours after the resident was admitted when the family and/or resident met with all the members of the Interdisciplinary Team and they can share any personal preferences at that time.<br><br>An interview with the Activity Director on 04/09/14 at 11:40 AM revealed she completes Section F of the MDS which is a scripted interview. She stated she asked about their preference between a bath or a shower but didn't ask about their preference for the time of day the shower is given or the frequency of showers.<br><br>An interview with Nurse #1 on 04/09/14 at 3:44 PM about the shower schedule revealed showers were scheduled based on the resident's room number so the showers were divided between the day and evening shifts. She stated residents could change the time of their shower based on their preference and could get more frequent | F 242 | | |

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| F 242 | Continued From page 12<br>showers if they requested them. She stated she wasn't aware of any current resident who had made any specific requests. She stated she adjusted the shower schedule to accommodate any specific resident requests. She stated she didn't specifically ask residents about their preferences for frequency of showers.<br><br>An interview with NA#3 on 04/09/14 at 5:56 PM revealed she was familiar with Resident #2. She stated Resident #2's assigned shower days were Wednesday and Saturday on the 3-11 shift. NA#3 stated Resident #2 liked to be clean and was very good about taking her shower and bed baths. She further revealed Resident #2 would always take her showers unless she felt too bad and would then take a bed bath instead. NA#3 confirmed that Resident #2 would not refuse her showers.<br><br>An interview with the Director of Nursing (DON) on 04/10/14 at 5:03 PM revealed she attends some of the 72 hour meetings with newly admitted residents. She stated she usually tells the resident and/or family member that the resident will get 2 showers a week unless they want more frequent showers. The DON stated she tells them they can have a shower every day if they want one. She was not aware of any other time when residents were asked about their choice for frequency of showers or their preference for the time of day of their shower.<br><br>Review of the documentation of Resident #2's showers revealed she had received 1 shower and 5 bed baths from March 9, 2014 through April 7, 2014.<br><br>Review of the facility's admission packet did not | F 242 | | |

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| F 242 | Continued From page 13<br>reveal any information regarding resident preferences for frequency of showers. | F 242 | | |
| F 244 SS=E | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews, the facility failed to provide resolution to Resident Council concerns related to issues with call lights and knocking on resident doors before entering and staff identifying themselves.<br><br>Findings included:<br><br>An interview was conducted on 04/07/14 at 4:28 PM with the Resident Council President. (Resident #2). According to her MDS dated 01/14/14 she was assessed as cognitively intact. She reported concerns had been discussed in many resident council meetings regarding issues relating to call lights, staff knocking on resident doors prior to their entry and identifying themselves with no follow up as of the last meeting on March 18, 2014.<br><br>Review of the Resident Council minutes for November 19, 2013 through March 18, 2014 revealed no documentation on follow up with grievances had been discussed in the council | F 244 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F-244**<br><br>**1. Resident Council meeting was held to review unresolved grievance and planned resolution.**<br><br>**2. All residents have the potential to be affected.**<br><br>**3. The IDT will be re-educated on the Grievance Process.**<br><br>**Staff will be re-in serviced on answering call-lights timely and knocking on doors prior to entry.**<br><br>**4. The grievances/concerns received will be documented on the Concern form and provided to the Administrator or designee. The Administrator or designee will log the concern and forward to the appropriate department head for resolution. Daily during morning meeting NHA or designee will review status of concerns. Once resolved, the** | 5\|8\|14 |

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| F 244 | Continued From page 14<br>meetings during this time.<br><br>A review of the facility form entitled " Concern Form " for November 19, 2013 through March 18, 2014 revealed no documentation on resolution of concerns had been completed related to the concerns expressed by resident council during those months.<br><br>An interview was conducted on 04/10/14 at 11:06 AM with the Social Service Director who revealed she led and read minutes from the last meeting. She stated minutes had been read at the following resident council meeting from the meeting before under old business. The Social Service Director stated she had written up the minutes of the meetings and had taken them to the Interdisciplinary Team Meeting the morning after the resident council meeting and the concerns were given to the appropriate team member/department head. The particular team member/department head would address, educate and provide the resolution for the concerns. The resident council concern form would be returned to the Social Service Director with the completed resolution and if there were any in-services provided they would be attached to the concern form. The Director of Social Services stated resident council reported call lights, knocking on resident doors and staff identifying themselves were continued problems that she written up monthly and presented at the Interdisciplinary Team meetings. She further reported the former Director of Nursing (DON) had not provided her with the resolutions for resident council concerns.<br><br>An interview was conducted on 04/10/14 at 1:00 PM with the DON stating she had no role in the | F 244 | **assigned department head contacts the appropriate party. The form will be completed and returned with documentation to the Administrator or designee. The Administrator will monitor daily for compliance in morning meeting (M-F)**<br><br>**During each month's Resident Council meeting, Old Business to include Grievances/Concerns will be reviewed to assure resolution has occurred.**<br><br>**5. Trends from Concerns are reported to QAPI Committee monthly for review and action if needed.** | |

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| F 244 | Continued From page 15<br>resident council unless she was invited to the meetings. She further stated the Director of Social Services had written up the resident council concerns and she would address the nursing concerns. The Director of Nursing had been there for the past 2 months and confirmed she was still in the process of addressing resident council concerns she had received. | F 244 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to keep clean and in good repair fixtures, walls, floors and wheelchairs for 10 of 55 resident rooms.<br><br>Findings included:<br><br>During a facility tour and interview with the Maintenance Director (MS) and Housekeeping Supervisor (HS) on 04/10/14 from 11:00 AM to 1:30 PM, the following environmental concerns were noted:<br><br>1. Room 404 bathroom revealed a broken towel bar with a metal piece lying in the corner, a loose toilet seat and cracked vinyl covering on armrests of a commode booster seat. The armrests were loosely connected to the metal frame of the commode booster seat with the left armrest observed wrapped in paper tape around the | F 253 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F-253**<br><br>**1. The broken towel bars in rooms 404 and 104 will be replaced, the toilet seats and commode booster seat for rooms 404 and 301 will be replaced and/or repaired and the commode booster seat in room 301 will be clean, wheelchair repairs and/or replacements for room 305, 303, and 301 will occur, the PTAC unit with a protruding metal corner in room 305, 303 will be repaired, the PTAC in room 301 will be dusted, the PTAC unit cover in room 202 will not have scraped paint across the front, the caulk at the commode base in room 307 will be repaired, the** | 5/8/14 |

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| F 253 | Continued From page 16<br>metal frame<br><br>2. Room 305 revealed a resident seated in a wheelchair (WC) with cracked vinyl covering on the armrests and a protruding metal corner of a black metal cover over the old condenser of a package terminal air conditioner (PTAC) unit<br><br>3. Room 307 bathroom revealed brown stained caulk at the base of the commode, lack of caulk in the space between the bathroom floor and shower pan and crumbling drywall measuring approximately 2 inches by 5 inches in a corner section along the baseboard and to the right of the shower enclosure<br><br>4. Room 303 bathroom revealed brown stained caulk at the base of the commode and grey/black caulk in the space between the bathroom floor and shower pan. Areas on the drywall to left of shower enclosure were observed patched but not completely filled in, not sanded smooth, nor primed and painted. In this room was observed a WC in active use with cracked, peeling vinyl covering to the armrests<br><br>5. Room 301 bathroom revealed grey/black grout in the space between the bathroom floor and shower pan and brown smeared material on two spots on the back left side of the metal frame of the commode booster seat, both spots measuring approximately 1 inch by 2 inches in size. The inside of the wood bathroom door was observed as heavily marred and nicked along the bottom with a jagged appearance. In this room, the PTAC vent along the floor under the unit was observed covered in dust and a WC in active use was observed with cracked and peeling vinyl covering on the armrests. | F 253 | **tile will be repaired and/or replaced in room 104, the drywall in rooms 307, 303, 205, and 206 will be repaired, the grout in the space between the bathroom floor and shower pan in room 301 will be repaired, the inside of the wood bathroom door in rooms 301 and 104 will be repaired, the non-slip strips on the bathroom floor will be repaired and/or replaced in rooms 202, 205, 206, and 208 the wallpaper in room 206 will be repaired by May 8, 2014.**<br>**2. All residents have the potential to be affected.**<br><br>**3. The Residents have the potential to be affected.**<br><br>**An environmental audit was completed on 4-11-14 and 4-30-14 findings were addressed.**<br><br>**4. Re-in-service staff on the use and locations of the maintenance log books. The maintenance log books will checked by the Maintenance Director, each work day for any concerns and will complete in a timely manner.**<br>**5. The IDT will complete daily (M-F) rounds. Any housekeeping or environmental concerns will be reported for resolution.** | |

