STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING ______ B. WING ______	C 08/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET** **WINDSOR, NC 27983**

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F 242 SS=D	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 observation, staff interviews and record review the facility failed to honor the personal preference of 1 of 4 residents (Resident # 50), reviewed for personal preferences, to dress in house dresses that button down the front. Findings included: Resident # 50 was admitted on 2/14/13 with diagnoses that included cerebrovascular accident with resulting left sided hemiparalysis. Review of the Minimum Data Set (MDS), as recorded on 8/18/14, indicated Resident # 50 had significant cognitive impairment. The resident was also coded as requiring extensive to total assistance with all activities of daily living, including dressing. The Activity Care Plan, reviewed 08/14/14, indicated Resident # 50 liked to wear house dresses that buttoned down the front. Observations on 08/25/14 at 12:27 PM, 08/26/14 11:30 AM, 8/27/14 at 10:10 AM, 2:47 PM and	F 242	F242 Resident # 50 responsible party was contacted on September 19, 2014, by Activity Director to review residentJ s individual preferences. Resident # 50 care plans were reviewed by interdisciplinary team(that consists of Resident Care Manager, Social Worker, Activity Director and Dietary Manager) and updated to reflect residents personal preferences. The assigned charge nurse will visually check daily and document on the 24 hour report to ensure she is dressed according to her preferences. The facility interdisciplinary team that consists of the Resident Care Manager, Social Worker, Activity Director and Dietary Manager reviewed each of the residents Activity Assessments and care plans to ensure that individual preferences were reflected. One member of the Interdisciplinary team (that consists of Resident Care Manager, Social Worker, Activity Director and Dietary Manager) will interview 2 Residents that are identified as	9/26/14

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

Electronically Signed — 09/25/2014

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

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3:39 PM and on 8/28/14 at 8:22 AM revealed the resident to be dressed in a facility supplied institutional gown.

During an observation on 8/27/14 at 10:10 AM, it was noted the Nursing Assistant (NA) completed morning care and left the resident in a facility provided institutional gown. Additionally, on observation, Resident # 50 had clothing in her closet that matched her stated preference.

The Social Worker (SW) was interviewed on 8/27/14 at 3:49 PM. She stated during the admission process residents and/or family members were encouraged to bring personal clothing. If a resident had no clothing, then the family would be called. If needed, staff looked in the laundry for extra or donated clothing. The SW added she expected residents to be dressed in their own clothing, unless the resident was acutely ill. If the resident chose to wear a facility supplied gown instead of personal clothing, then that individual's preference should be care planned.

An interview was held with the MDS Coordinator on 8/27/14 at 4:29 PM. The MDS nurse stated an Individual Preference Sheet was used to identify a resident's personal choice and preference about care and included the resident's personal choice for dress. She added she had not been notified Resident # 50 prefered to wear the facility supplied gowns. Additionally, the MDS nurse added unless the resident had expressed a preference to wear the facility provided gowns, then she expected to find Resident # 50 in her own clothing. Review of the Individual Preference Sheet for Resident # 50 did not include information about personal choice for dress.

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inter-viewable to ensure that individual preferences are being honored. The interviews will be documented on the Resident Interview and Resident Observation tool. This tool will be completed weekly times 4 and monthly times 90 days. The Residents identified as non-interviewable will be observed by one member of the Interdisciplinary team (that consists of the Resident Care Manager, Social Worker, Activity Director and Dietary Manager) to ensure that individual preferences are being honored. The observations will be documented on the Resident Interview and Resident Observation tool. This tool will be completed weekly times 4 and monthly times 90 days
The Interdisciplinary team will communicate on the in-house communication form any new preferences or choices. This information will be reviewed in the morning meeting. Care plans and the Kardex will be updated.
The facility staff including the Nursing Assistants, Licensed Nurses, Interdisciplinary team, and Department Managers (Administrator, Director of Nursing, Maintenance Supervisor, Housekeeping and Laundry Supervisor and Rehab Manager) were provided education on how to communicate resident individual preferences to interdisciplinary team by the Staff Development Manager on 9/25/14. The in-service included use of the in-house communication form to report any new preferences or choices. The facility staff including the Nursing Assistants, Licensed

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F 242	Continued From page 2 An interview was held with NA # 2 on 8/28/14 at 8:22 AM. NA # 2 had worked with Resident # 50 at least 3 times per week for the last 2 weeks on day shift. The NA stated any instructions needed to take care of a resident was found on the Kardex that was kept at the nurse's station. Information included diet, transfer status and continence status. The NA stated she did not think the Kardex included information about a resident's preference for dress. This information, she stated, would be obtained from the nurse. NA # 2 stated she had asked Resident # 50 before if she would like to wear her own clothing and the resident would tell her there was "no need of messing up clean clothes". The NA stated if a resident preferred wearing the facility supplied gowns, she had been instructed to let a nurse know. She stated she had reported this, but was unable to remember to whom she gave the report. The NA stated she had not been made aware of the resident's preference to wear the house dresses that buttoned down the front. On 8/28/14 at 11:32 AM, an interview was held with the Activity Director (AD). The AD stated she was responsible for initiating the Activity care plan from information gathered from the resident, family interviews and observations. The information included on the Activity Care Plan, for Resident # 50, including the fact she liked to be dressed in house dresses that button down the front had been received from family members. On 8/28/14 at 10:00 AM, the resident was observed wearing her own gown. She stated it felt good to have her own clothes on. On 8/29/14 at 8:40 AM, the resident was	F 242	Nurses, Interdisciplinary team, and Department Managers (Administrator, Director of Nursing, Maintenance Supervisor, Housekeeping and Laundry Supervisor and Rehab Manager) will have access to view the Kardex which list the resident's preferences. The Kardex is located at the nurses station. Newly hired staff will receive the education during orientation. The Director of Nursing will report the results of the interviews to the Quality Assurance Performance Improvement Committee meeting (QAPI) weekly times four weeks and monthly x 90 days. Any findings pertaining to resident's preferences and choices not being honored will be corrected by the Administrator or Director Nursing. Additional Education will be provided to staff as needed by the facility Staff Development Manager. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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F 242	Continued From page 3 observed up in a geri-chair wearing her clothing of choice. Review of the resident's nurse's notes from 01/01/14 until 08/28/14 did not include documentation regarding refusal to dress in her own clothing. The MDS and the care plan did not refect any resident refusals to dress in her own clothing.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide activities that met the individual interest for 2 of 3 residents (Residents # 50 and 20) reviewed for activities. Findings included: 1. Resident # 50 was admitted on 2/14/13 with diagnoses that included cerebrovascular accident with left sided hemiparalysis and a significant contracture in her left leg. Review of the Minimum Data Set (MDS), dated 08/18/14, indicated Resident # 50 had significant cognitive impairment. The resident was identified as dependent on staff for all activities of daily living.	F 248	F248 Resident # 50 responsible party was contacted on September 19, 2014, by the Activity Director, to review residentJ s individual preferences. Resident # 50 activity assessment was reviewed and updated on September 22, 2014 by activity director. The family will assist with information related choices and preferences. The Activity Director will provide activities to meet the needs of the resident population to include those residents with impaired cognition. Resident # 20 activity assessment was reviewed and updated on September 22, 2014, by the facility Activity Director. The Activity Director will provide activities to	9/26/14

