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	345264	A. BUILDING _____ B. WING _____	C 12/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

(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 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to honor resident choices when staff started morning medication pass at 5:00 AM and woke residents for their morning medications for 4 of 4 residents who were asleep (Resident #18, #135, #4 and #108). The findings included: 1. Resident #18 was admitted to the facility on 09/17/13 with diagnoses which included dementia, depression and esophageal reflux (heartburn). The most recent 60 day Minimum Data Set dated 11/14/13 indicated Resident #18 had short term and long term memory problems and was severely impaired in cognition for daily decision making. A review of a monthly Medication Administration Record dated 12/01/13 through 12/31/13 indicated Protonix 40 milligrams daily by mouth at 6:00 AM. During an observation on 12/19/13 of a medication pass on the 500 hall at 5:04 AM all of	F 242	Medication times for residents #18, #135, and #4 were reviewed and changed to more appropriate times during the resident's normal waking hours on 1/14/14. The specific medication in question for resident #108 was a scheduled antibiotic that was completed on 12/20/13 and no longer of concern--all other medications for resident #108 were reviewed and changed to a more appropriate time during normal waking hours on 1/14/14. Nurses were in-serviced by the Administrator on 12/26/13 of the importance of not waking residents for medications unless medically necessary for acute needs--this in-service included discussion specifically with the 11-7 nurses (including Nurse #3) that routine medications not be given prior to the resident waking for their day. All medications and treatment times, including fingerstick blood sugars, were reviewed by the Nursing Management	1/17/14

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

Electronically Signed | 01/16/2014

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F 242	Continued From page 1 the lights on the 500 halls were turned on and the hallways were very bright. Nurse #3 who was a 11:00 PM to 7:00 AM nurse pulled a pill labeled Protonix 40 milligrams from a medication cart parked in the hallway outside the door of Resident #18's room and knocked on her door. Nurse #3 opened the door and entered the room. There were no lights on in the room and Nurse #3 turned on a light and called Resident #18's name and stated it was time for her morning medication. Resident #18 was lying in bed and opened her eyes and raised her head up off her pillow. Nurse #18 placed the medication in Resident #18's mouth and gave her a sip of water to drink, washed her hands, turned off the lights and closed the door of the room and walked back to the medication cart in the hallway. During an interview on 12/19/13 at 5:30 AM the night shift nursing supervisor verified the early morning medication pass always started at 5:00 AM. She further explained she sometimes assisted the night shift nurse with her medication pass so she could finish her medications before shift report with the oncoming day shift nurses. During an interview on 12/19/13 at 7:32 AM Nurse #3 explained it was routine practice to start medication pass at 5:00 AM. She stated medications were ordered to be given at 6:00 AM or 6:30 AM but they had a 1 hour window before and after the medication was ordered to give the medication so they started the medication pass at 5:00 AM so they could have all of the medications given by the time first shift arrived and shift report was given at 7:00 AM. She further stated she had to wake approximately 80 percent of the residents that she gave morning medications to on a regular basis but if nurse aides were doing	F 242	Team to determine a more routine scheduling of medications and eliminate any from being scheduled during normal hours of sleep unless medically necessary for acute medical needs. A new medication time policy implemented on 1/17/14 allows residents to sleep uninterrupted as desired and also includes directions for any medications specifically ordered around the clock (every 6 hours, every 8 hours)--the nurse will verify the specific times with the physician required for acute mecial needs, will obtain this in writing on the acutal order for such medications to indicate the necessity, and will ensure the resident/responsible party understand this specific timing requirement for medical needs on a short-term basis that may affect hours of sleep. In-servicing was conducted for nursing staff by the ADON/SDC on 1/15/14 for this revised policy/procedure and the importance of not allowing resident's a choice in not be awakened for medication purposes unless medically necessary for acute medical needs. The Social Worker will review any possible concerns regarding nurses waking residents for routine medications and/or treatments with the monthly Resident's Council meeting X 6 months beginning with the January meeting. Any concerns voiced by residents will be reported to the DON and addressed through specific monitoring of named staff, re-education, and progressive	