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| F 253 | Continued From page 17<br><br>6. Room 202 was observed with scraped paint across front of PTAC unit cover. The bathroom revealed one non-slip strip on the floor of the shower enclosure, in the vicinity of the shower head in the corner of the shower, measuring approximately 12 inches in length with no other non-slip strips noted<br><br>7. Room 205 revealed exposed paper layer of drywall by the door to bathroom, without being primed or painted. In the bathroom, a non-slip strip on the floor of the shower enclosure was peeling and baseboard was also peeling away from the drywall<br><br>8. Room 206 revealed peeled areas of wallpaper above a resident's bed. In the bathroom, a section of unprimed and unpainted drywall measuring approximately 1 inch by 4 inches was exposed along top of shower enclosure. 2 of 3 non-slip strips on the floor of the shower enclosure were missing half way along their length in the vicinity of the shower seat. The middle length of non-slip strip was observed peeling at the edges and when pressure was applied in the middle of strip, the strip moved across the surface of the shower floor<br><br>9. Room 208 bathroom revealed approximately 2/3 the length of a non-slip strip on the floor of the shower enclosure missing and 2 entire lengths of non-slip strip missing.<br><br>10. Room 104 revealed a heavily scraped and marred door jamb to the bathroom. In the bathroom, brown stained floor tile was observed surrounding the commode and a towel bar was broken. | F 253 | **The Administrator or designee, Housekeeping and the Maintenance Director will conduct weekly environmental rounds.**<br><br>**6. The Maintenance Director and Housekeeping Supervisor will report findings to the QAPI Committee monthly and action if needed.** | |

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| F 253 | Continued From page 18<br><br>The Maintenance Supervisor (MS) and Housekeeping Supervisor (HS) were interviewed on 04/10/14 commencing at 11:00 AM and during a tour of the above resident rooms which concluded at 1:30 PM. The MS stated staff noted facility concerns in books at each nursing station and in the kitchen. He stated when he had an assistant, these books were checked twice a day but with the assistant no longer employed, he was by himself and checked them once a day or every other day. He stated it was difficult to get to everything, he tried to prioritize and housekeepers were good to help out. He stated the books tended to work and staff was trained to find the book. The MS stated issues that were true safety hazards were attended to immediately. He stated staff were aware of what was a danger that needed to be reported immediately and he would sometimes do an in-service. The MS stated he created a master action plan two years and to date, 300 and 400 unit rooms and the main dining room were remodeled. He stated 100 and 200 unit rooms were remaining and he had to re-prioritize the list to address the worse rooms in these units. The MS stated WC concerns were noted by staff in the books and therapy staff would also report concerns. He stated the corporation used a computerized system and recently added a check of WC and he expected staff to put cracked or ripped armrests in the book. The MS and HS stated housekeeping staff would scrub caulk, but if there were discoloration from being old, then maintenance would scrape it out and replace it. The MS stated some but not all of the shower pans were covered in a textured material and nurse aides would report problems. He stated some shower pans had non-slip strips that would | F 253 | | |

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| F 253 | Continued From page 19<br>peel up and some residents would complain this would irritate their feet. He stated there had been no recent reports of falls so they went by what NAs would report. The MS stated if drywall and wallpaper issues were not severe, he would try to save repairs for the remodeling project. He stated some rooms had new PTAC units and those remaining would have them replaced out three at a time. The HS stated commode booster seats were to be cleaned every day and housekeeping staff were expected to report when they were rusty or needing replacement.<br><br>An interview with the administrator on 04/10/14 at 3:35 PM revealed her expectation that every month there was to be some continual improvement. She stated wear and tear concerns should be addressed as they occurred. | F 253 | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews the facility failed to obtain labs as ordered by the physician for 6 of 11 sampled resident reviewed for labs.<br>(Residents #1, #6, #16, #28, #60, #121)<br><br>The findings are:<br><br>1. Resident #121 was admitted to the facility from the hospital on 02/27/14 with diagnoses which included left hip fracture with repair, | F 281 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F- 281**<br><br>**1. Residents #121 was discharged from the facility on 04/07/14. The physician was notified of the omission of the CBC.**<br><br>**Resident #1's physician's order for C-Diff was discontinued.**<br><br>Resident #6 expired 03/21/14.<br><br>Resident #60 Folic Acid and B12 were obtained. MD was notified. | 5/8/14 |

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| F 281 | Continued From page 20<br>coronary artery disease and non operative acute cholecystitis.<br><br>On 04/04/14 a physician's order was written at 4:00 PM for a chest X-ray, STAT (immediately) CBC (complete blood count) and weight due to decreased oxygen with saturation 82%, respiratory distress and abnormal lung sounds.<br><br>A nurse's note written by Nurse #3 on 04/04/14 at 5:00 PM noted the physician was called and ordered chest X-ray, CBC lab draw, weight today for hypoxia, abnormal lung sounds. X-ray ordered, technician is already here in the building. Patient's O2 saturation decreased down to 84%, somewhat lethargic. Lung sounds clear X 4 with intermittent crackles in left lower lobe with diminished profusion, no signs/symptoms of fever, infection at present. Will monitor for changes. On 04/04/14 at 6:45 PM Nurse #3 documented, Oxygen saturation increased 98% on 3 liters oxygen via nasal cannula. Z-Pack ordered. CBC to be drawn.<br><br>Review of the medical record of Resident #121 revealed no results of the STAT CBC ordered 04/04/14. On 04/10/14 at 11:15 AM Nurse #1 stated although labs were contracted by an outside agency if a lab was ordered STAT it is to be drawn immediately by a nurse and taken to the hospital lab. Nurse #1 verified the STAT CBC ordered 4/4/14 for Resident #121 was not in the medical record. Nurse #1 called the hospital to see if the lab was done. In a follow-up interview on 04/10/14 at 11:30 AM Nurse #1 stated the hospital did not have the CBC which was ordered STAT on 4/4/14. Nurse #1 noted that the need for the CBC was entered in the facility computer system which generates the lab to be drawn by | F 281 | Resident #16 Folic Acid was obtained.<br><br>Resident #28 BMP was obtained.<br><br>**2.Residents with lab orders have the potential to be affected.**<br><br>**An audit will be conducted any findings will be resolved. MD notified and orders implemented if applicable.**<br><br>**1. Licensed Nurses will be re-in-serviced on processing, reporting, documentation and filing of lab results.**<br><br>**2. DON or designee will complete daily audits 7 days weekly for lab collection, results and MD notification. Any findings will be addressed with MD for further direction.**<br>**3. Findings will be reported to QAPI Committee monthly for review and action if needed.**<br>**4. DON or designee will complete daily audits (M-F) for lab collection, results and MD notification. Any findings will be addressed with MD for further direction.**<br>**5. Findings will be reported to QAPI Committee monthly x 3 for review and actions if needed.** | |

