

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

AUG 13 2013

PRINTED: 08/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/25/2013
NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885	
(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 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide complete and sanitary bed bath for 1 of 1 sampled residents (Resident #62) who was observed receiving personal care. Findings included:</p> <p>The facility's procedure for providing perineal care, dated 10/01/11, noted the purpose of providing perineal care was to cleanse the perineum and prevent infection and odor. Equipment need included in a cleansing solution, wash cloths and towels. In the procedure section, it was noted if the resident was soiled with feces, the resident should be placed on their side and the perineum and rectal area were to be cleansed to remove the stool. The water was to be changed and the soiled linens discarded. The resident was then turned onto their back and the perineum was to be cleansed.</p> <p>Resident #62 was admitted to the facility on 08/19/12. Cumulative diagnoses included end stage alzheimer's disease, dementia with behavior disturbances and diabetes mellitus.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 05/08/13 indicated Resident #62 was severely impaired in her</p>	F 312	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p><b>F 312 SS= D</b></p> <p><b>Corrective Action for Resident Affected</b> Resident # 62 received proper perineal care on 7/25/13.</p> <p><b>Corrective Action for Resident Potentially Affected</b> All residents who are unable to carry out bathing activities without assistance have the potential to be affected by this alleged deficient practice.</p>	8/12/13

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

TITLE

(X6) DATE

*Sheldene Weatherly, RN, NHA*

*Administrator*

*8/12/13*

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 312	<p>Continued From page 1</p> <p>decision making skills with long and short term memory impairment. She appeared down or depressed and wandered. There were no other behaviors documented. She required extensive assistance from staff for bed mobility, transfer, toilet use, eating and locomotion. She required total assistance for dressing, hygiene and bathing. Resident #62 was incontinent of both bowel and bladder. It was noted that she had received antipsychotic medications daily for last 7 days.</p> <p>Resident #62's care plan, last revised on 05/09/13, identified a problem with having a history of urinary tract infections. Included in the interventions was to always perform pericare wiping front to back. A problem was also identified with total bladder incontinence. Interventions included to check frequently for incontinence and to wash, rinse and dry the perineum after incontinent episodes.</p> <p>An observation of a bed bath being provided to Resident #62 was conducted on 07/25/13 at 10:30 AM. Nurse Aide #2 (NA #2) prepared a basin of warm water and liquid soap. She had one wash cloth and one towel. She squirted the liquid soap into the water causing the water to become very sudsy. She washed and rinsed her face and upper extremity using the sudsy water. NA #2 dried her skin with a clean towel. She then washed and rinsed her legs and feet with the same cloth and sudsy water. She untaped the soiled brief and pressed it down between Resident #62's legs. Using the same basin of water and the same wash cloth, NA #2 washed the pubic area, groins and perineal area. As she wiped downward into the perineal region it was noted that the wash cloth had brown stool</p>	F 312	<p><b>Systemic Changes</b> One on one in-services were conducted on 07/25/13-8/7/13 by the Director of Nursing. All Certified Nursing Assistants, FT, PT, and PRN employed by this facility have completed the in-service. Hospice providers were also included. The in-service topic included: Proper technique for the provision of a bed bath and perineal care. (See attachment #1)</p> <p>This information has been integrated into the standard orientation training for all certified nursing assistants and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p><b>Quality Assurance</b> The Director of Nursing or Designee will monitor this issue using the "Providing Perineal Care" Monitoring QA Tool. The monitoring will include verifying that perineal</p>		

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F 312	<p>Continued From page 2</p> <p>smears. She rinsed the cloth in the basin of water and continued to wash the perineum. NA #2 rolled Resident #62 onto her left side and removed the soiled brief and discarded it. It was noted that Resident #62 had a very large amount of soft brown stool on her skin. NA #2 used disposable wipes to remove the bulk of the stool and discarded the wipes. She reached into the basin and obtained the same wash cloth to continue removing the stool residue from her buttocks and perineum. As she cleaned the stool away, she rinsed the soiled cloth out several times in the basin of water. She then dried her skin and placed a clean brief.</p> <p>NA #2 was interviewed immediately followed the observation on 07/25/13 at 11:00 AM. She stated it was up to staff discretion as to whether they used one basin or two basins for providing a bed bath and/or perineal care. NA #2 stated she usually used one basin. She reported the liquid soap was a soap that needed to be rinsed from the resident's skin. NA #2 reported she should have changed the basin of water before providing perineal care. She also reported she should have used a clean wash cloth but she only had the one at the bedside. NA #2 commented that once the wash cloth was soiled with stool she should not have placed the soiled cloth back into the basin of water. She stated she should have discarded it and left the room to obtain another clean cloth.</p> <p>During an interview with the Director of Nurses (DON) on 07/25/13 at 11:45 AM, she stated staff were expected to change the basin of water after they bathed the resident and use clean water to rinse the body if they chose to use only one basin. She stated the liquid soap needed to be rinsed from the resident's skin. The DON reported if</p>	F 312	<p>care is provided using proper technique (See attachment #2)</p> <p>Results will be reported weekly to the QOL/QA committee and corrective action initiated as appropriate. This will be done weekly for three months or until resolved by QOL/QA committee.</p> <p>The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.</p>		