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F 248	Continued From page 4 The resident's activity care plan, reviewed on 8/26/14, indicated the resident liked music and liked to keep things neat and clean. Review of nurse's notes and activity notes from 3/8/14 through 8/27/14 did not reveal any documentation to suggest the resident had refused activities. An Annual Activity Progress Note, dated 2/18/14, indicated the resident required total care by staff. She required assistance to and from activities when held in the dining room. The note documented the resident had the television going for stimulation her while in the room. The resident was also documented as placed in the hall way for visualization of others. On 5/20/14, activity notes indicated Resident # 50 continued to receive one on one visitation which included brushing her hair, talking and reading to her. Activity notes from 8/14/14 indicated the Activity Director (AD) visited with the resident in her room, combed her hair and completed mouth care. Observations on 08/25/14 at 12:27 PM, 08/26/14 at 11:30 AM, 8/27/14 at 10:10 AM, 2:47 PM and 3:39 PM and on 8/28/14 at 8:22 AM revealed the resident lying in bed with no type of activity seen. An interview was held with Nursing Assistant (NA) # 2 on 8/28/14 at 8:22 AM. The NA stated she had worked with Resident # 50 at least 3 times per week for the last 2 weeks. The NA stated she had no knowledge of the resident attending activities. In the last 2 weeks, the resident had been out of bed 4 times and had been available to go to activities. She added she had not seen	F 248	Resident # 20 to meet his needs based on his assessment and care plan. All resident activity assessments and care plans were reviewed by interdisciplinary team that consists of the Resident Care Manager, Social Worker, Activity Director and Dietary Manager and updated to reflect the needs of the resident population to include those residents with impaired cognition. September 25, 2014 The facility Activity Director was provided education regarding the development of the resident activity care plan based on resident assessment of the interest, preference and ability of the resident to participate in the activity program. This education was provided on September 17, 2014, by the Divisional Director of Clinical Services. The education provided also included documentation of resident participation in activity programs. In addition the Activity Director was sent out of the facility on September 23, 2014, for specialized training on the activity role in long term care. This training included: assessment, planning, included the interests, physical and mental/psychological needs of the residents for development of 1:1 visits. In addition, the training also included in room visits/activities, sensory stimulation for the lower functioning and dementia residents, group activities and outings. The facility interdisciplinary team that consists of the Resident Care Manager, Social Worker, Activity Director and	

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F 248	Continued From page 5 anyone from activities in the room interacting with the resident. An interview was held with the Activity Director on 8/28/14 at 11:32 AM. She stated she had been an AD for about 8 years, but had only received one training session on providing activities for the cognitively impaired. The AD added that session was held last October and centered around music. Within the facility, the AD stated she provided music, combed Resident # 50's hair and sat with her. Sometimes, she added, she would take residents outside for fresh air. Activities of this type are provided once a week. The AD stated on the other 6 days the cognitively impaired residents do nothing. Participation logs are kept for residents receiving 1 on 1 activities. Resident # 50 was identified as receiving 1 on 1 activities. She stated that while there was no physical reason the resident could not go to out of room activities, she did not attend out of room activities. The AD stated the absence of attending out of room activities was because the resident was not up and in her geriatric chair. In the last 2 weeks, the AD stated she had not seen the resident out of bed. The AD stated she was responsible for initiating the Activity care plan. Information is gathered from the resident, family and observations. Review of the care plan indicated the resident enjoyed sitting in the hall. The AD stated she could not remember the last time the resident sat in the hallway. The AD stated she had not provided music for Resident # 50 because the resident had no radio. The AD stated she did not remember the last time the resident was out of her room to a singing or social. The AD stated she had not mentioned the fact the resident is never up to any nursing staff or the Administrator. Review of the 1 to 1 Activity	F 248	Dietary Manager reviewed each of the residents Activity Assessments and care plans to ensure that activities provided meets the needs of the resident population to include those residents with impaired cognition. September 25, 2014 One member of the Interdisciplinary team (that consists of Resident Care Manager, Social Worker, Activity Director and Dietary Manager) will interview 2 Residents that are identified as inter-viewable to ensure that individual activity preferences are being honored. The interviews will be documented on the Resident Interview & Resident Observation tool. This will be completed weekly times 4 and monthly times 90 days. The Residents identified as non-interviewable will be observed by one Interdisciplinary team member to ensure that the activity preferences are being honored. The interviews will be documented on the Resident Interview & Resident Observation tool. This will be completed weekly times 4 and monthly times 90 days The facility administrator will review 3 sampled residents (to include the cognitively impaired residents) activity participation grids and care plans. The review is to ensure that activities are being provided are based on the resident interest and or needs weekly times four weeks and monthly times 90 days. The facility Administrator will report the results of the interviews and observations to the Quality Assurance Performance Improvement Committee meeting weekly times four weeks and monthly times 90	

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F 248	Continued From page 6 Program Documentation for Resident # 50 indicated an A beside the word TOUCH. Touch, per the AD meant just touching and rubbing the resident's skin. Another A was seen by Socializing/Conversation. The AD stated this meant she went into the room to talk with the resident. The AD added when she went into the room to socialize and converse with the resident, she stayed 10-15 minutes. The Activity Director acknowledged the time she had coded added up to a maximum of 2 hours for the entire month of August. The AD stated 2 hours out of an entire month did not provide enough activities for a resident. 2. Resident #20 was admitted on 7/2/14 then went to the hospital on 7/31/14 and returned to the facility on 8/4/14. His diagnoses included Biventricular Pacemaker, Congestive Heart Failure, Deep Vein Thrombosis (DVT) and Atrial Fibrillation. His latest Minimum Data Set (MDS), a readmission MDS dated 8/11/14, revealed resident #20 had severe cognitive impairment. A care plan dated 8/18/14 revealed the resident had impaired cognition/communication related to a diagnosis of cognitive communication deficit. The activity care plan dated 8/19/14 revealed the problem or need was "Resident is often present and available for group programs but does not self-imitate (sic) involvement or participation. He likes to be in the hallways. He requires redirecting." The Approach was listed as "Place calendar in room and Assist resident when needed in group activity participation." The Activity Assessment/History form dated 8/19/14 revealed Resident #20 required reminders or cues and needed encouragement for activity participation. In addition this Activity Assessment/History identified his activity pursuit	F 248	days. Any results pertaining to resident activities not being provided will be corrected by the Administrator or Director Nursing. Additional Education will be provided to staff as needed by the facility Staff Development Manager. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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F 248	Continued From page 7 patterns of watching TV, watching movies, music, talking/conversing, spiritual/ religious and exercise as current interest. During an interview with the Activity Director on 8/29/14 at 11:30am she stated this form was completed based on a conversation with the resident's daughter when the resident was originally admitted on 7/2/14. On 8/27/14 at 11:00am Resident #20 was observed outside on the patio with 4 other men and the Activities Director. The Activity Director was not observed to attempt conversation with Resident #20. During an interview with the Activity Director on 8/28/14 at 10:00am she stated that Resident #20 went out on the patio yesterday for the first time. She reported that she did not have any documentation about her visits with the resident. She stated that the resident wandered, he did not stay in group activities so that may be why he was not taken to the activities. On 8/28/14 at 11:15am Nurse #1 stated the resident was confused and would go into other residents' rooms. She added he went to the front lobby, dining room or wandered up and down the halls. During an additional interview on 8/29/14 at 11:30am, the Activity Director was asked about Resident #20's interest in talking or conversing. She stated that she talked with the resident yesterday when she redirected him and took him to his room. She stated she did not talk with him about his topic of interest, she just redirected him back to his room.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		9/26/14

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sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews the facility failed to maintain wheelchair arms and leg rests on a wheelchair in good condition for residents #7, 57 and 71 which could have resulted in resident injury, failed to keep the mattress clean and provide clean pillow cases for Resident # 50 and failed to keep 1 of 1 mechanical lift observed free of white matter.

Findings included:

1. An observation was made on 8/25/14 at 12:02 PM of the wheelchair used by Resident # 7. The left arm of the wheelchair was torn, exposing the foam inside and revealed rough edges to the torn fabric.