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F 242	Continued From page 2 their rounds then the resident would already be awake and she would not have to wake them. She explained most of the medications she gave during the 5:00 AM medication pass included medications given by mouth or finger stick blood sugar checks and she had not asked residents about their choices regarding their early morning medications. Nurse #3 confirmed the hallway lights were always turned on brightly at night. During an interview on 12/20/13 at 5:42 PM the Director of Nursing stated it was his expectation for resident choices to be honored regarding early morning medication pass. He stated if residents did not want their medications given early the medication time should be adjusted and if a resident could not state their choices the nursing staff should watch for indications a resident did not want to be awakened early for medications. He also confirmed there was a way to turn some of the lights off during the night and it was his expectation for the lights to be turned down and should not be burning brightly at night. 2. Resident #135 was admitted to the facility on 07/03/13 with diagnoses which included heart disease and dementia. The most recent quarterly Minimum Data Set (MDS) dated 10/02/13 indicated Resident #135 had no short term or long term memory problems and had no impairment in cognition for daily decision making. The MDS further indicated Resident #135 required extensive assistance from staff for activities of daily living. A review of a monthly Medication Administration Record dated 12/01/13 through 12/31/13 indicated Protonix 40 milligrams by mouth daily at 6:00 AM.	F 242	disciplinary action as necessary. The Quality Assurance Nurse will review medication times specifically during hours of sleep Monday (viewing Friday night through Sunday night) through Friday x 1 month, weekly x 1 month, and monthly x 4 months to ensure staff continue to follow the written policy and procedure and that residents are not being given medications prior to 7:00am unless medically necessary for acute conditions. Any concerns will be reported to the DON for follow-up as necessary. This audit will begin on 1/17/14. The DON will monitor the results of the medication audits and Resident's Council concerns and will report results and any trends or patterns to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further interventions or systemic changes are needed to assure continued compliance with F242.	

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During an observation on 12/19/13 of a medication pass on the 500 hall at 5:06 AM all of the lights on the 500 halls were turned on and the hallways were very bright. Nurse #3 who was a 11:00 PM to 7:00 AM nurse pulled a pill labeled Protonix 40 milligrams from a medication cart parked in the hallway outside the door of Resident #135's room who was also the roommate of resident #18 and knocked on her door. Nurse #3 opened the door and entered the room. There were no lights on in the room and Nurse #3 turned on a light and called Resident #135's name and stated it was time for her morning medication. Resident #135 was lying in bed and opened her eyes and raised her head up off her pillow. Nurse #3 placed the medication in Resident #135's mouth and gave her a sip of water to drink, washed her hands, turned off the lights and closed the door of the room and walked back to the medication cart in the hallway.

During an interview on 12/19/13 at 5:30 AM the night shift nursing supervisor verified the early morning medication pass always started at 5:00 AM. She further explained she sometimes assisted the night shift nurse with her medication pass so she could finish her medications before shift report with the oncoming day shift nurses.

During an interview on 12/19/13 at 7:32 AM Nurse #3 explained it was routine practice to start medication pass at 5:00 AM. She stated medications were ordered to be given at 6:00 AM or 6:30 AM but they had a 1 hour window before and after the medication was ordered to give the medication so they started the medication pass at 5:00 AM so they could have all of the medications given by the time first shift arrived and shift report

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was given at 7:00 AM. She further stated she had to wake approximately 80 percent of the residents that she gave morning medications to on a regular basis but if nurse aides were doing their rounds then the resident would already be awake and she would not have to wake them. She explained most of the medications she gave during the 5:00 AM medication pass included medications by mouth or finger stick blood sugar checks and she had not asked residents about their choices regarding their early morning medications. Nurse #3 confirmed the hallway lights were always turned on brightly at night.

During an interview on 12/20/13 at 3:22 PM with Resident #135 she confirmed nursing staff woke her up every morning for her stomach pill. She stated nursing staff had not asked her about her choices regarding when to take her morning medication so she just took it because she needed it for her stomach.

During an interview on 12/20/13 at 5:42 PM the Director of Nursing stated it was his expectation for resident choices to be honored regarding early morning medication pass. He stated if residents did not want their medications given early the medication time should be adjusted and if a resident could not stated their choices nursing staff should watch for indications a resident did not want to be awakened early for medications. He also confirmed there was a way to turn some of the lights off during the night and it was his expectation for the lights to be turned down and should not be burning brightly at night.