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F 312	Continued From page 3 staff were providing a bed bath the water should be changed before providing perineal care. She commented they should never clean stool and place visibly soiled wash cloths back into the basin of water. The DON added a clean wash cloth should be used.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review for 1 of 1 sampled residents (Resident #16) who experienced a urinary tract infection (UTI) the facility failed to follow physician instructions to obtain a repeat urinalysis after completion of the prescribed antibiotic (which was not effective in treating the bacterial organism identified in the culture and sensitivity). Findings included:  Resident #16 was admitted on 02/23/10. Her documented diagnoses included urinary incontinence, Alzheimer's disease, and dementia with behavioral disturbances.	F 315	<b>F 315 SS= D</b>  <b>Corrective Action for Resident Affected</b> Resident # 16- Urinalysis was rechecked on 7/24/13.  <b>Corrective Action for Resident Potentially Affected</b> All residents residing in the facility with physician ordered urinalysis have potential to be affected by this alleged deficient practice. All residents with urinalysis orders were reviewed by the Director of Nursing on 7/26/13 and it was verified that all urinalysis were obtained and proper procedure for disposition was followed.	8/12/13	

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F 315	<p>Continued From page 4</p> <p>On 11/29/12 "I have frequent incontinence of bladder" was identified as a problem in the resident's care plan. "I will not develop complications related to incontinence such as skin breakdown or UTI" was identified as the goal for the problem. Interventions for the problem included use of incontinent briefs, frequent checking for incontinence, and proper perineal care.</p> <p>A 05/07/13 electronic progress note documented urine was collected from Resident #16 for a urinalysis due to an escalation in behaviors.</p> <p>A 05/08/13 physician progress note documented the resident was seen for "confusion-urine positive".</p> <p>A 05/08/13 6:19 PM electronic progress note documented, "Resident seen by MD (doctor of medicine/physician) this shift. He ordered cipro (antibiotic) for suspected UTI. Recheck urinalysis after completion of antibiotics."</p> <p>A 05/08/13 physician order began Resident #16 on Cipro 500 milligrams twice daily (mg BID) x 7 days.</p> <p>The resident's May 2013 medication administration record (MAR) documented the resident received the physician-ordered dose of Cipro from 05/09/13 through 05/15/13.</p> <p>Resident #16's 05/13/13 Quarterly Minimum Data Set (MDS) documented the resident's cognition was severely impaired, she required extensive assistance by two staff members for toileting, she was always incontinent of bladder, and she was not on a urinary toileting program</p>	F 315	<p><b>Systemic Changes</b></p> <p>In-services were conducted on 07/29/13-8/7/13 by the Director of Nursing. All RNs and LPNs, FT, PT, and PRN employed by this facility have completed the in-service. Hospice providers were not included because they are not involved in the provision of lab services at the facility. (See attachment #3)</p> <p>The in-service topics included:</p> <ol style="list-style-type: none"> <li>1) Laboratory Process changes- Yearly laboratory wall calendar</li> <li>2) Proper documentation and follow-up on laboratory results on the laboratory calendar.</li> </ol> <p>This information has been integrated into the standard orientation training for all licensed staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p>	