An interview was held Nursing Assistant (NA) # 1 on 8/27/14 at 3:43 PM. If resident care equipment was found dirty or arms/legs of wheelchairs torn the NA stated she reported problem to the Maintenance Supervisor or the Nursing Supervisor. The NA added she had not noticed any equipment damaged or dirty.

The Maintenance Supervisor was interviewed on 8/28/14 at 8:42 AM. He stated he was responsible for maintenance of equipment which included replacing wheelchair parts such as arms or legs that may be torn . Notification of needed repairs can be made verbally or through entries on the maintenance log. He added he had no recent reports of any wheelchairs that needed arms or legs replaced. The Maintenance

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Resident #7 left wheelchair arm rest was replaced on August 28, 2014, by the Maintenance Supervisor.
Resident # 71 right wheelchair arm rest was replaced on August 28, 2014, by the Maintenance Supervisor.
Resident # 57 left leg rest was replaced on August 28, 2014, by the Maintenance Supervisor.
Resident # 5 IV pole was cleaned on August 28, 2014 by housekeeping.
Mechanical Lift was cleaned on August 28, 2014 by housekeeping.
Resident # 50 air mattress was cleaned on August 28, 2014, by housekeeping.
The resident pillow case that was observed on 8/25/14 was changed on 8/27/14 by resident care specialist assigned.
Facility Housekeeping Supervisor completed an audit of each facility residents equipment to include that each chair, IV poles , G- T pumps , concentrators, resident specialty mattresses and mechanical lifts were cleaned disinfected on August 28, 2014.

The Facility Maintenance Supervisor completed audits on September 18, 2014, of facility residents chairs to ensure that each was in good working order.

The facility Housekeeping Supervisor will

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Supervisor observed the wheelchair for Resident # 7 and stated the wheelchair arm should have been reported and replaced. He added the rough edges on the cracked arm could cause skin tears for residents.

The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff were expected to observe equipment on a daily basis and report any damaged equipment to the Maintenance Supervisor. Any wheelchair found damaged would either be repaired or taken out of service. If torn wheelchair arms or legs were not replaced, the Administrator stated residents were at risk for skin tears.

2. An observation was made on 8/26/14 at 8:24 AM of the wheelchair used by Resident # 71. The right arm of the wheelchair was torn with the foam exposed and rough edges of the torn fabric present.

An interview was held Nursing Assistant (NA) # 1 on 8/27/14 at 3:43 PM. If resident care equipment was found dirty or arms/legs of wheelchairs torn the NA stated she reported problem to the Maintenance Supervisor or the Nursing Supervisor. The NA added she had not noticed any equipment damaged or dirty.

The Maintenance Supervisor was interviewed on 8/28/14 at 8:42 AM. He stated he was responsible for maintenance of equipment which included replacing wheelchair parts such as arms or legs that may be torn . Notification of needed repairs can be made verbally or through entries on the maintenance log. He added he had no recent reports of any wheelchairs that needed arms or legs replaced. The Maintenance

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conduct audits of resident equipment and lifts, one per hall. The audit form will be documented on the Health Care Services Equipment log. The audit will be completed to ensure equipment is disinfected weekly times four and monthly times 90 days.
A cleaning schedule of the lifts will be reviewed and a copy will be given to the Administrator. The hoyer lift cleaning schedule is as follows: Hoyer Lifts are cleaned Tuesdays, Thursdays and as needed.
The facility Maintenance supervisor will conduct 3 random audits resident chairs to ensure they are in good working order weekly times four and monthly times 90 days.

The facility staff including nursing assistants, licensed nurses, department Managers, Rehab department, dietary staff and housekeeping staff were provided education on monitoring resident equipment for cleanliness on September 25, 2014. The staff were trained to fill out the maintenance log when equipment concerns were identified. This log is located at at the nurses station. The Maintenance Supervisor checks the log daily to review new entries.
The Housekeeping Supervisor will be notified daily by the Maintenance Supervisor if any concerns of dirty equipment is listed on log. The Newly hired staff will receive education during orientation. The Housekeeping Supervisor and Maintenance Supervisor will monitor this log book to ensure compliance in

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BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

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F 253	Continued From page 10 Supervisor observed the wheelchair for Resident # 71 and stated the wheelchair arm should have been reported and replaced. He added the rough edges on the cracked arm could cause skin tears for residents. The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff were expected to look at equipment on a daily basis and report any damaged equipment to the Maintenance Supervisor. Any wheelchair found damaged would be repaired or taken out of service. If torn wheelchair arms or legs were not replaced, the Administrator stated residents were at risk for skin tears. 3. On 8/26/14 at 2:25 PM, an observation was made of the wheelchair used by Resident # 57. The left leg rest of the wheelchair was torn, exposing foam and rough edges along the border of the fabric. An interview was held Nursing Assistant (NA) # 1 on 8/27/14 at 3:43 PM. If resident care equipment was found dirty or arms/legs of wheelchairs torn the NA stated she reported problem to the Maintenance Supervisor or the Nursing Supervisor. The NA added she had not noticed any equipment damaged or dirty. The Maintenance Supervisor was interviewed on 8/28/14 at 8:42 AM. He stated he was responsible for maintenance of equipment which included replacing wheelchair parts such as arms or legs that may be torn . Notification of needed repairs were made verbally or through entries on the maintenance log. He added he had no recent reports of any wheelchairs that needed arms or legs replaced. The Maintenance Supervisor	F 253	addition to their audits and daily rounds. The facility staff nursing, rehab, dietary, Housekeeping and Maintenance were provided education of reporting equipment that is not in good working order or other issues by the Staff Development Manager. The staff were trained to fill out the maintenance log when equipment concerns were identified. This log is located at at the nurses station. The Maintenance Supervisor checks the log daily to review new entries. September 25, 2014. The facility housekeeping staff was provided education regarding the cleaning schedule of residents equipment and lifts by Housekeeping Supervisor on September 25, 2014. The hoyer lift cleaning schedule is as follows: The hoyer lifts are cleaned on Tuesdays, Thursdays and as needed. The facility Administrator will report results of the cleaning audits to the Quality Assurance Performance Improvement Committee Meeting weekly times four and monthly times 90 days. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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observed the wheelchair for Resident # 57 and stated the wheelchair leg rest should have been reported and replaced. He added the rough edges on the cracked leg rest could cause skin tears for residents.

The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff were expected to look at equipment on a daily basis and report any damaged equipment to the Maintenance Supervisor. Any wheelchair found damaged would be repaired or taken out of service. If torn wheelchair arms or legs were not replaced, the Administrator stated residents were at risk for skin tears.

4. During an observation on 8/25/14 at 4:01 PM of the tube feeding pump for Resident # 5, dried white matter was noted on the base of the pole.

An interview with the Housekeeping Supervisor was held on 8/28/14 at 9:04 AM. She stated housekeeping was responsible for keeping resident care equipment clean. This included tube feeding pumps, lifts, oxygen concentrators and wheelchairs. She added that cleaning tube feeding pumps and poles was an everyday event. Observations were made by the Housekeeping Supervisor of the tube feeding pump and pole and agreed both should have cleaned.

The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff were expected to observe equipment on a daily basis and report any damaged or dirty equipment to the Maintenance Supervisor or the Housekeeping Supervisor.

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5. An observation was made of the air mattress and the pillow case for Resident # 50 on 8/25/14 at 12:30 PM. In the upper right corner, the mattress was observed to have a dried white matter that extended down and across the mattress for several inches. The pillow case had 3 black marks that were visible from the door way.

On 8/26/14 at 3:00 PM, the white matter on the mattress and the black marks on the pillow case were still present.

During an observation on 8/27/14 at 10:12 AM, the pillow case with the 3 black marks were still used by Resident # 50. The white matter remained in the top right corner of the air mattress.