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| F 281 | Continued From page 21<br>the contract lab company. The electronic documentation noted the need for the CBC had been entered into the system on 4/4/14 at 6:17 PM with notation under "status" that the collection was pending with no results. Nurse #1 stated that Nurse #3 working with Resident #121 on 04/04/14 was an agency nurse and only worked at the facility two days. Nurse #1 stated that Nurse #3 could not have entered the order for the CBC in the computer system because agency nursing staff are not given a password. Nurse #1 stated Nurse #3 should have known what a STAT order meant and if she needed clarification she should have asked the nurse on duty 04/04/14 that entered the order in the computer system. Nurse #1 stated she could not tell who entered the order in the computer system for the CBC for Resident #121 on 04/04/14. Nurse #1 stated that she did not know how to get in touch with Nurse #3 since she was an agency nurse and only worked at the facility two days. On 04/10/14 at 12:20 PM Nurse #1 stated she called the contract lab company and they verified the CBC ordered 04/04/14 for Resident #121 was not done and the lab company could not explain why the CBC was not done as ordered.<br><br>On 04/10/14 at 3:45 PM the DON stated she was not aware the STAT CBC ordered 04/04/14 for Resident #121 had not been done. The DON stated knowing Nurse #3 was an agency nurse she would have expected her to ask another staff nurse how to handle a STAT order if she was unfamiliar with the facility protocol. The DON stated she was aware there were problems with labs not being done as ordered and had implemented changes the end of March. The DON stated one of the changes was to keep a record of all labs and, although she was keeping | F 281 | | |

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| F 281 | Continued From page 22<br>this record, she had missed this one due to being away from the facility.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #121 stated he was unaware the STAT CBC ordered 04/04/14 for Resident #121 was not completed. The physician stated there had been issues with labs not being completed as ordered and it was concerning to him.<br><br>2. Resident #1 was admitted to the facility 02/04/14 with diagnoses which included senile dementia.<br><br>Nurses notes on 02/18/14 included, Resident noted to have watery mucousy foul smelling stools. MD notified. Nursing order obtain stool culture for clostridium difficile (c diff). Physician orders on 02/18/14 included to do a Stool culture for c diff.<br><br>Review of the medical record of Resident #1 noted there was not a result of the stool culture which was ordered on 02/18/14.<br><br>On 04/08/14 at 3:45 PM the facility Director of Nursing (DON) stated she was unaware the stool culture for Resident #1 had not been done as ordered by the physician on 02/18/14. The DON stated nursing staff should have obtained a stool sample from Resident #1 and had it available for the contract lab to pick up to culture for c diff. In a follow-up interview at 4:20 PM the DON stated she found an Incomplete Notification slip from the lab dated 02/19/14 which indicated there was not a stool sample available for the lab to be completed. The DON stated this slip was located in the lab book at the nurses station and should have been sent to her for follow-up. The | F 281 | | |

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| F 281 | Continued From page 23<br>DON confirmed the lab should have been completed as ordered.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #1 stated he was unaware the c diff ordered 02/18/14 for Resident #1 was not completed. The physician stated there had been issues with labs not being completed as ordered and it was concerning to him.<br><br>3. Resident #6 was admitted to the facility 12/18/12 with diagnoses which included Alzheimers and hallucinations.<br><br>Review of physician orders noted Resident #6 had been taking 250 milligrams of Depakote ER every day since 11/19/13.<br><br>A physician's progress note dated 03/13/14 noted resident with advanced dementia with behavioral disturbances, unable to make her own needs known. No recent exacerbation of behavioral disturbance. Her medications include Depakote. 93 lbs. Patient demonstrates significant debility to warrant frequent monitoring by staff as well as preventaive measures for complications such as skin breakdown and infections and falls with potential injury or fractures. We will continue to provide a safe environment, preventive measures and support to optimize this patients safety, function and quality of lift. Check Valproic acid level to assess status. Physician orders on 03/13/14 included to check Valproic acid level, CBC, BMP and TSH.<br><br>Review of the medical record of Resident #6 noted the results of the Valproic acid level were not available. | F 281 | | |

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| F 281 | Continued From page 24<br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) reviewed the facility process for obtaining labs. The DON stated the nurse that takes the order notes the need in the electronic computer system set up with the contract lab. The DON stated Nurse #5 had taken the order for the Valproic acid on 03/13/14. The DON stated she was not aware the Valproic acid ordered 03/13/14 for Resident #6 had not been completed as ordered. The DON stated there had not been a system in place to ensure labs were done as ordered until very recently. The DON stated she was aware there were problems with labs not being done as ordered and she was in the process of putting systems in place to resolve the issue. On 04/08/14 at 4:15 PM the DON stated she looked at the labs that were ordered for Resident #6 on 03/13/14 and the Valporic Acid was not included with the other labs that were ordered that day.<br><br>On 04/09/14 at 5:30 PM Nurse #5 stated she recalled the order for Valproic Acid for Resident #6. Nurse #5 stated she recalled entering the order for the labs for Resident #6 in the facility electronic computer system for the lab. Nurse #5 could not explain why the Valproic Acid was not included in the lab orders entered in the system on 03/13/14.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #6 stated he was unaware the Valproic acid ordered 03/13/14 for Resident #6 was not completed. The physician stated there had been issues with labs not being completed as ordered and it was concerning to him. | F 281 | | |

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| F 281 | Continued From page 25<br><br>4. Resident #60 was admitted on 06/11/13 with diagnoses including diabetes mellitus, atrial fibrillation, polyneuropathy in diabetes, depression and anxiety.<br><br>Review of Resident #60's medical record revealed a physician's order dated 02/13/14 for a Vitamin B-12 and Folic Acid serum concentration level. Further review of the medical record revealed results of the lab tests were not on Resident #60's medical record.<br><br>On 04/08/14 at 2:30 PM Nurse #2 stated the nurse who takes the order makes a note on the 24 hour report that the lab is pending so the nurses can make sure the lab is drawn and the result is received.<br><br>On 04/09/14 at 2:42 PM the Director of Nursing (DON) verified the the labs for Resident #60 were not obtained as ordered. The DON stated the 24 hour reports were not available to determine if the need for the lab was noted by the nurse that took the order on 02/03/14.<br><br>On 4/09/14 at 4:30 PM the Director of Nursing (DON) stated she just implemented a system for ensuring lab results were completed which included review of telephone orders for labs and all lab results in an effort to ensure lab work was completed as ordered. She could offer no explanation why the results of the labs ordered for Resident #60 on 02/13/14 were not obtained as ordered. | F 281 | | |

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| F 281 | Continued From page 26<br><br>An interview with Nurse #1 on 04/09/14 at 6:56 PM revealed she completed an audit of all residents charts in January 2014 and checked to see if results for all labs that had been ordered in the previous 3 months were on the residents' medical record. She stated she made a list of all ordered labs that didn't have results on the resident's medical record and gave the list to the former DON so she could follow up with the physician and get orders for the labs. Nurse #1 stated she did the audit because they had identified a concern with labs that were ordered without results being on the residents medical record. Nurse #1 stated she was still in the process of inservicing staff on the process of completing lab work for residents.<br><br>On 04/09/14 at 7:08 PM the Regional Clinical Director (RCD) stated the concern with lab results not being on the resident's medical record was identified in January 2014. She stated she provided the facility with an audit tool which they used to review all the residents' medical records through January 2014. The RCD stated they identified ongoing problems last week and they were in the process of putting plans in place to address the concern. She was unable to explain why the labs ordered for Resident #60 on 02/13/14 were not obtained as ordered. The RCD stated she expected all ordered labs to be obtained and the results put on the resident's medical record. She stated the physician should be notified of all abnormal labs by phone and should also be provided with a copy of the results of all labs to review.<br><br>An interview with the Medical Director on 04/10/14 at 4:33 PM revealed he was aware there | F 281 | | |

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| F 281 | Continued From page 27<br>was an ongoing problem with laboratory tests not being obtained as ordered and of abnormal labs not being reported to either himself or the nurse practitioner. He stated it was very concerning to him to know that labs were not done as ordered or that lab results were not being given to them to review.<br><br>5. Resident #16 was admitted to the facility on 08/16/12 with diagnoses including diabetes mellitus type 2, end stage renal disease with dialysis, anemia and history of liver transplant.<br><br>Review of Resident #16's medical record revealed a physician's order dated 02/13/14 for a Folic Acid serum concentration level. Further review of the medical record revealed the result of the lab test was not on Resident #16's medical record.<br><br>On 04/08/14 at 2:30 PM with Nurse #2 stated the nurse who takes the order makes a note on the 24 hour report that the lab is pending so the nurses can make sure the lab is drawn and the result is received.<br><br>On 4/09/14 at 4:30 PM the Director of Nursing (DON) stated she just implemented a system for ensuring lab results were completed which included review of telephone orders for labs and all lab results in an effort to ensure lab work was completed as ordered. She could offer no explanation why the results of the Folic Acid ordered 02/13/14 for Resident #16 was not done.<br><br>An interview with Nurse #1 on 04/09/14 at 6:56 PM revealed she completed an audit of all residents charts in January 2014 and checked to see if results for all labs that had been ordered in | F 281 | | |

