

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

PRINTED: 03/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345374	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ APR 01 2011	(X3) DATE SURVEY COMPLETED 03/11/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856
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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
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F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting</p>	F 156	<p>F 156</p> <p>1. Corrective action has been accomplished for residents #64 and #15. Both have been given their Medicare Liability Beneficiary notices. The facility was unable to identify resident # 56 on the resident sample list provided.</p> <p>2. Residents receiving Medicare benefits have the potential to be affected by the deficient practice.</p> <p>The administrator completed an audit of medical records for residents receiving Medicare benefits to ensure that verbal notice as well as the Medicare Liability beneficiary notice is provided appropriately. Measures/Systems in place to ensure that the alleged deficient practice does not reoccur are:</p> <ul style="list-style-type: none"> All residents who are being discharged from therapy will receive Medicare denial letters (Form #CMS101123 or CMS #1005) detailing the person, date, reason, for services being discontinued; the appeal process will also be included in this letter. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy A Carter</i>	TITLE NHA	(X8) DATE 3-31-11
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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	<p>Continued From page 1</p> <p>personal funds, under paragraph (c) of this section;</p> <p>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.</p> <p>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.</p> <p>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</p>	F 156	<p>The resident, RP, POA and/or guardian will receive this letter 48 hours before services are discontinued. They may appeal this process at this time.</p> <p>The Therapy Department will make Social Services aware of the pending discharge dates and this will be discussed at the daily Department Head/Medicare meetings.</p> <p>Social Service will complete and mail the denial letters and inform the resident verbally where indicated.</p> <p>A copy of the denial letter will be maintained in the Business office file.</p> <p>The Social Worker and Business office Manager were in-serviced on this regulation and their responsibilities on 3-29-11 by the facility Administrator.</p>		

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F 156	<p>Continued From page 2 applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Medicare Liability Beneficiary Notices were issued for residents in the facility that had been discharged from Medicare services for three (3) of three (3) residents (Resident #s 57, 64 and 15). The findings include:</p> <p>On 3/ 10/11 at 3:00 p.m., record reviews and an interview was conducted with the facility's Regional Business Office Manager (RBOM). She stated the previous Business Manager left the facility as of 2/11/11.</p> <p>Review of the resident's records with the RBOM revealed, Resident # 57 was discharged from Medicare services on 2/19/11, Resident # 64 was discharged from Medicare services on 11/25/10 and Resident #15 was discharged from Medicare services on 12/20/10 and all three residents are presently in the facility. She stated, "The system for maintaining the 'Cut letters' (Liability Notices &</p>	F 156	<p>4. Monitoring to ensure corrective action:</p> <ul style="list-style-type: none"> A log will be maintained by the social service director indicating the resident's name, date of discharge, reason for denial, and if an appeal is being placed. <p>This log will be reviewed by the business office daily.</p> <p>The log will be monitored by the Administrator for compliance weekly for 4 weeks (1 month) then once monthly for 2 months.</p> <p>The business office manager will review the results of the monitoring at the QA meetings monthly. The QA committee will adjust this plan according to identified patterns/trends.</p> <p>Date of compliance: 4-10-11</p>	

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F 156	Continued From page 3 Beneficiary Appeal Rights notices) was not the same for each facility she covers." The ROBM confirmed that the residents should have received Liability Notices. The RBOM contacted the facility's Social Work Director, the Business Office Manager in training and attempts were made to contact the prior facility's Business Office Manager. She verified the facility did not have records of providing Liability Notices and Beneficiary Appeal Rights notices to residents in the facility.	F 156		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to invite and involve 1 of 3 sampled residents (Resident #71), whose activity records were reviewed, in activities. Findings include: Resident #71 was admitted to the facility on 02/02/11. The resident's documented diagnoses included cerebrovascular accident, cardiovascular disease, degenerative joint disease, and muscle weakness. The resident's 02/08/11 Admission Minimum Data Set (MDS) documented Resident #71 had impaired short term memory, intact long term	F 248		

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F 248	<p>Continued From page 4</p> <p>memory, and was moderately impaired in decision making. In this assessment Resident #71 was not interviewed about his activity interests, but it was determined by the nursing staff that the resident did not enjoy reading, listening to music, pet therapy, keeping up with news, group activities, or religious activities.</p> <p>At 9:17 AM on 03/11/11 Resident #71 stated he attended part of two church services (religious activity) and part of two bingo games (church and bingo both being group activities) since being in the facility. He stated no staff members invited him to activities, and he heard no announcements about activities taking place. The resident explained he heard the music and sermon coming from church services so decided to see what was going on, and saw bingo taking place as he wheeled himself around the facility. He commented he did not remember staff visiting him in his room other than asking him a few questions about how he felt. Resident #71 reported he liked to watch television (there was no television in the resident's room), talk with other people, eat snacks, go to church, and listen to music.</p> <p>On 02/08/11 "Elopement risk" was identified as a problem on Resident #71's care plan. Interventions to the problem included, "Distract resident from wandering by offering pleasant diversions, food, conversation, television."</p> <p>On 02/10/11 "Activity intolerance. Wants to go home." was identified as a problem on Resident #71's care plan. The goal for the problem was "Resident will have 1:1 (one-on-one) room visits twice a week through next review." Interventions to the problem included, "Provide socialization by</p>	F 248	<p>F 248</p> <p>1. Corrective action has been accomplished for resident #71. The facility MDS Nurse, DON, ADON, Activity Assistant and nursing direct care givers (Licensed nurses and C.N.A.'s) have interviewed and re-evaluated the resident, updated his care plan so that a program of activities has been designed to meet his physical, mental, and psychosocial well-being.</p> <p>2. Residents who are admitted to this facility have the potential to be affected by the alleged deficient practice, therefore a certified activities director from a sister facility completed initial activity assessments on residents on 3-12-11 and 3-19-11. Thos residents care</p>	

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F 248	<p>Continued From page 5</p> <p>visiting resident prn (as needed).", "Offer books and/or magazines prn.", "Ask volunteers to visit resident prn.", Offer activities of choice to resident prn.", "Monitor mood state and report any changes to nurse/MD (doctor of medicine).", "Offer alternative activities if resident declines current activity.", and "Visit routinely 1:1."</p> <p>The facility's activity calendar documented at 10:00 AM on 03/07/11 Methodist church/bingo was taking place.</p> <p>At 10:17 AM on 03/07/11 Resident #71 was resting in bed.</p> <p>The facility's activity calendar documented at 11:00 AM on 03/07/11 easy listening was taking place.</p> <p>At 11:11 AM on 03/07/11 Resident #71 was still in bed.</p> <p>The facility's activity calendar documented at 2:00 PM on 03/07/11 checkers were being played.</p> <p>At 2:08 PM on 03/07/11 Resident #71 was still in bed.</p> <p>The facility's activity calendar documented at 10:00 AM on 03/08/11 chair aerobics was taking place.</p> <p>At 10:21 AM on 03/08/11 Resident #71 was resting in bed.</p> <p>The facility's activity calendar documented at 2:00 PM on 03/08/11 Mardi Gras trivia was taking place.</p>	F 248	<p>plans were also updated where necessary.</p> <p>3. Measures/systems in place to ensure that the alleged deficient practice does not reoccur are:</p> <ul style="list-style-type: none"> The facility administrator is continuing to recruit and interview for the open activities director position. The MDS Nurse and/or DON/ADON or Social Worker will assess and/or interview new admissions and with the assistance of the IDT will determine a care plan designed to meet the residents physical, mental and psychosocial well- 	

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F 248	<p>Continued From page 6</p> <p>At 2:14 PM on 03/08/11 Resident #71 was still in bed.</p> <p>The facility's activity calendar documented at 10:30 AM on 03/09/11 a stretch class was taking place.</p> <p>At 10:32 PM on 03/09/11 Resident #71 was resting in bed. The Director of Nursing asked the resident if he would mind getting out of bed so his wanderguard could be checked at the front door. The resident stated getting out of bed was not a problem.</p> <p>The facility's activity calendar documented at 11:00 AM on 03/09/11 an event involving a religious event was taking place.</p> <p>At 11:13 AM on 03/09/11 Resident #71 was in the hallway in his wheelchair.</p> <p>The facility's activity calendar documented at 2:00 PM on 03/09/11 the Mardi Gras social party was taking place.</p> <p>At 2:06 PM on 03/09/11 Resident #71 was using his feet to navigate his wheelchair down the halls of the facility.</p> <p>The facility's activity calendar documented at 10:30 AM on 03/10/11 jazzercise was taking place.</p> <p>At 10:33 AM on 03/10/11 Resident #71 was in the hallway in his wheelchair.</p> <p>The facility's activity calendar documented at 10:45 AM on 03/10/11 arts and crafts was taking place.</p>	F 248	<p>being.</p> <ul style="list-style-type: none"> An In-service titled "Activity alternatives" developed by (CCME) The Carolina's Center for Medical Excellence was conducted by the DON on 3-29-11 licensed nurses, C.N.A.'s, activities assistant, and social services. <p>4. Monitoring in place to assure continued compliance:</p> <ul style="list-style-type: none"> Compliance rounds will be made daily by assigned members of the Management team ((Administrator, DON, ADON, Social Services, 	

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F 248	Continued From page 7 At 10:52 AM on 03/10/11 Resident #71 was still in the hallway in his wheelchair. At 11:20 AM on 03/10/11 Nurse #1 stated she did not remember staff inviting Resident #71 to many activities, but she did not think the resident could sit still long enough to attend. She commented she was unsure about the provision of in-room visits to the resident. At 12:26 PM on 03/10/11 the activity assistant provided the activity log for review. Resident #71's activity participation log for February 2011 was blank, and the only two activities recorded on the March 2011 log were the resident actively wheeling himself down the hallways on 03/01/11 and 03/02/11. The activity assistant stated she may have had to recreate Resident #71's participation log because someone may have misplaced or destroyed some of the logs. (Review of the participation logs revealed other residents had detailed documentation of activity attendance in February 2011 and March 2011.) She reported the activity logs captured participation in group events as well as 1:1 (one-on-one) visits with residents. According to the activity assistant, she thought Resident #71 may have attended bingo a couple of times, entered a coffee/news event once, and entered and left an arts and craft event. She commented she visited Resident #71 in his room occasionally, with varying degrees of resident responsiveness. She commented no staff members approached her about providing diversional activities to lessen the resident's anxiousness or wandering tendencies. She stated for the past week and a half to two weeks Resident #71 spent most of his time in bed, so she did not bother him.	F 248	Housekeeping supervisor, MDS nurse, Medical records, Nurse supervisors and/or week-end Manager on Duty) to observe residents participation in group or one to one room activities. Residents found often not in attendance or participating will be discussed at the daily department head meetings and communicated to the IDT team to determine if their needs are being met. The care plans of these residents will be changed as indicated. • The results of the	

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F 248	<p>Continued From page 8</p> <p>The facility's activity calendar documented at 2:30 PM on 03/10/10 resident council was taking place.</p> <p>At 2:46 PM on 03/10/11 Resident #71 was using his feet to navigate his wheelchair down the halls of the facility.</p> <p>At 9:22 AM on 03/11/11 the activity assistant stated an activity director left the facility on either 12/07/10 or 12/08/10, and another activity director who only stayed in the facility for about three weeks was hired on 02/07/11. As the activity assistant, she reported she was not allowed to conduct activity assessments or write activity progress notes (there was no documentation in Resident #71's chart under the activities tab). She explained one weekend the activity director hired on 02/07/11 came into the facility by herself, and afterwards some of the paperwork on residents disappeared. According to the activity assistant, the amount of time to spend with residents during 1:1 in-room visits was limited because she devoted a lot of time to coordinating the group events in the building. She stated from visits with Resident #71 when he was first admitted she thought she remembered the resident liking roller skating and watching movies. She commented she did not think Resident #71 was interested in church, music, or arts and crafts. She reported she had never attempted sensory stimulation activities with the resident on a 1:1 basis. The activity assistant reported she and the nursing assistants on the hall invited residents to activities. She stated when Resident #71 was first admitted she remembered him being non-committal when invited to activities, putting the staff off and commenting he might</p>	F 248	<p>compliance rounds will be turned in to the facility Administrator at the daily Department Head Meeting.</p> <ul style="list-style-type: none"> The results of the compliance rounds will be reviewed at the QA meetings by the social worker and the QA Committee will adjust this plan based on identified trends/patterns. <p>Compliance date: 4/10/11</p>	

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F 248	Continued From page 9 have other things to do. At 2:47 PM on 03/11/11 nursing assistant (NA) #1, who worked with Resident #71 on first shift, stated the activity staff was supposed to invite residents to activities. She reported hall NAs would assist residents to activities if they expressed interest to overhead announcements about them. NA #1 commented Resident #71 had never expressed interest after an announcement although she commented she was not sure announcements were made before all activities and was not sure Resident #71 would understand the announcements. She stated she remembered seeing activity staff in Resident #71's room when he was first admitted, but not since then. She commented she was not sure Resident #71's attention span was long enough for group activities. At 2:52 PM on 03/11/11 a telephone conversation was held with NA #7, who worked with Resident #71 on second shift. She stated she was not aware of the resident expressing much interest in activities. She commented it was difficult for the resident to stay in one place for long so she mainly saw him going in and out of the television room, wheeling himself along the halls in his wheelchair, and talking with other residents. According to NA #7, she thought she saw Resident #71 in bingo one day. She reported she could not remember activity staff in the resident's room, but that did not mean that they were not visiting the resident on first shift. She stated Resident #71 never responded to an announcement before activities, asking for her assistance to the activity.	F 248			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280			

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F 280	Continued From page 10 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure Care Plans were revised for three (2) of ten (10) sampled residents. (Resident # 69 Care Plan did not include updated nutritional interventions; Resident # 70 Care Plan was not revised for wound treatment). The findings include: 1. Resident # 69 was admitted to the facility on 12/8/10, with multiple diagnoses including Other Non infected Gastroenteritis, Dehydration, Other	F 280	F 280 1. Corrective action has been accomplished for Resident #69: His care plan, C.N.A. care guide and (MAR) medication administration record was updated to include nutritional supplements, fortified foods and assistive dining. Resident #70 no longer resides in the facility. 2. Residents with weight loss and who have orders for nutritional supplements and other dietary recommendations; and residents with wounds and orders for specific treatments have the potential to be affected by alleged deficient practice. Therefore current residents have been identified as having weight loss and development of a wound (pressure or non-pressure ulcer) have had their medical records, including the treatment record (TAR) and medication administration record (MAR) reviewed by the DON/ADON/MDS Nurse, treatment nurse on 3/24/11. All residents care plans, MAR and TAR are current and reflect the interventions ordered by the physician and/or recommended by the dietitian. 3. Measures/systems in place to ensure alleged deficient practice does not reoccur are: • New admissions. Re-admissions and residents with a change in condition charts including their MAR and TAR, 24 hour nursing reports, physician telephone orders, incident reports, dietary	