An interview was held with Nurse # 1 at this time. The nurse acknowledged the black marks on the pillow case and the white matter on the air mattress. She stated the expectation was for any linen that was frayed, stained or visibly soiled to be removed from the resident's bed. After identifying the black stains on the resident's pillow case, she stated it should have been removed this morning after care and in reality should have been removed the first day it was noticed.

Nursing Assistant (NA) # 3 was interviewed on 8/27/14 at 10:20 AM. She stated mattresses were usually cleaned when the room was deep cleaned. The NA added if something was on the mattress, cleaned the mattress or asked housekeeping staff to clean the mattress. The NA and the nurse identified the stain at the top right hand corner of the resident's mattress as "probably tube feeding " that had dried. The NA

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stated the white matter should have been wiped off before it dried.

An interview with the Housekeeping Supervisor was held on 8/28/14 at 9:04 AM. She stated housekeeping was responsible for keeping resident care equipment clean. This included tube feeding pumps, lifts, oxygen concentrators, air mattresses and wheelchairs. Air mattresses were usually wiped down when a urine smell was reported by the NA. Otherwise, the mattresses were cleaned daily unless the bed had been made. If the bed was made and there was no odor, then the mattress was cleaned on deep cleaning days. The Housekeeping Supervisor observed the air mattress for Resident # 50. She stated Resident # 50 was in bed most of the time, so therefore it was more difficult to find a time to clean the mattress.

The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff are expected to observe equipment on a daily basis and report any damaged or dirty equipment to the Maintenance Supervisor or the Housekeeping Supervisor.

6. A mechanical lift on the 200 hall was observed to have a white, dried matter on the left side near the center pole. The matter was observed daily from 8/25/14 through 8/28/14.

During an interview with the Housekeeping Supervisor on 8/28/14 at 9:04 AM, she stated housekeeping was responsible for keeping resident care equipment clean, including lifts. The Housekeeping Supervisor stated she tried to catch the lifts when they were setting in the hall or the shower rooms. The Housekeeping Supervisor observed the lift on the 200 hall. She

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F 253	Continued From page 14 wiped part of the white matter off with her finger and agreed the lift should have been cleaned. The Administrator was interviewed on 8/28/14 at 9:49 AM. Staff are expected to observe equipment on a daily basis and report any damaged or dirty equipment to the Maintenance Supervisor or the Housekeeping Supervisor. .	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		9/26/14

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F 279	Continued From page 15 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop an individualized care plan for activities based on current interest and needs for 1 (resident #20) of 3 residents reviewed for activities. The findings included: Resident #20 was admitted on 7/2/14 then went to the hospital on 7/31/14 and returned to the facility on 8/4/14. His diagnoses included Biventricular Pacemaker, Congestive Heart Failure, Deep Vein Thrombosis (DVT) and Atrial Fibrillation. The Activity Assessment/History with the date of admission of 8/4/14 revealed Resident #20 required reminders or cues and needed encouragement for activity participation. In addition, this Activity Assessment/History identified watching TV, watching movies, music, talking/conversing, spiritual/ religious and exercise as current interest. His latest Minimum Data Set (MDS), a readmission MDS dated 8/11/14, revealed the resident had severe cognitive impairment. A care plan dated 8/18/14 revealed Resident #20 had impaired cognition/communication related to a diagnosis of cognitive communication deficit. The activity care plan dated 8/19/14 revealed the	F 279	F279 Resident # 20 activity assessment and care plan was reviewed and updated on September 22, 2014, by Activity Director to ensure his needs and preferences were care planned. The residentJ s activity care plan was reviewed by the interdisciplinary team consisting of the Social Worker, Resident Care Manager, Dietary Manager and Activity Director to ensure the Residents needs and preferences related to activities were care planned. The facility interdisciplinary team completed an audit of each resident activity assessment and care plans to ensure that activities were being provided to meet the residentJ s needs by September 25, 2014 The facility Activity Director was provided education regarding the development of the resident activity care plan based on resident assessment of the interest, preference and ability of the resident to participate in the activity program. This	

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F 279	Continued From page 16 problem or need was "Resident is often present and available for group programs but does not self-imitate (sic) involvement or participation. He likes to be in the hallways. He requires redirecting." The Approach was listed as "Place calendar in room and Assist resident when needed in group activity participation." The Goal was listed as "Will redirect resident when needed when he is out of his room." Resident #20 was not observed in group activities on 8/25/14 or 8/26/14. During an interview with the Activity Director on 8/29/14 at 11:30am she stated she talked to Resident #20 yesterday when she redirected him to his room but she did not engage in conversation about the resident's interest. She stated there was a calendar in the resident's room but he could not read it so it was not effective as an approach on his care plan. She stated she needed to direct and take the resident to the activity. She added she could improve the approach on the care plan.	F 279	education was provided on September 17, 2014, by the Divisional Director of Clinical Services. The education provided also included documentation of resident participation in activity programs. In addition the Activity Director was sent out of the facility on September 23, 2014, for specialized training on the activity role in long term care. This training included: assessment, planning, included the interests, physical and mental/psychological needs of the residents for development of 1:1 visits. In addition, the training also included in room visits/activities, sensory stimulation for the lower functioning and dementia residents, group activities and outings. The interdisciplinary team member will review 3 sampled residents activity assessments and activity care plans to ensure the residents needs and preferences related to activities are reflected weekly times four and monthly times 90 days. The facility administrator will review 3 sampled residentJ s activity participation grids and care plans to ensure that activities are being provided are based on resident interest and/ or needs of the resident weekly times four and monthly times 90 days. The facility Administrator will report the results of the activity participation grids and care plan review to the Quality Assurance Performance Improvement Committee weekly times four and	

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F 279	Continued From page 17	F 279	monthly times 90 days. Any findings would have been addressed at the time discovered and reported to the Administrator. Any education would have been given to correct and insure that residents interests and preferences and quality activities are being offered. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain a medication error rate of < 5% (2 errors out of 25 opportunities) for a medication error rate of 8%. Findings included: 1. On 8/27/14 at 8:26 AM, Nurse # 1 was observed passing medication to Resident # 33. In preparing the medication, the nurse took Fish Oil, 500 milligrams (mgs) 1 capsule and cut the end off the capsule. She squeezed the liquid from the Fish Oil capsule into the crushed medication and gave the medication to Resident # 33. Review of the physician's orders indicated	F 332	F-332 Resident # 33 attending physician was notified on August 27, 2014, by the Director of Nursing, of the medication variance administration of 500mg Fish oil tablet. Resident # 50 attending physician was notified on August 27, 2014, by the Director of Nursing, of the medication variance. An order was obtained to administer Aspirin 81 milligrams via gastronomy tube on August 27, 2014. All of the facility resident (100%) physician orders were reviewed for the past 60	9/26/14