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| F 281 | Continued From page 28<br>the previous 3 months were on the residents' medical record. She stated she made a list of all ordered labs that didn't have results on the resident's medical record and gave the list to the former DON so she could follow up with the physician and get orders for the labs. Nurse #1 stated she did the audit because they had identified a concern with labs that were ordered without results being on the resident's medical record.<br><br>On 04/09/14 at 7:08 PM the Regional Clinical Director (RCD) stated the concern with lab results not being on the resident's medical record was identified in January 2014. She stated she provided the facility with an audit tool which they used to review all the residents' medical records through January 2014. The RCD stated they identified ongoing problems last week and they were in the process of putting plans in place to address the concern. She was unable to explain why the Folic Acid level ordered for Resident #16 was not done as ordered. The RCD stated she expected all ordered labs to be obtained and the results put on the resident's medical record. She stated the physician should be notified of all abnormal labs by phone and should also be provided with a copy of the results of all labs to review.<br><br>An interview with the Medical Director on 04/10/14 at 4:33 PM revealed he was aware there was an ongoing problem with laboratory tests not being obtained as ordered and of abnormal labs not being reported to either himself or the nurse practitioner. He stated it was very concerning to him to know that labs were not done as ordered or that lab results were not being given to them to review. | F 281 | | |

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| F 281 | Continued From page 29<br><br>On 04/10/14 at 5:30 PM the Director of Nursing (DON) stated the lab result for Resident #16 was not obtained as ordered. She could offer no explanation why the results of the labs ordered for Resident #16 on 02/13/14 were not obtained as ordered.<br><br>6. Resident #28 was admitted on 07/15/13 with diagnosis including quadriplegia, paranoid schizophrenia, psychotic disorder with delusions and lower extremity cellulitis.<br><br>Review of Resident 28's medical record revealed a physician's order dated 10/02/13 for a Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) to be drawn on 10/03/13. Further review of the medical record revealed the results of the lab test for the CBC was on Resident #28's medical record but the BMP was rejected as the quantity was not sufficient for testing. There was not a follow up BMP on Resident #28's medical record.<br><br>An interview on 04/08/14 at 2:30 PM with Nurse #2 about the facility's system for ensuring labs were done as ordered revealed the nurse who takes the order makes a note on the 24 hour report that the lab is pending so the nurses can make sure the lab is drawn and the result is received.<br><br>An interview on 04/09/14 at 4:30 PM with the Director of Nursing (DON) revealed she had just | F 281 | | |

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| F 281 | Continued From page 30<br>implemented a system for ensuring lab result were completed which included a review of telephone orders for labs and labs results in an effort to ensure all lab work was completed as ordered.<br><br>An interview with Nurse #1 on 04/09/14 at 6:56 PM revealed she completed an audit of all residents charts in January 2014 and checked to see if results for all labs that had been ordered in the previous 3 months were on the residents' medical record. She stated after the audit she made a list of all ordered labs that didn't have results on the residents medical record and gave the list to the former DON. Nurse #1 stated she was in the process of in-servicing staff on labs and the process of completing the lab work for residents.<br><br>On 04/09/14 at 4:26 PM the Director of Nursing (DON) stated the lab result for Resident # 28 revealed the lab was not obtained as ordered. She could offer no explanation why the results of the BMP ordered for Resident #28 on 10/03/14 were not obtained as ordered. The DON also stated if staff received a report that there wasn't sufficient blood they should have ordered another test.<br><br>On 04/09/14 at 7:08 PM with the Regional Clinical Director (RCD) stated the concern with labs not being done as ordered was identified in January 2014. Although the concern had been identified in January 2014 she was unable to explain why the BMP was not obtained as ordered. The RCD stated she expected all ordered labs to be obtained and the results put on the resident's medical record. She stated the physician should be notified of all abnormal labs by phone and | F 281 | | |

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| F 281 | Continued From page 31<br>should also be provided with a copy of the results of all labs to review.<br><br>An interview with the Medical Director on 04/10/14 at 4:33 PM revealed he was aware there was an ongoing problem with laboratory tests not being obtained as ordered and of abnormal labs not being reported to either himself or the nurse practitioner. He stated it was very concerning to him to know that labs were not done as ordered or that lab results were not being given to them to review. | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews the facility failed to administer a multivitamin/mineral as ordered for 1 of 5 sampled residents with medications reviewed. (Resident #51)<br><br>Findings included:<br><br>Resident #51 was admitted to the facility 09/07/11 with diagnoses which included hypopotassemia and dementia. | F 309 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F-309**<br><br>**1. Resident #51 physician and responsible party notified. Medication Error was completed.**<br>**2. The residents with medication orders have the potential to be affected. Re-capulation of physician orders was conducted. Any findings were corrected and the MD and RP notified.**<br>**3. Licensed Nurses were re-in-serviced on transcribing and processing medication orders.**<br>**Nurse management or designee will be re-in-serviced on the monthly Re-capulation of physician orders.** | 5/8/14 |

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| F 309 | Continued From page 32<br>The current care plan for Resident #51 was last updated 02/14/14 and included a problem area, At risk for nutritional complications related to dementia and Alzheimers and potential for weight loss. Decline may be expected related to dementia and Alzheimers. Approaches to this problem area included, Multivitamin with minerals and supplements as ordered.<br><br>Review of physician orders for Resident #51 included an order for a multivitamin mineral supplement every day since 11/20/12. There had been no changes to this order up through the time of the review on 04/09/14.<br><br>Review of the printed physician recap monthly orders and Medication Administration Records (MARs) for Resident #51 noted the following: December 2013-The order for the daily multivitamin mineral supplement was included on the printed December 2013 physician recap orders and was given daily through 12/31/13. January 2014-The order for the daily multivitamin mineral supplement was not included on the printed January 2014 physician recap orders. A handwritten entry on the January 2014 physician recap orders included a once a day dose of the Multivitamin mineral supplement. However, the January 2014 MAR did not include the multivitamin mineral supplement and it was not administered the month of January 2014. February 2014 through April 2014-The order for the daily multivitamin mineral supplement was not included on the printed physician recap orders or MARs and was not given during this time frame.<br><br>On 04/09/13 at 4:43 PM the Director of Nursing (DON) reviewed the medical record of Resident #51 and stated she could not explain why the | F 309 | **4. DON or designee will review physician telephone orders for transcribing and processing daily (M-F) in morning clinical meeting. Monthly the DON or designee will review all orders and verify the orders are implemented on the Re-capulation of Physician Orders.**<br>**5. DON or designee will report findings to QAPI committee monthly x 3 and action if needed.** | |

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| F 309 | Continued From page 33<br>multivitamin mineral supplement was left off the January 2014-April 2014 Physician recap orders and MARs.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #51 stated if medications are ordered he expected them to be administered to residents as ordered, including multivitamins. | F 309 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced | F 329 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F- 329**<br><br>**1. Resident # 1 Current medication has been D/C's by physician and physician has given new order to initiate medication daily beginning April 9, 2014 for 1 week then discontinue.**<br>**2. All resident with medication orders have the potential to be affected. Re-capulation of physician orders was conducted. Any findings were corrected and the MD and RP notified.**<br>**3. Licensed Nurses were re-in-serviced on transcribing and processing medication orders including duration of medication therapy. Nurse management designee and 7pa-7a nurses will be re-in-serviced on the monthly Re-capulation of physician orders.** | 5/8/14 |

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| MOUNTAIN TRACE REHABILITATION & NURSING CENTER | 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779 |

