

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2014
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
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F 000	INITIAL COMMENTS On 9/7/14 through 9/10/14 a complaint investigation survey was conducted. There were no deficiencies as a result of the complaint investigation. Event #Z7WG11.	F 000			
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 by: Based on observations, record review, resident interview, and staff interviews, the facility failed to cover, label, and date leftover foods prior to storage. The facility failed to thoroughly clean steam table pans, the large mixing bowl, and sectional plates to prevent food borne illness. The facility also failed to store tuna salad and chicken salad sandwiches under refrigeration during transport to the Dialysis Center for 9 of 9 residents receiving Dialysis (Residents #11, #34, #68, #100,#128, #161, #204, #214, and #245). Findings include: 1. During the Kitchen/Food Service observations conducted on 9/7/2014 at 11:20 AM revealed the following: One quarter sized pan of Pureed Squash was observed not labeled and not dated,	F 371	Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents . The Plan of Correction is submitted as a written allegation of compliance. Maple Grove's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further , Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal	10/3/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/03/2014

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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F 371	<p>Continued From page 1</p> <p>one quarter sized pan of cooked Pureed Chicken dated 9/6/14 was observed stored uncovered, one quarter sized pan of Vegetable Soup dated 9/6/14 was observed stored uncovered, and one quarter sized pan of Chicken Gravy dated 9/6/14 was observed stored uncovered.</p> <p>A staff interview with the Day Cook on 9/7/14 at 11:30 AM indicated, "I usually check the cart with the leftovers, and discard what is past three days old, but I didn't check it this morning. Our policy is three days. " The Cook also indicated the leftovers should have been covered when stored in the refrigerator.</p> <p>2. During the Kitchen/Food Service observations on 9/7/14 at 11:50 AM, two full sized baking pans were observed stored for service with accumulated food debris and a greasy film on the inside and outside of the pans. One half size steam table pan was observed stored for service with accumulated food debris on the inside corners of the pan. The food debris was white in appearance. A large mixer bowl was observed stored for service with a greasy film on the inside and outside of the bowl. A total of three sectional plates were stored for service as follows: One sectional plate was stored for service wet, one sectional plate was stored for service with food debris of a brown appearance, on the outer edge of the plate, and one dinner plate was stored for service chipped on the outer edge.</p> <p>A follow-up observation on 9/09/14 at 11:45 AM revealed one half sized steam table pan was observed stored for service with accumulated food debris on the inside of the pan. Three sectional plates were observed as follows: One sectional plate was observed stored for service,</p>	F 371	<p>procedures and / or any other administrative legal proceeding.</p> <p>The pureed squash, cooked pureed chicken and vegetable soup was discarded and the full sized baking pans were removed from storage on 9/7/14, thoroughly washed and dried appropriately: and placed back into storage by the Dietary Manager. The steam table was removed from service, washed and dried appropriately and returned to service on 9/7/14 by the Dietary Manager. The large mixing bowl and 3 three -section plates were removed from service, washed and dried appropriately and placed back into service by the Dietary Manager and the dinner plate was discarded. On 9/10/14, the 3 three -section plates were removed from service, washed and dried appropriately by the Dietary Manager.</p> <p>Resident # 128 was assessed by the Charge Nurse on return from dialysis on 9/9/14 for nausea/vomiting ,diarrhea and abdominal pain. No gastrointestinal symptoms were noted. All residents who returned from dialysis on 9/9/14 were also assessed by each charge nurse for signs and symptoms of gastrointestinal distress. No symptoms were noted. All dialysis residents were interviewed by the Dietary Manager on 9/10/14 for food preferences for box meals and meals were updated.</p> <p>An audit of all kitchen equipment to include steam table pans, mixing bowls and sectional plates was done on 9/11/14 by the Dietary Managers and Cooks. A</p>		