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F 280	<p>Continued From page 11</p> <p>Persistent Mental Disorder and Diabetes Mellitus.</p> <p>The Minimum Data Set, dated 12/10/10 coded the resident under Nutrition Status as: "Need or special diet or altered consistency which may not appeal to resident; Other-Dementia, poor memory. Care Plan will be developed r/t (related to) nutrition.</p> <p>The Care Plan was developed 12/17/10, Problem List Included: Risk for Altered Nutritional Status/ Wt Loss; Has dentures which fit well at present; Currently on RCS (reduced concentrated sweets); Diet controlled Diabetic. The Goal: Resident's weight will remain stable + or - 5 lbs through next review. Interventions Included: RCS Diet as ordered, weigh per routine, assist with set-up as needed, Dietary to monitor for likes/dislikes, Monitor labs, RD(Registered Dietician) , Monitor oral/dental status to review per routine, Encourage resident to come out of room for Dining, Consult MD prn (when necessary).</p> <p>Resident # 69 was observed on 3/9/11 at 12:40 p.m., eating lunch in the room. The resident had eaten less than 10% of the meal, and did not drink all of the health shake.</p> <p>The resident's weight on admission was 121lbs (pounds) and on 3/1/11 the resident's weight was 110 lbs. The Dietary assessments dated 12/30/10, 1/11/11, 1/27/11, and 3/7/11 begin to document the resident's significant weight loss. The Registered Dietary Manager referred the resident to the Supervised Assistive Dining Program on 12/30/10. As of 3/7/11, the resident had not been involved in the Supervised Assistive Dining Program. The Care Plan was not revised/updated to reflect new</p>	F 280	<p>recommendations and restorative referrals will be reviewed for completion and accuracy by the IDT at the daily clinical meeting.</p> <ul style="list-style-type: none"> Friday admissions will be reviewed at the next working days clinical meeting. Corrections will be made when found and care plans updated. Nurses identified as making transcription or other errors will be re-in serviced or disciplined by the DON. Weekly SOC meetings will be held and weights, wounds, physician orders, dietary referrals to restorative, nutritional and other recommendations will be reviewed. Care Plans will be updated as necessary. In-services were conducted for the licensed nurses, C.N.A staff, restorative staff and dietary staff on 3/29/11 – 3/31/11 by the DON and the topics were: "The importance of observing and reporting resident's dietary 	

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F 280	<p>Continued From page 12</p> <p>approaches/interventions to manage Resident # 69's significant weight loss.</p> <p>During an interview with the Dietary Manager on 3/8/11 at 4:15 p.m., she reported she had talked to resident about weight loss. She further stated, "The resident knew she was losing weight to some extent and I talked to the resident about going to the dining room." The Care Plan did not document that the resident was resistive to attending the Dining Room.</p> <p>Interviews with the Assistant Director of Nurses on 3/9/11 at 5:00 p.m., and Registered Dietician on 3/10/11 at 12:15 p.m. confirmed that the Care Plan on 3/1/11 was not reflective of needs and approaches for Resident # 69's significant weight loss.</p> <p>2. Resident # 70 was admitted on 12/28/10 with cumulative diagnoses of chronic kidney disease, diabetes, chronic anemia and history of stroke.</p> <p>The Interdisciplinary Assessment, dated 12/28/10, indicated the resident had no compromise in skin integrity on her sacrum or buttocks.</p> <p>The Admission MD'S, dated 12/31/10, indicated the resident was totally dependent on staff for all activities of daily living. The MD'S indicated Resident # 70 had no pressure ulcers.</p> <p>On 12/31/10, the resident was sent to the hospital for evaluation of seizure activity. The resident's hemoglobin was listed as 10.9 (12 to 15.5). The readmission assessment, dated 01/05/11,</p>	F 280	<p>habits and documentation of dietary supplements and wound treatments to protect residents from developing weight loss and/or pressure ulcers."</p> <ul style="list-style-type: none"> • "Whose responsibility is it to update care plans for supplements and treatments. (Nursing vs. MDS vs. Treatment Nurse)." • MAR/TAR documentation requirements for accuracy and completeness. • "Reporting and recording new treatments, MD orders, etc on the 24 hour nursing report." • Transcription of new Orders for supplements, Restorative dining, documenting medications, supplements and treatments. " <p>"Monitoring residents for weight loss",</p> <p>"Referring residents to restorative dining procedures".</p> <p>"Reporting and recording residents who are not eating well."</p>	

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F 280	<p>Continued From page 13</p> <p>indicated the had no skin breakdown in her sacral area or on her buttocks.</p> <p>The resident's care plan, dated 01/14/11, indicated she was at risk for skin breakdown. Interventions to prevent skin breakdown included keeping the skin clean and dry, applying protective barrier after incontinence, avoid hot water and irritating soaps, keep linen clean and wrinkle free, turn and position during care rounds, postillion to avoid pressure, transfer to geriatric chair as tolerated, maintain adequate nutrition and hydration and inspect skin integrity weekly.</p> <p>Resident # 70 was sent to the hospital on 01/16/11 for evaluation of tachycardia and abnormal respiratory patterns. She returned to the facility on 01/17/11. Transfer orders did not indicate pressure ulcers.</p> <p>A nurse's note, dated 01/31/11 at 1:50 PM, indicated the resident had 2 new Stage II pressure ulcers located on her sacrum and right buttocks. Treatment orders were received. The pressure ulcers nor new interventions were added to the care plan for Resident # 70..</p> <p>An interview was held with the treatment nurse, 03/09/11 at 10:20 AM. The treatment nurse stated the MD'S nurse was responsible for care planning skin breakdown. Information about wounds was given to the MD'S nurse either verbally or in writing.</p> <p>An interview was held with the MD'S Coordinator on 03/10/10 at 2:52 PM. The MD'S nurse stated the purpose of a care plan was to address problems/care areas that affected the resident. The care plan included a goal and interventions to</p>	F 280	<p>4. Monitoring in place to ensure continued compliance:</p> <ul style="list-style-type: none"> Care plans will be updated/revise daily with the utilization of the following systems: Daily clinical meeting, review of the Nursing 24 hour report, review of the telephone orders daily, weekly standards of care meeting and with each MDS completed. Weekly care plan audits will be completed for 4 weeks. Results of these reviews will be reviewed at the monthly QA meeting for 3 months. This plan will be adjusted by the QA committee based on identified trends and patterns. <p>Compliance date: 4/10/11</p>	

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F 280	Continued From page 14 achieve goals. Care plans should be individualized to the resident. The MD'S nurse stated care plans were revised as needed. She was unable to give a reason the care plan had not been revised to reflect the development of actual skin impairment for Resident # 70	F 280		
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 staff interview and record review the facility failed to implement a nutrition recommendation signed off on by the physician for 1 of 6 sampled residents (Resident #65) with nutrition concerns. Findings include: Review of hospital laboratory reports for Resident #65 revealed on 09/20/10 the resident's albumin was low at 3.4 grams per deciliter (g/dL) and on 09/21/10 low at 3.2 g/dL (with the normal range being 3.5 to 5.2 g/dL). The resident was admitted to the facility on 09/24/10. The resident's documented diagnoses included fracture of the left hip, hypertension, and Alzheimer's dementia. The resident's Weight Record documented he weighed 98.3 pound on 09/24/10. The resident's 09/24/10 Admission Interdisciplinary Assessment documented the resident was at risk for the development of pressure ulcers.	F 281	F 281 1. Resident #65 no longer resides in the facility. 2. Residents with weight loss and who have orders for nutritional supplements have the potential to be affected by alleged deficient practice. Therefore, residents who have been identified as having weight loss and have the potential for development of a pressure ulcer have had their medical records, including the treatment record (TAR) and medication administration record (MAR) reviewed by the DON/ADON and/orMDS Nurse on 3-24-11. All residents care plans, MAR and TAR are current and reflect the interventions ordered by the physician and/or recommended by the dietitian. 3. Measures/systems in place to ensure alleged deficient practice does not reoccur are: • New admissions. Re-admissions and residents with a change in condition charts including their MAR and TAR, 24 hour nursing reports, physician telephone orders, and physician change in condition request forms, incident reports, dietary recommendations and restorative referrals will be reviewed for completion and accuracy by the IDT at the daily clinical meeting.	

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F 281	Continued From page 15 A 09/27/10 Change of Condition Report documented, "Can we have order for Medpass 120 cc (cubic centimeters) QID (four times a day) to prevent wt. (weight) loss? Poor appetite." On 09/27/10 a physician initialed the form. Record review revealed a physician's order was never written to begin the provision of Medpass to Resident #65, and the resident's Medication Administration Records (MAR's) revealed Medpass was not administered to the resident. The resident's Interim/Admission Care Plan was updated on 09/30/10 to reveal Resident #65 weighed 98 pounds. Resident #65's 10/01/10 Pressure Ulcers Resident Assessment Protocol (RAP) documented, "Nature of Condition: Resident is incontinent and has impaired mobility. Complications and Risk Factors: Resident also has poor intake and nutrition. Resident is at high risk for pressure ulcer development." The resident's 10/01/10 Nutritional Status RAP documented, "Nature of Condition: Resident is on mechanically altered diet. Resident routinely eats less than 75% of meals. Complications and Risk Factors: Resident is at risk for wt loss"	F 281	Friday admissions will be reviewed at the next working days clinical meeting. Corrections will be made when found and care plans updated. Nurses Identified as making transcription or other errors will be re-in serviced or disciplined by the DON. The MDS nurse will review the charts also for restorative referrals to ensure the communication. Between dietary and nursing is intact. Weekly SOC meetings will be held and weights, wounds, physician orders, dietary referrals to restorative, nutritional and other recommendations will be reviewed. Care Plans will be updated as necessary. In-services were conducted for the licensed nurses, C.N.A staff, restorative staff and dietary staff on 3-29-11 by the DON and the topics were: "The Importance of observing and reporting resident's dietary habits and documentation of dietary supplements and wound treatments to protect residents from developing weight loss and/or pressure ulcers."	
	A 10/01/10 physician's order documented, "Cleanse stage II area to left (symbol used) buttock with NS (normal saline) & (and) 4 x 4's. Air dry. Apply 2 x 2 hydrocolloid Q (every) 3 days & prn (as needed)." During a 03/09/11 5:28 PM interview with the Director of Nursing (DON), she explained the physician initials on the 09/27/10 request to begin		<ul style="list-style-type: none"> "Whose responsibility is it to update care plans for supplements and treatments. (Nursing vs. MDS vs. Treatment Nurse)." <p>MAR/TAR documentation requirements for accuracy and completeness.</p> <p>"Reporting and recording new treatments, MD orders, etc on the 24 hour nursing report."</p>	

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F 281	Continued From page 16 Resident #65 on Medpass were an indication the resident ' s primary physician or associate agreed with the recommendation. According to the DON, the nurse who received the initialed form should have written a physician's order to begin the provision of the supplement which would have been beneficial in addressing the resident's weight loss and pressure ulcer development.	F 281	"Transcription of new Orders including orders written and signed on the physician change in condition report form for supplements, fortified foods, etc" 4. Monitoring in place to ensure continued compliance:	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to identify a wound on the right heel which delayed treatment and resulted in discovery of black eschar (necrotic tissue) for 1 (Resident # 35) of 4 residents sampled with wounds. Findings include: Resident #35 was admitted to the facility on 12/14/10 with a diagnosis of atrial fibrillation, hypertension, and Alzheimer's disease. An admission Minimum Data Set (MDS) assessment completed on 12/20/10 documented Resident #35 had short term and long term memory impairment, severe cognitive impairment and required extensive assistance from one staff member for bed mobility and transfers and was	F 309	<ul style="list-style-type: none"> Daily clinical meetings and weekly SOC meetings by the DON and/or ADON or MDS nurse. <p>25 residents MAR and TAR will be monitored for accuracy of documentation 5 times a week by the nurse supervisor/ADON for 30 days.</p> <p>Nurses identified as not documenting per facility policy will be either re-inserviced or disciplined by the DON.</p> <p>Results of these reviews will be reviewed at the monthly QA meeting for 3 months. This plan will be adjusted by the QA committee based on identified trends and patterns.</p> <p>Compliance date: 4-10-11</p>	
			F 309 1. Corrective action has been accomplished for resident #35; the resident is receiving daily treatment and observation of the wound on the left heel per physician's orders. The resident was assessed for any additional untreated wounds by the Director of Nursing (DON) on 3-8-11 and none were found. The resident's care plan has been updated and addresses interventions for each wound as well as prevention techniques.	

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F 309	<p>Continued From page 17</p> <p>non-ambulatory. The same assessment documented Resident #35 was at risk for skin breakdown but did not have any pressure ulcers or venous or arterial ulcers. There were no preventative interventions put in place documented on the MDS.</p> <p>Resident #35's care plan, dated 12/22/10 identified her at risk for potential skin breakdown related to immobility and incontinence. Interventions listed included assist resident to turn and reposition and position with pads and cushions to prevent pressure. There were no specific interventions to address the residents heels in place.</p> <p>A WEEKLY SKIN ASSESSMENT was completed on Resident #35 on 02/01/11 by Nurse #5 documented no new skin issues noted.</p> <p>A WOUND/SKIN HEALING RECORD documented onset date of 02/09/11, Resident #35 was found to have an unstageable wound on the right inner heel covered with black eschar which measured 1.5 cm (centimeters) by 1.5cm.</p> <p>On 02/22/11 the diagnosis of peripheral arterial disease was added to Resident #35's diagnoses by the physician after a Doppler study was completed on 02/18/11.</p> <p>A wound care observation was done on Resident #35 on 03/08/11 at 11:05 AM by Nurse #5. The wound present on Resident #35's right inner heel was approximately 1.5 cm by 1.5 cm and the wound bed was 100% covered with yellowish slough.</p> <p>In an interview conducted with Nurse #5 on</p>	F 309	<p>2. Residents at risk for pressure ulcer development have the potential to be affected by the deficient practice. Therefore:</p> <ul style="list-style-type: none"> Residents residing in the facility had a Braden Scale pressure ulcer risk assessment and skin integrity assessments conducted by the DON and evening shift nursing supervisor, DON and/or treatment nurse on 3-16-11 The resident's care plans were updated as necessary based on the outcome of the assessment. Residents were also assessed for preventive measures/equipment such as pressure relief mattresses and chair cushions on 3-16-11. Interventions identified were added to the residents individual care plan and C.N.A. care guides. <p>3. Measures/systems put in place to ensure deficient practice does not occur are:</p> <ul style="list-style-type: none"> Weekly skin integrity assessments are conducted by the RN treatment nurse and recorded in the residents chart. The Physician's will be contacted and care plans up-dated when treatment additions or changes are necessary. Residents who have been sent to the ER and not admitted, sent home on a leave of absence or a day pass or admitted to hospital and not discharged from the facility will also have their skin integrity assessments re-done when they return to the facility by the treatment nurse and in her absence this will be done by the charge nurse. The Certified Nurse Assistants (C.N.A.'s), members of the shower team, restorative aides and other licensed nurses making observations of changes in skin conditions 	

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F 309	<p>Continued From page 18</p> <p>03/09/11 at 4:20 PM, Nurse #5 said she performed a body check on Resident #35 on 02/01/11 and there had been no skin impairments observed. Nurse #5 said she went to measure another wound on 02/09/11 that had been found by the physician on 02/08/11 on the resident's right ankle and discovered the area of eschar on the right inner heel. Nurse #5 said she would expect to find a wound at a stage 2 or less and not at an unstageable level. Nurse #5 attempted to contact the physician or the nurse for interview but was unsuccessful. The physician's progress note, dated 02/08/11, was obtained but only referred to a 1 centimeter pressure ulcer on the right ankle. There was no mention of any impairment on Resident #35's right heel.</p> <p>In an interview with Nurse Aide (NA) #10 on 03/10/11 at 2:50 PM who cared for Resident #35 on 02/05/11, 02/06/11, 02/07/11, and 02/08/11 on the day shift, NA #10 said she did not remember seeing anything on Resident #35's heels prior to her having a dressing in place after 02/09/11 on her right foot. NA #10 said there were no interventions in place prior to Resident #35 having the dressing on her foot but now she had a cushioned boot to her right foot and heels floated while in bed.</p> <p>An interview was conducted with Nurse #8 on 03/10/11 at 10:50 AM. Nurse #8 stated he would expect to find a wound on a resident's heel at a stage 1 or stage 2. Nurse #8 said he was the nurse working on the floor on 02/08/11 when the resident's physician found a stage 2 wound on the resident's right ankle. Nurse #8 said the physician had his own nurse with him and he did not look at the resident or see the wound. Nurse #8 stated he did not remember anyone reporting any</p>	F 309	<p>on their assigned residents will report these changes to the treatment nurse and/or nurse supervisor working at the time. The Physician will be contacted when necessary for physician orders for treatment and other interventions. The change in resident's condition, treatment orders or other interventions initiated will be documented on the residents care plan, C.N.A. Care Guide and 24 hour nursing report, physician's telephone order form and reviewed by the IDT at the following day's clinical meeting.</p> <ul style="list-style-type: none"> • Braden scale risk assessments will be performed by licensed nurses on residents on all new admission or re-admission weekly X times 4, then; quarterly, annually and with a change in condition. • Any changes in the residents' skin condition will be documented in the nurse's notes, 24 hour nursing report form and reviewed for accuracy by the inter-disciplinary team (IDT) at the daily clinical meeting. • Residents with pressure ulcer treatments or potential for pressure ulcers and related nutritional or other care needs will be reviewed at the weekly Standard of Care Meeting. • The IDT will not only review appropriate treatment interventions for identified wounds but also preventative approaches to care. • The facility DON and Administrator have put a purchasing plan in place for specialty mattresses, beds, chairs and cushions and other devices. • In-services for licensed nurses and C.N.A.'s were conducted by the DON on 3-8-11 the lesson plan included: a."Prevention, treatment, reporting and documentation of Pressure Ulcers and other wounds." 	