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| F 329 | Continued From page 34<br>by:<br>Based on medical record review and staff interviews the facility failed to follow physician orders to taper and discontinue use of a psychoactive medication for 1 of 5 sampled residents with medications reviewed. (Resident # 1)<br><br>Findings included:<br><br>Resident #1 was admitted to the facility 02/04/14 with diagnoses which included senile dementia and anxiety. Admission physician orders included 12.5 milligrams of Seroquel twice a day. The Psychoactive Medication Evaluation completed by facility staff on 02/18/14 noted the 12.5 milligram dose of Seroquel was given due to occasional confusion and wandering at night.<br><br>The care plan for Resident #1 was last updated 02/17/14 and included a problem area noting a diagnosis of depression, anxiety and dementia. Approaches to this problem area included consults with specialists as recommended.<br><br>On 02/27/14 Resident #1 was assessed by a psychiatric nurse practitioner and the progress note included:<br>Referred for psychiatric evaluation with known history. Patient is poor historian. Per chart, history of depression and anxiety. Staff report patient has been presenting with stable mood and intermittent anxiety related to roommate. Staff denies any current signs of psychosis or aggression. Patient was alert and oriented X 1. He denied problems with mood, sleep or appetite. He reported intermittent anxiety. He denied audio/visual hallucinations and provider was unable to elicit delusional thinking. No reports or | F 329 | **4. DON or designee will review physician telephone orders for transcribing and processing daily (M-F) in daily clinical meeting. Monthly the DON or designee will review all orders and verify the orders are implemented on the Re-capulation of Physician Orders by the end of each month. A second nurse will verify by midnight on the last day of the month all orders are correct on the Physician recap of orders.**<br><br>**5. DON will report finding to QAPI Committee monthly x 3 and action if needed.** | |

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| F 329 | Continued From page 35<br>observations of medication side effects. Will decrease Seroquel 12.5 milligrams daily for one week then discontinue.<br><br>An order was written 02/27/14 to, Decrease Seroquel to 12.5 milligrams every day X 7 days then discontinue. Review of the February 2014 Medication Administration Record (MAR) for Resident #1 noted the Seroquel was decreased to 12.5 milligrams once a day on 02/27/14. Review of the March 2014 Monthly Physician recap orders and March 2014 MAR for Resident #1 noted the order for Seroquel 12.5 milligrams twice a day. Resident #1 was given the 12.5 milligrams of Seroquel twice a day from 03/01/14-03/26/14. On 03/26/14 Resident #1 spent the night in the hospital and on return 03/27/14-03/31/14 the 12.5 milligrams of Seroquel was given twice a day. Review of the April 2014 Monthly Physician recap orders and April 2014 MAR for Resident #1 noted the order for Seroquel 12.5 milligrams twice a day. Resident #1 received the 12.5 milligrams of Seroquel twice a day in April up through 04/09/14.<br><br>The monthly consultant pharmacist drug review completed 03/17/14 for Resident #1 noted the Seroquel had been "discontinued".<br><br>On 04/08/14 at 4:40 PM the DON reviewed the March 2014 monthly Physician recap orders and March and April 2014 MARs for Resident #1. The DON confirmed the 12.5 milligrams of Seroquel for Resident #1 was given twice a day in March-April 2014 inconsistent with the 02/27/14 physician order. The DON noted the March 2014 monthly Physician recap Orders were printed 02/21/14 and were reviewed by a nurse on 02/26/14. The DON stated, after reviewed, the | F 329 | | |

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| F 329 | Continued From page 36<br>MARs are supposed to be checked one final time against any orders received after the monthly Physician Orders/MARs were checked to ensure accuracy. The DON stated this final check is not designated to any one staff person, just whoever has time prior to the first of the month. The DON stated, since the 02/27/14 order came in after the March 2014 Physician recap Orders and MAR were printed and checked it should have been identified prior to placing the March 2014 MAR in the administration book. The DON stated the responsibility is not designated to any one staff member and she did not have an explanation why the 02/27/14 order had not been identified prior to implementation of the March 2014 MAR.<br><br>After the interview on 04/04/14 with the DON a physician's order was written to decrease the Seroquel to 12.5 milligrams for Resident #1 for one week then discontinue.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #1 stated he relied on recommendations from specialists like the psychiatric nurse practitioner to assist in managing a resident's care and expected all orders to be followed. | F 329 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it - | F 441 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F -441** | 5/8/14 |

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| F 441 | Continued From page 37<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews, the facility failed to properly disinfect a blood glucose monitor for 1 of 4 monitored residents (Resident #16) and failed to post correct signage for 1 of 1 residents observed on isolation precautions (Resident #89).<br><br>Findings included: | F 44 | **1. Resident #89 isolation precautions were discontinued on 4-7-14 Nurse #4 and licensed nurses were re-educated by DON during survey on proper disinfection of blood glucose monitors.**<br><br>**2. Residents with blood glucose monitoring and isolation precautions have the potential to affected.**<br>**An audit was conducted to assure appropriate signage was posted for isolation precautions. Nurse #4 and licensed nurses were re-educated by DON during survey on proper disinfection of blood glucose monitors.**<br><br>**3. Licensed Nurses will be re-in-serviced on how to properly disinfect blood glucose monitors and Isolation Precaution procedures and signage.**<br>**4. DON or designee will conduct random audits of the proper procedure in disinfection blood glucose monitors. Finding and re-education will be conducted immediately.**<br>**DON or designee will monitor for appropriate Isolation Precaution** | |

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| F 441 | Continued From page 38<br>1. Review of a facility policy titled Equipment Management with an effective date of 04/13 revealed "equipment will be cleaned, disinfected or sterilized following guidelines and manufacturer's recommendations." Printed directions on a single use germicidal disposable wipe used by the facility for equipment disinfection stated "use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipes if needed to assure continuous two (2) minute wet contact time. Let air dry."<br><br>An observation on 04/09/14 at 5:00 AM revealed Resident #16 taken to her room by Nurse #4. Nurse #4 removed a plastic bin with a blood glucose monitor (glucometer) and supplies from the top of her medication cart and took them into the resident's room. After performing blood glucose monitoring on Resident #16, Nurse #4 removed a single use germicidal disposable wipe from its wrapper and wiped the glucometer for approximately 20 seconds and discarded the wipe. At 5:05 AM she was observed placing the glucometer in a plastic cup and clocking the time interval with her watch. At approximately 60 seconds the glucometer appeared dried. At 5:07 AM Nurse #4 was observed removing the dried glucometer from the cup and returning it to the plastic bin which was returned to the medication cart.<br><br>An interview on 04/09/14 at 6:00 AM with Nurse #4 revealed she normally took a single use germicidal disposable wipe out of the medication cart, wiped down the glucometer, placed it in a plastic cup and timed it to dry for 2 minutes. She stated this was how she was told to do it. Unable | F 441 | Signage during daily rounds (M-F)<br>5. DON will report findings of audits to QAPI Committee monthly x 3 and action if needed. | |

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| F 441 | Continued From page 39<br>to locate a single use germicidal disposable wipe in her medication cart, Nurse #4 was observed opening another medication cart where she obtained a single use germicidal disposable wipe. Nurse #4 reviewed the printed directions on the wipe wrapper and stated she did not wipe the glucometer that long and she was timing 2 minutes of drying time.<br><br>An interview on 04/09/14 at 6:20 AM with the interim director of nursing (DON) revealed was not aware of any facility policy specifically regarding disinfection of glucometers, but the expectation was for nurses to follow the manufacturer's instructions of the disinfection product they were using.<br><br>2. Review of a facility policy titled Identification of Residents on Isolation Precautions (IP) with an effective date of 04/13 revealed "IP requires the use of a STOP sign to assist the healthcare worker and others in identifying the need for special precautions." Attachment A to this policy titled Category Specific Precautions listed Clostridium difficile (C. diff.) with Contact Precautions as indicated for the duration of the illness. Review of a facility policy titled Introduction to Isolation Precautions with an effective date of 04/13 revealed adherence to isolation practices as recommended by the Center for Disease Control guidelines. This policy directed Standard Precautions as the first tier of precautions and designed for the care of all residents regardless of their diagnoses. A list of second tier precautions, which included Contact Precautions, were used with "persons known or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens" requiring additional precautions and | F 441 | | |