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F 315	<p>Continued From page 5</p> <p>A 05/15/13 final urine culture report and culture and sensitivity (C &amp; S) documented the presence of greater than 100,000 colony forming units (CFU) of Escherichia coli (bacteria) in Resident #16's urine sample. The C &amp; S documented Ciprofloxacin (cipro) was not effective in treating this bacteria. Nurse #2 hand wrote the notation, "faxed to pharmacy" 05/15/13 at 6:40 PM on the bottom of the report.</p> <p>Record review revealed there was no urinalysis obtained for Resident #16 after the completion of the Cipro on 05/15/13.</p> <p>At 1:38 PM on 07/24/13 Nurse #2 stated some lab results were faxed to the pharmacy. However, she reported usually final urinalysis/C &amp; S reports were faxed to the primary physicians. She commented she hoped that she had incorrectly documented on the bottom of Resident #16's 05/15/13 final urinalysis/C &amp; S report that she had faxed the results to the pharmacy.</p> <p>At 1:47 PM on 07/24/13 Resident #16's primary physician stated he frequently began residents on an antibiotic when he ordered a urinalysis to help alleviate some of the symptoms they were experiencing. However, he reported that he expected the facility to notify him if the antibiotic he initiated was not effective in treating the organism when the C &amp; S was received from the lab. The physician explained 99% of the time in such cases, he discontinued the non-effective antibiotic and prescribed another effective drug to combat the bacteria. According to the physician, his standard procedure was to draw a follow-up urinalysis after antibiotic treatment was completed for a UTI. He commented for</p>	F 315	<p><b>Quality Assurance</b></p> <p>The monitoring will include verifying that all laboratory specimens are obtained as ordered and protocols are followed. Monitoring will be done weekly by the Director of Nursing. Reports will be given during the daily QOL and corrective action initiated as appropriate. This will be done weekly for three months or until resolved by QOL/QA committee.</p> <p>Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.</p>	
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F 315	<p>Continued From page 6</p> <p>precaution's sake, he would request an immediate follow-up urinalysis for Resident #16. However, he stated that the way the facility handled the treatment of Resident #16's UTI was not typical. He also reported that there was a notation on Resident #16's 05/15/13 final urinalysis/C &amp; S report that he had viewed it, but he was uncertain when he viewed it in relation to the completion of a non-effective antibiotic.</p> <p>At 3:52 PM on 07/24/13 the director of nursing (DON) stated it was typical for Resident #16's primary physician to request a follow-up urinalysis after treating a resident with an antibiotic. She reported the facility usually drew this follow-up lab a week after completion of the antibiotic. She was unable to explain why this was not done for Resident #16. She explained that the need to draw and the date of the follow-up urinalysis was usually documented on the blue Lab Orders sheets, but there was no such documentation on these forms or the MARs for Resident #16.</p> <p>Resident #16's 07/24/13 "stat" (at once) urinalysis documented the presence of cloudy urine and trace blood and leukocytes with 10 - 25 white blood cells and "many" bacteria.</p> <p>At 10:06 AM on 07/25/13 the DON reported Resident #16's primary physician was not going to treat the resident with an antibiotic because there were only a few white blood cells which could have been caused by contamination of the specimen (although the physician order requested the use of an in and out catheter to obtain the specimen), and the resident was not presenting currently with symptoms of a UTI. She commented, therefore, no C &amp; S was to be obtained.</p>	F 315			

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F 329 SS=D	<p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician interview, the consultant pharmacist and staff interviews, the facility failed to attempt a gradual dose reduction and/or provide a risk versus benefit statement for the continued use of an antipsychotic medication for 1 of 10 sampled residents (Resident #62) who was reviewed for unnecessary medications. Findings included:</p>	F 329	<p><b>F 329 SS= D</b></p> <p><b>Corrective Action for Resident Affected</b> A benefit versus risk statement was obtained from the Primary Care Physician for resident #62 on 7/25/13.</p> <p><b>Corrective Action for Resident Potentially Affected</b> All residents receiving antipsychotic medications have the potential to be affected. The medical records for all residents receiving antipsychotics medications were reviewed by the consultant pharmacist on 8/2/13 and 8/5/13 for the potential for gradual dose reductions and /or risk versus benefit statements. Recommendations were sent to the Primary Care Physician as indicated by the review. (See attachment #4)</p> <p><b>Systemic Changes</b> The Consultant Pharmacist will develop and maintain a</p>	8/12/13

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F 329	<p>Continued From page 8</p> <p>Resident #62 was admitted to the facility on 08/19/12. Cumulative diagnoses included end stage alzheimer's disease, dementia with behavior disturbances and diabetes mellitus.</p> <p>A physician's order of 09/08/12 indicated Resident #62 had been placed on Geodon (an antipsychotic medication) 20 milligrams (mg) in the morning and at bedtime.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 10/08/12, indicated Resident #62 had been placed on Geodon on 09/08/12. A pharmacy recommendation of 10/08/12 indicated a request had been made for a diagnosis for use of the Geodon.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 11/07/12, indicated a request had been sent to the physician for a diagnosis for the use of the Geodon. The physician replied with a diagnosis of atypical psychosis.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 01/07/13 indicated Resident #62 was still having behaviors. The review also noted that a gradual dose reduction (GDR) was not appropriate but no request was made to the physician for an attempt at GDR.</p> <p>According to the January 2013 physician's orders, Resident #62 had a PRN (as needed) order Geodon 20 mg every 6 hours PRN and Geodon 20 mg (milligrams) in the morning and at bedtime.</p> <p>Another drug review completed by the facility's consultant pharmacist, dated 02/08/13, indicated a GDR was not appropriate for GDR for the use</p>	F 329	<p>spreadsheet for all residents receiving antipsychotic medications that will include:</p> <ol style="list-style-type: none"> <li>1) Resident Name and location</li> <li>2) Diagnosis related to Antipsychotic medication</li> <li>3) Date started</li> <li>4) Dates of dose reductions or risk versus benefit statement</li> </ol> <p>The Director of Nursing and the Administrator will be provided with an updated copy of the spread sheet monthly. (See attachment #4)</p> <p><b>Quality Assurance</b></p> <p>The Director of Nursing and/or the Administrator will monitor this issue using the "Antipsychotic Medication Spreadsheet" The monitoring will include verifying that all resident receiving antipsychotic medications medical record has been reviewed and recommendations have been made to the Primary Care</p>		

