The resident has the right to choose activities, schedules, and healthcare 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 resident and staff interviews, the facility failed to allow a resident to choose the temperature in their room for two of two residents (Resident #85, resident #83).

Findings included:
1. Record review indicated Resident #83 was admitted to the facility on 10/25/2012.
2. Review of the resident’s Minimum Data Set (MDS) dated 12/29/2012 indicated the resident had no cognitive impairment.
3. In an interview with the resident on 1/23/2013 at 10:40 AM, the resident reported facility staff came in the room all the time and turned the heat off if they thought it was too hot. The resident did not give specific staff names or particular shifts and indicated it occurred on all shifts with different staff.

F242 - The Administrator has done rounds to each resident room and has interviewed each individual resident to see what their ideal room temperature would be. The Administrator has adjusted each thermostat to account for each resident's temperature choice. The Director of Nursing has inserviced all staff on Self-Determination and the ability of each resident to make their own choices for their room temperatures on the dates of 01/24/2013 to 01/29/2013. The DON or her designee will interview two residents per week for three weeks, then one per week for two weeks to ensure that each resident is able to make their own choices, and that they are happy with their room temperatures. The
Continued From page 1
staff. The resident further revealed she told staff on many occasions she liked it warm in her room, but they turned it off anyway.

2. Record review indicated Resident #5 was admitted to the facility on 10/30/2003.

Review of the resident's Minimum Data Set (MDS) dated 10/12/2012 indicated the resident had no cognitive impairment.

In an interview with the Resident #5 on 1/23/2013 at 10:45 AM, the resident reported facility staff came in the room "all the time" and turned the heat off if they thought it was too hot. The resident further reported it happened on all shifts and was done by many staff.

In an interview with the Director of Nursing (DON) on 1/23/2013 at 3:45 PM, the DON indicated the temperature in a resident's room should be the resident's choice.

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.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff and resident

results of the resident interviews will be brought to the QA committee for review and interventions will be put into place as needed.

F309- The residents mentioned were monitored for signs and symptoms of bleeding immediately, as well as all dialysis residents. All dialysis residents were palpated for thrill and auscultated for bruit immediately. There were no
F 309 Continued From page 2

signs and symptoms of bleeding and thrill and bruit were present for each dialysis resident. The Director of Nursing has inserviced all Nurses on the new policy for dialysis residents on the dates of 01/24/2013 to 01/29/2013.

Documentation for receiving a resident back from dialysis will be communicated on the new dialysis communication form. This form includes checking for thrill and bruit, vital signs, signs and symptoms of bleeding, and condition of shunt site. On non-dialysis days, thrill and bruit, and signs and symptoms of bleeding will be documented on the MAR. If signs and symptoms of bleeding are present then medical attention will be provided STAT. If thrill or bruit are absent then the attending MD will be notified

interviews, the facility failed to monitor a resident's condition for 2 of 2 residents (#32 and #65) upon return from a dialysis treatment. The findings included:

1. Resident #32 was admitted to the facility on 04/10/12 with cumulative diagnoses that included renal failure, lupus, hypertension, anemia and end stage renal disease requiring dialysis.

   The resident was coded on the most recent annual MDS (minimum data set) dated 04/26/12 as being cognitively intact. In addition, the resident was coded as requiring extensive assistance with ADLs (activities of daily living) and was coded as receiving dialysis.

   A review of the resident's care plan dated 11/05/12 revealed a problem "H/O (history of) incontinent episodes R/T (related to) ESRD (end stage renal disease) with hemodialysis." The Goals included "resident will have no complications related to hemodialysis." Under the approaches was listed "monitor shunt for complications and report to MD as needed."

   A review of the medical record did not reveal any indication that the facility was monitoring the
Continued from page 3

resident's shunt upon return from the dialysis.

During an interview with the Director of Nursing (DON) on 01/23/13 at 4:20 PM it was revealed "I would expect that the resident is checked on when she returns from the dialysis. This would include checking the shunt and taking the resident's vital signs (blood pressure, pulse, respirations)." When asked where this would be documented the DON stated "I guess we don't have any place for it at this time. We do have a dialysis communication sheet that we document on." A review of the form titled "Dialysis Communication Record" did not reveal any documentation of post dialysis monitoring.

During an interview with the resident on 01/24/13 at 10:20 AM it was revealed "when I come back the only thing they do is give me my medication. They don’t look at my arm or take my blood pressure."

During an interview with Nurse #1 on 01/25/13 at 8:00 AM it was revealed "I might check the blood pressure when she comes back but that would be all I would do. A review of the medical record did not reveal any documentation to indicate that the resident's blood pressure had been taken post dialysis.

2. Resident #65 was admitted to the facility on 08/17/12 with cumulative diagnoses that included left cerebral hemorrhage with left side hemiplegia and end stage renal disease requiring dialysis.

The resident was coded on the most recent annual MDS dated 09/23/12 as being cognitively intact. In addition, the resident was coded as immediately. The DON will conduct audits on two residents per week for two weeks and one resident per week for three weeks to ensure that this monitoring and documentation, and communication with the MD is occurring. All findings will be reported to the QA
F 309 Continued From page 4
requiring extensive assistance with his ADLs and was coded as requiring hemodialysis.

A review of the resident's care plan updated 12/05/12 revealed a Problem "care of resident receiving dialysis." Under the Approaches was listed "protect/monitor access site - Lt. (left) arm."

A review of the medical record revealed that there were no vital signs documented for the month of January and there was no documentation in the nurse notes to indicate that the facility monitored the resident upon return from dialysis.

During an interview with the Director of Nursing (DON) on 01/23/13 at 4:20 PM it was revealed "I would expect that the resident is checked on when she returns from the dialysis. This would include checking the shunt and taking the resident's vital signs (blood pressure, pulse, respirations)." When asked where this would be documented the DON stated "I guess we don't have any place for it at this time. We do have a dialysis communication sheet that we document on." A review of the form titled "Dialysis Communication Record" did not reveal any documentation of post dialysis monitoring.

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This Life Safety Code (LSC) survey was conducted as per the Code of Federal Register at 42 CFR 483.70(e); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V protected construction utilizing Delayed Egress Special Locking arrangements, and is equipped with an automatic sprinkler system.

K038: The delayed egress door at the exit of the EBC has been repaired by Carolina Phone and Alarm, and now functions as required. The mag lock mechanism needed to be adjusted. The administrator has reinspected the maintenance department on proper functioning of all exit doors and the delayed egress requirements. The administrator will make rounds to the exits once per week for one month then monthly thereafter. The findings will be brought to the QA committee for review and interventions as needed.

K062: Inspected automatic sprinkler systems are currently maintained in reliable operating condition and are inspected and tested weekly.

Administrator

Date: 3/1/2013
K062—The sprinkler head in room 64 has been cleaned and now is able to operate as it was designed. The sprinkler heads in the main nurse's station have been reviewed by Simplex-Grinnell and the technician has stated that the sprinkler heads are compatible without replacing the existing one, (see attached letter from Technician). The maintenance department has been inserviced on the importance of sprinkler head functioning and cleaning. The administrator will make weekly rounds for one month then monthly thereafter to ensure that compliance with sprinkler head functioning is continued. The findings will be brought to the QA committee for review and changes will be initiated as needed.