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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856	
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F 309	Continued From page 19 impairment on Resident #35's right heel prior to the discovery of the eschar on 02/09/11.	F 309	b. "Observing and reporting of skin condition during bathing. "Following residents care plan for prevention interventions". C. A Directed In-service will be conducted for licensed nurses and C.N.A.'s on 3-31-11 by Sterling Grimes R.N., Program Director with Nash Health Care Systems Wound Clinic. The subject was "Wound assessment, prevention and treatment." d. This in-service will be integrated into the new employee orientation content.	
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, staff interview, and record review the facility failed to provide 1 of 2 sampled residents (Resident #71), reviewed for Activity of Daily Living concerns and requiring extensive assistance from staff for hygiene, with fingernail care. Findings include: Resident #71 was admitted to the facility on 02/02/11. The resident's documented diagnoses included cerebrovascular accident, cardiovascular disease, degenerative joint disease, and muscle weakness. The resident's 02/08/11 Admission Minimum Data Set (MDS) documented he required extensive assistance by a staff member with hygiene and bathing, but did not exhibit rejection of care. His Care Area Trigger (CAT) Worksheet for ADL (activities of daily living)/Rehabilitation Potential	F 312	4. Monitoring in place to ensure continued compliance are: • The DON, ADON and/ or MDS nurse will review the following at the daily clinical meetings and determine if the problems are identified, treated, care planned and documented appropriately. 1. Braden Scales on new admissions, readmissions, change of conditions, 2. Weekly skin assessments. 3. New Skin assessments of residents who were out of the facility to home or hospital. • The results of the monitoring will be reported to the monthly QA meeting for three months. This plan will be adjusted based on trends/patterns identified. Compliance date 4/10/11	

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F 312	<p>Continued From page 20</p> <p>documented, "Resident is currently receiving therapy. Resident requires varying degrees of ADL assistance at present ...Resident believes he can be independent however this is not feasible"</p> <p>At 12:40 PM on 03/07/11 Resident #71 was in bed. The resident's fingernails extended approximately a half inch from the ends of his fingers, and there was brown matter under the nails. The resident's thumb nails and the nails on his little fingers were jagged.</p> <p>At 9:54 AM on 03/08/11 Resident #71 was in bed. The resident's fingernails extended approximately a half inch from the ends of his fingers, and there was brown matter under the nails. The resident's thumb nails and the nails on his little fingers were jagged.</p> <p>At 9:03 AM on 03/09/11 Resident #71 was in bed. The resident's fingernails extended approximately a half inch from the ends of his fingers, and there was brown matter under the nails. The resident's thumb nails and the nails on his little fingers were jagged.</p> <p>At 9:12 AM on 03/09/11 the Director of Nursing (DON) stated nursing assistants could cut non-diabetic nails unless they were thick and mycotic, and nurses could cut diabetic fingernails unless they were thick and mycotic. She commented Resident #71 was usually resistive to the staff cutting his fingernails. She explained the facility was waiting until Resident #71's behaviors were under control before dealing with much nail care.</p> <p>At 9:14 AM on 03/09/11 the DON entered</p>	F 312	<p>F312</p> <p>1. Corrective action has been accomplished for resident #71; his fingernails have been cleaned and cut, his care plan updated to reflect his level of cooperation with his care and; the C.N.A. care guide has also been updated as to whose nursing responsibility it is to provide this care.</p> <p>2. Residents admitted to the facility have the potential to be affected by alleged deficient practice therefore, compliance rounds were made on 3-12-11 by the treatment nurse and any other resident identified with long, unclean fingernails had their nails cleaned and trimmed on that same day. C.N.A care guides were updated as needed.</p> <p>3. Measures/systems in place to ensure continued compliance are:</p> <ul style="list-style-type: none"> Fingernails are to be checked daily by the C.N.A during am care and on the residents scheduled bath by the shower aide. The shower aide is to report long nails and the assigned C.N.A. is to clip, clean and file the resident's long fingernails. The exception is diabetics. In this case the C.N.A. is to report the need for diabetic's nails to be cut to the charge nurse. The nurse is then to trim. File and clean nails appropriately. <p>Toenails of diabetics need to be referred to the podiatrist for cutting and toenails of non-diabetics must be trimmed by the charge nurse. Fingernails and toenails during care and refers to the C.N.A, the charge nurse. The condition of the nails will also be documented on the weekly skin assessments form.</p>	

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F 312	<p>Continued From page 21</p> <p>Resident #71's room, and asked the resident if it would be okay if she cut and cleaned his fingernails. The DON commented the resident's fingernails were too long, had debris under them, and were jagged in places. The resident immediately agreed that such a procedure was acceptable. The resident did not pull away, complain, or grimace while the DON clipped, cleaned, and filed the fingernails on both of his hands.</p> <p>At 9:27 AM on 03/09/11 Nurse #1, who cared for Resident #71, reported the resident did not exhibit behaviors on first shift so if care needed to be rendered, first shift was the best time to do such. She stated the resident sundowned, and frequently became anxious, irritable, and argumentative in the late afternoon and evening. According to Nurse #1, Resident #65 did not resist care on first shift.</p> <p>At 9:55 AM on 03/09/11 nursing assistant (NA) #1, who cared for Resident #71, stated the resident did not refuse care. She explained sometimes the resident argued about the provision of care, but when she talked with the resident about what care she needed to provide and why, the resident cooperated.</p> <p>At 10:12 AM on 03/09/11 NA #1 stated she did not remember Resident #71's fingernails being long. She reported if his nails were long, it was the responsibility of the shower team to cut them.</p> <p>At 11:38 AM on 03/09/11 NA #2, a member of the shower team for four months, stated the shower team did sometimes cut nails, but it was the responsibility of all NAs to screen for and out long nails. She reported Resident #71 did not like to</p>	F 312	<p>In-service regarding the topic "care of fingernails, toenails and Podiatry referral" will be completed on by 4-4-11 by the ADON and/or the treatment nurse and will be included in new employee orientation.</p> <p>4. Monitoring to ensure continued compliance:</p> <ul style="list-style-type: none"> Daily compliance rounds will be made by the assigned administrative staff to observe for residents fingernail care daily by assigned staff and reported at the daily department head meeting. <p>The treatment nurse will monitor and record the status of resident's fingernails on the weekly skin assessment form and give to the DON/ADON every week.</p> <p>The results of these audits will be reviewed by the DON at the monthly QA meeting for 3 months. The QA committee will adjust this plan based on identified</p> <p>The treatment nurse also checks</p> <ul style="list-style-type: none"> trends/patterns. <p>Compliance date: 4/10/11</p>	

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F 312	<p>Continued From page 22</p> <p>take showers, and would usually agree to only one shower a week as opposed to the two showers a week he was scheduled to receive. She commented since showers aggravated Resident #71, it was not the best time to attempt cutting his nails. However, according to NA #2, since the resident's nails were so long, she attempted to cut his fingernails two weeks ago. She reported she could only clip about two fingernails before the resident refused to let her continue.</p> <p>During a telephone interview with Nurse #4 on 03/09/11 at 2:55 PM she stated she worked with Resident #71 on first and second shift. This nurse reported even though it sometimes took a lot of encouragement, the resident usually allowed staff to provide care. She stated she was not aware that Resident #71's nails needed to be cut.</p> <p>At 3:38 PM on 03/09/11 NA #3, who worked with Resident #71 some on second shift, stated the resident would let you provide care, but sometimes it was necessary to talk to the resident and explain what it was that needed to be done. She reported she was not aware that Resident #71's nails needed to be cut.</p> <p>At 6:02 PM on 03/09/11 the DON stated if it was difficult to perform ADL care on a resident she would expect for the staff to keep making attempts to provide the care at different times of the day, attempt to provide the care on different days of the week, have different staff members attempt to provide the care, and/or talk to the resident to explain what needed to be done and why.</p>	F 312		

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F 312	Continued From page 23	F 312		
F 315 SS=D	<p>During a 03/11/11 2:52 PM telephone interview with NA #7, who worked with Resident #71 some on third shift, she stated sometimes it took a lot of persuasion, but the resident usually allowed his care to be provided. She reported she was not aware that Resident #71's nails needed to be cut.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to develop a toileting program for 1 of 1 sampled residents (Resident #71) with periods of continence. Findings include: Resident #71 was admitted to the facility on 02/02/11. The resident's documented diagnoses included cerebrovascular accident, cardiovascular disease, degenerative joint disease, and muscle weakness. The resident's 02/08/11 Admission Minimum Data Set (MDS) documented he was always incontinent of bowel and bladder. The assessment also documented the resident had</p>	F 315	<p>F 315</p> <p>Resident # 71 is receiving appropriate assistance with elimination needs. The resident was assessed on 3/31/11 by the MDS Nurse and was determined to be incontinent.</p> <p>Residents residing in the facility assessed as being incontinent or requiring assistance to go to the bathroom or use a urinal to maintain continence may be affected by the deficient practice.</p>	

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F 315	<p>Continued From page 24</p> <p>impaired short term memory, no impairment of long term memory, and was moderately impaired in decision making.</p> <p>On 02/10/11 "Total incontinence of bowel and bladder" was identified as a problem on the resident 's care plan. Interventions included, "Check resident routinely on care rounds and provide incontinent care."</p> <p>A 03/05/11 6:00 PM Nurse's Note documented, "Resident fell on floor attempting to go to bathroom unassisted ..."</p> <p>At 9:54 AM on 03/08/11 Resident #71 was in bed. There was no urinal in the resident's room or in his bathroom.</p> <p>At 4:25 PM on 03/08/11 there was no urinal in Resident #71's room or bathroom.</p> <p>At 9:03 AM on 03/09/11 Resident #71 was in bed. There was no urinal in The resident's room or in his bathroom.</p> <p>At 4:42 PM on 03/09/11 there was no urinal in Resident #71's room or bathroom.</p> <p>At 9:27 AM on 03/09/11 Nurse #1, who cared for Resident #71, reported sometimes the resident was able to tell when he needed to urinate, and used a urinal.</p> <p>At 9:55 AM on 03/09/11 nursing assistant (NA) #1, who cared for Resident #71, stated sometimes the resident was able to tell her when he needed to urinate or have a bowel movement. She commented the resident had a urinal, but rarely used it. According to NA #1, Resident #71</p>	F 315	<p>The DON, ADON and Unit Manager completed urinary incontinence assessments by 4-10-11 on residents who were coded a 2 or higher in section H of their most recent MDS.</p> <p>Residents will be assessed for urinary incontinence on admission, quarterly and with a significant change in condition and the care plan will be reflective of current status. The CNA care guides will be audited monthly for accuracy and individual resident needs as related to toileting and will be updated as indicated.</p> <p>Education was provided to Licensed Nurses and Certified Nursing Assistants by the DON on 3-31-11 The topics of this in-service were;</p>	

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F 315	<p>Continued From page 25</p> <p>preferred to go the bathroom, although he frequently wet his bed.</p> <p>During a telephone interview with Nurse #4 on 03/09/11 at 2:55 PM she stated she worked with Resident #71 on first and second shift. This nurse reported the resident frequently attempted to get up unassisted to go to the bathroom. She commented the staff took the resident to the bathroom sometimes, but he did not always do anything when he was positioned on the commode.</p> <p>At 3:38 PM on 03/09/11 NA #3, who worked with Resident #71 some on second shift, stated sometimes the resident was able to tell her when he needed to go to the bathroom. She reported the resident was supposed to have a urinal in his room, but he still preferred to go to his bathroom at times.</p> <p>During a phone interview with NA #4 at 11:18 PM on 03/09/11 she reported Resident #71 was continent of bowel and bladder at times. She stated the staff put briefs on the resident, but sometimes he would transfer to his wheelchair and go the bathroom by himself, although he was supposed to call for staff assistance. She commented the resident had a urinal at one time, but poured it out in his room at times.</p> <p>At 11:03 AM on 03/10/11, during a telephone interview with NA #5, she stated Resident #71 used a urinal.</p> <p>At 11:15 AM on 03/10/11 there was no urinal in Resident #71's room or bathroom.</p> <p>At 3:43 PM on 03/10/11 Nurse #1 reported</p>	F 315	<ul style="list-style-type: none"> • "Assessing the resident for toileting needs and continent status" • "Following the CNA care guide for individual resident toileting needs." • "Adapting the toileting plan to include resident safety" • "Communicating changes through use of the 24 hour report." <p>The facility will monitor compliance through review of the 24 hour report in daily clinical meeting, through review of the urinary assessments in Standards of Care meeting weekly, and through individual resident observation of compliance.</p>	