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F 329	<p>Continued From page 9 of the Geodon. There was no request made to the physician for an attempt at GDR.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 04/05/13, indicated a GDR was not appropriate but no request was made to the physician for a GDR. There was also no mention of obtaining a risk versus benefit statement for the use of the Geodon. The review noted Resident #62 was still having behaviors.</p> <p>A nurse's note of 05/09/13 indicated Resident #62 was in bed awake and agitated.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 05/08/13 indicated Resident #62 was severely impaired in her decision making skills with long and short term memory impairment. She appeared down or depressed and wandered. There were no other behaviors documented. She required extensive assistance from staff for bed mobility, transfer, toilet use, eating and locomotion. She required total assistance for dressing, hygiene and bathing. Resident #62 was incontinent of both bowel and bladder. It was noted that she had received antipsychotic medications daily for last 7 days.</p> <p>The May 2013 behavior sheet for Resident #62 indicated daily behaviors of agitation. There was no PRN (as needed) Geodon given.</p> <p>Resident #62's care plan, last revised on 05/09/13, identified a problem with behaviors related to dementia with behaviors. Included in the interventions was to consult with pharmacy and physician to consider dosage reduction when clinically appropriate. A potential problem with</p>	F 329	<p>Physician for dose reductions or risk versus benefit statements as needed</p> <p>This will be done monthly for three months or until resolved by QOL/QA committee. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled monthly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2013</b>
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F 329	<p>Continued From page 10 demonstrating physical behaviors was also identified.</p> <p>A nurse's note of 05/12/13 indicated staff were unable to obtain vital signs from Resident #62 due to agitation and moving about too much.</p> <p>The June 2013 behavior sheet for Resident #62 indicated she had daily behaviors of agitation.</p> <p>A nurse's note of 06/03/13 at 1:29 PM indicated Resident #62 was very agitated at the beginning of the shift. The note indicated she was slapping and yelling at the writer.</p> <p>The July 2013 behavior monitoring form for Resident #62 indicated she was having agitation daily.</p> <p>A nurse's note of 07/15/13 at 1:05 AM indicated Resident #62 had increased agitation this evening. The note indicated her behaviors were getting worse in the evenings. She was pulling hair, kicking and hitting staff. She refused her medications and was given Geodon 20 mg intramuscularly.</p> <p>A nurse's note of 07/15/13 at 3:25 PM indicated Resident #62 was clapping her hands and yelling out at times throughout the shift.</p> <p>A nurse's note of 07/15/13 at 10:40 PM indicated Resident #62 was clapping her hands and saying "here here here".</p> <p>A nurse's note of 07/16/13 at 10:59 AM indicated she was given medication for facial grimacing and clapping repetitively.</p>	F 329			

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

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F 329	<p>Continued From page 11</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 05/08/13 indicated Resident #62 was severely impaired in her decision making skills with long and short term memory impairment. She appeared down or depressed and wandered. There were no other behaviors documented. She required extensive assistance from staff for bed mobility, transfer, toilet use, eating and locomotion. She required total assistance for dressing, hygiene and bathing. Resident #62 was incontinent of both bowel and bladder. It was noted that she had received antipsychotic medications daily for last 7 days.</p> <p>The July 2013 physician's medication orders included Geodon 20 milligrams (mg) in the morning and at bedtime. There was also an order for PRN Geodon 20 mg every 6 hours.</p> <p>Resident #62 was observed sitting quietly in her wheelchair in the hallway on 07/23/13 at 2:10 PM. Her head was slumped over onto her chest.</p> <p>Nurse #1 was interviewed on 07/23/13 at 3:15 PM. She stated Resident #62 had lots of behaviors. She stated she yelled out, was combative with staff during care, grabbed out at other residents. Nurse #1 reported her to wander about the facility in her wheelchair and would at times mock the other residents. She stated she would stay up late at night and would usually be sleepy in the mornings but was more alert in the afternoons. Nurse #1 reported her as being very confused.</p> <p>Resident #62 was observed sitting in her wheelchair in the hallway on 07/24/13 at 12:45 PM. She was clapping her hands and tapping her</p>	F 329			

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

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F 329	<p>Continued From page 12 feet on the floor.</p> <p>Resident #62's physician was interviewed about use of the Geodon on 07/24/13 at 3:10 PM. He stated a GDR would not be appropriate for Resident #62 as her behaviors would escalate if it was changed. He stated he had not provided a risk versus benefit statement for the Geodon as no one had brought it to his attention nor had anyone requested a GDR. He stated he relied on the consultant pharmacist for any issues with medications. The physician stated the Geodon was not controlling her behaviors even at the dose she was currently receiving and she needed the Geodon due to her end stage dementia. The physician stated she was resistive to care and would push him away when he attempted to examine her. He commented until she was started on the Geodon her behaviors were totally out of control but had improved with the use of the Geodon. The physician stated he reviewed her medications each time he visited to make sure they were appropriate. He commented that the benefit of the Geodon for Resident #62 far outweighed the risks of continuing it.</p> <p>Resident #62 was observed her sitting in her wheelchair in the hallway on 07/24/13 at 3:50 PM. She appeared to be reaching out into the air for something and was mumbling and tapping her feet.</p> <p>During an interview with the second shift nurse aide (NA#1), on 07/24/13 at 4:00 PM, she was pushing Resident #62 in her wheelchair. She stated she was pushing her to keep her occupied so she wouldn't be agitated. NA#1 stated Resident #62 usually got restless and would yell out. She stated she would reach out into space</p>	F 329			