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F 371	<p>Continued From page 2</p> <p>wet. One sectional plate was observed with food debris of a brown appearance on the outer edge of the plate, and one dinner plate was observed chipped on the outer edge.</p> <p>During observations in the kitchen on 9/10/14 at 7:10 AM, three sectional plates were observed stored for service with accumulated food debris on the insides of the plates.</p> <p>A staff interview was conducted on 9/10/14 at 9:30 AM with the Food Service Manager regarding who was responsible for checking the dishes and preparation equipment prior to service. The Food Service Manager indicated, "The person stacking from the dish machine to the service area is responsible for checking the dishes and pots and pans. The Cook is supposed to go through and check before serving. "</p> <p>3. Review of the Dialysis Residents list revised 9/08/2014 revealed there were 9 sampled residents who went out of the facility for Dialysis services on 9/09/2014.</p> <p>During Breakfast observations conducted on 9/09/2014 at 8:45 AM, it was discovered resident #128 had gone to Dialysis.</p> <p>A staff interview with Nurse #1 was conducted on 9/09/2014 at 8:50 AM. When asked what time the resident went to Dialysis, Nurse #1 indicated "She usually goes around 6:00 AM. "</p> <p>An interview with the Food Service Manager was conducted on 9/09/2014 at 8:50 AM regarding the specific snacks given to the residents who went to the Dialysis Center on 9/09/2014. The Food Service Manager indicated," the residents</p>	F 371	<p>100% audit of all residents requiring box lunches were interviewed by the Dietary Manager on 9/10/14 for food preference and for box lunch meals and meals were updated .</p> <p>100% of dietary staff were in serviced on food storage and food safety by the Dietary Manager and was completed by 9/12/14. 100% of the dietary were in serviced on storing cold food under refrigeration by the Dietary Manager and was completed on 9/12/14. 100% of dietary staff were also re educated on cleaning procedures for washing and drying cookware and dishware by the Dietary Manager and was completed on 9/12/14 . An in service was completed with 100% of the dietary staff on monitoring for chipped dishware by the Dietary Manager on 10/2/14. An in-service was completed with 100% of dietary staff on 9/11/14 on preparing early meal trays for residents planning to leave prior to a scheduled meal time. Dietary staff were also in serviced on preparing lunch boxes for those residents leaving prior to a meal. All new dietary staff will receive the in service information in orientation.</p> <p>The Transportation Driver, every Friday for the following week, will provide dietary with a list of all planned appointments for the week. Early meal trays will be sent to resident leaving for dialysis or other appointments beginning 9/9/14. Lunch box / coolers have been purchased on 9/9/14 along with ice packs to provide cool temperatures for lunch box meals that will</p>		

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F 371	<p>Continued From page 3</p> <p>received a Tuna Salad Sandwich, Applesauce, and Apple Juice, which was delivered to the resident in a white paper bag. It's usually a tuna salad or chicken salad sandwich." When asked how the snacks for the residents receiving Dialysis were kept cold and held at appropriate temperature, the Food Service Manager stated, "That's a good question. I will have to come up with something to keep the sandwiches cold." When asked what time the snacks were delivered to the residents prior to going to Dialysis, the Food Service Manager stated, "The driver picks up the sandwiches before they leave. I'm not sure what time they left this morning."</p> <p>A staff interview with the Nurse #2 was conducted 9/09/2014 at 11:00 AM. The time of the residents ' arrival to the Dialysis Center was verified by Nurse #2, which indicated the residents, "arrived at 6:45 AM." When asked what time the snack was usually consumed, Nurse #2 stated, "The residents can eat the snack anytime they want to." When asked where the snacks were kept during the residents ' stay at the Dialysis Center, Nurse #2 stated, "The snacks are kept with the resident and not refrigerated." Nurse #2 also indicated the residents usually were sent back to the facility between 11:30 AM - 12:00 Noon.</p> <p>A staff interview was conducted on 9/09/2014 at 12:05 AM with the Dietary Aide #1, who prepared the sandwiches for the Dialysis residents. When asked what type of sandwiches were prepared for the residents receiving Dialysis, Dietary Aide #1 indicated, "I prepared three tuna salad and six chicken salad sandwiches. I sent a tuna salad sandwich to Resident # 128."</p> <p>An interview with the Food Service Manager was</p>	F 371	<p>be sent with the resident for their appointments. Lunch box meals with an ice pack will be prepared for identified residents by dietary 9/10/14.</p> <p>QI monitoring tools were developed on 9/11/14 by the QI nurse to monitor resident snacks/foods that go to dialysis for snacks/meals: safe storage of foods: labeled and dated leftovers, and dishware cleanliness</p>		