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F 315	<p>Continued From page 26</p> <p>Resident #71 could be very lucid and reliable at times, but would make "off-the-wall" comments at other times. She stated the resident's cognition varied from day to day.</p> <p>At 4:26 PM on 03/10/11 Nurse #2 stated Resident #71 sometimes removed his brief. She commented use of a urinal was discontinued because the resident either poured urine in his bed or missed the urinal. Nurse #2 reported the resident urinated on occasion in the trash can, in cups, etc.</p> <p>At 6:16 PM on 03/10/11 Resident #71 was resting on his bed. There was no urinal in the resident 's room or bathroom. The resident stated he had recent falls. The resident reported staff had told him to ring his call bell before getting out of bed. However, the resident commented, "I can't wait on them to get here." The resident clarified, "I can't wait on them to get me to the bathroom."</p> <p>At 8:45 AM on 03/11/11 the Assistant Director of Nursing reported Resident #71 was interviewable at times, but there were times when the resident "talked out of his head."</p> <p>At 9:45 AM on 03/11/11 NA #1 stated Resident #71 was very "with it" sometimes, but could also say things which did not make any sense.</p> <p>At 9:48 AM on 03/11/11 the MDS nurse stated she based her continence determination in MDS assessments on nurse's note, clinical assessments, ADL (activity of daily living) sheets, and conversations with NAs. She reported she assessed Resident #71 as being totally incontinent of bowel and bladder. The nurse commented she had not been made aware of any</p>	F 315	<p>The QA committee will evaluate this plan monthly for 3 months and will adjust as indicated.</p> <p>Compliance date:4/10/11</p>		

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F 315	Continued From page 27 changes in the resident ' s continence/incontinence. According to the MDS nurse, Resident #71 wore briefs/pads as part of a protection/containment program. She reported nursing completed a Bladder Incontinence Evaluation form which accompanied resident Admission Interdisciplinary Assessments. However, upon reviewing Resident #71's medical record, she stated she was unsure why there was no such incontinence evaluation included in it. The MDS nurse explained the Bladder Incontinence Evaluation was important because it required observation to establish a voiding pattern, and evaluated the resident's perception of the need to void. At 11:02 AM on 03/11/11 the Director of Nursing (DON) stated a Bladder Incontinence Evaluation was not completed on Resident #71 because of his history of incontinence. She explained the resident ' s responsible party (a family member) was unable to care for him at home, in part due to his incontinence. According to the DON, this family member reported Resident #65 was wetting and defecating in the bed and furniture. The DON commented use of the urinal was not successful for Resident #71 because he emptied urine in the trash can, bed, dresser drawer, etc. The DON reported she was unaware of the resident being wet when he fell (although review of incident/accident reports revealed there was no documentation whether the resident was wet or dry).	F 315			
F 323 SS=G	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	F 323			

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F 323	<p>Continued From page 28</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide the supervision necessary to prevent 1 of 1 sampled residents (Resident #71), who exhibited exit -seeking behaviors and periodic confusion, from experiencing multiple incidents/accidents. Findings include:</p> <p>Resident #71 was admitted to the facility on 02/02/11. The resident's documented diagnoses included cerebrovascular accident, cardiovascular disease, degenerative joint disease, deep venous thrombosis, gait abnormality, and muscle weakness.</p> <p>A 02/04/11 11:00 AM Nurses Note documented, "(Resident #71) Attempt to get up out of bed (symbols used) unasst. (unassisted) balance et (and) gait unsteady. Bed et chair alarms placed on res."</p> <p>A 02/08/11 12:30 AM Nurses Note documented, "Bed alarm disconnected by pt. (patient). Attempted to re-connect but [the] found to have been urinated on. Replaced it with (symbol used) "personal" alarm.</p> <p>Nurse #6 documented in a 02/08/11 10:15 PM Nurses Note, "Resident was OOB (out of bed) in w/c (wheelchair) propelling self. Stated that he was going home. Stated he was going outside to</p>	F 323	<p>F 323</p> <p>1. Corrective action has been accomplished for resident #71; the resident is receiving adequate supervision and assistance to prevent accidents. Resident #71 has been reassessed for fall and elopement risks by the Interdisciplinary team and his care plan and C.N.A care guide has been updated and communicated to the residents care givers. The resident's medication regimen has also been reviewed by his physician. The resident's incontinence needs have also been assessed by nursing.</p> <p>2. Residents who have been identified at risk for falls, and elopement have the potential to be affected by alleged deficient practice.</p>	

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F 323	<p>Continued From page 29</p> <p>wait for a ride. Wanderguard was [place] on resident for safety on right (symbol used) ankle."</p> <p>Resident #71's 02/08/11 Admission Minimum Data Set (MDS) documented the resident's short term memory was impaired, the resident's long term memory was intact, and the resident 's decision making skills were moderately impaired. The assessment also documented the resident could be slow/fidgety/restless, and the resident did not reject care. In addition, it was documented the resident required limited assistance by a staff member with bed mobility and transfers, the resident was independent with walking in the room and locomotion on the unit, the resident required extensive assistance by a staff member with walking in the corridor and locomotion off the unit, the resident required extensive assistance by a staff member with toileting, the resident was unsteady in his balance with all tasks, and the resident was always incontinent of bowel and bladder.</p> <p>On 02/08/11 "Elopement risk as evidenced by: Resident talks about leaving facility and going home. Propels self throughout the facility in wc." was identified as a problem on Resident #71's care plan. The goal for the problem was, "Resident will not leave facility unattended." Interventions to the problem included, "Wanderguard anklet for alarm doors", "To remain on unit with alarm doors", "Picture at front desk and at nsg (nursing) stations in Wander Risk book", "Make sure all staff aware of elopement risk", "Check on resident location routinely", "Staff to accompany resident to and from locations prn (as needed)", "Distract resident from wandering by offering pleasant diversions, food, conversation, television", and</p>	F 323	<p>Therefore, residents were reassessed for falls and elopement risks on 3-6-11 by the ADON and/or treatment nurse. Residents who triggered at risk had their care plans and C.N.A care guides reviewed and updated where necessary by the IDT.</p> <p>3. Monitoring/Systems in place to ensure alleged deficient practice does not occur are:</p> <ul style="list-style-type: none"> Residents with falls, and behaviors requiring interventions such as elopement gestures shall have their charts, investigative follow-up reports, care plans, C.N.A. Care Guides reviewed by the IDT at the daily 		

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F 323	<p>Continued From page 30</p> <p>Likes to smoke and get sodas from vending machine".</p> <p>Nurse #6 documented in a 02/09/11 10:20 PM Nurses Note, "Alert with (symbol used) some confusion. Wanderguard in place. Continue to go to front door stating he is waiting for his ride."</p> <p>Nurse #6 documented in a 02/10/11 10:15 PM Nurses Note, "Res. (resident) continues to go to lobby looking for a ride."</p> <p>On 02/10/11 "Fall risk related to impaired mobility and psychotropic med use. Noncompliant; does not call for assistance with transfers and ambulation. "was identified as a problem on Resident #71's care plan. Goals for the problem included, "Resident will remain free from injuries." Interventions to the problem included provision of a bed and chair alarm and keeping the resident's wheelchair within reach.</p> <p>A 02/15/11 8:20 PM Nurses Note documented Resident #71 was taking the batteries out of his alarms and cutting his alarms off.</p> <p>A 02/17/11 11:30 PM Nurses Note documented, "Resident attempted to get OOB unassisted & fell onto floor ...no (symbol used) apparent injury noted..."</p> <p>A 02/19/11 10:30 PM Nurses Note documented Resident #71 was asking the staff for the keys to his car so he would not be late getting home.</p> <p>A 02/22/11 9:15 PM Nurses Note documented, "Nurse walked by room. Resident was on floor. Saw blood on floor. Resident was holding brief to head. Removed brief to evaluate head. Resident</p>	F 323	<p>clinical meeting.</p> <p>Those events occurring on week-ends or Holidays will be reviewed at the next working day's clinical meeting. The DON and/or administrator shall be notified of unusual occurrences such as falls with injury, elopements, and elopement gestures with injury requiring their guidance by telephone during non-business hours.</p> <ul style="list-style-type: none"> In-service Education was conducted on 3-6-11 by the DON subject:"Elopement prevention" which gave instructions to the staff when to contact the 		

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F 323	<p>Continued From page 31</p> <p>had a laceration left (symbol used) forehead ...____ (name of physician) gave the order to send to ER (emergency room)."</p> <p>On 02/22/10 the new interventions of "Resident removes alarm" and "Res. removes chair cushion" were added to Resident #71's care plan in regard to his fall risk.</p> <p>A 02/23/11 1:15 AM Nurses Note documented, "Returned from ER per EMS (emergency medical services) via stretcher. Steri-strips noted left (symbol used) side of forehead."</p> <p>02/23/11 10:35 PM and 02/26/11 10:15 PM Nurses Notes documented Resident #71 continued to get out of bed unassisted.</p> <p>A 03/03/11 12:45 AM Nurses Note documented, "Resident found sitting on floor. States he was trying to get his plate on top of the stove. There [is] no visible signs of injury ..."</p> <p>A 03/04/11 11:00 AM Nurses Note documented, "Resting in bed @ (at) this time, agitation noted earlier this AM, Ativan given with (symbol used) effectiveness, will cont (continue) to monitor. "</p> <p>A 03/04/11 10:30 PM Nurses Note documented, "Resident up (symbol used) OOB in w/c propelling self in w/c up & down hall looking for his brother"</p> <p>A 03/04/11 11:45 PM Nurses Note documented, Pt fell & injured Rt (right) arm. C/O (complains of) pain. No deformity or swelling noted. Alert to self. Confused of time & place. Is adamant that he wants to leave"</p>	F 323	<p>administrator and/or DON and frequency of monitoring resident with multiple attempts to leave the facility."</p> <p>In-services for licensed nurses and C.N.A.'s were conducted by the DON and/or ADON on 3-10-11 on the following topics." Completing Incident reports and follow-up investigative reports on falls and behaviors including elopement gestures, Updating care plans and C.N.A. care guides, notification requirements to DON, Administrator and/or DON, documentation of</p>	

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F 323	<p>Continued From page 32</p> <p>A 03/04/11 Incident/Accident Report completed by Nurse #2 documented, "Pt trying to gout all day. Went to west hall (rest home hall across the building from Resident #71 's room on the east hall)-out back door. W/C turned over spilling pt to grass. C/O Rt arm & shoulder pain. No deformity noted."</p> <p>A Fall Investigation report initiated by Nurse #3 on 03/04/11 documented the resident was toileted thirty minutes prior to going out the door, and " Resident has been attempting all day to get out of facility ..."</p> <p>The 24-hour report for 03/04/11 documented Resident #71 was sent for an x-ray of his right arm due to a fall, and received prn Ativan at 12:30 AM on 03/05/11.</p> <p>At 4:06 PM on 03/10/11 Nurse #4, who cared for Resident #71 on 03/04/11 first shift, stated she could not remember anything about the resident ' s behavior on 03/04/11 other than what she documented in her Nurses Notes. This nurse reported Resident #71 had a history of getting up unassisted to go to the bathroom, although he sometimes was unable to urinate or have a bowel movement once on the toilet. She commented the resident had a history of wandering and looking for "a way out of the building", although he had not eloped from the building before.</p> <p>At 4:13 PM on 03/10/11 Nurse #6, who cared for Resident #71 on 03/04/11 second shift, stated she was not absolutely sure, but thought she remembered the resident being in his room much of 03/04/11, coming to his room door frequently. This nurse reported she was not aware of the resident talking about wanting to or making</p>	F 323	<p>incidents on incident report forms, nurses notes, 24 hour nursing report, acute charting log and physician order form where indicated."</p> <p>An interdisciplinary team meeting comprised of nursing staff, activities, social service, administrator and regional nurse consultant was conducted by Maria Fisher from CCME on 3-31-11. The purpose was to identify systems failures and root cause analysis with regard to residents experiencing falls or other incidents/accidents.</p>	

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F 323	<p>Continued From page 33</p> <p>attempts to go home. (However, See Nurse #6's 02/08/11 10:15 PM, 02/09/11 10:20 PM, and 02/10/11 10:15 PM Nurses Notes in which she documented about the placement of Resident #71's wanderguard due to his desires to go home and meet a friend who would give him a ride).</p> <p>During a 03/10/11 11:40 AM phone interview with NA #6, who worked on the rest home hall on 03/04/11 third shift, she stated she was the first to reach Resident #71 after his 03/04/11 fall. She reported Resident #71 was on the rest home or West hall earlier in the evening of 03/04/11, around 8:00 PM. She commented it was not unusual for this resident to wander over to the rest home hall looking for snacks or talking to rest home residents/staff. According to NA #, she was standing at the rest home nursing station around 11:45 PM when she thought she saw something/somebody moving fast out of the corner of her eye. Seconds later she reported she heard a door alarm sounding, and rushed down the hall where she saw Resident #71 opening the last side door (when heading toward the back of the building). She stated the resident had to have come through the back cross hall and main dining room because the resident did not pass her at the nurse's station. According to NA #6, she yelled for Resident #71 to stop, but he kept going. She commented part of the resident's wheelchair crossed the threshold of the door, veered to the right on a concrete pad outside the door, and threw the resident in the grass beyond the pad. She reported the resident's wheelchair was still caught in the door.</p> <p>During a 03/09/11 11:18 PM phone interview with NA #4, who worked with Resident #71 on the nursing home hall on 03/04/11 third shift, she</p>	F 323	<p>Education on fall, Elopement and other potential accidents and injury prevention will be integrated into the facility new employee orientation program.</p> <p>4. Monitoring in place to ensure continued compliance:</p> <ul style="list-style-type: none"> The DON/ADON and/or MDS will review the Medical Record documentation, care plan, C.N.A. care guide, physician orders and/or unusual occurrence follow-up reports of every resident who experiences a fall, elopement gestures or attempts, at the 	

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F 323	Continued From page 34 stated the resident was up, fussy, and refusing to go to bed when she started her rounds shortly after 11:00 PM on 03/04/11. She reported Resident #71 had a trash bag packed with some pads and clothing, and the resident was adamant about going home to his house. NA #4 commented out-going staff informed her that the resident had been anxious, trying to leave the building, and talking about going home all day. She stated she informed the hall nurse (Nurse #2) about the resident's behavior. NA #4 reported no out-going staff mentioned to her about watching the resident more closely or documenting periodic checks on Resident #71. According to NA #4, as she and Nurse #2 were finishing up resident rounds, around 11:45 PM, she heard a door alarm going off on the other side of the building, and "just knew it was Resident #71." When she reached the side door on the rest home hall, she commented Resident #71 was in the grass beyond a concrete pad, and the resident's wheelchair was on the concrete pad. She reported the resident was taken back to his room and remained in his wheelchair while vital signs were taken. According to NA #4, Resident #71 was complaining of right shoulder and arm pain. She stated it took about an hour to get the paperwork and resident ready to be transported to the emergency room. The NA commented sometime before the rescue squad arrived the resident went to bed. She reported the resident was not gone more than two hours before he returned to the facility. Once he returned, the NA stated Resident #71 stayed in bed the rest of the night/morning. She estimated she tried to check on the resident about every thirty minutes (although this was not documented). She explained the resident's alarms were discontinued about two weeks prior	F 323	<p>daily clinical meeting. To ensure that the residents' needs have been appropriately documented and interventions are in place. Those staff identified as not following facility guidelines for care will either be re-in serviced and/or disciplined as appropriate.</p> <ul style="list-style-type: none"> The findings of these daily clinical meeting findings will be reported to the QA committee monthly for 3 months. The QA Committee will adjust this plan based on identified trends/patterns. <p>Compliance date 4/10/11</p>	