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| F 441 | Continued From page 40<br>in addition to Standard Precautions.<br><br>Resident #89 was admitted to the facility on 01/20/14 then transferred to the hospital on 03/18/14 with abdominal pain. She returned to the facility on 03/27/14 with a diagnosis of C. diff. A review of medical orders dated 03/27/14 directed Contact Isolation due to C. diff.<br><br>Observations on 04/06/14 at 2:50 PM and on 04/07/14 at 8:29 AM revealed a fluorescent pink sign labeled Standard Precautions affixed to the inside surface of the opened door to Resident #89's room.<br><br>Review of medical orders dated 04/07/14 discontinued Contact Precautions for the resident.<br><br>An observation on 04/07/14 at 10:13 AM revealed no signage on the inside surface of the opened door to Resident #89's room.<br><br>An interview on 04/10/14 at 5:14 PM with Nurse #1 revealed her sharing the responsibilities of infection control representative with the interim Director of Nursing (DON). She stated protective personal equipment was placed outside a resident's room on IP and a colored sign was posted on the door. Nurse #1 stated the Standard Precaution sign should not have been used on Resident #89's door, but rather a Contact Isolation sign. | F 441 | | |
| F 514 SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each | F 514 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.** | 5/8/14 |

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| F 514 | Continued From page 41<br>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to provide lab results to the physician for review for 6 of 11 residents (Residents # 1, 35, 51, 60, 111, 121) and failed to do skin assessments for 1 of 4 residents reviewed with pressure ulcers (Resident # 86).<br><br>The findings are:<br><br>1. Resident #1 was admitted to the facility 02/04/14 with diagnoses which included senile dementia, hypertension and chronic obstructive pulmonary disease.<br><br>Review of physician orders in the medical record of Resident #1 included orders for labwork on 03/23/14 to do a urinalysis with culture and sensitivity, complete blood count (CBC) and basic metabolic package (BMP). The 03/23/14 BMP results for Resident #1 were not avalable in the medical record.<br><br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) stated lab results are sent from | F 514 | **F- 514**<br><br>**1. Resident #1,121, 35,111, 51, and 60, lab results were reviewed with MD and any additional orders implemented and plan of care updated. Lab reports were provided for MD signatures and a copy placed in the medical record until original is signed. Once original copy is signed the copy will be removed from medical record and original placed in the chart.**<br><br>**Resident #86 was assessed and treatment ordered by physician.**<br><br>**2. All residents with skin impairment have the potential to be affected An audit of residents with skin impairments were conducted any findings were corrected and MD notified.**<br><br>**All residents with lab orders have the potential to be affected.**<br><br>**An audit was conducted of lab orders to assure results were reported to the MD, documented and filed in the medical record.** | |

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| F 514 | Continued From page 42<br>the lab to the facility and print on one central fax machine located at a nurses stations in the facility. The DON stated any available staff check this fax machine throughout the day and deliver the lab results to the charge nurse assigned on the corresponding hall. The DON stated if the results were abnormal the physician/nurse practitioner was notified. The DON stated the lab results would be placed in the physicia/nurse practitioner book for them to review and sign. The DON stated a copy of the lab would also be placed in the residents medical record. The DON stated staff were supposed to remove the unsigned lab from the residents medical record and replace it with the signed lab results after the results were reviewed by the physician/nurse practitioner. The DON stated she was aware there was a problem with labs not being done and results not being provided to the physician/nurse practitioner for review. The DON stated she was in the process of putting systems in place to address the concern. The DON reviewed the medical record of Resident #1 and stated the 03/23/14 results of the BMP were not located in the medical record with the other labwork that had been completed that day.<br><br>In a follow-up interview on 04/08/14 at 3:45 PM the DON stated she located the 03/23/14 BMP results for Resident #1 in the computer system. The DON stated she could not explain why the results had not been available to the physician/nurse practitioner to review and sign. Review of the 03/23/14 BMP results noted an elevated creatnine level of 1.5 with the normal range of .3-1.2.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #1 stated there had been an ongoing problem | F 514 | 3. Licensed nurses will be re-in-serviced on the Skin program including weekly skin assessments and documentation of wound care as ordered. Licensed Nurses will be re-in-serviced on processing, reporting,<br><br>4. DON or designee will complete daily audits (M-F) for lab collection, results and MD notification. Any findings will be addressed with MD for further direction.<br><br>DON or designee will review residents with skin impairments weekly for completion of documented orders. Any findings from the review will be addressed with MD.<br><br>DON or designee will conduct random weekly audits on weekly skin assessments. Any finding will be addressed and skin assessment performed. Any skin impairments noted will be reviewed with MD and orders implemented and plan of care updated. | |

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| F 514 | Continued From page 43<br>with labs, including receiving lab results. The physician stated he expected labs to be available for review as ordered.<br><br>2. Resident #121 was admitted to the facility from the hospital on 02/27/14 with diagnoses which included left hip fracture with repair, coronary artery disease and non operative acute cholecystitis.<br><br>A physician's progress note dated 03/06/14 noted Resident #121 was being seen for an acute visit due to a recent fall. "Dementia in conditions classified elsewhere without behavioral disturbance. I have assessed the course of this patient's dementia, and the patient demonstrates instability requiring significant support and frequent monitoring. The risk of other complications of dementia persists. We will continue to provide support and preventative measures for this patient and remain vigilant for changes in condition. Check urinalysis, basic metabolic package (BMP) and complete blood count (CBC) for possible corretable causes".<br><br>Physician orders on 03/06/14 included a urinalysis, BMP and CBC. Review of the medical record of Resident #121 noted the UA and BMP results from 03/06/14 were signed and included in the medical record. The results for the CBC ordered 03/06/14 were not included in the medical record of Resident #121.<br><br>On 04/10/14 at 11:15 AM Nurse #1 located the 03/06/14 ordered CBC in the facility electronic computer system. Nurse #1 could not explain why they were not signed and included in the medical record of Resident #121 along with the other lab results done that day. | F 514 | **5. Finding from weekly review and random audits will be presented to QAPI committee monthly x 3 for additional follow up and recommendations.** | |

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| F 514 | Continued From page 44<br><br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) stated lab results are sent from the lab to the facility and print on one central fax machine located at a nurses stations in the facility. The DON stated any available staff check this fax machine throughout the day and deliver the lab results to the charge nurse assigned on the corresponding hall. The DON stated if the results were abnormal the physician/nurse practitioner was notified. The DON stated the lab results would be placed in the physicia/nurse practitioner book for them to review and sign. The DON stated a copy of the lab would also be placed in the residents medical record. The DON stated staff were supposed to remove the unsigned lab from the residents medical record and replace it with the signed lab results after the results were reviewed by the physician/nurse practitioner. The DON stated she was aware there was a problem with labs not being done and results not being provided to the physician/nurse practitioner for review. The DON stated she was in the process of putting systems in place to address the concern. The DON reviewed the medical record of Resident #121 and could not explain why the results of the CBC ordered 03/06/14 were not located in the medical record with the other labwork that had been completed that day.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #121 stated there had been an ongoing problem with labs, including receiving lab results. The physician stated he expected labs to be available for review as ordered.<br><br>3. Resident #35 was admitted to the facility 07/28/08 with diagnoses which included | F 514 | | |

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| F 514 | Continued From page 45<br>alzheimers, dysphagia, hypertension, bipolar and history of fall.<br><br>A family nurse practitioner note dated 01/21/14 noted Resident #35 was being seen to evaluate difficulty swallowing and advanced dementia. Nursing staff noted that the patient appeared to be having difficulty swallowing. She was referred to speech therapy where she was placed on nectar thickened liquids. The patient without any coughing. She did have an elevated sodium of 149 on 12/06/13. Will check basic metabolic package (BMP) to reevaluate the sodium and electrolytes status.<br><br>Orders for Resident #35 on 01/21/14 included BMP next lab day due to hypernatremia. Review of the medical record of Resident #35 did not reveal lab results for the 01/21/14 BMP.<br><br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) stated lab results are sent from the lab to the facility and print on one central fax machine located at a nurses stations in the facility. The DON stated any available staff check this fax machine throughout the day and deliver the lab results to the charge nurse assigned on the corresponding hall. The DON stated if the results were abnormal the physician/nurse practitioner was notified. The DON stated the lab results would be placed in the physicia/nurse practitioner book for them to review and sign. The DON stated a copy of the lab would also be placed in the residents medical record. The DON stated staff were supposed to remove the unsigned lab from the residents medical record and replace it with the signed lab results after the results were reviewed by the physician/nurse practitioner. The DON stated she was aware | F 514 | | |

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| F 514 | Continued From page 46 | F 514 | | |

there was a problem with labs not being done and results not being provided to the physician/nurse practitioner for review. The DON stated she was in the process of putting systems in place to address the concern.