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F 371	<p>Continued From page 4</p> <p>conducted on 9/09/2014 at 12:10 PM, which indicated the Manager was unaware the Dialysis Center did not refrigerate the residents' snacks. The Food Service Manager stated, "I was under the assumption the Dialysis Center refrigerated the snacks while the residents were receiving their dialysis. I did not know they were not being refrigerated."</p> <p>A staff interview was conducted with the Transport Driver on 9/09/2014 at 3:40 PM. When asked what time the transport van left the facility for the Dialysis Center and when was the residents returned to the facility, the driver indicated, "We left at 5:55 AM and we returned to the facility at 1:00 PM. I picked up the snacks about 5:53 AM after the residents were loaded in the van. That is the last thing I do before we leave. The sandwiches were in paper bags in a metal pan in the kitchen refrigerator, and I took the metal pan and put it in the van. The snacks are not refrigerated in the van."</p> <p>Interview with Resident #128 on 9/09/14 at 4:05 PM indicated the resident received the Renal Diet snack in a white paper bag prior to leaving for the Dialysis Center at approximately 5:55 AM. The resident stated she received a tuna salad sandwich, a four ounce cup of applesauce and a small cup (4 ounces) of apple juice. The resident also indicated the tuna salad sandwich was consumed at 8:00 AM. The resident stated it was usually served warm and not cold.</p> <p>An additional staff interview was conducted on 9/10/2014 at 7:03 AM with the Dietary Aide #1, who prepared the sandwiches for the Dialysis residents. When asked about how she knew which sandwiches to prepare for the residents</p>	F 371			

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F 371	Continued From page 5 who receive Dialysis, Dietary Aide #1 indicated, " I was trained that the Renals (referring to residents receiving Dialysis) cannot have cheese and peanut butter and jelly, so I know to fix chicken salad and tuna salad sandwiches. " During an interview with the Administrator on 9/10/14 at 7:05 AM, the Administrator revealed," We purchased new insulated bags yesterday evening (9/09/14) for all the Renal Diet residents' snacks. We also got frozen ice packs to put in the bags. This was done as part of our Action Plan." Review of the undated Snack List received from the Administrator on 9/10/14 at 9:15 AM, revealed the snacks listed for the Renal Diets/residents receiving dialysis included: Three ounces each of a Chicken Salad Sandwich, Pimento Cheese Sandwich, Tuna Salad Sandwich, Creamed Cheese Sandwich, Jelly Sandwich, and Peanut Butter and Jelly Sandwich.	F 371			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		10/3/14	