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F 332	Continued From page 18 Resident # 33 was to have received Fish Oil 1000 mg by mouth. An interview was held with Nurse # 1 at 10:25 AM on 8/27/14. She reviewed the order for the Fish Oil and stated the resident was to have received 1000 mg of the Fish Oil. Nurse # 1 acknowledged she had given 1 capsule, but after looking at the bottle of Fish Oil 500 mg, she stated she should have given 2 capsules to total the 1000 mg ordered by the physician. An interview was held with the Director of Nursing (DON) on 8/28/14 at 1:46 PM. The DON stated Nurse # 1 reported to her she had been distracted when she had to stop her medication pass to call the physician for one of Resident # 33's medications that had been missing. The distraction of stopping during medication pass was given as the cause for only giving 1 capsule of Fish Oil. 2. At 9:51 AM on 8/27/14, Nurse # 1 took Aspirin 81 milligram (mg) out of a container and crushed the medication. The medication was mixed with water and given to Resident # 50 via her gastrostomy tube. Review of the physician's order indicated the medication was to be given by mouth. Nurse # 1 stated Resident # 50 was unable to take anything by mouth and the aspirin order had been written incorrectly. She stated the order should have been clarified to indicate the aspirin would be given by the resident's gastrostomy tube. Nurse # 1 added the administration route mistake for the aspirin should have been identified and changed during the end of the	F 332	days to ensure that medications were being administered per physician orders including the correct dosage and route. This audit was conducted by the Director of Nursing, Unit Coordinator and the Staff Development. September 26, 2014. The facility Director of Nursing or Staff Development Manager will review daily previous day physician orders and newly admitted residents Monday thru Friday to ensure that each physician order has been transcribed and implemented , to include the correct dosage and route weekly times four weeks and monthly time 90 days. All weekend orders will be reviewed every Monday morning at the daily morning meeting by the Director of Nursing or the Staff Development Manager. The facility Director of Nursing or Staff Development Manager will conduct 1 medication pass per shift weekly times four and monthly times 90 days. The licensed nurses were provided re-education regarding prevention of medication errors by Staff Development Manager and completed on September 25, 2014. The content of the in-service included: The five rights of the resident during med-pass, prevention of medication errors, prevention of errors during transcribing orders, professional standard related to a medication pass and how medications errors impact the elderly. Newly hired facility staff will receive education during orientation The facility Director of Nursing will report results of the medication pass	

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F 332	Continued From page 19 month physician order reconciliation. An interview was held with the Director of Nursing (DON) on 8/28/14 at 1:46 PM. The DON stated the accuracy of orders should be verified monthly during end of month reconciliation. The DON stated Resident # 50 was unable to take anything by mouth. The DON stated she would have expected the nurses to call the physician and clarified the correct the route of medication administration for this resident.	F 332	observations to the Quality Assurance Performance Improvement Committee meeting weekly times four and monthly thereafter x 90 days. Any findings will be corrected immediately and reported to Administrator. Additional training interventions will be implemented at the time an error is found. Root cause analysis will be used to determine if additional system changes might be needed. Other interventions as recommended by QAPI committee.	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transcribe an order for Dilantin correctly for 1 of 1 residents receiving Dilantin (Resident # 59) resulting in a critical Dilantin level and hospitalization. Findings included: Resident # 59 was admitted on 01/24/13 with diagnoses that included seizures, hypertension and chronic kidney disease. Review of laboratory results, dated 12/31/13, indicated a Dilantin level of 19.4 (acceptable range is 10.0-20.0). The results were reported to the physician who then ordered a repeat Dilantin level in one month.	F 333	F 333 Resident # 59 physician order for Dilantin was discontinued 2-14-14. Facility residents physician orders were reviewed for the past 60 days for all residents a 100% audit, by the Director of Nursing, Unit Coordinator and the Staff Development Coordinator to ensure that medications were being transcribed and administered per physician orders, including the correct dosage and route by September 25, 2014. The licensed nurses were provided re-education regarding prevention of medication errors by Staff Development	9/26/14

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On 1/31/14, a Dilantin level of 38.9 was reported to the facility. The results were flagged as "Alert". On the laboratory result slip was handwritten (check mark) 200 mg (milligrams) q (symbol for every) hs (bedtime). The nurse had also written to recheck the level in 1 week. Under "see below", were the words, "Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity".

The nurse reported the elevated Dilantin level and on 1/31/14 at 6:30 AM a physician's telephone order was written to (symbol for decrease) Dilantin 200 mg via G tube (gastrostomy tube) (symbol for every) hs (hour of sleep). The physician had initialed the laboratory form, but there was no date of review.

Review of the Medication Administration Record (MAR) for January 2014, indicated Resident # 59 had received Dilantin 200 mg at 9:00 AM and 300 mg at bedtime. After receiving the 1/31/14 order, the nurse discontinued the 300 mg bedtime dose of Dilantin and rewrote the bedtime dose to reflect the 200 mg ordered by the physician.

Laboratory results received by the facility, on 02/08/14, indicated Resident # 59's Dilantin level was 48.6. The results were flagged as "Critical". The laboratory report also documented the results were confirmed. Under "see below", were the words, "Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity". Hand written at the bottom of the laboratory reporting form was instructions to repeat the Dilantin level on 02/09/14 and to hold all doses of Dilantin on 02/08/14 until the physician was notified of the Dilantin level on

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Manager and completed on September 25, 2014. The content of the in-service included: The five rights of the resident during med-pass, prevention of medication errors, prevention of errors during transcribing orders, professional standard related to a medication pass and how medications errors impact the elderly. The licensed nurses were provided education regarding the monthly changeover process by the Staff Development Manager. The changeover process is as follows: Check #1 J Check all current physician orders against new physician orders arriving from Pharmacy. Check #2- Check all old medication administration records (MARS) against new MARS. Check #3- Check physician orders against new MAR. September 25, 2014 Newly hired facility staff will receive education during orientation

The facility Director of Nursing or Staff Development Manager will review previous day physician orders and newly admitted residents Monday thru Friday. Weekends orders will be reviewed on Monday morning during morning nursing meeting by the clinical team to ensure that each physician orders has been transcribed and implemented , to include the correct dosage and route weekly times four weeks and monthly times 90 days.

The facility Director of Nursing or Staff Development Manager will complete 3 MAR to chart audits and one medication pass observations per shift, weekly times

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F 333	Continued From page 21 02/09/14. A physician's telephone order with the same information was written and timed at 10:00 AM. Review of the MAR for February 2014 indicated Resident # 59 had received Dilantin 200 mg every morning at 9:00 AM and had also received Dilantin 300 mg every night at 8:00 PM. Further review of the February 2014 MAR revealed the 1/31/14 order for the decrease in the bedtime dose of Dilantin to 200 mg had not been transcribed onto the February 2014 MAR. At 8:00 PM on 02/08/14, a physician's telephone order was written to send Resident # 59 to the emergency department for evaluation and treatment. A SBAR (a written assessment that is used prior to calling the physician) with a date of 02/08/14 and a time of 8:15 PM, indicated the Resident # 59 presented with shortness of breath, lethargic and non-responsive. Under SITUATION, the nurse documented a decrease in oxygen, change in level of consciousness and breath sounds. She documented the symptoms started on 02/08/14. Vital signs were listed as a blood pressure of 161/107 (the top number or systolic has a high normal of 140 and the bottom number or diastolic should not exceed 90), pulse of 125 (normal standard is 72), respiratory rate of 32 (normal range is 16-20), and a temperature of 100.8 (normal is usually defined as 98.6 degrees Fahrenheit). Under FUNCTIONAL STATUS, the nurse documented Resident # 59 ws not responding to any stimuli. The HOSPITAL DISCHARGE SUMMARY, dated 02/14/14, indicated the admitting and final	F 333	four and monthly times 90 days. The facility Director of Nursing will report results of the MAR to chart audits and the medication pass observations to the Quality Assurance Performance Improvement Committee meeting weekly times four and monthly times 90 days. Any findings related to Med pass or errors will be addressed at the time the error or transcription error is discovered and reported to the Administrator for additional interventions. Additional interventions will be implemented as recommended as indicated by the QAPI team.	