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F 323	Continued From page 35 to 03/04/11 because they were not working. According to NA #4, she told on-coming staff on 03/05/11 about Resident #71's incident. At 4:26 PM on 03/10/11 Nurse #2, who cared for Resident #71 on 03/04/11 third shift, stated NA #4 told her at the beginning of the shift that out-going staff informed her Resident #71 was anxious, attempting to leave the building, and talked about going home all day. Nurse #2 commented as she was making resident rounds she tried to check on the resident every time she passed his door. She reported she thought Resident #71 was in bed 15 -20 minutes before he attempted to exit the building. However, she commented the bed alarm was not on at this time because the resident urinated on it. In fact, she commented alarms were discontinued for Resident #71 about two weeks before 03/04/11 because they were not effective. Nurse #2 reported she heard a door alarm sound on the rest home hall around 11:45 PM, and when she was arrived at the door, Resident #71 was in the grass beyond a concrete pad. She stated she had to pick up clothes which had spilled from the bag on the resident 's wheelchair. Nurse #2 commented it was a good thing there was a concrete pad outside the door, because if the ground outside the door was flat, "we would have been up the creek." According to Nurse #2, Resident #71 was in the bed when the rescue squad came to pick him up for x-rays at the emergency room. When he returned to the nursing home, the nurse reported the resident stayed in bed the rest of the night/morning. She commented the staff tried to check on the resident anytime they passed his room door (although this was not documented). Nurse #2 stated she was not aware she was supposed to notify the DON or Administrator about Resident	F 323			

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F 323	<p>Continued From page 36 #71's exit from the building.</p> <p>A 03/05/11 1:10 AM (late insert) Nurses Note documented Resident #71 was transported to the emergency room.</p> <p>A 03/05/11 2:10 AM Nurses Note documented, "Report received from ___ (name of hospital emergency room) that resident does not have any injury to right (symbol used) shoulder et arm. What was seen on x-ray was due to degenerative arthritis."</p> <p>A 03/05/11 2:30 PM Nurses Note documented Resident #71 re-entered the facility after his emergency room visit.</p> <p>Record review revealed no more Nurses Notes until a 03/05/11 1:00 PM note which documented, "Resting in bed @ this time, A & O (alert and oriented) to name only. Increased (symbol used) agitation this AM & given prn Ativan with (symbol used) effectivenessWill cont to monitor."</p> <p>A 03/05/11 6:00 PM Nurses Note documented, "Resident fell onto floor attempting to go to bathroom unassisted....No (symbol used) apparent injuries noted"</p> <p>A 03/05/11 11:30 Nurses Note documented, "Resident up OOB, propels self in w/c around facility. No (symbol used) attempts to get OO (out of) chair."</p> <p>The 24-hour report for 03/05/11 documented Resident #71 received Ativan at 2:30 AM, was non-ambulatory, and "Fall 1800 (6:00 PM) x 2."</p> <p>A 03/06/11 4:00 AM Nurses Note documented,</p>	F 323		

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F 323	<p>Continued From page 37</p> <p>"Resident given Ativan PRN d/t (due to) OOB wheeling around facility, going into [others] rooms, finally went to bed with (symbol used) encouragement."</p> <p>A 03/06/11 2:30 PM Nurses Note documented, "Resident with increased (symbols used) agitation, attempting to go out of doors, attempted to reorient w/o (without) success, Ativan 0.5 mg po (by mouth) given."</p> <p>The 24-hour report for 03/06/11 documented Resident #71 was "post fall."</p> <p>During a 03/09/11 2:55 PM phone interview with Nurse #4, who cared for Resident #71 on 03/05/11 and 03/06/11 7 AM to 7 PM, she stated she could not remember whether Resident #71 was in or out of the bed on these days, or if he continued to exhibit wandering or exit-seeking behaviors. She reported that between the NA and herself, they checked on Resident #71 every 15 - 20 minutes, although this increased frequency of checks was not documented.</p> <p>During a 03/10/11 11:03 AM phone interview with NA #5, who cared for Resident #71 on 03/05/11 and 03/06/11 first shift, she stated she was not aware the resident exited the building or fell on 03/04/11. She reported Resident #71 stayed in his room or in his bed most of this time. She stated the resident 's bed rails were up, a table was beside his bed, and there were no alarms in use on these days. According to NA #5, she checked on Resident #71 as usual on 03/05/11 and 03/06/11, every two hours on rounds. She commented she was aware Resident #71 sometimes talked about leaving the facility and going home, but reported she had no seen the</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>resident make any actual attempts to leave the building.</p> <p>At 2:52 PM on 03/11/11 NA #7, who cared for Resident #71 on 03/05/11 and 03/06/11 second shift, stated she was not aware the resident exited the building or fell on 03/04/11. She reported she could not remember for sure where Resident #71 was in the building or what his behaviors were like on 03/05/11 and 03/06/11, but she checked on him every one to two hours on these days. NA #7 commented Resident #71 vocalized his desire to go home and packed a bag with clothes on occasions when she worked with him in the past.</p> <p>At 12:40 PM on 03/07/11 Resident #71 was resting in bed. There were no alarms on the resident's bed or chair, and the bed was in its regular position.</p> <p>At 9:54 AM on 03/08/11 Resident #71 was resting in bed. There were no alarms on the resident's bed or chair, the bed was in its regular position, and bilateral half rails were up on the resident's bed.</p> <p>At 9:03 AM on 03/09/11 Resident #71 was resting in bed. There were no alarms on the resident's bed or chair, and the bed was in its regular position.</p> <p>At 9:55 AM on 03/09/11 nursing assistant (NA) #1 examined Resident #71's room and confirmed there were no type of alarms (no bed, chair, personal alarms, or pad alarms) being used for the resident. She stated she thought alarms were no longer used for the resident because they were not effective.</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>At 10:28 AM on 03/09/11 the Director of Nursing (DON) stated on the night of 03/04/11 Resident #71 went out the last side door (heading from the front of the building to the back of the building on the rest home side or West hall) even though he was a nursing home resident on the East hall. She stated this West hall side door was not wanderguard compatible, but emitted a shrill alarming sound when the door was opened.</p> <p>At 11:45 AM on 03/09/11 the DON stated as long as there was a registered nurse in the building she did not necessarily expect the staff to notify her of a resident's exit from the building unless the resident got into the parking lot or near a highway. The DON reported she and the Administrator did not learn about Resident #71's 03/04/11 exit from the side door of the West hall until they entered the facility on the afternoon of 03/06/11. At that time, the DON explained she found a 03/04/11 Incident/Accident report written up by Nurse #2 concerning Resident #71 in her mailbox.</p> <p>At 12:11 PM on 03/09/11 the DON stated once she learned about Resident #71's incident/accident on 03/04/11 she thought it was beneficial to place the resident on documented 15-minute checks which were started at 7:30 PM on 03/06/11, and were still in place. The DON provided a copy of the sign-in sheet for a 03/06/11 in-service of staff in the building, and a copy of the in-service handout. This handout was entitled "Elopement Inservice", and documented, "If at any time a resident is attempting an elopement and is able to get outside the building I expect the hall nurse to notify the DON or the Administrator as soon as possible. The resident</p>	F 323			

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F 323	Continued From page 40 is to be secured back into the building and then placed on 15 minute checks if the elopement risk is still possible. Any resident who leaves the facility and gets into the parking lot has eloped. An incident report and assessment is to be completed as soon as the resident is secure in the building. If multiple attempts to get outside the building continue to occur the resident must be put on documented 1:1." The DON reported continued in-servicing of the rest of her staff (those who were not working at the time of the 03/06/11 in-service) was continuing today. At 11:02 AM on 03/11/11 the DON stated the facility had Standards of Care (SOC) meetings weekly in which they discussed falls. She reported any recommendations stemming from these meetings were to be documented in the Nurses Notes and flagged as SOC information. (Review of Nurses Notes in Resident #71's chart did not reveal any SOC notes). She stated different types of alarms were used for Resident #71 (bed, chair, personal alarms, clip alarms, pad alarms), and the resident was moved to a room closer to the nurse ' s station. At some point she commented the resident tore up his alarms, most likely before or after his 03/05/11 fall. (See interviews with Nurse #2 on 03/10/10 and NA #4 on 03/09/11in which they reported Resident #71 was without any alarms two weeks prior to his 03/04/11 fall). According to the DON, Resident #71's pad alarm to the bed was replaced on 03/10/10. In the absence of alarms, the DON stated she expected very close supervision of Resident #71.	F 323			
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive	F 325			

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F 325	<p>Continued From page 41</p> <p>assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the Registered Dietician recommendations were acted upon for a resident experiencing significant weight loss for one (1) resident of four (4) sampled residents (Resident #69); and failed to ensure fortified foods were provided for two (2) of four (4) sampled residents (Resident #s 35 and 42) with nutritional risk.</p> <p>The findings include:</p> <p>Resident #69 was admitted to the facility on 12/8/10, with diagnoses which included Dementia, Diabetes, Hypokalemia, Hypertension, Depression and Renal Failure.</p> <p>The admission Minimum Data Set (MDS) dated 12/10/10 assessed the resident as being capable of able to address preferences and needs for self. The resident was coded as being able to eat independently. Resident #69's nutritional status was evaluated as needing a special diet or altered consistency which may not appeal to the resident.</p>	F 325	<p>F 325</p> <p>1. Corrective actions for Resident#69, #35 and #42 have been accomplished:</p> <p>Nutritional recommendations for resident #69 are implemented per the resident's nutritional plan of care. Resident's #35 and #42 are receiving fortified foods as per physicians order.</p> <p>2. All residents have the potential to be affected by this citation. Nutritional recommendations will be followed-up on in a timely manner. The Registered Dietitian consultant will provide a copy of her nutritional recommendations to the Food Service Director, Director of Nursing and Administrator. The</p>	

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F 325	Continued From page 42 The assessment documented that a Care Plan would be developed to address the resident's nutritional needs. The Dietary Manager (DM) completed the Nutritional Screening admission assessment on 12/13/10. The resident's weight was recorded as 121 pounds (lb) and height 64 inches. The Admission Nutritional Screening form was blank for the resident's food preferences, past normal weight, weight loss/gain and nutritional history. The resident's IBW (ideal body weight) was 120 lbs plus/minus 10%, appetite was assessed as adequate and the resident did not have edema but did have a history of Gastroenteritis with severe diarrhea. On 12/30/10 the Registered Dietician (RD) reviewed, edited, and co-signed the DM's assessment. In addition, she wrote an addendum to the assessment. The RD's addendum documented the following: The resident's percent of intake for breakfast, lunch and dinner was 75-100%, no supplements. The diet order was for RCS (reduced concentrated sweets, fortified foods. SF(sugar free)Health Shakes TID (three times a day). Calories 1800-2400, Supplement -540 Kcl (kilo calories), Estimated Requirements 1750-1855; Protein 75-92, Supplement 18 grams, Estimated Requirements 53-63 grams; Fluid 1500-1600, Supplement 320 ml (millimeters), Estimated Requirements 1600 ml/day. The addendum documented that the resident's CBW (charted body weight) was 107.2 lbs on 12/28/10, and was reflective of a decrease of 3.5 lbs in three weeks and was plus/minus 98% of IBW. The RD documented, "D/T (due to) Dementia and Adjustment to NH (Nursing Home), pt(patient) has been assigned to Assisted Dining	F 325	Interdisciplinary team will review and follow-up on nutritional recommendations weekly in the standards of care meeting. Residents will receive fortified foods as ordered by the physician. Fortified foods will be identified on the resident's tray card. The fortified foods will be served per facility policy and established fortified foods menu. 3. Nutritional recommendations will be audited for follow-up on a weekly basis times 4 weeks and then monthly by the Director of Nursing and/or Nursing Supervisor. Diet order accuracy, to include orders for fortified foods and other physician ordered dietary interventions, will be audited monthly for 3 months by the Food Service		

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F 325	<p>Continued From page 43</p> <p>program. SF Health Shakes and fortified foods expected to fill caloric gap to promote weigh.. ..will conduct random meal rounds in Assisted Dining Room to evaluate and update food preferences. Continue weekly weights until stable." The RD's note on 12/30 addressed the resident's significant weight loss. Resident #69 weight for: 1/1/11 = 116 lbs 1/4/11= 111 lbs 1/11/11 = 113 lbs 1/18/11 =112 lbs 1/26/11 = 111 lbs</p> <p>On 1/11/11 the dietary progress note documented, " Resident on weekly weights, still having weight loss, receiving HS (bed time) Tr (snack) adding Med Pass 90 cc qid (four times a day) to prevent weight loss."</p> <p>The RD documented on 1/27/10, "The resident has significant weight loss, monthly weights down 4.4 % x 30 days, 4.3% x 4 weeks, 8.5 %x 8 weeks since admission. IBW-120 plus/minus 10%. Skin Stage 2 on outer ankle. Diet: RCS with fortified foods, SF Health Shake TID (12/30/10). Meal consumption records reveal 50-100% of meals. Med Pass 90 ml qid. Decubivite 1 tab by mouth daily x 30 days. The significant weight loss is related to erratic/sporadic po (by mouth) intake. Recent use/add of supplementation is appreciated. CBW (charted body weight now below IBW at 93%, further weight loss is contraindicated. The RD recommends: "Appetite Stimulant Remeron 15 mg(milligrams) QHS(every bedtime) and refer resident to Supervised Assistive Dinning Program, continue weekly weights and follow up on meal rounds.</p>	F 325	<p>Director.</p> <p>Results of the nutritional recommendations and diet order accuracy audits will be reviewed at the facility QA meeting by the DON and Food service director for 3 months. The QA committee will adjust this plan based on identified trends and patterns.</p> <p>Compliance date: 4/10/11</p>	

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F 325	<p>Continued From page 44</p> <p>Resident # 69 was observed sitting at the bedside table in the room on 3/8/11 at 12:15 p.m., eating lunch. The meal consisted of 4 ounces (oz) of Mighty shake, vanilla ice cream, corn, fish nuggets, green beans, tea, water and a roll. The resident ate 100% of ice cream and Mighty Shake but took very little of the other items. The resident stated, "I don't want any more." Nurse # 5 passed by the resident's room and noted the surveyor's presence, she then attempted to encourage the resident to eat.</p> <p>During an Interview with the CNA # 9 on 3/8/11 at 12:50 p.m., she reported the resident eats better at breakfast, usually 90-100% of the meal.</p> <p>On 3/9/11 at 8:00 a.m., the resident was observed eating breakfast in the bedroom, the resident consumed approximately 90% of the meal.</p> <p>The resident was observed eating lunch alone in the bedroom on 3/9/11 at 12:40 p.m., less than 10% of the meal was eaten and did not drink all of the health shake. Resident # 69 state, "I am finished, maybe someone else needs it." The resident's conversation became disjointed and confused after a minute or so.</p> <p>Resident # 69 was not observed eating any meals in the Supervised Assistive Dining program. During an interview with the DM on 3/8/11 at 4:15 p.m., she stated she had consulted with the RD regarding the resident's weight loss. She further stated that the RD is requesting that the resident go to the Supervised Assistive Dining Program.</p> <p>During an interview with the Dietary Manager on 3/8/11 at 4:15 p.m., she stated that Resident</p>	F 325		