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

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F 329	<p>Continued From page 13</p> <p>for things that weren't there and would mumble outloud. NA#1 stated at times she would clap her hands loudly but usually did not resist care when she cared for her.</p> <p>The Director of Nurses (DON) was interviewed on 07/24/13 at 4:15 PM. She stated Resident #62 had lots of behaviors including resisting care, scratching, biting and hitting. She stated it was almost impossible for staff to provide care due to her mental decline. She stated the consultant pharmacist usually sent a note to the physician about 3 months after the beginning of an antipsychotic medication in regards to the GDR and/or the risk versus benefit. She stated she was surprised that it wasn't addressed. She reviewed the pharmacist's notes and stated she was unable to determine if the pharmacist had sent a request.</p> <p>NA#2 was interviewed on 07/25/13 at 10:10 AM. She stated she provided care for Resident #62 daily. She stated she had a lot of behaviors including resisting care frequently, pushing and hitting at staff. She stated she would clap her hands loudly all hours of the day. NA#2 stated at times Resident #62 would allow care and other times she would resist. She stated she was usually alert unless she had been restless the night before. NA#2 stated if she was restless during the night, she would be drowsy the next day.</p> <p>A bed bath was observed on 07/25/13 at 10:30 AM. Resident #62 was noted to be calm and cooperative during the entire bath.</p> <p>A telephone interview was conducted with the facility's consultant pharmacist on 07/25/13 at</p>	F 329		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 14 11:15 AM. She stated Resident #62 had many behaviors with a diagnosis of psychosis. She stated she felt a GDR was not appropriate for the Geodon but she had not brought it to the attention of the physician. She stated she made the determination that a GDR was not appropriate for the Geodon and documented Resident #62 was continuing to have behaviors in her reviews. The pharmacist stated she did not think she had to ask the physician as long as the behaviors were occurring. When questioned about a risk versus benefit statement for the continued use of the Geodon, she responded she had not requested one. She added that she should have at least requested the GDR from the physician even though she felt it was not appropriate.	F 329			
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 observation and staff interview the facility failed to keep slaw made with mayonnaise and salad dressing at or below 41 degrees Fahrenheit during the operation of the trayline. The facility also failed to make sure cups were dry before placing juice into them, failed to	F 371	<b>F 371 SS= E</b>  <b>Corrective Action for Resident Affected</b> No specific resident is identified.  <b>Corrective Action for Resident Potentially Affected</b> All residents residing in the facility have potential to be effected. All expired items were removed from the walk-in cooler on 7/22/13. The coleslaw was removed from all meal trays prior to service on 7/22/13. All glasses are completely air dried prior to use effective 7/25/13. Kitchenware noted to have	8/12/13	