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F 425	<p>Continued From page 6</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, interview with the consultant pharmacist and record review, the facility staff failed to ensure that a medication from an outside source was readily identifiable and accurately split to ensure correct for 1 of 1 sampled resident who was administered medications from an outside source (Resident #274). Findings included:</p> <p>Review of the undated policy and procedure for medications brought to the facility by the Resident or Resident's Family/Responsible party revealed in part;</p> <p>A. Purpose: " The facility is responsible for the quality and identity of all medications administered to the residents at the facility. There is always need for concern about the identity of medications and the conditions under which they have been stored.</p> <p>B. Procedure: " All medications brought into the facility by the resident at the time of admission should be reviewed for consistent color and shape within the storage container by the facility staff. " " Any medication that does not appear to have been appropriately stored or labeled shall be sent home with the resident ' s responsible party at that time. "</p> <p>Resident #274 was admitted to the facility on</p>	F 425	<p>Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents . The Plan of Correction is submitted as a written allegation of compliance. Maple Grove's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further , Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and / or any other administrative legal proceeding F425</p> <p>The medication from the outside source for Resident #274 was removed from the medication cart on 9/9/14. The single tablet dose of the medication was ordered from facility's pharmacy on 9/9/14 by the Charge Nurse. The facility pharmacy sent the order to the backup pharmacy on 9/9/14 and the medication was obtained that day. The Nurse Practitioner was</p>		

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F 425	<p>Continued From page 7</p> <p>8/22/14 with cumulative diagnoses which included diabetes and depression.</p> <p>Nurse #1 who admitted Resident #274 was not available for interview.</p> <p>Review of the admission physician orders dated 8/22/14 in part revealed citalopram 20 milligrams by mouth (po) every day. Citalopram is an antidepressant medication.</p> <p>Review of the medication cart revealed the consultant pharmacy dispensed citalopram 20 milligrams on 8/22/14 to the facility for Resident #274.</p> <p>Review of Resident #274 ' s Medication Administration Record for August 2014 revealed a handwritten comment of citalopram 20 mg po located " in bottle. " Interview on 9/9/14 at 2:00 PM with the Administrator revealed Medication Administration Technician #1 (MT) handwrote this entry (referring to the medication bottle brought into the facility). The pills were originally 20 mg and the label on the bottle indicated to give one tablet.</p> <p>Observation during the medication pass on 9/9/14 at 9:42 am with MT #1 revealed a labeled container of citalopram 20 mg that were pink in color. These pink tablets were broken, uneven in multiple sized pieces and not broken where the tablets were originally scored. Further observation during the medication pass revealed MT #1 poured one of these uneven pieces of citalopram into a cup dispenser. The surveyor inquired about the broken pills and the medication giver continued to add other prescribed pills to the medication cup to be dispensed. The</p>	F 425	<p>present in the facility on 9/9/14 and made aware of the concern and no new orders were received. Medication Aide #1 received immediate education on 9/9/14 on the Five Rights of Medication Administration and avoiding medication errors and the facility policy entitled Medications Brought to the Facility by the Resident or Resident's Family/Responsible Party by the Director of Nursing. A medication pass audit was made with Medication Aide #1 by the Staff Facilitator on 9/9/14. No errors were noted during the audit.</p> <p>A 100% audit of all medication carts was completed on 9/9/14 by the DON, ADON, QI, and Staff Facilitator Nurses to ensure that medications from outside source was readily identifiable and accurately split. No similar concerns or other concerns were noted as a result of the audit. An in-service was initiated by the Director of Nursing on 9/9/14 for 100% of all Nurses and Medication Aides on the Five Rights of Medication Administration and avoiding medication errors and the facility policy on Medications Brought to the Facility by the Resident or Resident's Family/Responsible Party. The in-service was 100% complete on 10/2/14 by the Staff Facilitator. All newly hired nurses and medication aides will receive the education material during orientation.</p> <p>The Charge Nurse will check any medications being brought into the facility from an outside source/vendor for accurate labeling, medication is stored in</p>		