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F 325	<p>Continued From page 45</p> <p>#69, had not attended the Supervised Assistive Dining Program as recommended by the RD on 12/30/10. She also confirmed the RD's recommendation on 1/27/11 for an appetite stimulant, Remeron 15 mg qhs(every night) had not been implemented.</p> <p>Interview with the Assistant Director on Nurses on 3/ 9/11 at 5:00 p.m, she confirmed that the resident had not been attending the Supervised Assistive Dinning Program and there was no documentation that the doctor had reviewed the RD's recommendation for an appetite stimulant for Resident # 69.</p> <p>The RD was interviewed on 3/10/11 at 12:12 p.m., she reported the process for acting on recommendations after her dietary assessments were made included:" I write a nutrition care document, some are directed at nursing some are directed at dietary. A copy is made and placed in DON's (Director of Nurses) mailbox. She stated she would expect the recommendations to be acted upon, usually within 7-10 days. The RD verified the recommendations made 12/30/10 for Supervised Assistive Dinning and 1/27/11 for an appetite stimulant had not been acted upon even when the resident continued to show a downward trend of weight loss. The RD had not monitored implementations of the recommendations. The RD stated, " The resident's weight loss is 9.4% in 90 days due to erratic, sporadic po intake, ranging from 50-100% per meal. Thought is that supervised dining would be helpful."</p> <p>The RD's note that was written on 3/7/11 further</p>	F 325			

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F 325	<p>Continued From page 46</p> <p>documented that the prior recommendations had not been acted upon. The note read, "Significant Weight Loss, CBW 110 lbs (3/1/11), down 9.39% x 90 days based on admission weight of 121 lbs. The resident's skin had healed." The meal consumption records revealed that resident consumes 50-75% (50% most meals), supplements and health shakes continued. Significant weight loss correlates with suboptimal inadequate po intake which averages more/less 1200 Kcal and 45 gm Protein which is only 60-70% of estimated requirements. Recommendation: Restorative Supervised Dining Program, increase SF MedPass 120 ml TID, Appetite stimulant if next weight reflects weight loss, attempt to identify/observe own food preferences."</p> <p>2. Resident #35 was admitted to the facility on 12/14/10 with a diagnosis of atrial fibrillation, hypertension, failure to thrive and Alzheimer's disease.</p> <p>An admission Minimum Data Set (MDS) assessment completed on 12/20/10 documented Resident #35 had short term and long term memory impairment, severe cognitive impairment and required extensive assistance from one staff member for eating. Review of Care Area Trigger (CAT) worksheet documentation identified Resident #35 as losing weight due to poor oral intake and at risk for further decline related to dementia progression.</p> <p>Resident #35's care plan, dated 12/23/10 and updated 01/20/11,01/27/11,02/01/11, and 02/10/11, listed at risk for altered nutritional status and weight loss as a problem. An</p>	F 325		

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F 325	<p>Continued From page 47</p> <p>intervention added 12/30/10 was to receive fortified foods.</p> <p>A physician's order was dated 12/30/10 for fortified foods on Resident #35 per the Registered Dietician's recommendations.</p> <p>A DIET ORDER FORM dated, 12/30/10 documented a diet change and to add fortified foods and continue regular mechanical soft diet.</p> <p>On 02/19/11 a DIET ORDER FORM documented Resident #35 was to receive a mechanical soft diet with fortified foods.</p> <p>On 02/24/11 there was a clarification physician's order for Resident #35 to receive a mechanical soft with puree meats and fortified foods.</p> <p>A DIET ORDER FORM dated 02/24/11 documented Resident #35 was to receive a mechanical soft diet with puree meats and fortified foods.</p> <p>A meal observation was done 03/08/11 at 12:30 PM of Resident #35. Observation of Resident #35's meal slip indicated she was to receive a health shake and ice-cream on her lunch tray which were present. Resident #35's diet was listed as mechanical soft with puree meat. The diet slip did not include fortified foods. Resident #35 was being fed by Nurse Aide (NA) #11. Resident #35 only took a few sips of the healthshake and a few spoonfuls of pureed meat.</p> <p>In an interview with NA #11 on 03/08/11 at 1:00 PM, NA #11 said Resident #35's appetite varied. NA #11 said Resident #35 averaged 25% to 50% for meal consumption. NA #11 said she did not</p>	F 325			

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F 325	<p>Continued From page 48 eat well for lunch.</p> <p>During an interview with NA #12 on 03/08/11 at 2:45 PM, NA #12 said Resident #35's appetite varied day to day. NA #12 said Resident #35 had to be fed and ate some days better than others.</p> <p>Weights reviewed on Resident #35 were 12/15/10 98.1 pounds, 01/04/11 91 pounds, 02/01/11 96.3 pounds, and 03/01/11 92.2 pounds.</p> <p>Review of the Consultant Dietician's note on Resident #35 dated 03/07/11 noted significant weight loss of 6.3% in 90 days. The diet in the note read mechanical soft with pureed meats and fortified foods.</p> <p>A meal observation was done 03/10/11 at 8:30 AM of Resident #35. Observation of her meal slip did not include fortified food.</p> <p>In an interview with the Food Service Manager (FSM) on 03/10/11 at 10:45 AM, she said if a resident was on fortified foods, it would be written on the dietary slip to alert dietary staff to place the fortified foods on the resident's tray. After review of Resident #35's clinical record with the facility's Dietary Consultant, the FSM said the fortified foods had not been discontinued on Resident #35 and should have been on the diet slip.</p> <p>During an interview with Nurse #8 on 03/10/11 at 10:50 AM, he said a resident's dietary slip indicated the prescribed diet a resident should receive. Nurse #8 said he would expect to see fortified foods listed on a diet slip for a resident that was suppose to receive fortified foods. After review of Resident #35's medical record, Nurse #8 said Resident #35 was to receive fortified</p>	F 325		

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F 325	<p>Continued From page 49 foods.</p> <p>The Director of Nurses (DON) stated in an interview on 03/11/11 at 8:45 AM that it was her expectation that a diet slip would have fortified foods listed if prescribed by the physician for nurse aide verification that fortified foods had been served on the tray.</p> <p>3. Resident #42 was admitted to the facility on 12/19/07 and readmitted on 09/11/08. The resident ' s documented diagnoses included senile dementia, mild rhabdomyolysis, glaucoma, and hypertension.</p> <p>A 05/28/10 Dietary Progress Note written by the facility ' s Registered Dietitian (RD) documented, " ...Diet: Pureed w/ (with) fortified foods, changed (symbol used) 4/8/10 from Mech (mechanical) soft w/health shakes/each meal ... "</p> <p>Resident #42 ' s Weight Record documented she weighed 79.4 pounds on 06/10/10.</p> <p>A 09/01/10 Dietary Progress Note written by the facility ' s RD documented, " ...Diet: Puree with (symbol used) fortified foods-total assist by staff in assistive DR (dining room), health shakes B/W (between) meals & (and) med pass 120 cc (cubic centimeters) QID (four times daily)receives Marinol-? (question) effectiveness re: (regarding) appetite; will decrease (symbol used) health shakes to q (each) day at 10 AM, con ' t (continue) with (symbol used) med pass QID "</p> <p>A 09/06/10 Nutritional Status Resident</p>	F 325			

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F 325	<p>Continued From page 50</p> <p>Assessment Protocol (RAP) documented, " Nature of condition: Resident leaves 25% of food uneaten and meals. Resident is also on a mechanically altered (pureed) diet. Complications and Risk Factors: Resident is at risk for wt (weight) loss. "</p> <p>Resident #42 ' s Weight Record documented she weighed 78 pounds in September 2010 (no specific date documented), 80.2 pounds on 12/1/10, 72.7 pounds on 01/01/11.</p> <p>A 01/06/11 Dietary Progress Note written by the facility ' s RD documented, " Significant Weight Loss: CBW (current body weight)-72.7 lbs (pounds) (down 9.4% x 30 days) ...Diet: Pureed w/fortified foods ...Will continue the current plan of nutritional support, will add ice cream to dinner meal "</p> <p>A 01/27/11 physician ' s order discontinued the administration of Marinol to Resident #42.</p> <p>Resident #42 " s Weight Record documented she weighed 71.3 pounds on 02/01/11.</p> <p>The resident ' s 02/28/11 Quarterly Minimum Data Set (MDS) documented Resident #42 was severely impaired in cognition (per staff assessment), required extensive assistance by a staff member with eating, presented with swallowing disorder, was on a mechanically altered diet, and had a stable weight.</p> <p>Resident #42 ' s Weight Record documented she weighed 69.2 pounds on 03/01/11.</p> <p>A 03/07/11 Dietary Progress Note written by the facility ' s RD documented, " Significant Weight</p>	F 325		

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F 325	<p>Continued From page 51</p> <p>Loss: CBW-69.2 lbs (down 13.7 % x 90 days) ...Diet Pureed w/fortified foods ...Recommend: 1. an appetite stimulant-Remeron Q HS (every night) 2. continue weekly wts x 30 days 3. update food preferences. "</p> <p>At 12:50 PM on 03/08/11 Resident #42 was being fed in her room by a nursing assistant. The resident ' s tray slip did not document the resident was to receive fortified foods.</p> <p>At 8:50 AM on 03/09/11 Resident #42 was being fed in her room by a nursing assistant. The resident ' s tray slip did not document the resident was to receive fortified foods.</p> <p>At 4:49 PM on 03/09/11 nursing assistant (NA) #13 stated Resident #42 was supposed to be fed in the assistive dining room, but since a recent fall with injury the resident was being fed in her room where she would be more comfortable. The NA reported the resident had to be fed by staff, and was on a pureed diet. She commented NAs were supposed to compare tray slips to the food on resident trays as they set them up. However, she remarked the accuracy of diet prescription would be something better determined by the dietary staff in the kitchen.</p> <p>At 5:52 PM on 03/09/11 Resident #42 was being fed in her room by a nursing assistant. The resident ' s tray slip did not document the resident was to receive fortified foods.</p> <p>At 8:55 AM on 03/10/11 the dietary manager (DM) provided a copy of the Menu for Fortified Foods, and explained the facility offered fortified foods at two meals daily. The DM reported all residents on fortified foods received super cereal</p>	F 325		

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F 325	<p>Continued From page 52</p> <p>at breakfast which was a hot cereal such as oatmeal or grits. She stated butter, cream, sugar, and cinnamon were added to regular oatmeal, and cream and butter were added to regular grits. She commented the second meal at which fortified foods were offered alternated between lunch and supper when either fortified juice or mashed potatoes were offered at lunch or mashed potatoes were offered at supper. According to the DM, the pre-fortified juice was purchased from a vendor, and extra butter, cream, and/or cheese were added to regular mashed potatoes in order to fortify them. She reported the only way the dietary staff working at the trayline knew when to add fortified foods to resident trays was by looking at the tray slips which should have the words " fortified foods " printed on them.</p> <p>At 12:12 PM on 03/10/11 the DM reviewed Resident #42 ' s chart, and reported there was no physician ' s order to stop the provision of fortified foods.</p> <p>Review of Resident #42 ' s care plan revealed the intervention of " fortified foods " was crossed through for the 09/23/08 problem, " Alteration in nutrition AEB (as evident by) weight loss. "</p> <p>At 1:00 PM on 03/10/11 the facility ' s RD stated by providing fortified foods at two meals daily the facility could add an extra 300 to 500 calories a day to resident caloric intakes if these foods were eaten.</p> <p>At 2:48 PM on 03/10/11 the DM stated she did not know how fortified foods were removed from Resident #42 ' s tray slips. She reported approximately two weeks ago the facility did an</p>	F 325		

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F 325	Continued From page 53 audit in which resident tray slips were compared against the trays, and she did not realize at that time there was a problem with fortified foods not showing up on some resident tray slips. At 3:22 PM on 03/10/11 the PM cook stated the only way she knew residents were on fortified foods was to scan the tray slips when preparing the plates at the trayline. She explained the words " fortified foods " showed up under the diet section of the tray slips. She commented more calories and nutrients were added to grits, oatmeal, and mashed potatoes when residents received fortified foods. According to the cook, fortified mashed potatoes contained cream, butter, and sometimes cheese; fortified grits contained cream, butter, and cheese; and fortified oatmeal contained cream, butter, and syrup. At 9:48 AM on 03/11/11 the MDS nurse stated she was unsure why she crossed " fortified foods " off Resident #42 ' s care plan as an intervention to the problem of weight loss.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	F 328 1. Corrective action has been accomplished for resident #71; he is scheduled to have his toenails cut by the podiatrist. His care plan has been updated.	

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F 328	<p>Continued From page 54</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide 1 of 2 sampled residents (Resident #71), reviewed for Activity of Daily Living concerns and requiring extensive assistance from staff for hygiene, with toenail care. Findings include:</p> <p>Resident #71 was admitted to the facility on 02/02/11. The resident's documented diagnoses included cerebrovascular accident, cardiovascular disease, degenerative joint disease, and muscle weakness.</p> <p>The resident's 02/08/11 Admission Minimum Data Set (MDS) documented he required extensive assistance by a staff member with hygiene and bathing, but did not exhibit rejection of care. His Care Area Trigger (CAT) Worksheet for ADL (activities of daily living)/Rehabilitation Potential documented, "Resident is currently receiving therapy. Resident requires varying degrees of ADL assistance at present ...Resident believes he can be independent however this is not feasible"</p> <p>At 12:40 PM on 03/07/11 Resident #71 was in bed. His feet were uncovered. The resident's toenails extended approximately a half inch to three quarters of an inch from the ends of his toes, and were very thick and mycotic.</p> <p>At 9:54 AM on 03/08/11 Resident #71 was in bed. His feet were uncovered. The resident's toenails extended approximately a half inch to three quarters of an inch from the ends of his toes, and were very thick and mycotic.</p>	F 328	<p>2. Residents admitted have the potential to be affected by alleged deficient practice therefore, compliance rounds were made on 3-25-11 by the treatment nurse and any other resident identified with the need for toenail care has either been referred to Podiatry or has had toenails cut and trimmed by licensed nurses .Care plans and C.N.A care guides were updated as needed.</p> <p>3. Measures/systems in place to ensure continued compliance are:</p> <ul style="list-style-type: none"> Resident's toenails are to be checked daily by the C.N.A during am care and on the residents scheduled bath by the shower aide. The shower aide is to report long nails and 	

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F 328	<p>Continued From page 55</p> <p>At 9:03 AM on 03/09/11 Resident #71 was in bed. His feet were uncovered. The resident's toenails extended approximately a half inch to three quarters of an inch from the ends of his toes, and were very thick and mycotic.</p> <p>At 9:12 AM on 03/09/11 the Director of Nursing (DON) stated nursing assistants could cut non-diabetic nails unless they were thick and mycotic, and nurses could cut diabetic fingernails unless they were thick and mycotic. She reported a contracted podiatry service, present in the facility approximately every three months, usually cut diabetic toenails and any thick and mycotic nails. According to the DON, Resident #71's toenails needed to be cut by the podiatry service which she stated had not been in the building since this resident was admitted. She commented Resident #71 was usually resistive to the staff cutting his nails. She explained the facility was waiting until Resident #71's behaviors were under control before dealing with much nail care.</p> <p>At 9:14 AM on 03/09/11 the DON entered Resident #71's room, and examined Resident #71's feet. She stated the resident's toenails needed to be cut.</p> <p>At 9:27 AM on 03/09/11 Nurse #1, who cared for Resident #71, reported the resident did not exhibit behaviors on first shift so if care needed to be rendered, first shift was the best time to do such. She stated the resident sundowned, and frequently became anxious, irritable, and argumentative in the late afternoon and evening. According to Nurse #1, Resident #65 did not resist care on first shift.</p> <p>At 9:48 AM on 03/09/11 the medical records clerk</p>	F 328	<p>the assigned C.N.A. is to clip, clean and file the resident's long toenails. The exception is diabetics. In this case the C.N.A. is to report the need for diabetics nails to be cut to the charge nurse .The nurse is then to trim, file and clean nails appropriately. If the nails are thick and mycotic or if the licensed nurse feels that a podiatry referral is appropriate then that nurse may make that referral.</p> <p>The treatment nurse also checks fingernails and toenails during care and refer to the</p>	