3. Resident #4 was admitted to the facility on 09/01/10 with diagnoses which included osteoarthritis, depression and anxiety. The most

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recent quarterly Minimum Data Set dated 11/17/13 indicated Resident #4 had no short term or long term memory problems and had no impairment in cognition for daily decision making.

A review of a monthly Medication Administration Record dated 12/01/13 through 12/31/13 indicated Hydrocodone/APAP 10-325 milligrams by mouth twice a day at 6:00 AM and 6:00 PM.

During an observation on 12/19/13 of a medication pass on the 500 hall at 5:08 AM all of the lights on the 500 halls were turned on and the hallways were very bright. Nurse #3 who was a 11:00 PM to 7:00 AM nurse pulled a pill labeled Hydrocodone/APAP 10-325 milligrams from a medication cart parked in the hallway outside the door of Resident #4's room and crushed the medication and placed it in jelly in a cup. The door of the room was already open and Nurse #3 knocked on the door and entered the room. Resident #4 was making snoring sounds and Nurse #3 stated to resident to wake up, it was time for her morning medications. Resident #4 continued to make snoring noises and Nurse #4 tapped Resident #4 on her shoulder and again told her to wake up for her morning pill. Nurse #3 continued to call Resident #4's name, raised the head of the bed and Resident #4 partially opened her eyes. Nurse #3 placed a straw in Resident #4's mouth and told her to take a sip of water, then placed the pill in Resident #4's mouth and told her to swallow the pill and gave her another sip of water. Nurse #3 lowered the head of Resident #4's bed, turned off the light and walked out of the room to her medication cart in the hallway.

During an interview on 12/19/13 at 5:30 AM the

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night shift nursing supervisor verified the early morning medication pass always started at 5:00 AM. She explained she sometimes assisted the night shift nurse with her medication pass so she could finish her medications before shift report with the oncoming day shift nurses.

During an interview on 12/19/13 at 7:32 AM Nurse #3 explained it was routine practice to start medication pass at 5:00 AM. She stated medications were ordered to be given at 6:00 AM or 6:30 AM but they had a 1 hour window before and after the medication was ordered to give the medication so they started the medication pass at 5:00 AM so they could have all of the medications given by the time first shift arrived and shift report was given at 7:00 AM. She further stated she had to wake approximately 80 percent of the residents that she gave morning medications to on a regular basis but if nurse aides were doing their rounds then the resident would already be awake and she would not have to wake them. She explained most of the medications she gave during the 5:00 AM medication pass included medications by mouth or finger stick blood sugar checks and she had not asked residents about their choices regarding their early morning medications. Nurse #3 confirmed the hallway lights were always turned on brightly at night.

During an interview on 12/20/13 at 2:52 PM with Resident #4 she stated she liked to sleep when she could. She stated nursing staff had not asked her about her choices regarding her morning medications and she just took what they gave her.

During an interview on 12/20/13 at 5:42 PM the Director of Nursing stated it was his expectation

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for resident choices to be honored regarding early morning medication pass. He stated if residents did not want their medications given early the medication time should be adjusted and if a resident could not state their choices the nursing staff should watch for indications a resident did not want to be awakened early for medications. He also confirmed there was a way to turn some of the lights off during the night and it was his expectation for the lights to be turned down and should not be burning brightly at night.

4. Resident #108 was admitted to the facility on 12/28/12 with diagnoses which included Alzheimer's disease, dementia, cataracts and inflammation of eyelids. The most recent annual Minimum Data Set dated 12/04/13 indicated Resident #108 had short term and long term memory problems and was severely impaired in cognition for daily decision making.

A review of a monthly Medication Administration Record dated 12/01/13 through 12/31/13 indicated Sulfacetamide 10 percent (2) drops in left eye every 6 hours for 7 days at 12:00 AM; 6:00 AM; 12:00 PM and 6:00 PM.

