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	355110	A. BUILDING _____ B. WING _____	07/11/2012

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/09/12 and completed on 07/11/12, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	A letter and signature page for "Request for Medicare Intermediary Review" was sent to affected Residents #16 and #17 of the survey. Also any and all other residents were reviewed within the effected period that did not receive this form and were also notified and the form signed. All forms have received proper signatures. The form, Medicare Denial Notice, was added to the computer files and will be completed with each Medicare discharge. This will ensure that no infringement to resident's right to demand bill would be prevented. With this form back in place and monitoring in place all residents should have their residents rights honored. Monitoring will be done by the Social Worker Designee or a	

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

Robert Owens | Adm | 7/26/12

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	designee weekly for the first month, every other week for one month and monthly till January 25th and then quarterly thereafter. See example 156 A for monitoring log.	8/06/2012

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to issue denial notices to 2 of 2 supplemental residents (Resident #16 and #17) whose Medicare coverage ended. Failure to issue denial notices does not ensure residents receive an option to request a demand bill, which is an infringement of the residents' rights. Findings include:	F 156		

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F 156	Continued From page 3 Review of the facility's Medicare billing records occurred on 07/11/12. The records identified Resident #16 and #17's Medicare coverage ended on the following dates: *Resident #16: 05/23/12 *Resident #17: 05/17/12 Although the above residents received a "Notice of Medicare Provider Non-Coverage," the facility failed to provide the residents with a denial notice (including the option to request a demand bill). During an interview on 07/11/12 at 2:54 p.m., a social services staff member (#4) stated she stopped sending denial notices 05/01/12 and confirmed no resident received a denial notice after that date.	F 156		
F 257 SS=C	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, resident group interview, family interview, and staff interview, the facility failed to maintain a comfortable temperature levels for 3 of 3 days of survey. Failure to maintain comfortable temperature levels between 71-81 degrees Fahrenheit (F) can lead to resident discomfort. Findings include:	F 257	The control thermostats have been provided with security boxes so that settings cannot be changed by anyone but maintenance staff. HR Thompson was notified and the temperature setting for the building was moved up 2 degrees to add to the temperature increase needed to make sure that all areas of the building would be held at a higher temperature than at time of survey. In a meeting with the maintenance department a system of monitoring temperature was put in place to make sure that all areas of the care center were with-in proper temperatures. If	

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F 257	Continued From page 4 - During an interview on 07/09/12 at 1:10 p.m., Resident #9 (identified by the facility as interviewable) stated the temperature in the Willow family room and the Great Room is cool. At 1:40 p.m., the temperature in the Willow family room measured 68 degrees F. At 1:55 p.m., the temperature in the Great Room measured 71 degrees F. - The resident group interview occurred on 07/09/12 at 3:30 p.m. Six of the eight residents in attendance stated the temperature in the Willow and Oak family rooms, the Great Room, dining room, and the resident hallways was cold. They stated they often needed a sweater or blanket when they leave their individual rooms. At 5:10 p.m., the temperature in the Great Room measured 69 degrees F. - During an interview on 07/09/12 at 4:45 p.m., Resident A stated her room "gets too cold" and "the dining room is cold." - During an interview on 07/09/12 at 7:45 p.m., Resident A's family member stated the hallways in the facility are "cold." - A tour of the environment occurred on 07/11/12 at 10:00 a.m. with a supervisory environmental staff member (#9). Temperature readings during the tour included: Great Room - 70 degrees F Oak family room - 68 degrees F Willow family room - 63 degrees F During the tour, the staff member (#9) observed thermostats set at 65 degrees F. He stated his expectation is for staff to set the thermostats at	F 257	at any time the temperature of any area was to be below 71 degrees the area would be addressed for corrective action by the maintenance staff. The monitoring will be done by the maintenance staff and the administrator and will be logged 3 days per week for one month, 2 days per week thereafter. See F257 Sample 1.This will also be monitored by the interdisciplinary committee on a monthly basis.	8/6/2012