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F 328	<p>Continued From page 56</p> <p>reported the contracted podiatry service was last in the facility on 02/25/11. She commented the podiatry service screened residents approximately two weeks before arriving on site to provide services. She stated she could add names to the list of residents drawn up by the podiatry service if nurses or nursing assistants made referrals to her for residents with diabetic, thick, or mycotic nails. According to the medical records clerk, she did not remember any staff members telling her about Resident #71's nails needing to be cut by the podiatrist.</p> <p>At 9:55 AM on 03/09/11 nursing assistant (NA) #1, who cared for Resident #71, stated the resident did not refuse care. She explained sometimes the resident argued about the provision of care, but when she talked with the resident about what care she needed to provide and why, the resident cooperated.</p> <p>At 10:12 AM on 03/09/11 NA #1 stated she did not remember Resident #71's toenails being long.</p> <p>At 10:50 on 03/09/11 the medical records clerk provided a copy of a list of all residents scheduled to be seen in the facility on 02/25/11 by contracted podiatry services (including residents placed on the list by the service and by the facility). Notations were made on the list of those residents who refused the service, were out of the facility at the time, or who did not have a signed order for the service. Resident #71 did not appear on the list.</p> <p>At 11:38 AM on 03/09/11 NA #2, a member of the shower team for four months, stated the shower team always examined resident nails during showers. She reported she told Nurse #5 (the</p>	F 328	<p>C.N.A, the charge nurse or to the podiatrist as appropriate. The condition of the nails will also be documented on the weekly skin assessments form.</p> <p>A calendar of podiatry requests and visitations will be maintained by medical records.</p> <p>In-service regarding the topic "care of fingernails, toenails and Podiatry referral" will be done before 4-10-11 by the DON and will be included in new employee orientation.</p> <p>4. Monitoring in place to ensure continued compliance:</p>	

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F 328	Continued From page 57 treatment nurse) that Resident #71's toenails were thick and mycotic. During a telephone interview with Nurse #4 on 03/09/11 at 2:55 PM she stated she worked with Resident #71 on first and second shift. This nurse reported even though it sometimes took a lot of encouragement, the resident usually allowed staff to provide care. She stated she was not aware that Resident #71's nails needed to be cut. At 3:22 PM on 03/09/11 the treatment nurse (Nurse #5) stated she was told by a member of the shower team that Resident #71's toenails needed to be cut. However, since cutting nails was not part of her responsibility, she told one of the hall nurses, although she could not recall which one. At 3:38 PM on 03/09/11 NA #3, who worked with Resident #71 some on second shift, stated the resident would let you provide care, but sometimes it was necessary to talk to the resident and explain what it was that needed to be done. She reported she was not aware that Resident #71's nails needed to be cut. During a 03/11/11 2:52 PM telephone interview with NA #7, who worked with Resident #71 some on third shift, she stated sometimes it took a lot of persuasion, but the resident usually allowed his care to be provided. She reported she was not aware that Resident #71's nails needed to be cut.	F 328	<ul style="list-style-type: none"> The treatment nurse will monitor and record the status of resident's toenails and fingernails on the weekly skin assessment form and give to the DON/ADON every week. <p>The Podiatry referral list will be maintained by the Medical Records nurse and will also be given to the DON/ADON weekly to ensure that residents needing toenails trimmed are referred to the Podiatrist.</p>		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	The results of these audits will be reviewed by the DON at the monthly QA meeting for 3 months. The QA committee will adjust		

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F 329	<p>Continued From page 58</p> <p>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, staff interviews and record review, the facility failed to provide medical justification for the increase in an antianxiety medication for 2 of 3 sampled residents (Residents # 39 and # 10) whose psychoactive medications were reviewed. Findings include:</p> <p>1. Resident # 39 was readmitted on 12/04/09 with cumulative diagnoses of Alzheimer's dementia, generalized pain and depression.</p> <p>Review of the March 2010 Medication Administration Record (MAR) indicated the</p>	F 329	<p>this plan based on identified trends/patterns.</p> <p>Compliance date 4/10/11</p> <p>F 329</p> <p>1. Corrective action has been accomplished for resident #39 and resident #10. Both residents have been assessed for behaviors by their physician, medication orders re-evaluated and re-adjusted based on resident's current needs.</p> <p>2. Residents with current orders for antipsychotic or anti-anxiety medications have the potential to be affected by the deficient practice, therefore; the DON/ADON/MDS Nurse and/or nurse supervisor have reviewed those residents' medical records including the physician orders, Care Plans, MAR and the Behavior monitoring forms to ensure appropriate monitoring and medication adjustments are in place.</p> <p>If the resident has received a routine or PRN medication antipsychotic or anti-anxiety drug without supporting diagnoses; without related behaviors documented; or without a care plan that lists non-pharmacological ways to approach behaviors, the Physician has been notified and the resident's medication needs have been re-evaluated by the physician.</p> <p>3. Measures/system in place to ensure that alleged deficient practice will not reoccur is:</p>	

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F 329	<p>Continued From page 59</p> <p>resident had an order for Ativan (an antianxiety medication) 0.5 milligrams (mg) every 12 hours as needed. The order had a start date of 12/09/09.</p> <p>Nurse's notes from 03/02/10 through 04/30/10 did not indicate Resident # 39 had behaviors or increased anxiety.</p> <p>DOCUMENTATION of BEHAVIOR sheets for 03/10 through 05/10 were reviewed. No behaviors were recorded for Resident # 39. Review of MARs for 03/10 through 05/10 indicated the resident did not receive any as needed Ativan.</p> <p>A nurse's note dated 05/01/10 at 3:00 PM, indicated Resident # 39 could be very agitated at times and resistant to care. The nurse documented during bathing and incontinent care the resident would be verbally abusive to staff. There was no corresponding Ativan documented as given on the MAR.</p> <p>On 05/03/10 at 9:30 AM, the nurse documented in the notes the resident screamed when receiving a shower. There was no Ativan documented as given on the MAR.</p> <p>On 05/06/10 at 1:00 AM, the nurse's note indicated the resident usually yelled at staff when care provided. The nurse added the resident talked to voices not heard by staff and called out for someone daily. There was no indication Ativan was used for Resident # 39.</p> <p>The June and July 2010 MARs indicated Resident # 39 received no Ativan. The June 2010 Documentation of Behavior Sheet indicated behaviors were exhibited on 06/04/10 at 5:00 PM.</p>	F 329	<ul style="list-style-type: none"> Behavior monitoring forms will be initiated and completed for each resident on a psychoactive drug. Behaviors specific to that resident will be identified. <p>Diagnosis or justification for the drug will be identified by the physician and written by the nurse when an order is received for all psychoactive drugs routine or PRN.</p> <p>Daily monitoring and recording of behaviors will be completed by the medication nurse every shift.</p> <ul style="list-style-type: none"> Nurse Notes will be written to support behaviors on the monitoring or if greater explanations are necessary. <p>AIMS tests will be completed by the nurse on initiation of a psychoactive drug, every 6 months or if condition changes.</p> <p>The Pharmacy consultant reviews the resident's drug regimen monthly and makes recommendations to the physician and to the nurse. These recommendations will be monitored by the DON for timely responses.</p> <p>Care plans for residents receiving psychoactive drugs will include non-pharmacological approaches to care needs.</p>		

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F 329	<p>Continued From page 60</p> <p>Ativan was not given at that time. Nurse's notes for June and July 2010 did not document behaviors for Resident # 39. Documentation of Behavior Sheets for July 2010 through October 2010 did not indicate the resident exhibited behaviors.</p> <p>A nurse's note, dated 08/03/10 at 11:30 PM, indicated Resident # 39 was easily agitated at times, but was able to be redirected and/or Ativan given as needed. No behaviors were documented in the nurse's notes for August 2010.</p> <p>On 08/19/10, Resident # 39 received Ativan 0.5 mg. There was no indication on the back of the MAR why the medication had been given or any documentation of effectiveness.</p> <p>On 09/02/10, Physician Progress Notes indicated the resident was combative at times.</p> <p>On 09/17/10 at 2:45 PM, a nurse's note indicated the Standard of Care (SOC) team had reviewed Resident # 39 for behavior management. Medications were reviewed. There was no documentation of alternate methods of managing the resident's behaviors other than medication. At this time, Ativan was added to the care plan.</p> <p>Resident # 39 did not have Ativan documented as received on the September 2010 MAR. There were no nurse's notes that indicated the resident had exhibited behaviors during the month.</p> <p>On 10/21/10 at 1:55 PM, the SOC team reviewed the resident's behaviors and medications. No alternate plans were documented to attempt resolution of the resident's behaviors.</p>	F 329	<p>Documentation of behaviors and administration of psychoactive drugs will be reviewed by the IDT at the weekly standards of care (SOC) meeting. The physician will be notified of any concerns. Nurses failing to document behaviors will be identified, re-in serviced or disciplined as necessary.</p> <p>The 24 hour nursing report, physician orders, resident change of condition forms and incident reports will be reviewed at the daily clinical meeting by the DON/ADON and/or MDS nurse.</p> <p>Licensed nurses and C.N.A.'s have been in-serviced by the DON on 2-10-11 on the following topics: "identifying and documenting resident behaviors. Assessing residents for pain that may increase resident behaviors. The regulations requiring justification for use of this category of drugs. AIMS testing, what it is and why it is done."</p> <p>4. monitoring to ensure continued compliance:</p> <ul style="list-style-type: none"> Behavior monitoring forms will be monitored weekly times 4 weeks by the DON/ADON or MDS nurse. <p>Physician orders for new orders for psychoactive medications or an increase in dosages or frequency will be reviewed by the IDT at the daily clinical meeting. Questions pertaining to these orders will be referred to the physician for clarification. Clarification orders and nurses notes will be written as necessary.</p>	

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F 329	<p>Continued From page 61</p> <p>The October 2011 MAR indicated the Resident # 39 received Ativan 0.5 mg one time on 10/30/10 at 8:00 AM for severe agitation. The response was listed as effective. There were no behaviors listed for 10/10 on the DOCUMENTATION OF BEHAVIOR sheet. There were no nurse's note for 10/30/10 describing the resident's behavior or other methods of addressing the resident's behaviors prior to medication administration.</p> <p>The November 2010 MAR indicated Resident # 39 received as needed Ativan 0.5 mg twice. Once on 11/03/10 and once on 11/06/10. There was no reason for giving the medication or effectiveness listed on the MAR. The DOCUMENTATION OF BEHAVIOR SHEET did not list any behaviors for these days. There were no nurse's notes for 11/03/10 or 11/06/10 indicating non-pharmaceutical methods had been attempted in dealing with the resident's behaviors.</p> <p>On 11/17/10 at 12:00 PM, the nurse documented in the notes the baseline for Resident # 39 was yelling out. The nurse further indicated the resident was very demented and had no abnormal behaviors.</p> <p>Resident # 39's care plan, last revised on 11/18/10, indicated Resident # 39 exhibited inappropriate behaviors such as hitting and cursing at staff. Interventions to ensure the resident's improved cooperation with ADL care included attempting to converse with the resident, stopping care for a while, asking permission to begin care and explaining what will be happening, offering resident the opportunity to participate in care, provide comfort measures and if the resistance worsens stop care and return later. The care plan also identified the resident was</p>	F 329	<p>The night nurses will monitor the behavior forms for documentation nightly for 30 days and review findings with DON.</p> <p>The DON will review the results of the audits with the QA committee monthly for 3 months. The QA committee will adjust this plan based on patterns and trends.</p> <p>Date of compliance: 4/10/11</p>

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F 329	<p>Continued From page 62</p> <p>receiving psychotropic medications that may cause discomfort and side effects. Interventions to ensure freedom from side effects included giving the medication as ordered, reviewing the medication for possible dose reductions every 3 months, monitor behavior every shift and document, observe for side effects. On the care plan was listed the resident received Ativan as needed.</p> <p>Nurse's notes for 11/19/10 at 8:00 AM indicated the resident spit her medications out. The nurse described this as normal for the resident and added she had no abnormal behaviors. On 11/20/10 at 10:30 AM, the nurse stated the resident did get agitated at times, but was easily redirected.</p> <p>The resident was listed as yelling and screaming on the DOCUMENTATION of BEHAVIOR sheet for 11/19/10 at 6:00 AM and 7:00 AM. Ativan had not been given to Resident # 39 on 11/19/10.</p> <p>Nurse's notes, dated 11/28/10 at 9:00 PM, indicated the resident complained of pain to her knee. Lortab (a medication used for pain) was given. Results of an X-ray indicated the resident had a fractured knee. A nurse's note, dated 11/30/10, indicated the family chose not to treat the fracture. The resident did not receive any pain medication for the remainder of the month.</p> <p>On 12/01/10, the facility received a physician's order to discontinue the as needed Ativan and give the resident Ativan 0.5 mg every 12 hours. The MAR did not reflect the resident had been assessed for pain prior to increasing the Ativan. The MAR did no reflect the resident had been given pain medication for her recently fractured</p>	F 329			

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F 329	<p>Continued From page 63 knee.</p> <p>There were no behaviors documented for Resident # 39 on the December 2010 DOCUMENTATION OF BEHAVIORS sheet.</p> <p>The resident's quarterly Minimum Data Set (MDS), dated 02/22/11, indicated the resident was usually understood and was sometimes able to understand others. The resident was coded as having impairment of her short and long term memory and severely impaired cognitive skills for daily decision making. The MDS indicated Resident # 39 had exhibited physical and verbal behavioral symptoms 1 to 3 days during the assessment period. Rejection of care did not occur.</p> <p>Review of the February 2011, Medication Administration Record, indicated Resident # 39 has scheduled Ativan 0.5 mg every 12 hours.</p> <p>The January and February 2011 DOCUMENTATION OF BEHAVIOR sheet indicated the resident had no behaviors listed.</p> <p>An observation was made on 03/08/11 at 2:50 PM. Resident # 39 was lying in bed with her eyes closed.</p> <p>An observation was made on 03/09/11 at 10:06 AM. The resident was sitting in a geriatric chair in the TV room. There were 8 other residents in the room. Resident # 39's head was drooped with her chin almost touching her chest. The resident's eyes were closed.</p> <p>An interview was held with Nurse # 5 on 03/09/11 at 10:38 AM. She stated she was the resident's</p>	F 329		