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F 371	<p>Continued From page 15</p> <p>discard plastic cereal/soup bowls which were abraded, and failed to discard food items in refrigerated storage past their "use by" dates. Findings included:</p> <p>1. At 12:10 PM on 07/22/13 the cook stated the dietary staff was beginning to place lunch trays into the last meal cart going out to residents who ate in their rooms. A container of Cole slaw was removed from one of these trays, and a calibrated thermometer registered 50.1 degrees Fahrenheit when the temperature was checked. At this time the dietary manager (DM) stated the slaw was commercially prepared. The cook reported she brought bowls of the slaw out of the walk-in refrigerator at 11:25 AM, and placed them on the lunch trays in the meal carts. According to the DM, this was the method the staff usually used when serving cold salads. However, the cook stated she probably brought the slaw out of refrigerated storage a little earlier than usual. The DM commented she liked cold salads to remain at 45 degrees Fahrenheit or below during the entire operation of the trayline.</p> <p>Review of the ingredient list for the commercially prepared Cole slaw served for lunch on 07/22/13 revealed the ingredients in order of prevalence were cabbage, sugar, mayonnaise (soybean oil, water, egg yolks, vinegar, corn syrup, salt, spice, calcium disodium EDTA to protect flavor, and salad dressing (soybean oil, water, corn syrup, vinegar, egg yolks, modified corn starch sugar salt, spice, and lemon juice).</p> <p>At 2:43 PM on 07/24/13 the DM stated commercially prepared salads were stored in the walk-in refrigerator. She explained on the days these salads were being served to residents a</p>	F 371	<p>abraded areas were discarded 7/25/13.</p> <p><b>Systemic Changes</b> An in-service was conducted on 07/26/13 by the Dietary Services Director. All cooks and dietary aides, FT, PT, and PRN employed by this facility have completed the in-service. The in-service included:</p> <ol style="list-style-type: none"> <li>1) Perishable food items will be checked upon arrival from the vendor and daily by dietary staff. Any expired item will be discarded.</li> <li>2) All cold food items will remain in the walk-in cooler or on ice until tray carts are ready for delivery. Temperatures of cold food items will be checked prior to exit from the kitchen for delivery.</li> <li>3) All kitchenware will be completely air dried prior to being placed in service.</li> <li>4) Kitchenware noted to be abraded will be discarded.</li> </ol>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 16</p> <p>dietary employee removed the bulk containers, immediately placed the salads into bowls, and immediately placed the bowls of salad back into the walk-in refrigerator. According to the DM, the cook probably brought the bowls of Cole slaw out early on 07/22/13, at 11:25 AM, since the trayline did not begin operation until 11:45 AM. She commented she expected her staff to place the bowls of salad on ice if time became an issue.</p> <p>At 2:50 PM on 07/24/13 the PM cook stated she was trained that salads were to be placed in bowls the day before being served to residents, and they were to be stored in the walk-in refrigerator until right before the trayline began operation. She reported she was taught to keep the bowls of salad on ice until they were placed on resident trays.</p> <p>2. At 9:50 AM on 07/24/13 a dietary employee began filling four-ounce cups with orange juice. 5 of 18 of these cups had moisture inside of them.</p> <p>At 2:43 PM on 07/24/13 the dietary manager (DM) stated kitchenware in the facility was sanitized by heat only in the dish machine. She explained there was no chemical which fed into the dish machine system to sanitize the kitchenware. The DM commented that she did not think her dietary staff had been in-serviced on the need for kitchenware to be dry before placing food or beverage inside of it.</p> <p>At 2:50 PM on 07/24/13 the PM cook stated she had been in-serviced that kitchenware was to be completely dry before any food or beverage was placed in it.</p> <p>3. At 9:57 AM on 07/24/13 9 of 15 plastic</p>	F 371	<p>(See attachment #5)</p> <p><b>Quality Assurance</b></p> <p>The Dietary Manager or Cook will monitor this issue using the "Dietary Services QA Checklist", temperature logs, and general observation. The monitoring will include verifying that all sanitation procedures are followed.</p> <p>(See attachment #6)</p> <p>This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.</p>		

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F 371	<p>Continued From page 17</p> <p>soup/cereal bowls were abraded inside. The plastic was sloughing off, and was rough to the touch.</p> <p>At 2:43 PM on 07/24/13 the dietary manager (DM) stated the dietary staff was trained to present damaged kitchenware to her, and then it was disposed of. The DM explained she liked to know how many items were discarded so she could make sure replacements were ordered. She commented the staff was trained to assess damaged kitchenware using eyesight, and maybe they were not aware they should also assess by touch when kitchenware appeared abraded. The DM reported she did not want kitchenware used which was "breaking down" inside.</p> <p>At 2:50 PM on 07/24/13 the PM cook stated the dietary staff disposed of damaged kitchenware including cracked, chipped, and abraded pieces. She reported the DM was informed of the number of pieces that were discarded and the reason why.</p> <p>4. During initial tour of the kitchen, beginning at 9:32 AM on 07/22/13, in the walk-in refrigerator there were six four-ounce cups of yogurt with a "use by" date of 07/12/13, two half gallons of buttermilk with a "use by" date of 07/19/13, and a five-pound container of pasta salad with a "use by" date of 07/20/13.</p> <p>During a follow-up tour of the kitchen, at 9:57 AM on 07/24/13, in the walk-in refrigerator there were six four-ounce cups of yogurt with a "use by" date of 07/12/13 and two half gallons of buttermilk with a "use by" date of 07/19/13.</p> <p>At 2:43 PM on 07/24/13 the dietary manager</p>	F 371			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 18 (DM) stated the facility did not use food items which were past their "use by" dates, and it was a good idea for them to be removed from refrigerated storage once past the "use by" dates so staff would not accidentally use them. She reported daily all dietary staff who went in and out of storage areas were supposed to monitor the "use by" dates and discard all items past their "use by" dates.  At 2:50 PM on 07/24/13 the PM cook confirmed that she was trained that all staff were responsible for disposing of food items as soon as they passed their "use by" dates.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician interview, consultant pharmacist and staff interviews, the consultant pharmacist failed to alert the physician of the need for an attempt at a gradual dose reduction and/or risk versus benefit statement for the continued use of an antipsychotic medication for 1 of 10 sampled	F 428	<b>F 428 SS= D</b>  <b>Corrective Action for Resident Affected</b> A benefit versus risk statement was obtained from the Primary Care Physician for resident #62 on 7/25/13.  <b>Corrective Action for Resident Potentially Affected</b> All residents receiving antipsychotic medications have the potential to be affected. The medical records for all residents receiving antipsychotics medications were reviewed by the consultant pharmacist on 8/2/13 and 8/5/13 for the potential for gradual dose	8/12/13	