During an observation on 12/19/13 of a medication pass on the 500 hall at 5:26 AM all of the lights on the 500 halls were turned on and the hallways were very bright. Nurse #3 who was a 11:00 PM to 7:00 AM nurse pulled a bottle labeled Sulfacetamide Eye drops from a medication cart parked in the hallway outside the door of Resident #108's room and knocked on his door. Nurse #3 entered the room and turned the lights on, washed her hands and put on gloves. Resident #108's eyes were closed and he was making snoring sounds. Nurse #3 spoke to

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Resident #108 but he did not open his eyes and continued to make snoring sounds. Nurse #3 patted Resident #108's chest then placed the eye drops in Resident #108's left eye. Resident #108 stretched his arms out to his sides but did not open his eyes. Nurse #3 removed her gloves, washed her hands, turned off the light and walked out into the hallway to her medication cart.

During an interview on 12/19/13 at 5:30 AM the night shift nursing supervisor verified the early morning medication pass always started at 5:00 AM. She further explained she sometimes assisted the night shift nurse with her medication pass so she could finish her medications before shift report with the oncoming day shift nurses.

During an interview on 12/19/13 at 7:32 AM Nurse #3 explained it was routine practice to start medication pass at 5:00 AM. She stated medications were ordered to be given at 6:00 AM or 6:30 AM but they had a 1 hour window before and after the medication was ordered to give the medication so they started the medication pass at 5:00 AM so they could have all of the medications given by the time first shift arrived and report was given at 7:00 AM. She further stated she had to wake approximately 80 percent of the residents that she gave morning medications to on a regular basis but if nurse aides were doing their rounds then the resident would already be awake and she would not have to wake them. She explained most of the medications she gave during the 5:00 AM medication pass included medications given by mouth or finger stick blood sugar checks but sometimes she had eye drops to give. She stated she had not asked residents about their choices regarding their early morning medications and also confirmed the hallway lights

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F 242	Continued From page 9 were always turned on brightly at night. During an interview on 12/20/13 at 5:42 PM the Director of Nursing stated it was his expectation for resident choices to be honored regarding early morning medications. He stated if residents did not want their medications given early the medication time should be adjusted and if a resident could not state their choices the nursing staff should watch for indications a resident did not want to be awakened early for medications. He also confirmed there was a way to turn some of the lights off during the night and it was his expectation for the lights to be turned down and should not be burning brightly at night.	F 242		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide linens in clean condition when a resident 's soiled linen was not changed on her bed for 1 of 2 residents (Resident # 60). Review of the medical record revealed Resident # 60 was admitted to the facility on 11/08/10 with diagnoses including Alzheimer's, dementia, depression, anxiety, debility, muscle weakness and lack of coordination. A review of the most recent annual Minimum Data Set (MDS) dated	F 252	Linens for Resident #60 were changed immediately upon notifaction to the DON on 12/19/13. NA #2 was re-educated on the current policy and expecation for changing linens with each shower and as needed on 12/23/13. Linens for all residents were checked any any discovered to be soiled were changed by assigned nursing staff on 12/19/13. Nursing staff (including NA #2) were	1/17/14

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F 252	Continued From page 10 10/28/13 revealed Resident # 60 was severely impaired for cognitive skills for daily decision making and required extensive assistance with activities of daily living which included bathing and dressing. Review of the facility record shower list revealed Resident # 60 was scheduled to receive showers on Mondays and Wednesdays. During an observation on 12/17/13 at 8:34 AM Resident # 60's bed was made with the sheet turned down at the head of the bed which revealed a 2 inch long by ½ inch wide purple grape colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. During an observation on 12/18/13 at 9:36 AM Resident # 60's bed linen sheets remained with the same purple colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. During an observation on 12/18/13 at 5:21 PM Resident # 60's bed linens sheets remained with the same purple colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. During an observation on 12/19/13 at 8:50 am Resident # 60's bed linen sheets remained with the same purple colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. During an interview on 12/17/13 at 11:47 AM with Nursing Assistant (NA) # 4 responsible for the showers for residents 5 days a week stated	F 252	in-serviced by the Administrator on 12/26/13 of the current policy and expectations for changing linens with each shower and as needed when visibly soiled. The policy for bed linens was revised effective 1/16/14 to include "bed linens will be stripped by the 1st shift Shower Aide on the day the resident receives his/her skin assessment (once weekly) and will be replaced by the assigned nursing assistant". The revised policy continues to state "bed linens will be changed as needed by the assigned nursing assistant when visibly soiled". The assignment sheet for the nursing assistants/shower aides will indicate daily skin assessments--the shower aide will initial when the bed has been stripped and the assigned nursing assistant will initial when the new linens have been replaced. In-servicing was conducted for all nursing staff on this revised policy and expecations for clean linens by the ADON/SDC on 1/15/14. The Unit Nurse on each hall assignment will monitor 2 beds per nursing assistant assignment per shift daily x 4 weeks, weekly x 4 weeks, and monthly x 4 months in random order to verify clean linens are in place and are changed as required and necessary. Any issues noted in the failure to follow this policy will be identified, documented, and corrected during the observation. Staff involved will be re-educated or issued progressive disciplinary action as necessary. These	