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F 257	Continued From page 5 70 degrees F. The staff member then reset the thermostats. - A recheck of facility temperatures occurred on 07/11/12 at 11:15 a.m. with the environmental staff member (#9). Temperature readings included: Great Room - 67 degrees Oak family room - 68 degrees F Willow family 69 degrees F	F 257		
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	Those residents #3 and #5 that were not recorded properly in section J of the MDS have now been recorded correctly. Those residents #1 through #13 of section Z have been corrected. In service was held on 7/26/12. See agenda sample marked F278 A. To reflect education of the proper documentation to the MDS from the fall tracking log. It will also reflect proper procedure for each individual who completes a portion of the assessment and that they signed and certify the accuracy of that portion of the assessment. At each interdisciplinary meeting held monthly 4 residents outside the Resident Sample will be selected for committee screening to meet both requirements of Section J and Section Z of the MDS.	

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F 278	Continued From page 6 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately complete Minimum Data Set (MDS) assessments for 13 of 13 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) regarding Section Z, and for 2 of 13 sampled residents (Resident #3 and #5) regarding Section J. Failure to accurately complete Section Z does not ensure the staff member attests to the accuracy of the response for the information collected on a specific section of the MDS. Failure to identify falls on Resident #3 and #5's MDS limited the facility's ability to develop and implement individualized care plans consistent with the residents' needs and functional status. Findings include: Record review for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13 occurred between July 9-11, 2012. The MDS item Z0400, "Signature of Persons Completing the Assessment or Entry/Death Reporting," contains a column titled "Sections," under which staff members enter specific sections they complete. Nursing staff members entered the statement "All except below" in the "Sections" column, but failed to specifically identify each section they completed. - Review of Resident #3's medical record occurred July 9-11, 2012. Nurses' notes identified	F 278	Monitoring will be done by MDS Coordinator or designee. Monitoring for section J will be completed by reviewing nurse's notes to insure that falls are recorded on fall tracking log. This will be done weekly times 4, monthly thereafter. Monitoring for section Z will be done by the MDS coordinator or designee and will include all sections for completion and proper signage. This will be done weekly times 4 and monthly thereafter. Sample Tracking forms are included marked F278 B and C.	8/06/2012

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F 278	Continued From page 7 Resident #3 fell on 04/15/12. A quarterly MDS, dated 05/11/12, failed to identify this fall under Section J. During an interview on 07/11/12 at 2:30 p.m., a supervisory nursing staff member (#2) stated the facility identified the April 15 fall on their fall tracking log, but staff failed to code it on Resident #3's MDS. - Review of Resident #5's medical record occurred July 9-11, 2012. Nurses' notes identified Resident #5 fell on 02/22/12. A quarterly MDS, dated 04/08/12, failed to identify this fall under Section J. During an interview on 07/10/12 at 9:20 a.m., two supervisory nurses (#10 and #11) stated staff failed to identify Resident #5's fall on 02/22/12 on their tracking log, which resulted in staff failing to code it on his quarterly MDS.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to provide care and services in accordance with professional standards for 1 of 1 sampled resident (Resident #1) with alternative feeding route. Failure to administer medications according to professional standards has the potential to cause the feeding tube to plug or the	F 281	All nurses will be re-educated by in-service on proper procedure of medication administration per feeding tube. Nurse LPN #3 was directly re-educated on proper medication administration. The nurse meeting was held July 26, 2012. See Agenda form F281 A. Policy and procedure was reviewed and presented to the nurses at the in-service on July 26, 2012. See policy F281 B.	