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F 333	Continued From page 22 diagnosis was Dilantin toxicity. The doctor documented the resident was admitted with acute renal failure and Dilantin toxicity. An interview was held with the Staff Development Coordinator (SDC) on 8/28/14 at 3:40 PM. The SDC described the process for end of the month reconciliation. She stated after one nurse checks the orders against the physician's orders in the chart, the second nurse checks the new orders against the MAR and the previous month's orders. Any changes that occurs after the second check should be written on the current and the new MAR by the nurse that received the order. The 11-7 shift, prior to the start of the new month, also checked for any new orders and transcribed those, as needed, to the new MAR. The SDC stated that any nurse that received an order or checked the MAR (such as the 11-7 nurse checks) after MARS were completed was not expected to sign the MAR indicating another check had been completed. The SDC added that laboratory results identified as criticals and alerts were called to the physician immediately. New orders were customarily written on the laboratory result sheet as received from the physician, but added new orders also had to be written on a physician's telephone order sheet. The nurse added If a critical labs were received, the nurse on the hall was expected to call the physician immediately and carry through any orders received. The SDC stated if a nurse received an alert or critical Dilantin level, that nurse would need to assess the resident to see if the resident was arousable. The SDC stated It would be reasonable to expect the nurse would compare the previous month's MAR with the new MAR on the first day of the new month. She stated she could not say that was the current practice. The	F 333		

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F 333	Continued From page 23 SDC stated the nurse that wrote and transcribed the 1/31/14 order did not work for the facility any longer. The Director of Nursing (DON) was interviewed on 8/28/14 at 4:42 PM. She stated the expectation would have been to assess and document the findings after the Dilantin alert was received. She also stated she considered the Dilantin transcription error a significant medication error. On 8/29/14 at 11:57 AM, the Corporate Nurse Consultant stated an action plan for transcription of orders, especially end of month reconcilliation had been identified in April 2014. She stated at that time, only 1 check of orders was completed by staff. Medication variances were completed and given to the physician. A new process, that included checking pink slips (copies of physician's orders) against the MAR was initiated. Audits were completed, but she stated she was unable to locate the audit results.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		9/26/14

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F 371	Continued From page 24 by: Based on observations and staff interview, the facility failed to provide an appropriate barrier between residents' ready to eat food and drinking straws touched with the servers' bare hands. Staff Nursing Assistants (NAs) picked up residents' bread and touched residents' drinking straws with their bare hands during 2 of 2 observed meals (NA #3, NA #4, NA #6 and NA #8). The findings included: A dining observation was conducted on 8/25/14 at 11:55 AM until 12:55 PM in the main dining room. The Business Office Director and Activities Director were present and assisting NAs with applying clothes protectors, passing out hand sanitizing wipes to residents, cleaning resident hands with hand sanitizing wipes, passing out resident trays and setting up resident meals. During this observation, NA #4 touched the open ended tip of a resident's straw with her bare hands prior to inserting the straw into the resident's glass of tea. NA #8 pushed a lid that contained an open ended straw onto a resident's cup by pushing both with the open palm of her bare hand. The open ended straw bent down from the pressure of the bare palm and then popped back up when NA #8 removed her bare palm. A dining observation was conducted on 8/26/14 at 11:50 AM until 12:55 PM in the main dining room. The Business Office Director and Activities Director were present. During this observation, NA #6 touched the open ended tip of a resident's straw with her bare hands prior to inserting the straw into the resident's glass of tea. NA #4	F 371	F371 NA # 4, NA #6, NA# 8 and NA # 3 received immediate -education regarding providing barrier between resident ready to eat food and drinking straws on 8/27/14 by Staff Development Manager. Rounds and observations were conducted by the Director of Nursing on resident units and dining room. There was no issues or concerns related to not providing barrier between resident ready to eat food and drinking straws on August 28, 2014. Facility staff were provided education regarding providing a barrier between resident ready to eat foods and drinking straws by the Staff Development Manager and completed on September 25, 2014. Newly hired facility staff will be provided education during orientation. Facility department managers will conduct 3 random dining and resident room meal observation weekly times four and monthly times 90 days to ensure that staff are providing barrier between ready to eat foods and drinking straws. All three meals will be included in the monitoring including the meals being served in the resident rooms. The facility Administrator will report results of the dining and resident room meal observations to the Quality Assurance Performance Committee weekly times four and monthly times 90 days.	

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F 371	Continued From page 25 touched the open ended tip of a resident's straw with her bare hands prior to inserting the straw into the resident's glass of tea. NA #4 picked up a resident's biscuit with her bare hands and moved it to the side of the resident's plate. NA #3 touched the tip of two residents' straws, sitting at the same table, with her bare hands prior to inserting the straws into the residents' tea glasses. NA #3 removed the same two residents' biscuits from their food wrapper and placed them on the residents' plates with her bare hands. NA #3 did not wash her hands between setting up the two residents' food trays. During the same dining observation NA #3 removed the paper wrapping from a resident's straw and touched the open ended tip of a resident's straw with her bare hands prior to inserting the straw into the resident's glass of tea. During an interview with the Business Office Director, on 8/25/14 at 12:00 PM she stated that "The Activities Director and I are the assigned department heads this week to help in the dining room." She indicated that all department heads have a calendar with a rotation schedule on it to indicate what day or week they are assigned to help in the dining room. She stated that "We are trained by the facility to pass out trays to residents, help set-up resident trays if they are unable to do so, put clothes protectors on residents and make sure residents have what they need to eat their meals. I do not feed residents, but the Activities Director does. She is a trained NA." During an interview with NA #4 on 8/26/14 at 12:45 PM she indicated that she had never been taught by the facility to wash her hands in-between residents when feeding them or not to	F 371	Additional interventions will be implemented as recommended as indicated by the QAPI team.	

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F 371 Continued From page 26
touch their food or straws.

During an interview with NA #6 on 8/26/14 at 1:00 PM she indicated that the facility had not made her aware to not touch the resident's food or straws with her bare hands.

During an interview with NA #3 on 8/26/14 at 1:05 PM she indicated that she washed her hands between residents if she has touched them, but not between setting up resident trays. She also indicated that she was not aware that she could not touch resident bread to move it aside or to not touch residents' straws.

During an interview with the Dietary Manger (DM) on 8/27/14 at 11:05 AM. The DM indicated that the Staff Development Coordinator (SDC) trained NAs regarding safe serving of food. The DM stated "I would expect that anyone serving food would not touch food items, there must be a barrier between the server and the food item such as gloves or utensils. In the kitchen staff have been trained to wear gloves when bagging food items and to use utensils if they have to move anything around on a food tray."

During an interview with the Activities Director on 8/28/14 at 8:30am she indicated that the facility had taught her in the past and also recently on 8/26/14 good hand hygiene practices and safe food serving practices. She stated that "When serving food we were taught to help set up the residents' trays by not touching the eating part of utensils, not to touch food or straws with our bare hands. We learned how to remove paper from a straw and put straw in cup without touching the straw. We also learned how to move food like bread or a biscuit with the tissue paper it comes

F 371

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F 371	Continued From page 27	F 371		

on or with utensils, and not to touch food items with our bare hands."

During an interview with the Staff Development Coordinator (SDC) on 8/28/14 at 10:17 AM she indicated that, upon employment and during orientation, all Nursing Assistants (NAs) and licensed staff are taught to wash hands or use an alcohol based hand sanitizer before and after resident care, before and after meal times, before and after handling linens and as needed. She indicated that safe food handling is also taught and that staff does know not to touch residents' food items or straws. The SDC did not have employee orientation documents that reflected the stated orientation training. The SDC indicated that she did have documentation from the recent 8/26/14 staff training that included good hand hygiene practices and safe food serving practices. The sign in sheet for the 8/26/14 in-service was reviewed; NA #3, NA #4, NA #6 and NA #8 had signed indicating that they had attended. The SDC indicated that she made occasional observations of NAs in the dining room and food handling had been perceived as a problem. She stated that when she does observe breaks in infection control, hand washing or food handling that she handles that on the spot with in-service training but does not keep records of these observations.