In a follow-up interview on 04/08/14 at 3:41 PM the DON located the 01/21/14 BMP results for Resident #35 in the electronic computer system. These results revealed an elevated sodium level of 153 with the normal level being 132-145. The prior sodium level referenced in the family nurse practitioner progress notes was from 12/6/13 at 149. The DON stated she could not explain why the results had not been available to the physician/nurse practitioner to review and sign.

On 04/10/14 at 4:50 PM the physician of Resident #35 stated there had been an ongoing problem with labs, including receiving lab results. The physician stated he expected labs to be available for review as ordered.

4. Resident #111 was admitted to the facility 12/06/13 with diagnoses which included hemiplegia, hypertension and depression.

Nurses notes in the medical record of Resident #111 included a note on 02/15/14 that Resident #111 complained of two loose stools. Physician orders on 02/15/14 included to check stool for clostridium difficule (c diff). The 02/15/14 c diff results for Resident #111 were not located in the medical record.

On 4/10/14 at 9:25 AM Nurse #1 located the 02/15/14 c diff results in the facility electronic computer system.

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| F 514 | Continued From page 47<br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) stated lab results are sent from the lab to the facility and print on one central fax machine located at a nurses stations in the facility. The DON stated any available staff check this fax machine throughout the day and deliver the lab results to the charge nurse assigned on the corresponding hall. The DON stated if the results were abnormal the physician/nurse practitioner was notified. The DON stated the lab results would be placed in the physicia/nurse practitioner book for them to review and sign. The DON stated a copy of the lab would also be placed in the residents medical record. The DON stated staff were supposed to remove the unsigned lab from the residents medical record and replace it with the signed lab results after the results were reviewed by the physician/nurse practitioner. The DON stated she was aware there was a problem with labs not being done and results not being provided to the physician/nurse practitioner for review. The DON stated she was in the process of putting systems in place to address the concern.<br><br>In a follow-up interview on 04/10/14 at 3:41 PM the DON stated she could not explain why the 02/15/14 c diff results for Resident #111 had not been available to the physician/nurse practitioner to review and sign.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #111 stated there had been an ongoing problem with labs, including receiving lab results. The physician stated he expected labs to be available for review as ordered.<br><br>5. Resident #51 was admitted to the facility 09/07/11 with diagnoses which included a fracture | F 514 | | |

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| F 514 | Continued From page 48<br>with spinal cord injury, psychosis and dementia with behavioral disturbances.<br><br>The care plan for Resident #51 included a problem area dated 02/14/14 of, Resident is at risk for complications due to her diagnosis of dementia with behaviors and Alzheimers; she can be verbally and physically abusive. She has a history of delusional thoughts. She is often repetitive; she is very forgetful. Decline may be expected related to dementia. An approach to this problem area was, diagnostics as indicated and report abnormal results to physician.<br><br>Review of physician orders in the medical record of Resident #51 noted she had received 125 milligrams of Depakote every morning since 07/12/13 and 250 milligrams of Depakote every evening since 07/12/13.<br><br>On 11/22/13 the consultant pharmacist recommended a Valproic acid level be done. On 12/18/13 a Valproic acid level was ordered by the physician of Resident #51. The results of the 12/18/13 Valproic acid level test were not located in the medical record of Resident #51.<br><br>On 04/08/14 at 3:20 PM the facility Director of Nursing (DON) stated lab results are sent from the lab to the facility and print on one central fax machine located at a nurses stations in the facility. The DON stated any available staff check this fax machine throughout the day and deliver the lab results to the charge nurse assigned on the corresponding hall. The DON stated if the results were abnormal the physician/nurse practitioner was notified. The DON stated the lab results would be placed in the physicia/nurse practitioner book for them to review and sign. | F 514 | | |

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| F 514 | Continued From page 49<br>The DON stated a copy of the lab would also be placed in the residents medical record. The DON stated staff were supposed to remove the unsigned lab from the residents medical record and replace it with the signed lab results after the results were reviewed by the physician/nurse practitioner. The DON stated she was aware there was a problem with labs not being done and results not being provided to the physician/nurse practitioner for review. The DON stated she was in the process of putting systems in place to address the concern.<br><br>On 04/09/14 at 2:00 PM the regional clinical director located the Valproic acid test levels in the facility electronic computer system. There was no explanation why the results were not in the resident's medical record and signed as reviewed by the physician/nurse practitioner.<br><br>On 04/10/14 at 4:50 PM the physician of Resident #51 stated there had been an ongoing problem with labs, including receiving lab results. The physician stated he expected labs to be available for review as ordered.<br><br>6. Resident #60 was admitted on 06/11/13 with diagnoses including diabetes mellitus, atrial fibrillation, polyneuropathy in diabetes, depression and anxiety.<br><br>Review of Resident #60's medical record revealed a physician's order dated 03/24/14 for a urinalysis (UA) with culture and sensitivity, a complete blood count (CBC) and a basic metabolic profile (BMP). Further review of the medical record revealed results of the lab tests were not on Resident #60's medical record. | F 514 | | |

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| F 514 | Continued From page 50<br><br>On 04/08/14 at 2:30 PM Nurse #2 stated the nurse that takes a lab order makes a note on the 24 hour report that the lab is pending so other nurses can make sure the lab is drawn and the result is received. Nurse #2 retrieved the results of the UA, CBC and BMP ordered for Resident #60 on 03/24/14 from the facility computer. Nurse #2 stated staff call the physician or nurse practitioner with any abnormal results and also left a copy of the lab in the physician/nurse practitioner's mail box. Nurse #2 was asked if the physician or nurse practitioner had been notified of the abnormal CBC and BMP and she stated she would call the nurse practitioner and check.<br><br>A follow-up interview on 04/08/14 at 4:30 PM with Nurse #2 revealed she had spoken with the Nurse Practitioner about the CBC and BMP results for Resident #60. Nurse #2 stated the nurse practitioner stated she thought she had reviewed the labs when she did rounds at the facility on 04/07/14.<br><br>On 4/09/14 at 4:30 PM the Director of Nursing (DON) stated she just implemented a system for ensuring lab results were completed which included review of telephone orders for labs and all lab results in an effort to ensure lab work was completed as ordered. She could offer no explanation why the results of the labs ordered for Resident #60 on 03/24/14 were not signed and in the medical record.<br><br>An interview with Nurse #1 on 04/09/14 at 6:56 PM revealed she completed an audit of all residents charts in January 2014 and checked to see if results for all labs that had been ordered in the previous 3 months were on the residents' | F 514 | | |