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F 252	Continued From page 11 Resident # 60 received showers on Mondays and Wednesdays. NA # 4 stated Resident # 60 received her shower on Monday as was scheduled. NA # 4 further stated the NAs assigned to the residents on the halls were responsible for changing the bed linens on the resident ' s shower days and as needed when linens were soiled. During an interview on 12/18/13 at 4:30 PM with NA # 5 for 3-11 PM shift for Resident # 60 stated she received report from the day shift NA that Resident #60's shower was completed today and no other tasks were reported as incomplete. NA # 5 explained that showers included, hair washing, nail care, clean clothes and clean linens. During an interview on 12/19/13 at 9:00 AM the Nurse-In-Charge (NIC) floor supervisor confirmed Resident # 60's sheet was soiled with a grape colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed and it should have been changed on the resident's shower day and any time they were soiled. The nurse supervisor further stated it was her expectation that sheets were changed on shower days Mondays and Wednesdays for this resident or any time they were soiled. During a telephone interview on 12/20/13 3:26 PM with NA # 2 for the day shift responsible for the care of Resident # 60 on Monday, Tuesday and Wednesday stated Resident # 60 shower days were Monday and Wednesday. NA # 2 stated she changed Resident # 60's sheets on Monday first thing in the morning after breakfast. NA # 2 revealed she did not change the linens on Resident # 60's bed on Tuesday or Wednesday. NA # 2 further revealed that she did not give a	F 252	audits will begin on 1/17/14. The ADON/SDC will monitor the results of the nursing audits for completion and will report results and any trends or patterns to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further interventions or systemic changes are needed to assure sustained compliance with F252.	

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	345264	A. BUILDING _____ B. WING _____	C 12/20/2013

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F 252	Continued From page 12 report to the next shift NA to change the linens. During an interview on 12/19/13 at 09:04 AM the Director of Nursing (DON) stated it was his expectation that bed linens should be changed twice a week on the resident shower days Mondays and Wednesdays and more often when the linens were soiled. The DON confirmed Resident # 60's sheet were soiled with a purple grape colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. During an interview on 12/19/13 at 9:32 AM the Administrator verified Resident #60's linens were soiled with purple grape colored stain on the middle of the top edge of the sheet folded down below the pillow at the head of the bed. The Administrator stated it was her expectation that soiled linens should be changed on resident 's showers days and more frequently when they were soiled.	F 252		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain comfortable sound levels for sampled residents residing on the 500 hall during the night shift hours between 11:00 PM and 7:00 AM.	F 258	There were no residents named specifically in the citation; however, shift supervisors addressed concerns of noise level during hours of sleep with all shifts immediately following the survey on 12/20/13 - 12/21/13.	1/17/14