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F 428	<p>Continued From page 19</p> <p>residents (Resident #62) who was reviewed for unnecessary medications. Findings included:</p> <p>Resident #62 was admitted to the facility on 08/19/12. Cumulative diagnoses included end stage alzheimer's disease, dementia with behavior disturbances and diabetes mellitus.</p> <p>A physician's order of 09/08/12 indicated Resident #62 had been placed on Geodon (an antipsychotic medication) 20 milligrams (mg) in the morning and at bedtime.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 10/08/12, indicated Resident #62 had been placed on Geodon on 09/08/12. A pharmacy recommendation of 10/08/12 indicated a request had been made for a diagnosis for use of the Geodon.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 11/07/12, indicated a request had been sent to the physician for a diagnosis for the use of the Geodon. The physician replied with a diagnosis of atypical psychosis.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 01/07/13 indicated Resident #62 was still having behaviors. The review also noted that a gradual dose reduction (GDR) was not appropriate but no request was made to the physician for an attempt at GDR.</p> <p>According to the January 2013 physician's orders, Resident #62 had a PRN (as needed) order Geodon 20 mg every 6 hours PRN and Geodon 20 mg (milligrams) in the morning and at bedtime.</p>	F 428	<p>reductions and /or risk versus benefit statements. Recommendations were sent to the Primary Care Physician as indicated by the review. (See attachment #4)</p> <p><b>Systemic Changes</b> The Consultant Pharmacist will develop and maintain a spreadsheet for all residents receiving antipsychotic medications that will include:</p> <ol style="list-style-type: none"> <li>1) Resident Name and location</li> <li>2) Diagnosis related to Antipsychotic medication</li> <li>3) Date started</li> <li>4) Dates of dose reductions or risk versus benefit statement</li> </ol> <p>The Director of Nursing and the Administrator will be provided with an updated copy of the spread sheet monthly. (See attachment #4)</p> <p><b>Quality Assurance</b> The Director of Nursing and/or the Administrator will monitor</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>346407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROSS CREEK HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885</b>		
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F 428	<p>Continued From page 20</p> <p>Another drug review completed by the facility's consultant pharmacist, dated 02/08/13, indicated a GDR was not appropriate for GDR for the use of the Geodon. There was no request made to the physician for an attempt at GDR.</p> <p>A drug review completed by the facility's consultant pharmacist, dated 04/05/13, indicated a GDR was not appropriate but no request was made to the physician for a GDR. There was also no mention of obtaining a risk versus benefit statement for the use of the Geodon. The review noted Resident #62 was still having behaviors.</p> <p>Resident #62's care plan, last revised on 05/09/13, identified a problem with behaviors related to dementia with behaviors. Included in the interventions was to consult with pharmacy and physician to consider dosage reduction when clinically appropriate. A potential problem with demonstrating physical behaviors was also identified.</p> <p>The May 2013 behavior sheet for Resident #62 indicated daily behaviors of agitation. There was no PRN (as needed) Geodon given.</p> <p>The June 2013 behavior sheet for Resident #62 indicated she had daily behaviors of agitation.</p> <p>The July 2013 behavior monitoring form for Resident #62 indicated she was having agitation daily.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 05/08/13 indicated Resident #62 was severely impaired in her decision making skills with long and short term memory impairment. She appeared down or</p>	F 428	<p>this issue using the "Antipsychotic Medication Spreadsheet" The monitoring will include verifying that all resident receiving antipsychotic medications medical record has been reviewed and recommendations have been made to the Primary Care Physician for dose reductions or risk versus benefit statements as needed</p> <p>This will be done monthly for three months or until resolved by QOL/QA committee. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled monthly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting</p>		