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| F 514 | Continued From page 51<br>medical record. She stated she made a list of all ordered labs that didn't have results on the residents medical record and gave the list to the former DON so she could follow up with the physician and get orders for the labs. Nurse #1 stated she did the audit because of an identified concern with labs that were ordered without results being on the residents medical record.<br><br>An interview on 04/09/14 at 7:08 PM with the Regional Clinical Director (RCD) revealed the concern with lab results not being on the resident's medical record was identified January 2014. The RCD stated they identified ongoing problems with labs last week and were in the process of implementing changes. The RCD was unable to explain why the results of the labs ordered for Resident #60 on 03/24/14 were not available on the resident's medical record on 04/08/14. The RCD stated she expected all ordered labs to be obtained and the results put on the resident's medical record. She stated the physician should be notified of all abnormal labs by phone and should also be provided with a copy of the results of all labs to review.<br><br>An interview with the Medical Director on 04/10/14 at 4:33 PM revealed he was aware there was an ongoing problem with laboratory tests not being obtained as ordered and of abnormal labs not being reported to either himself or the nurse practitioner. He stated it was very concerning to him to know that labs were not done as ordered or that lab results were not being given to them to review.<br><br>7. Resident #86 was admitted to the facility on 03/03/14 with diagnoses including status/post | F 514 | | |

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| F 514 | Continued From page 52<br>repair of a right hip fracture, peripheral neuropathy and history of a pressure ulcer.<br><br>Review of an admission data collection form dated 03/03/14 revealed an anatomical diagram with bruising noted on the arms and a surgical incision with staples to the right hip with no other skin conditions noted. This same form noted her risk score for pressure ulcers noted to be 14 (moderate risk) and in the "foot problems" section the option "none" was checked.<br><br>Resident #86's most recent Minimum Data Set (MDS) dated 03/10/14 coded her as cognitively intact and requiring extensive 1 to 2 person assistance for most activities of daily living. This MDS coded Resident #86 as at risk for developing pressure ulcers through formal and clinical assessment with no pressure ulcers identified during the MDS assessment period. Review of her care plan dated 03/17/14 revealed her at risk for developing pressure ulcers related to impaired mobility following a fall with fracture, incontinence and required assistance for toileting.<br><br>Review of Resident #86's weekly skin integrity check form revealed the direction to "Note any change of condition on the Skin Condition/Assessment Form" and was checked for the following findings: no wound/skin condition present/no new change of condition for 03/05/14, no wound/skin condition present/no new change of condition for 03/12/14 and skin clear/no change of condition assessed on 03/19/14.<br><br>Review of a nursing note dated 03/24/14 revealed a plan for Resident #86 to see a podiatrist that day to have a right ingrown toenail excised. | F 514 | | |

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| F 514 | Continued From page 53<br>Review of a podiatrist visit note dated 03/24/14 revealed the presence of ingrown toe nails, fungal infection of the nails and an ulcer described as blue in color with mild severity. A noted exacerbating factor consisted of compression. The podiatrist assessment revealed a distal hallux blood blister without signs or symptoms of infection. Patient instructions included care for paronychia (nail disease) and pressure ulcer. An order requisition form from the podiatry clinic dated 03/24/14 noted diagnoses of pressure ulcer and acute paronychia with wound care instructions.<br><br>Review of Resident #86's weekly skin integrity check form for March 2014 revealed on 03/27/14 a check for the finding of no wound/skin condition present/no new change of condition with "R toe" added in the margin. No skin condition forms for the month of March 2014 documenting this new condition were identified in the medical record for review.<br><br>Review of Resident #86's weekly skin integrity check form revealed on 04/05/14 a check for the finding no wound/skin condition present/no new change of condition. Review of a nursing note dated 04/07/14 revealed Resident #86 was out to a podiatrist appointment. An order requisition form from the podiatry clinic dated 04/07/14 noted a diagnosis of a stage 2 pressure ulcer of the toe and wound care instructions. Review of a pressure ulcer record revealed an unstaged ulcer at the tip of the right great toe was first observed on 04/08/14, the date of the last doctor progress note by podiatry on 04/07/14 and measurements with a full assessment documented by Nurse #1.<br><br>An interview on 04/10/14 at 2:25 PM with Nurse | F 514 | | |

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| F 514 | Continued From page 54<br>#9, assigned to Resident #86 at the time of the interview, revealed weekly skin assessments were noted on the skin assessment form and significant findings were expected to be noted on the pressure or non pressure ulcer form. She stated she was not aware of Resident #86's skin assessment findings before the podiatry appointment as she returned to work shortly after the appointment, but was aware of wound care orders and did the dressing change as ordered.<br><br>An interview on on 04/10/14 at 2:39 PM with Nurse #1 revealed during her chart review for Resident #86 that could not locate wound care documentation she performed in March 2014. She stated she could not be sure when the issues with the right toe presented. She stated if any skin condition changes were noted by nurse aides, these should have been documented on skin observation forms and communicated to the nurses, who in response should have done skin assessments. Nurse #1 stated significant findings, including issues with the right great toe, should have been assessed and documented when they were first noted.<br><br>A phone interview on 04/10/14 at 3:22 PM with the podiatrist revealed the facility should have noticed Resident #86's right ingrown toenail and ulceration as it presented to him on the 03/24/14 appointment. He stated the right toe infection was pretty fulminate and should have been obvious, appearing as red, swollen and painful. He stated the blood blister had no sign of infection and he was not sure what caused the ulcer. | F 514 | | |
| F 520 SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET | F 520 | | |

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| F 520 | Continued From page 55<br>QUARTERLY/PLANS<br><br>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.<br><br>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.<br><br>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.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to have the correct disciplines on the quality assurance committee, such as the Medical Director and failed to address infection control issues.<br><br>Findings included:<br><br>1. An interview with the Medical Director (MD) on 04/10/14 at 4:33 PM about his involvement in | F 520 | **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.**<br><br>**F-520**<br><br>**1. QAPI Committee was held on April 23, 2014 with the Medical Director present. Labs and Infection Control were reviewed during the meeting.**<br><br>**2. Residents have the potential to be affected by this practice**<br><br>**3. QAPI Committee meeting will be held every third Wednesday of each month. The Medical Director will be informed in writing of the QAPI schedule.**<br><br>**4. The Regional Clinical Director will monitor for compliance of the QAPI meeting monthly x 3 the randomly ongoing.**<br><br>**5. The findings of the QAPI will be reviewed and any action that is needed.** | 5/8/14 |

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| F 520 | Continued From page 56<br>the facility's Quality Assurance and Assessment (QA and A) process revealed he had not attended a meeting in a long time and he thought the last meeting he attended was prior to December 2013. He stated he would like to attend the meetings but didn't know when they were held. The MD stated he told either the Administrator or Director of Nursing about 2 weeks ago that he wanted to attend the meetings. The interview further revealed he was given the minutes from the meetings to sign and he would prefer to attend the meetings rather than just review the minutes of the meetings. The MD stated he was aware there was an ongoing problem with laboratory tests not being obtained as ordered and of not being notified of abnormal labs. He stated the abnormal labs that really concerned him were urinalysis and PT/INR. The interview further revealed that the Nurse Practitioner who works with him sees residents at the facility every Monday and will find abnormal labs that neither of them had been called about. He stated it was very concerning to him to know that labs were not done as ordered or that lab results were not being given to them to review.<br><br>2. The facility on the previous survey dated 02/22/13 was cited for not following their policy and procedures for disinfecting blood glucose meters at F 441. This was recited on this current survey. Cross refer to F 441 - the facility failed to follow their policy and procedures and the manufacturer's instructions for disinfecting of blood glucose meters.<br><br>An interview on 04/10/14 at 6:18 PM with the Administrator revealed she is the chairperson of the QA and A committee which meets monthly. She stated every Department Manager is a | F 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345302 | A. BUILDING _____ B. WING _____ | 04/10/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNTAIN TRACE REHABILITATION & NURSING CENTER | 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779 |

| (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 57<br>member of the committee. A review of the signature page for the meetings that were held on 12/19/13, 01/31/14, 02/28/14 and 03/31/14 revealed there was no physician in attendance at any of the meetings. The Director of Nursing did not attend the meetings on 12/19/13 and 02/28/14. When asked why there was not a physician in attendance at the meetings, the Administrator stated she met with the Medical Director every week when he came to the facility to see residents. She stated she thought he knew when the meetings were held and she would make sure he was invited to attend QA and A meetings in the future. When asked if the committee had addressed concerns with blood glucose meters not being disinfected according to manufacturer's instructions as part of the QA and A monitoring, she stated the committee had not looked at either of those areas since she became Administrator in September 2013. | F 520 | | |