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F 425	<p>Continued From page 8</p> <p>medication giver then approached the resident to give him his pills and the resident took the pills from the medication giver before the surveyor could stop the administration. During observation of this the resident indicated he needed to hurry and get his pills because he was late for an outside appointment.</p> <p>Interview on 9/9/14 at 10:40 am with MT #1 revealed, " I know the pills were broken wrong. I did not see the citalopram that was dispensed from the pharmacy. " MT #1 stated she always used these pills that were in the bottle brought from home (that were in pieces) because she could not locate the medication dispensed from the pharmacy. Record review of the MAR revealed MT #1 documented administering citalopram on 8/26/14, 8/27/14, 8/28/14, 9/2/14, 9/3/14, 9/4/14, and 9/5/14.</p> <p>Interview on 9/9/14 at 11:20 am with the pharmacy consultant revealed the bottle was packaged by an outside vendor. The pharmacist observed the container of pink tablets that were broken, uneven in multiple sized pieces and not where the tablets were originally scored. The consultant pharmacist commented that the tablets were not well divided and appeared to be hand broken. Additionally the pharmacist validated that there were 41 broken pieces of citalopram in the bottle and that the consultant pharmacy dispensed citalopram to the facility on 8/22/14.</p> <p>Interview on 9/9/14 at 3:53 PM with MT #2 (who administered medications to Resident #274) revealed she administered the citalopram from the pharmacy dispensed medications. MT #2 indicated that if she observed pills that were not</p>	F 425	<p>an appropriate bottle, and consistent size and shape. The medication will also be checked for any damage. Any medication that does not appear to be stored, labeled, or consistent in size and shape will be sent home with the Responsible Party. Otherwise, the medication will be sent to the facility's pharmacy. A QI monitoring tool was developed on 9/10/14 by the QI Nurse to monitor all medications brought from outside sources to the facility to assure the medication meets all standards. The QI Nurse and ADON will monitor all new admissions daily for 2 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. The Administrator and Director of Nursing will review the QI monitoring tool weekly for 10 weeks, then monthly for 2 months.</p> <p>Results of the monitoring tools will be presented by the ADON to the Executive QI Committee monthly for 3 months to identify trends and the need for continued monitoring.</p>		

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F 425	Continued From page 9 evenly broken she would not administer them to the resident. Interview on 9/10/14 at 8:45 am with the Quality Assurance Coordinator and Assistant Director of Nurses revealed the charge nurse who admits the resident to the facility was responsible for ensuring that the outside medications were identifiable and in correct dosage. Interview on 9/10/14 at 8:50 am with the Director of Nurses (DON) revealed her expectations were for the charge nurse to have removed the bottle of citalopram when the pills were not properly split or identifiable. Additionally, the DON indicated any medication giver was expected to bring to the attention of the nurse any observed problems with the medications and not to administer the medication. Interview on 9/10/14 at 4:10 PM with the administrator revealed her expectations were for staff to follow the policy for medications brought in the facility from an outside source.	F 425			
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced	F 460		10/3/14	

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NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 460	<p>Continued From page 10</p> <p>by: Based on observations, record review, and staff interviews, the facility failed to provide full visual privacy for resident care for residents who resided on 3 of 4 Halls (North, South, and East) in the facility. Findings include:</p> <p>During Initial Tour of the facility on 9/7/14, privacy curtains were observed not wide enough to cover the resident's living space for rooms 205,206, 210,222, 224,226 A, and 235.</p> <p>Observation on 9/8/14 at 10:30 AM on the East Hall in room 201 A, there was 80 inches of insufficient privacy curtains. Hooks would not flow smoothly through the tracks. Observation at 10:50 AM in room 101 A, there was a 108 inches gap of insufficient privacy curtains.</p> <p>An observation of resident # 9 was conducted on 9/9/14 at 9:30 AM. The observation was conducted during a pressure ulcer treatment done by the Treatment Nurse. The resident's privacy curtain was pulled by the Treatment Nurse to prevent the roommate from watching, but the curtain was not wide enough to completely cover the resident, so the nurse shut the door. The resident was not alert and oriented and could not be interviewed.</p> <p>Follow-up observations on 9/10/14 at 2:30 PM on the North, South, and East Halls revealed rooms 106 A, 108 A, 201 A, 206 A, 207 A, 222 A, 223 B, 224 A, 224 B, 226 A, 235, and 906 B were observed with curtains that did not provide full visual privacy. The curtains were not wide enough to go around the residents.</p>	F 460	<p>Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents . The Plan of Correction is submitted as a written allegation of compliance. Maple Grove's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further , Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and / or any other administrative legal proceeding.</p> <p>Privacycurtainsinrooms205,206,210,222,226A,235,201,101,106,108,201,207,222,223,224,226,235,906,113,114,123,124,137,141 108, and 201 were replaced to ensure full coverage was provided around the beds for total visual privacy of the resident on 9/12/14 by the Environmental Director.</p> <p>All residents have the potential to be affected. A 100% audit of all privacy curtains was completed on 9/12/14 by the Environmental Director to ensure privacy curtains provided full coverage for each bed. All corrections were made to ensure all curtains provided full privacy coverage for each bed by 9/29/14 by the Environmental Director.</p>		