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F 428	<p>Continued From page 21</p> <p>depressed and wandered. There were no other behaviors documented. She required extensive assistance from staff for bed mobility, transfer, toilet use, eating and locomotion. She required total assistance for dressing, hygiene and bathing. Resident #62 was incontinent of both bowel and bladder. It was noted that she had received antipsychotic medications daily for last 7 days.</p> <p>The July 2013 physician's medication orders included Geodon 20 milligrams (mg) in the morning and at bedtime. There was also an order for PRN Geodon 20 mg every 6 hours.</p> <p>Resident #62 was observed sitting quietly in her wheelchair in the hallway on 07/23/13 at 2:10 PM. Her head was slumped over onto her chest.</p> <p>Nurse #1 was interviewed on 07/23/13 at 3:15 PM. She stated Resident #62 had lots of behaviors. She stated she yelled out, was combative with staff during care, grabbed out at other residents. Nurse #1 reported her to wander about the facility in her wheelchair and would at times mock the other residents. She stated she would stay up late at night and would usually be sleepy in the mornings but was more alert in the afternoons. Nurse #1 reported her as being very confused.</p> <p>Resident #62 was observed sitting in her wheelchair in the hallway on 07/24/13 at 12:45 PM. She was clapping her hands and tapping her feet on the floor.</p> <p>Resident #62 was observed her sitting in her wheelchair in the hallway on 07/24/13 at 3:50 PM. She appeared to be reaching out into the air for</p>	F 428		
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F 428	<p>Continued From page 22 something and was mumbling and tapping her feet.</p> <p>The Director of Nurses (DON) was interviewed on 07/24/13 at 4:15 PM. She stated Resident #62 had lots of behaviors including resisting care, scratching, biting and hitting. She stated it was almost impossible for staff to provide care due to her mental decline. She stated the consultant pharmacist usually sent a note to the physician about 3 months after the beginning of an antipsychotic medication in regards to the GDR and/or the risk versus benefit. She stated she was surprised that it wasn't addressed. She reviewed the pharmacist's notes and stated she was unable to determine if the pharmacist had sent a request.</p> <p>NA#2 was interviewed on 07/25/13 at 10:10 AM. She stated she provided care for Resident #62 daily. She stated she had a lot of behaviors including resisting care frequently, pushing and hitting at staff. She stated she would clap her hands loudly all hours of the day. NA#2 stated at times Resident #62 would allow care and other times she would resist. She stated she was usually alert unless she had been restless the night before. NA#2 stated if she was restless during the night, she would be drowsy the next day.</p> <p>A telephone interview was conducted with the facility's consultant pharmacist on 07/25/13 at 11:15 AM. She stated Resident #62 had many behaviors with a diagnosis of psychosis. She stated she felt a GDR was not appropriate for the Geodon but she had not brought it to the attention of the physician. She stated she made the determination that a GDR was not appropriate for</p>	F 428		

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F 428	Continued From page 23 the Geodon and documented Resident #62 was continuing to have behaviors in her reviews. The pharmacist stated she did not think she had to ask the physician as long as the behaviors were occurring. When questioned about a risk versus benefit statement for the continued use of the Geodon, she responded she had not requested one. She added that she should have at least requested the GDR from the physician even though she felt it was not appropriate.	F 428		

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

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CONSTRUCTION SECTION  
08/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
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K 000	INITIAL COMMENTS	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated	9/29/13
K 076 SS=D	This STANDARD is not met as evidenced by: A .Based on observation on 08/15/2013 the valve controlling the high and low air pressure side of the dry sprinkler was not supervised and the high side would give a signal if the vale was in the off position. 42 CFr 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	<b>K 061 SS=D Corrective Action</b> The High/ Low air pressure valve was replaced and integrated into the existing Fire Alarm Panel on 8/30/13 such that an audible alarm will be sounded when the pressure is too high. <b>Identification of related safety hazards potentially affecting Residents</b> The High/Low air pressure valve alarm will be integrated into the Fire Alarm Panel which is supervised 24 hours per day on 8/30/13 <b>Systemic Changes</b> In-services will be conducted 8/30/13-9/7/13 by the Environmental Services Director. All Staff, FT, PT, and PRN employed by this facility will complete the in-service. The in-service topics will include: 1) High/low air pressure switch alarm indicator on the fire alarm panel 2) Action to be taken when high/low air pressure alarm is indicated on the fire alarm panel 3) This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained <b>Quality Assurance</b> The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the weekly Fire Safety Check List. Reports will be given during the daily stand-up meetings and the Monthly Quality of Life- QA committee and corrective action initiated as appropriate	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sheldon Swartz* TITLE: Administrator (X6) DATE: 8/27/13

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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K 076	Continued From page 1  This STANDARD is not met as evidenced by: A. Based on observation on 08/15/2013 there were full and empty O2 cylinders in the O2 storage room. 42 CFR 483.70 (a)	K 076	<p>K 038 SS=D</p> <p><b>Corrective Action</b> The full oxygen tanks were segregated from the empty oxygen tanks on 8/15/13</p> <p><b>Identification of related safety hazards potentially affecting Residents</b> The oxygen storage room will be checked weekly by the Environmental Services Director to ensure that the oxygen tanks are segregated. (See attachment #1)</p> <p><b>Systemic Changes</b> In-services were conducted on 08/16/13-08/30/13 by the Environmental Services Director. All Licensed and Rehabilitation Staff, FT, PT, and PRN employed by this facility have completed the in-service. The in-service topics included:</p> <ol style="list-style-type: none"> <li>1) Proper storage of oxygen tanks segregating the empty tanks from the full tanks</li> <li>2) This information has been integrated into the standard orientation training for all licensed and rehabilitation staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. (See attachment #2)</li> </ol> <p><b>Quality Assurance</b> The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the weekly Fire Safety Check List. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.</p>	9/29/13