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F 281	Continued From page 8 resident not to receive the accurate dose of medication. Findings included: Kozier and Erb, "Fundamentals of Nursing. Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., Upper Saddle River, New Jersey, page 871, states, "Administering Medications by . . . Gastrostomy tube. . . . Crush a tablet into a fine powder and dissolve in at least 30 ml [milliliters] of warm water. Cold liquids may cause client discomfort. . . . Do not administer . . . undissolved medications because they will clog the tube. . . . Put 15 to 30 ml . . . of water into the syringe barrel to flush the tube before administering the first medication. . . . When you have finished administering all medications, flush with another 15 to 30 ml . . . of warm water to clear the tube. . . ." Observation of medication administration occurred on 07/10/12 at 9:15 a.m. with Resident #1. A licensed practical nurse (LPN) (#3) crushed three oral medications, combined them with liquid Megace (an appetite stimulant), and diluted them with cold water. Without flushing the feeding tube, the LPN attempted to administer the medications using a syringe. The LPN was unable to administer the medications as the syringe became plugged. The LPN stated, "I apparently used too cold of water this morning." The LPN then poured the medications into a cup, mixed them again, and administered them through the feeding tube. The LPN failed to flush the feeding tube prior to administrating medications and failed to ensure	F 281	Monitoring of medication administration for resident #1 per alternate route (feeding tube) will be completed by DON or designee 1x per week for 4 weeks then monthly thereafter. Review of findings will be discussed at monthly interdisciplinary meetings. See form F281C.	8/6/2012

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F 281	Continued From page 9 the medications were thoroughly dissolved.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received services to maintain personal hygiene for 3 of 4 sampled male residents (Resident #5, #6, and #13) observed during toileting. Failure to perform complete perineal cares increased the risk for skin breakdown and odors, and failed to enhance the residents' personal dignity. Findings include: Review of the facility policy "Toileting Hygiene" occurred on 07/11/12. This policy, dated July 2005, stated, ". . . To ensure cleanliness and prevent skin breakdowns [sic] and injection [sic] of the urinary system during toileting and/or incontinent episodes. . . . 3. Using a peri wipe - wipe front to back (towards rectum) assuring not to use the soiled area of the wipe more than one time. 4. Repeat wiping until resident is clean. . . ." - Review of Resident #5's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 04/08/12,	F 312	All certified nurse assistants will be re-educated on proper perineal care at the scheduled in-service August 1, 2012. See Agenda form F312 A All incontinent male residents have the potential to be affected by this practice. Review of Perineal Care and Toileting Hygiene policies will be conducted at meeting scheduled for August 1, 2012. See Policies forms F312 B and F312 C. Monitoring of perineal care for residents #5, 6, and 13 will be completed by DON or designee 1x per week for 4 weeks then monthly thereafter. These findings will be reviewed at monthly interdisciplinary meetings. See from F312 D.	per TC DON 7/31/12 gg. 8/6/2012

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F 312	Continued From page 10 identified Resident #5 required extensive assistance with toileting and personal hygiene. The record identified a history of "sore groin" and an open area to the scrotum. On 07/09/12 at 2:05 p.m., observation identified a Certified Nursing Assistant (CNA) (#12) assisted Resident #5 to the toilet. Observation showed the resident's brief wet with urine. Following toileting, the CNA (#12) failed to perform frontal perineal cares. Observation, on 07/09/12 at 3:00 p.m. showed two CNAs (#13 and #14) assisted Resident #5 to the toilet. Observation showed the resident's brief wet with urine. Following toileting, the CNAs (#13 and #14) failed to provide frontal perineal cares. On 07/10/12 at 3:15 p.m., observation showed Resident #5 seated in his recliner and two CNAs (#14 and #15) assisted him to stand. Observation showed the resident's pants and chair wet with urine. The CNAs (#14 and #15) toileted Resident #5 and failed to provide frontal perineal cares. - Review of Resident #6's record occurred on all days of survey. The medical record identified the resident with urinary incontinence and a history of skin breakdown to the groin. The current MDS, dated 04/15/12, identified extensive assistance of two people with transferring, toilet use, and personal hygiene and frequent bladder incontinence. Observation on 07/10/12 at 1:20 p.m. identified two CNAs (#6 and #7) assisted Resident #6 with toileting. Observation showed the resident incontinent of urine. The CNAs failed to perform	F 312		