During an interview with the Director of Nursing (DON) on 8/28/14 at 10:36 AM, the DON stated, "During orientation each nurse is instructed on hand washing and infection control which includes good hand hygiene practices and safe food serving practices." The DON indicated that she expected the NAs to sanitize or wash their hands with soap and water between each

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F 371	Continued From page 28 resident that they serve food trays to. The DON indicated that the topic of safe food serving had not been introduced or discussed in recent NA meetings, but that she did expect them to know better than to touch the residents' food items.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		9/26/14

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F 441	Continued From page 29 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to disinfect the glucometer per manufacturer's instructions after testing the blood sugar for 1 of 1 resident (Resident # 87) and failed to wash hands after leaving a room designated as an isolation room prior to entering other rooms in the facility. Findings included: 1. Manufacturer ' s recommendations, dated 11/30/12, instructed the facility to disinfect the surface of the glucometer with a solution containing bleach. On 8/27/14 at 4:19 PM, Nurse # 4 was observed completing a finger stick blood sugar on Resident # 87. Upon leaving the resident's room, Nurse # 4 used the foaming hand sanitizer to disinfect the glucometer. Then she used a tissue to wipe the glucometer, covered the glucometer with another tissue and placed the glucometer in the medication cart drawer for the next use. The nurse was interviewed at this time. Nurse # 4 stated she was unaware of the manufacturer's recommendations for disinfection of the glucometer. She added at times she used the hand sanitizer and at other times she would use an alcohol wipe. An observation of the hand sanitizer bottle did not list bleach as an ingredient. During an interview with the Director of Nursing (DON) on 8/27/14 at 5:04 PM, she stated Nurse # 4 had told her she had cleaned the glucometer	F 441	F441 Nurse #4 received re-education regarding cleaning and disinfecting of the glucometer by the Staff Development Coordinator. The glucometer is disinfected after each use using blue top wipes(Clorox Bleach Germicidel Wipes) and allow to air dry for at least one minute. August 25, 2014 The NA#4 received re-education regarding hand-washing and adhering to isolation precautions by the Staff Development Manager on September 4, 2014. This training included the appropriate use of PPE equipment and adhering to the practices of contact isolation. The education given is as follows: Perform hand hygiene before entering and before leaving room, Wear gloves when entering room, wear gown when entering room, once care is completed dispose of PPE equipment and wash hands. A description and explanation of cross-contamination was discussed as well. The staff was educated to prevent spread of infection perform hand hygiene and use personal protective equipment. The Staff Development Manager and	

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F 441	Continued From page 30 with hand sanitizer. The DON stated she had spoken with all other nurses and each of them knew the proper method of cleaning and disinfecting the glucometer. An interview was held with the Infection Control (IC) nurse on 8/28/14 at 10:28 AM. She stated she was responsible for teaching staff how to clean and disinfect the glucometers. The IC added staff were taught to clean the glucometers with a germicidal disposable wipe containing bleach. The IC nurse added the hand sanitizer used on top of the medication cart or alcohol wipes were not an appropriate choice to sanitize the glucometer since neither contained bleach. The DON was interviewed on 8/28/14 at 10:36 AM. She stated during orientation each nurse was instructed on hand washing and infection control to include cleaning and disinfecting glucometers. Most recently, on 7/16/14, an in-service was held that included information on cleaning and disinfecting the glucometer. Review of the sign in sheet for the 7/1/14 in-service was reviewed. Nurse # 4 had signed indicating she had attended. 2. On 8/29/14 at 8:55am NA #4 was observed entering a room designated by signage as a contact isolation room. Continued observation revealed she did not don gloves prior to entering the room or while she was in the room. The resident on contact isolation precautions was observed in the room. NA #4 then exited the isolation room with a breakfast tray. She placed the tray on the tray cart in the hall beyond the door way of the next room. She was not wearing gloves. She did not wash her hands prior to exiting the room or after placing the tray on the tray cart. She then went into another room and turned off the call light. Upon exiting that room she returned to the isolation room. NA #4 remove	F 441	Director of Nursing completed observations of residents that were identified as requiring glucose finger stick monitoring to ensure the glucometer was disinfected. September 25, 2014. Glucose Monitoring to include the cleaning of the glucometer will be conducted 1 per shift per week weekly times 4 and monthly times 90 days. The facility director of Nursing reviewed the infection surveillance log for the past 30 days . The logs did not reveal any acquired infections that would require isolation over past 30 days. The facility Staff Development Manager will complete two random observations of cleaning and disinfecting of glucometers weekly times four and bi- monthly times next 90 days all shifts including weekends and ongoing as deemed necessary by QAPI Team. The facility Staff Development Coordinator will complete 3 random observations of staff washing hands between resident care. The hand washing observation will also include residents requiring isolation. These observations will be done on all shifts and all hallways including weekends next 90 days. The facility Director of Nursing will report finding of audits to the Quality Assurance Performance Improvement Committee meeting weekly times four and monthly times 90 days . Any findings of improper hand-washing Infection control cross contamination practices will be addressed at the time of the observation (if improper	

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F 441	Continued From page 31 an additional breakfast tray. She did not don gloves prior to entering the room or while she was in the room. She did not wash her hands prior to exiting with the tray which she placed on the tray cart. She also did not wash her hands prior to entering a third room to remove a breakfast tray. During an interview with NA #4 at 9:00am she stated she did not wear gloves just to remove the two meal trays from the isolation room because she had previously provided that resident's morning care which included cleaning the over-bed table with "the wipes from the green package. Visualization of the green package revealed it was labeled Aloe Touch Personal Cleaning cloths. NA #4 stated she was not performing personal care so it was acceptable to remove the trays without wearing gloves. During an interview with the Director of Nursing (DON) on 8/29/14 at 9:10am she stated that staff members were to wear gloves every time they entered a room designated as an isolation room. The DON stated she expected the staff to remove the gloves and wash their hands prior to exiting the room of a resident who is on contact isolation. She stated that NA #4 was present for a training session on isolation precautions which was provided at the end of July. On 8/29/14 at 9:20am the DON provided a copy of the training for isolation precautions dated 7/31/14 including the attendance log which had NA #4's name and signature. The Isolation Contact Precautions (page 11) revealed gloves should be worn when entering the room and that hand hygiene should be completed prior to donning gloves and after gloves are removed just prior to exiting the isolation room.	F 441	technique is observed) Intervention will be implemented immediately via a 1:1 education Additional interventions will be implemented per recommended of QAPI meeting team recommendations.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		9/26/14

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F 463	Continued From page 32 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview the facility failed to maintain a call bell in working order for 2 of 30 sampled residents. (Resident # 21 and Resident #9) Findings included: On 8/26/14 at 2:30 PM, Nursing Assistant(NA) #5 entered the room in response to a call bell ringing for Resident # 9. Resident # 21 was asked to ring her bell. The NA noted the bell not working and informed the surveyor she would report the malfunctioning call bell to the Maintenance Director. An observation was made on 8/27/14 at 2:42 PM. The call light for Resident # 9 was not working. Resident # 21, who resided in the B bed stated the other day, when the surveyor was in her room, her call bell did not work, but Resident # 9's bell was working. NA # 3 was in the room at this time and switched the call bells from one plug to another. She stated that one plug was working and one was not. NA # 3 stated she did not realize Resident # 9's call bell was not working and had not been told there was any issue with the call bells in the residents' room. The NA stated both residents were able to use their call bells. She added Resident # 9 actually yelled more than she used the bell. NA # 3	F 463	F463 Resident # 21 call light was replaced on August 28, 2014 by the Maintenance Supervisor. The facility Maintenance supervisor completed an audit of facility resident rooms to ensure each call light was in good working order on September 18, 2014. The facility Maintenance Supervisor will complete 3 call light audits weekly times four and monthly times 90 days , to ensure that each is in good working order. On a monthly basis all rooms will have been checked to ensure that all call lights are working properly. A floor plan as to how he will complete this audit monthly will be given to the Administrator. The facility staff was provided education regarding notification of the Director of Nursing or Administrator by the Staff Development Manager. The training included details: If resident call light is not functioning properly it will be fixed immediately. If it cannot be fixed immediately, the staff will call the Administrator or Director of Nursing to	