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F 258	Continued From page 13 The findings included: During an observation on 12/19/13 at 4:53 AM a maintenance staff man entered and exited the back door of the 500 hall. On 12/19/13 at 5:04 AM as surveyors knocked on the door at the 500 hall to alert staff to open the door the door alarm immediately sounded loudly and the nursing supervisor attempted to silence the alarm but was unable to clear the alarm after 4 attempts. During her attempts to disengage the door alarm, she had to open and slam shut the door 4 times. She then asked for assistance from the 3rd shift 500 hall nurse who disengaged the door alarm. During an observation on 12/19/13 at 5:07 AM maintenance staff man entered the building from outside through the back door on the 500 hall. Maintenance personnel used the key pad to disengage the alarm prior to his entrance but the alarm sounded with beeps and the door slammed closed. On 12/19/13 at 5:17 AM the 3rd shift maintenance man was interviewed. He stated the back door on the 500 hall was locked at 9:00 PM every night and unlocked at 6:00 AM each morning and confirmed the door alarm was activated during these times. He revealed anyone who entered and/or exited the door during these times would cause the alarm to sound loudly. He stated the employee's parking lot was at the back of the building therefore all employees used the 500 hall door to enter and exit. He revealed staff went in and out the door to smoke as well as when staff took breaks and/or for their meal breaks during the 1st, 2nd, and 3rd shifts. He	F 258	The Social Worker held a Resident's Council meetings on 12/23/13 and discussed noise level throughout the entire building during hours of sleep--concerns voiced by the residents were addressed with nursing staff by the Administrator through an in-service on 12/26/13. The Social Worker then held a 2nd meeting with the Resident's Council on 1/8/14 for any further concerns related to noise levels and they stated it was "getting better". All areas of concern related to comfortable sound levels during hours of sleep were reviewed and changes were made to certain policies and procedures that had the potential to affect residents while sleeping--all changes were effective 1/17/14. Routine nursing assistant duties (passing ice, delivering nursing supplies, taking routine vital signs, and splint application) and all housekeeping/maintenance services including wheelchair washing will not occur prior to 7:00am and will end no later than 8:00pm unless a resident specifically requests such actions. All door closers will be checked on a monthly basis by Maintenance to ensure each is properly working to manage the sound of the door as it is closed. An Employee Only entrance/exit has been designated for staff between the hours of 8:00pm to 8:00am--no employee will enter or exit the doors on resident hallways	

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F 258	Continued From page 14 further stated nursing assistants took resident wheelchairs out the 500 hall door to the wheelchair pressure washing machine between 9:00 PM and 12:00 Midnight. Once the wheelchairs dried, the wheelchairs were brought back in through the back door of the 500 hall around 2 to 3 hours after the wheelchairs had been taken out. He further stated the 500 hall door was a like a revolving door used by all staff/employees during all hours of the day and night, by visitors, emergency medical services (EMS), as well as for vendor pickups and/or deliveries during the early morning hours. During an observation on 12/19/13 at 5:52 AM a door bell sounded at the front entrance door of the facility. A 3rd shift nurse opened the door for the 6:00 AM resident blood draw lady and the door loudly slammed behind her. During observations on 12/19/13 from 6:32 AM until 7:53 AM the 500 hall door was opened and loudly slammed shut multiple times by maintenance men, housekeeping staff, nursing staff, and nurse aids. During an observation on 12/19/13 at 7:03 AM the 3rd shift maintenance man and the 1st shift maintenance man used a power drill to remove screws on the door closure on the back door of the 500 hall. During observations 12/19/13 from 9:34 AM until 10:07 AM the 1st shift maintenance man and 3rd shift maintenance man continued using the power drill to replace the door closure of the back door of the 500 hall. On 12/20/13 at 5:40 PM the Director of Nursing	F 258	during these specific hours for any reason other than an emergency situation regarding resident care. Employee Only entrances do not have alarms that will sound for any reason and are not located in resident areas. Phlebotomy services will ring the front doorbell when they arrive and will be allowed to enter through the Employee Only entrance/exit. All departments were in-serviced on all policy changes related to noise level by the ADON/SDC and the Administrator on 1/15/14. The in-service also included the expectation that the nurse(s) assigned to each unit as well as department managers will monitor the noise levels during his/her shift and will address any concerns immediately with the employee(s) involved. The Social Worker will review any possible concerns regarding noise level during hours of sleep with the monthly Resident's Council x 6 months--any concerns voiced will be reported to the DON and will be addressed with the specifically named staff through redirection, re-education, and progressive disciplinary action as necessary. Assigned Nurse Managers, the HR Director, and the Administrator will rotate random "pop-in" visits on 11-7 shift once weekly x 6 weeks to determine if any concerns for noise level during hours of sleep are of concern and will address any issues immediately with the employee(s) involved.	