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F 312	Continued From page 11 frontal pericare. - Review of Resident #13's record occurred on July 10-11, 2012. The medical record identified the resident with urinary incontinence. The current MDS, dated 06/12/12, identified extensive assistance of one person with toilet use and personal hygiene and frequent urinary incontinence. Observation on 07/11/12 at 8:00 a.m. showed Resident #13 seated on the toilet. Observation showed the resident' brief and pants soaked with urine. The CNA (#8) failed to provide frontal pericare. When interviewed, on the afternoon of 07/11/12, an administrative nurse (#2) stated the facility policy for morning and bedtime cares includes complete perineal cares.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the safety needs for 1 of 1 sampled resident (Resident #11) who exhibited wandering	F 323	All nursing staff (RN, LPN, CNA) will have a review of the Policy on Wandering Residents and Door Locking Procedure. At the in-services scheduled for July 26, 2012 and August 1, 2012. See forms F 323 A and F 323 B. Resident #11 careplan was reviewed and updated to reflect walks in the courtyard. See from F 323 C All wandering residents have the potential to be affected TC & DW 7/30/12	

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(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 323	Continued From page 12 behaviors and exited the facility. Failure to implement specific safety measures to ensure wandering residents do not exit the facility placed Resident #11 and other wandering residents at risk of elopement and injury. Findings include: Review of the facility policy "POLICY ON WANDERING RESIDENTS" occurred on 07/11/12. This policy, dated 2006, stated, ". . . Should a resident leave the facility unattended follow and accompany on short walk before returning to facility . . ." Observation on 07/10/12 at 8:50 a.m. identified a knock on the exit door leading out to the courtyard. A certified nursing assistant (CNA) (#5) opened the door and an alarm sounded as Resident #11 entered the facility. The CNA stated the alarm sounds if a resident with a wanderguard is close to the exit. Observation showed the exit door locked from the inside, allowing residents and staff to exit to the courtyard, but not to re-enter the facility from the courtyard. Review of Resident #11's medical record occurred on 07/11/12. Medical diagnoses included Alzheimer's disease and dementia. The resident's Minimum Data Set (MDS), dated 06/29/12, identified severely impaired cognition and required supervision of one staff member for locomotion off the unit. Resident #11's current care plan stated, "Problem: Alteration in ADLs [activities of daily living] R/T [related to]: . . . Has Alzheimer's	F 323	Monitoring of the unlocking of the courtyard door will be conducted daily by the Housekeeping Dept. It will be done daily Aug 1st through Dec.31,2012 and thereafter 2 times per week on a random basis. See Sample F323D. The uneven surfaces have been repaired and a 2nd lock has been placed on the gate.	7/30/12 T.C. to POC 8/9/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/11/2012

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F 323	Continued From page 13	F 323		

[disease] and dementia . . . Approaches: . . . Ambulates per self with walker . . . Code Alert [wanderguard] on left ankle; . . ." The care plan failed to address Resident #11going out into the courtyard

A nurse's note, dated 09/06/11 at 12:00 p.m., stated, "res [Resident #11] was in courtyard walking, almost tripped on uneven part of sidewalk. [no] injury or c/o [complaint of], assistance given into facility." A nurse's note, dated 09/08/11 at 8:00 p.m., stated, "Res has 3 cm [centimeter] bruise to R) [right] hand, below joint to thumb & [and] 2nd digit. Doesn't rember [sic] where to [sic] came from. Possibly where res tripped outside."

A tour of the environmental occurred with a supervisory environmental staff member (#9) on 07/11/12 at 10:00 a.m. Observation of the courtyard showed a gate opening to the west, closed with a latch, which the surveyor easily lifted to open the gate. Observation showed the lawn on the other side of the gate steeply sloped down to the street. Further observation showed the sidewalk uneven just outside the door leading into the facility.

During the tour, the environmental staff member (#9) stated the charge nurse is responsible to unlock the door each morning so residents and staff can reenter the facility from the courtyard.

An activity staff member (#1) stated Resident #11 may walk in the courtyard at any time. She stated staff should always be present when a resident is in the courtyard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/11/2012

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F 323	Continued From page 14 A tour of the courtyard occurred on 07/11/12 at 10:30 a.m. with an administrative staff member (#2) This staff member stated facility staff allow Resident #11 to walk around the courtyard unattended.	F 323		