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F 460	<p>Continued From page 11</p> <p>Observations on the North Hall were conducted on 9/10/14 at 3:30 PM. The privacy curtains in rooms 113 A, 114 A, 123 A, 124 A, 137 A, and 141 B did not go all the way around the residents. There was a 12" -18" gap from the bathroom wall. In room 123 A, the hooks would not flow smoothly through the tracks.</p> <p>A staff interview was conducted on 9/10/14 at 3:40 PM with the second shift Nursing Assistant (NA#1) revealed, "All the curtains are like that on this hall. We just have to close the door and pull the curtain from the B beds. All the A beds curtains are short." When asked if NA #1 reported the problem to anyone, the NA stated, "I told a nurse, but I don't remember her name. She told me to just close the door."</p> <p>A staff interview was conducted with the Director of Nurses (DON) on 9/10/14 at 3:50 PM. When asked about her expectations of the nursing staff regarding privacy curtains, the DON indicated, " My expectation is that the privacy curtains will reach and will give the residents privacy."</p> <p>A staff interview with the Environmental Director was conducted on 9/10/14 at 3:55 PM. The Director stated, "I realized there was 1 foot missing on most of the curtains from a surveyor. I am adding an extra curtain and doing an audit and replacing them all."</p> <p>An additional follow-up observation was conducted 9/10/14 at 4:00 PM - 4:30PM. The curtains in room 906, 108 A, 201 A were observed replaced. All other rooms discovered during the survey, had not had the privacy curtains replaced.</p>	F 460	<p>The Environmental Director and Staff Facilitator initiated an in-service on 9/12/14 for all housekeeping staff and nursing staff on the correct closure of privacy curtains. The in service was completed by 10/2/14. A QI toll monitoring tool was developed by the Administrator on 9/12/14 for checking privacy curtains to ensure the facility promotes care for residents in n environment that maintains and enhances each resident's dignity and respect. All newly hired housekeeping and nursing staff will receive the education in orientation.</p> <p>Utilizing the QI Monitoring QI tool, the Environmental Director will check 10% of the room privacy curtain weekly for 4 weeks to assure full coverage is provided by the curtains and make any corrections as needed. Then, monitoring will occur every 2 weeks for1 month, then monthly for 3 months. The Administrator and DON will review the QI monitoring tool weekly for 4 weeks, then every 2 weeks for 1 month , then monthly for 3 months.</p> <p>Results of the monitoring tools will be presented by the Environmental Director to the Executive QI Committee monthly for 5 months to identify trends and the need for continued monitoring.</p>		

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

PRINTED: 10/13/2014
FORM APPROVED
OMB NO. 0938-0391

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F 460	Continued From page 12 Interview with the Administrator on 9/10/14 at 5:10 PM regarding who was responsible for making sure the bedrooms were equipped to provide full privacy, the Administrator stated, "The Environmental Director is responsible for making sure the privacy curtains fit and provide privacy." When asked if there was a facility policy regarding privacy curtains, the Administrator stated" I do not have a policy."	F 460			