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F 258	Continued From page 15 (DON) was interviewed. He stated his expectation was for the noise level to be kept at a minimum during the early morning and night time hours of 11:00 PM and 8:00 AM. He further stated he was unaware of any drilling on the 500 hall at 7:00 AM in the morning.	F 258	The Administrator will review video surveillance of all outside doors (2 on 500 unit and the front door) to determine any concerns related to employees and failure to follow the policy regarding the Empoyee Only entrance/exit between the hours of 8pm - 8am. These reviews will be done daily x 4 weeks, weekly x 4 weeks, and monthly x 4 weeks and any issues will be identified, documented, and corrected. Staff involved will be re-educated or issued disclipinary action as necessary. The audits will begin on 1/17/14. The DON will monitor the results of management inspections, video surveillance, and Resident's Council concerns related to noise levels and will report results and any trends or patterns to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further intervention or systemic changes are needed to assure sustained complaince with F258.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident	F 312	Upon notification of this concern to	1/17/14

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F 312	Continued From page 16 interviews, and medical record reviews the facility failed to clean the skin of a resident during incontinence care to 1 of 4 sampled residents dependent on staff for activities of daily living (ADL) and personal hygiene (Resident #99). The findings included: Resident #99 was admitted to the facility on 11/01/13 with diagnoses including lack of coordination, muscle weakness, hypertension, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 11/09/13 assessed Resident #99 as cognitively intact for daily decision making and capable of making her needs known. The MDS further assessed Resident #99 for frequent bowel and bladder incontinence, and required extensive assistance with 2 person physical assist with dressing, toileting, and personal hygiene. On the 11/13/13 plan of care Resident #99 was identified as requiring assistance with all ADLs and at risk for skin breakdown due to incontinence. Care plan interventions included the staff would provide all personal hygiene and incontinence care as needed. On 12/18/13 at 2:28 PM Nursing Assistant (NA) #1 and NA #2 entered Resident #99's room were she had removed her own wet soiled brief saturated with urine. NA #2 was observed picking up the urine saturated soiled brief off the floor. NA #1 placed a dry clean brief on Resident #99 and did not wash the resident's skin with soap and water or with a periwash. Further observations revealed there were no washcloths, basin of water, periwash, or any incontinence care supplies in the resident's room.	F 312	management on 12/20/13, Resident #99 was assessed for any concerns related to urinary incontinence and any needs for perineal care were addressed immediately. NA#1 and NA#2 were re-educated on the perineal care policy and the expectations of providing perineal care to all residents who are incontinent of bowel and/or bladder on 12/23/13. Nursing staff were in-serviced by the Administrator on 12/26/13 regarding the expectation for providing perineal care to all residents who are incontinent of bowel and/or bladder. Random perineal care audits were conducted by unit nurses randomly x 1 week (1/2/14 - 1/9/14) to ensure no other residents were affected and proper perineal care was being provided per policy. The ADON/SDC reviewed all audits on a daily basis for completion and any concerns. The perineal care policy was revised effective 1/16/14 to include the expectation that perineal care be provided to all residents who are incontinent of bowel and/or bladder with no exception. Each Unit Nurse will observe 1 nursing assistant on his/her assigned hall daily x 4 weeks, weekly x 4 weeks, and monthly x 4 months randomly to ensure perineal care is in fact being provided as required per policy. The 1st shift Nursing Supervisor	

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F 312	Continued From page 17 On 12/18/13 at 2:45 PM Resident #99 was interviewed. She stated "I took the brief off cause it was so wet." She further stated most of the time the NA's would not clean her skin prior to putting on a clean brief. On 12/18/13 at 2:53 PM NA #2 was interviewed. She stated incontinence care consisted of collecting all incontinence care supplies as well as explaining/talking to the resident. NA #2 explained the process of incontinence care which revealed the NA staff were trained to cleanse residents' perineal area by washing front to back using a clean area of the washcloth with each stoke. She confirmed Resident #99's brief was saturated with urine when she picked it up off the floor. NA #2 stated Resident #99's perineal area should have been cleansed front to back using a clean area of the washcloth each time prior to reapplying a brief. On 12/19/13 at 11:28 AM NA #1 was interviewed. She confirmed she did not clean the resident's skin before reapplying the brief. She stated she was in a hurry and had gotten ahead of herself. She further stated she "did it wrong" and that was not the way incontinence care should have been performed. On 12/20/13 at 5:00 PM the charge nurse was interviewed. She stated incontinence care should be provided the same for all residents requiring incontinence care as well as the staff should follow the incontinence care policy. She revealed her expectation for all NA's responsible for performing incontinence care would be for the resident to be washed with warm soapy water and/or peri-wash spray, resident should be dried,	F 312	will monitor these audits for completion and any issues noted in the failure to follow the perineal care policy will be identified, documented, and corrected during the observation. Staff involved will be re-educated or issued progressive disciplinary action as necessary. These audits will begin on 1/17/14. The ADON/SDC will monitor the results of the perineal care audits for completion and will report any trends/patterns to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further interventions or systemic changes are needed to assure continued compliance with F312.	