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	345339	A. BUILDING ______ B. WING ______	C 08/29/2014

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F 463	Continued From page 33 immediately called the Maintenance Director. The Maintenance Supervisor was interviewed on 8/28/14 at 8:42 AM. The Maintenance Supervisor stated he was responsible for maintenance of facility equipment including call bell systems. Notification of needed repairs iwas received from staff either verbally or through the maintenance log. The Maintenance Supervisor stated he had not received any information about the call bell system not working in the room where Resident # 21 and Resident # 9 lived. He stated had looked at the call system yesterday after NA # 3 called him. The Maintenance Supervisor stated sometimes dampness would get in the box where the bells plug in and the entire box would be changed. After the Maintenance Supervisor was notified the bells were not working today, he stated he would check the system out again, adding if the call bells worked he would not "mess with them", but if the call bells did not work, he would repair the call bells. The Maintenance Supervisor stated he had no idea what may happen to the residents if one of them needed assistance and the call bell would not work. The Maintenance Supervisor stated he tests the call bell systems in 3 rooms a day. Theoretically, he stated it could be months before he tested the call bell system in any given room and depended on staff to tell him if a call bell needed to be repaired.. On 8/28/14 at 9:49 AM the Administrator stated staff were expected to look at equipment on a daily basis and report issues to the Maintenance Director as needed. Anyone that noticed a call bell not functioning should bring it to administrative attention so the call bell could be repaired. The Administrator added the	F 463	report concern. September 25, 2014. Newly hired staff will receive education during orientation. The facility Administrator will report the results of the call light audits to the Quality Assurance Performance Improvement Committee meeting weekly times four and monthly times 90 days. Any findings would have already been fixed but will be addressed at the meetings for additional interventions or system changes as need as recommended by the QAPI team members.	

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F 463	Continued From page 34 Maintenance Supervisor was responsible for checking call bells as part of his preventative maintenance plan. She added if the call bell sometime worked and sometimes did not, the expectation would be for the call bell to be changed and then monitored to make sure the call bell worked correctly. The Administrator stated if a call bell was only working intermittently, then she expected the Maintenance Supervisor to notify nurses and NA's that the call bell was not consistently working. She added she expected that information to be placed on the 24 hour report so the call bell issue would be communicated to all shifts. The Administrator added if inconsistent functioning of a call bell had been reported, she would expect staff to monitor the room more closely to make sure the residents were safe and not in any need. NA # 3 was interviewed again on 8/29/14 at 8:35 AM. She stated the Maintenance Director worked on the call system in the room for Resident # 9 and Resident # 21 yesterday and since then, the call bells had worked properly. At this time, both call bells in the room were tested and found to be working properly. A telephone interview was held with NA # 5 on 8/29/14 at 9:30 AM. She stated she was the NA working on 8/26/14 and verified the call bell system for Resident # 9 and Resident # 21 did not work properly. The NA added she did not report the non-functional call bell to anyone. The NA added, I probably should have reported the non-functioning call bell since I have been taught to report any resident care equipment not working properly. An interview was held with the Administrator on	F 463		

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F 463	Continued From page 35 8/29/14 at 10:18 AM. She stated all staff were expected to report any resident care item, including call bells that were not working properly. Work orders were completed. The expectation for a NA would be to report the issue to a nurse or administrative personnel. The Administrator stated the call bell unit in Room 207 was replaced on 08/28/14.	F 463		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520		9/26/14

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by:
The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in September 2013 and April 2014. This was for two recited deficiencies which were oritinally cited in September 2014 on a recertification survey and on the current recertification survey. A medication error rate of greater than 5% was also cited during a complaint survey in April 2014. The deficiencies were in the areas of medication rate greater than 5% and in infection control. The continued failure of the facility during three federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referenced to:
1.a. F332 Medication Error Rate greater than 5%: Based on observation, staff interview and review of records the facility failed to maintain a medication error rates of less than 5%.

The facility was cited for F332 for failing to maintain a medication error rate of less than 5% during observations of medication administration. F332 was originally cited for not maintaining a medication error rate of less than 5% during the September 27, 2013 recertification survey and again during a complaint survey on April 23, 2014.

b. F441: Infection Control: Based on observations, staff interview and record review, the facility failed to disinfect a blood glucose meter, stored on the medication cart and used to test the blood sugar of a resident.

F 520

F520
The facility Quality Assurance Performance Improvement Committee meeting met on September 19, 2014 to review re- certification survey results, to include discussion of repeat citation related to F 332 and F441. The committee developed the plan of correction for the re- certification survey of 8/29/14.

The Staff Development Manager provided re- education to facility department managers regarding the Quality Assurance Performance Improvement Process on September 23, 2014. The in-service included: The QAPI process, an overview, Five elements of QAPI, and the system of Identify, prioritize, Root Cause (fishbone tool) improve/fix and Sustain/Follow up processes. Handouts and tools were included such as QAPI Performance Improvement plan tools and new minute tools for QAPI process.
The Divisional Director of Clinical Services will attend the weekly ad-hoc QAPI meetings weekly time 4 and monthly times 90 days related to survey plan of correction to ensure that plan of correction has been implemented and maintained.
The facility Quality Assurance Performance Improvement committee meeting will meet weekly times four and monthly times 90 days and ongoing as deemed necessary by QAPI committee team members. These meetings will be conducted to discuss results of audits

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F 520	Continued From page 37 During the recertification survey of September 27, 2013, the facility was cited for failure to wash hands between resident contact observed during medication administration. On the current recertification survey of August 29, 2014, the facility failed to disinfect a glucose meter, stored in the medication cart, after using the meter to test a resident's blood glucose. Additionally, the facility failed to assure staff washed hands after leaving a room designated as an isolation room before proceeding into other resident's rooms. An interview was held with the Administrator on 8/29/14 at 9:32 AM. She stated she was in charge of the Quality Assurance (QA) Committee for the facility. Issues were identified during the morning stand up meeting and received through action team meetings (meetings developed to determine specific facility issues such as falls, pressure ulcers, weight loss). The Administration added,after identification of a problem, a corrective action plan was developed. After determining who would be responsible for the corrective action plan, monitoring tools and audits were set up. Issues were then reviewed in QA meetings until the committee felt the identified problem was resolved. The Administrator identified several recent problems identified by the QA committee. Medication error rate and infection control issues were not identified as problems the QA committee had reviewed. The Administrator added she was aware a greater than 5% medication error rate and infection control had been a cited deficiency in prior surveys. She stated the Director of Nursing (DON) had in-serviced staff on medication administration, but was unsure if the medication error rate or infection control practices, especially	F 520	related to plan of correction post re-certification 8/29/14. The committee analyzes and trends the data to determine if revision to plan of correction needed.	

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F 520	Continued From page 38 hand-washing had been reviewed by the QA committee. The DON and Administrator were interviewed again on 8/29/14 at 10:30 AM. The DON and Administrator reviewed any QA action for infection control and medications that may have been addressed in the last 6 months. Medication issues addressed by the QA committee included timeliness of medication administration and expired medications. Infection control included covering/labeling personal items, covering oxygen tubing/nebs and following policy for gowns/gloves for those on isolation. The DON and Administrator stated that medication error rate and hand-washing had not been brought forth for the QA to develop a corrective action plan.	F 520		