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F 312	Continued From page 18 using front to back stroke technique, as well as using a different part of the washcloth with each stroke. They should apply a clean, dry brief on the resident after pericare was completed. She further stated she was unaware NA #1 was not performing incontinence care according to the facility's policy. On 12/20/13 at 5:40 PM The Director of Nursing (DON) was interviewed. He revealed during new employee orientation, annually, and periodically throughout the year, NA staff received training regarding proper incontinence care. The DON stated NA staff were trained and expected to cleanse the perineal area from front to back using a clean washcloth or a clean area of the washcloth with each stroke. He further stated his expectation was for the NA's who performed incontinence care/pericare for a dependent resident should be to clean the resident according to the facility's policy.	F 312		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 371	The Food Service Director discarded the	1/17/14

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F 371	Continued From page 19 facility failed to securely close frozen bags of vegetables to prevent freezer burn on 5 boxes of frozen vegetables. During an observation on 12/16/13 at 11:30 AM with the Dietary Manager (DM) the walk in freezer temperature was observed at 10 degrees below zero. The DM observed 5 boxes of opened bagged vegetables including 2 bags of frozen diced green peppers, 1 bag frozen peas, 1 bag frozen sliced carrots, and 1 bag of frozen okra. The DM verified the 5 boxes of bagged vegetables were not dated of when they were opened and all the vegetables had frosted ice covering the opened vegetables. Review of the dietary menus revealed the okra was last served for supper on 12/12/13, the green peppers were last used in meat loaf on 12/14/13, and the peas and carrots were last served on 12/14 for lunch. During an interview on 12/20/13 at 10:30 AM the DM stated there were no written food storage protocols for frozen foods that were opened. The DM further stated that after an item was opened and not used it was thrown away after three days if it was thawed and if an item was not open we referred to the expiration dates on the packages. The DM revealed the cooks and the cook's aids are the staff responsible for stocking and pulling items from the freezers. The DM further revealed that when an item in the freezer was opened by a staff they would have securely sealed the package and dated the box with the date of opening but would still go by the expiration date on the box. The DM verified the boxes in the freezer were opened and the bags were open with frosted ice covering the vegetables. The DM	F 371	vegetables in the freezer that were without proper seals immediately upon discovery on 12/16/13. The Food Service Director checked all food storage for proper labeling, dating, and seals after use with no other concerns noted on 12/16/13. The Food Service Director conducted an in-service with the staff responsible for the current procedures for checking food storage on the expectations for labeling, dating, and properly sealing all used foods on 12/24/13. A policy/procedure effective 1/16/14 was written for the guidelines and expectations of labeling, dating, sealing, and storing foods to include specific positions within the dietary department responsible for auditing and correcting this on a daily basis, including weekends. Dietary staff were in-serviced on this new policy by the Administrator and Food Service Director on 1/15/14. The 1st shift Cook will audit all food storage in the freezers/refrigerators daily x 4 weeks, weekly x 4 weeks, and monthly x 4 weeks to ensure all food items have been properly labeled, dated, sealed, and stored. Any issue noted in the failure to follow the policy will be identified, documented, and corrected during the observation. Staff involved will be reported to the Food Service Director for re-education or progressive disciplinary action as necessary. Audits will begin on	

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F 371	Continued From page 20 stated it was her expectation that packages should be sealed and dated after opened. During an Interview on 12/20/13 at 4:09 PM the Administrator stated it was her expectation that packaged food items were dated, labeled, and securely closed when opened.	F 371	1/17/14. The Food Service Director will monitor the results of the audit for completion and will report results and any trends or patterns to the QA&A Committee monthly x 6 months. The QA&A Committee will determine any further interventions or systemic changes as needed to assure continued compliance with F371.	