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F 329	<p>Continued From page 64</p> <p>hall nurse in September. Since then, her interaction had been treatments for skin tears. Nurse # 5 stated the resident did not like care of any kind including bathing or dressing. Resident # 39 did not like to take medication. During personal hygiene, the resident became combative and could be verbally abusive toward staff. Nurse # 5 stated she would "talk sweet" to the resident and at times would leave the resident to calm down before completing tasks.</p> <p>An interview was held with NA # 9 on 3/9/11 at 10:55 AM. She stated she worked with Resident # 39 at least 4 days a week. The NA stated the resident fights during any kind of care. The NA added she had the scratches to prove it.</p> <p>An interview was held with Nurse # 8 on 03/09/11 at 11:01 AM. Before giving medication, the nurse stated he would try talking with the resident, give some touches on the hand, try diversional activities. Nurse # 8 added that disorientation, hunger, or pain could cause anxiety and the exhibition of behaviors. If a resident exhibited anxiety he would do a pain assessment prior to medicating the resident for anxiety. The nurse stated if an as needed antianxiety medication was used, he was expected to document why medication was given and the effectiveness of the medication. Documentation could be in the nurse's notes, on the MAR, on the Documentation of Behavior sheet or the 24 hour report. Out of a week, Nurse # 8 stated he worked with Resident # 39 at least 3 to 4 times on the 7 to 3 shift. The resident could be combative at times. Nurse # 8 stated the most usual time for the resident to be combative was during her bath.</p> <p>An interview was held with the Assistant Director</p>	F 329		

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F 329	<p>Continued From page 65</p> <p>of Nursing (ADON) on 03/09/11 at 11:49 PM. The expectation for documentation of behaviors included documentation on the behavior sheet. A nurse's note should also be completed. If a resident receives an as needed medication, the nurse was expected to document on the MAR the reason for giving the medication and the effectiveness of the medication. A nurse's note should also be written. The ADON stated Resident # 39 had recently had a medication change and had become more calm. The resident would talk and get agitated during care. The ADON stated the use of an antipsychotic or antianxiety agent was justified through documentation. The ADON stated what was documented for Resident # 39 did not justify the change in medication from an as needed to scheduled twice daily. The ADON stated she would expect nurses to attempt interventions such as talking to the resident or reapproaching before medication was given. The ADON added that pain or hunger could make a resident agitated adding that Resident # 39 had suffered a fracture recently.</p> <p>An interview was held with the Director of Nursing (DON) on 03/09/11 at 2:54 PM. The expectation was for nurses to document behaviors on the Documentation of Behavior sheet. If a resident is combative or not easily directed, the behavior should also be documented in the nurse's notes. If an as needed medication was used, the nurse was expected to document on the back of the MAR. The information on the back of the MAR should include time, date, medication, reason used and the effectiveness of the medication. The DON stated documentation of behaviors was important to relay information to other staff, to alert the staff to targeted behaviors and to let</p>	F 329			

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F 329	<p>Continued From page 66</p> <p>other staff know if the medications were effective. Before giving the medication for anxiety, the DON stated she expected nurses to assess the reason for anxiety, try to redirect and/or calm the resident. The expectation would be for any interventions used prior to medication to be documented. The DON stated documentation was used to justify the use of an antianxiety or antipsychotic medication. The DON stated residents with severe dementia did not feel pain as normal people and were unable to communicate pain. She stated a fractured knee, such as suffered by Resident # 39, would probably cause pain. The DON stated unrelieved pain could contribute to increased anxiety and aggressiveness. The DON stated based on documentation on the behavior sheets, the MAR and the nurse's notes, the increase in the Ativan from an as needed basis to twice a day scheduled was not justified.</p> <p>An observation was made on 03/09/11 at 4:32 PM. The resident was sitting in a geriatric chair in the TV room. Her head was lying on the right arm rest. Resident # 39's eyes were closed. When her name was called, she smiled and said "hi honey". The resident did not appear agitated or anxious.</p> <p>A telephone interview was held with the consultant pharmacist on 03/14/11 at 12:31 PM. She stated if the as needed medication had only been used 4 times in 9 months and there were sporadic documentation of exhibited behaviors, she would not expect to see an increase in the antianxiety agent.</p> <p>2. Resident # 10 was admitted to the facility on 1/23/08 with multiple diagnoses which included</p>	F 329			

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F 329	<p>Continued From page 67</p> <p>Transient Cerebral Ischemia, Altered Mental Status, Depression and Insomnia.</p> <p>Review of the Physician's orders for January 2011, documented medication orders for Resident # 10 as: Ativan 1 mg (milligram) 1 tablet PO (by mouth) once daily at bedtime for marked anxiety, Ativan 0.5 mg 1 tab PO q (every) 6 hours as needed for mild anxiety, Ativan 0.5 mg take 2 tabs q 6 hours as needed for extreme anxiety. The start date for the Ativan was 12/20/10.</p> <p>A new Physician's order was written on 1/24/11 to discontinue all PRN (as needed) Ativan orders. Start Ativan 0.5 mg PO q am (every morning) and Ativan 1 mg PO q hs (bedtime). There was no Physician's progress note to document the rationale for the change from PRN Ativan to the routine morning dose of Ativan.</p> <p>The Medication Administration Record (MAR) documented that Resident # 10 received Ativan 0.5 mg 1 tab PRN on 1/3/11, 1/4/11, 1/17/11 for complaints of pain and anxiety. On 1/21/11, Ativan 0.5 mg 2 tabs given for increased agitation. There was no other documentation that the Ativan had been given as needed for behaviors.</p> <p>On the Physician's Orders for March 2011, the order read: Ativan 0.5 mg 1 tablet by mouth in the morning, Ativan 0.5 mg 2 tablets by mouth at bedtime.</p> <p>Review of the Behavior Monitoring Sheets for the months of January -March 9, 2011 did not reveal/ or support documented behaviors for the use of Ativan.</p>	F 329			

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F 329	Continued From page 68 The Consultant Pharmacist Note dated 1/5/11, documented Ativan 0.5 mg 2 tabs PRN q am for extreme agitation, Ativan 0.5 mg 1 tab PRN q am for mild, Ativan 1 mg q hs. The Pharmacist note also wrote: no behaviors documented on the Nurses Notes/ no behaviors documented on the Documentation of Behavior Sheets. The note communicated to discontinue all PRN Ativan. On 2/5/11 the Consultant Pharmacist noted that all PRN Ativan had been discontinued on 1/24/11. Now the resident is receiving Ativan 0.5 mg q am and Ativan 1mg q hs. The note did not address the rationale for Resident #10 's change from a PRN dose of Ativan to a routine dose of Ativan 0.5 mg q a.m. The Assistant Director of Nurses reported during an interview on 3/10/11 at 9:54 a.m., that she did not know why Resident #10's as needed dose of Ativan was changed to a routine daily dose. Review of the documentation with the ADON did not reveal a rationale for the additional routine dose of Ativan.	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	F 371			

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F 371	Continued From page 69 by: Based on observation, service representative interview, and staff interview the facility failed to maintain quaternary sanitizing solutions at the strength recommended by the manufacturer of the sanitizing system in use. Findings include: During food preparation observation, at 8:34 AM on 03/08/11, the AM cook took a rag from a red bucket of sanitizing solution, and wiped down the beverage area and her food preparation table in the kitchen. At 8:35 AM on 03/08/11 the cook tested the strength of the quaternary sanitizing solution in the bucket with a strip which registered 100 parts per million (PPM). The tip of the white plastic strip registered the strength of the solution by changing various shades of green. At this time the cook stated she was told by her dietary manager (DM) and service representative that the strips should register at least 200 PPM in quaternary solutions. She reported she made up a fresh bucket of sanitizer from the sanitizer dispensing system at the three-compartment sink at approximately 7:00 AM on 03/08/11. The cook commented maybe the strip was not registering correctly because the sanitizing solution in the bucket was now cold.	F 371	F 371 1.No specific resident was identified in this citation. 2.All residents have the potential to be affected by this citation. The sanitizing solution in the 3-compartment sink and the sanitizing buckets will be maintained at the strength recommended by the manufacturer. 3.The sanitizing solution in the 3-compartment sink will be checked using the appropriate test strips when the sink is set-up and again when cycle is completed. The sanitizer level will be recorded on an audit tool. The sanitizing solution in the sanitizing buckets will be checked using the	
	At 8:55 AM on 03/08/11 two tray pans, a cutting board, and assorted utensils were drying on the draining board of the three compartment sink. A strip which was used to check the quaternary solution in the sanitizing sink registered 100 PPM. At this time the DM stated the quaternary dispensing system at the three-compartment sink was changed about three months ago. She explained the staff used to have to add water to			

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F 371	<p>Continued From page 70</p> <p>the concentrated quaternary solution manually, but now the dispensing system mixed a predetermined amount of sanitizer and water when activated.</p> <p>At 8:50 AM on 03/10/11 the DM used a strip to check the quaternary solution at the three compartment sink. The inner part of the color-sensitive tip registered 200 PPM, but the outer edges of the tip registered 100 PPM.</p> <p>At 8:52 AM on 03/10/11 the DM used a strip to check the quaternary solution in the red sanitizing bucket. The inner part of the color-sensitive tip registered 200 PPM, but the outer edges of the tip registered 100 PPM. The cook stated she just made the bucket up from the three-compartment sink dispensing system at 8:45 AM, and the strip she used to check the solution at that time registered 200 PPM.</p> <p>At 11:45 AM on 03/10/11 the service representative responsible for servicing the sanitizing system in the facility ' s kitchen stated when he changed the sanitizer dispensing system at the facility ' s three-compartment sink he must have set the water temperature too high. He explained what was happening was the water was so hot that as it cooled down the sanitizing agent in the solution was dissipating. In addition, he reported the facility was not using the correct strips he left with them for the new three-compartment sink sanitizing system. He commented the white plastic strips with the tips that changed varying shades of green were not compatible with the new system, and were only meant to be used with the old system which was replaced. He stated all quaternary solutions in the kitchen should register at least 200 PPM.</p>	F 371	<p>appropriate test strips when they are prepared. The sanitizer level will be recorded on an audit tool. Any readings that fall below the recommended manufacturer strength will be corrected and reported to the Food Service Director.</p> <p>4. Audits will be done weekly times 4 weeks and the results of the audit tools will be reviewed at the facility QA meeting monthly times 3 months. This plan will be adjusted based on identified trends and patterns.</p> <p>Compliance date;4/10/11</p>	

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F 371	Continued From page 71 At 2:48 PM on 03/10/11 the DM stated she did not realize the wrong strips were being used to test the strength of the sanitizing solutions in the kitchen which were all made up from the dispensing system at the three-compartment sink. She commented the strips were changing color so she thought they were functioning okay. The DM reported the sanitizing solution in the three-compartment sink was changed three times a day after meals, and the quaternary solution in the sanitizer buckets was changed out every couple of hours. However, she explained the staff was only checking the strength of the solutions immediately after they were made up. At 3:22 PM on 03/10/10 the PM cook reported the sanitizing dispensing system at the three-compartment sink was changed out a couple of months ago. She stated the staff continued to use the same white plastic strips with the tips which changed varying shades of green, from the old sanitizing system, when checking the strength of solutions. The cook commented she had not noticed any problems with the strength of the solutions at the sink or in the buckets.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372	F 372	
	The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep the dumpster area free of standing liquids with the potential to breed insects		1. No residents were identified in this citation. Corrective action has occurred to ensure that the facility disposes of garbage and refuse properly.	

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F 372	<p>Continued From page 72 and rodents. Findings include:</p> <p>During the initial tour of the kitchen and associated food preparation/disposal areas which began on 03/06/11 at 4:00 PM, there were deep ruts in the ground to the left of the dumpster area. There was a light rain earlier in the day, and ten ruts were filled with standing water which ranged in depth from approximately three fourths of an inch to two inches.</p> <p>At 11:40 AM on 03/08/11, with no rain since early in the day on 03/06/11, the ten deep ruts to the left of the dumpster held from approximately two thirds to an inch and a half of standing water.</p> <p>At 11:21 AM on 03/09/11, with no rain since early in the day on 03/06/11, the ten deep ruts to the left of the dumpster held from approximately a half inch to an inch and a quarter of standing water.</p> <p>At 2:40 PM on 03/10/11, after heavy rain, the ten deep ruts to the left of the dumpster held from approximately one to three inches of standing water. At this time, the maintenance manager (MM) stated he had only worked in the facility for the last four weeks, but he thought the ruts to the left of the dumpster had been present for about five weeks. He stated the ruts were created when heavy trucks involved in a roofing project backed into soft land. He stated standing water near the dumpster area was not a good thing because flies and mosquitoes could breed off the stagnant liquid.</p> <p>At 2:48 PM on 03/10/11 the dietary manager (DM) stated she noticed the ruts near the dumpsters, but was unsure how long they had</p>	F 372	<p>2. The ruts behind the dumpsters were filled in with dirt; the areas smoothed over and seeded on 3-22-11.</p> <p>3. Monitoring to ensure corrective action:</p> <ul style="list-style-type: none"> The facility administrator has assessed the corrective action on 3-22-11 at the completion of the job to ensure it is complete and correct. The environmental director will keep the administrator informed at the daily clinical meeting if any damage to the grounds has occurred so repair can be prompt. The administrator will report findings at the monthly QA Meeting. 	

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F 372	Continued From page 73 been there or what caused them. She commented if water collected and stood stagnant in the ruts, this situation could increase the chance that roaches, flies, and mosquitoes could breed in the area.	F 372	F 428 1. Corrective action has been accomplished for resident #39 and resident #10. Both residents have been assessed for behaviors by their physician, medication orders re-evaluated and re-adjusted based on resident's current needs. 2. Residents with current orders for antipsychotic or anti-anxiety medications have the potential to be affected by the deficient practice, therefore; the DON/ADON/MDS Nurse and/or nurse supervisor have reviewed those residents' medical records including the physician orders, Care Plans, MAR and the Behavior monitoring forms to ensure appropriate monitoring and medication adjustments are in place. If the resident has received a routine or PRN medication antipsychotic or anti-anxiety drug without supporting diagnoses; without related behaviors documented; or without a care plan that lists non-pharmacological ways to approach behaviors, the Physician has been notified and the resident's medication needs have been re-evaluated by the physician. 3. Measures/system in place to ensure that alleged deficient practice will not reoccur is: • Behavior monitoring forms will be initiated and completed for each resident on a psychoactive drug. Behaviors specific to that resident will be identified. Diagnosis or justification for the drug will be identified by the physician and written by the nurse when an order is received for all psychoactive drugs routine or PRN. Daily monitoring and recording of behaviors	
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 pharmacist interview and record review the facility's consultant pharmacist failed to report to or make recommendations to the facility for 2 of 3 sampled residents (Resident # 39 and # 10) whose antianxiety medications were increased without medical justification. Findings include: 1. Resident # 39 was readmitted on 12/04/09 with cumulative diagnoses of Alzheimer's dementia, generalized pain and depression. Review of the March 2010 Physician orders indicated the resident had an order for Ativan (an	F 428		

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F 428	Continued From page 74 antianxiety medication) 0.5 milligrams (mg) every 12 hours as needed. Review of the Pharmacist Chart Reviews for July 2010 through October 2010, indicated the pharmacist documented a total of 1 documented behavior and 2 documented uses of as needed (PRN) Ativan for Resident # 39. Physician telephone orders, dated 12/01/10, indicated the PRN Ativan had been increased to Ativan 0.5 mg to be given twice daily at 8:00 AM and 8:00 PM. During the Pharmacist Monthly Chart Review, dated 12/04/10, the pharmacist indicated the PRN Ativan had been discontinued. The pharmacist indicated the PRN Ativan had been used twice during the month of November 2010. There was no documentation indicating the pharmacist questioned the increase in Ativan from PRN to scheduled twice daily. Review of Pharmacist Monthly Chart Reviews, from January 2011 through March 2011, indicated no behaviors were documented for Resident # 39. There was no documentation indicating the pharmacist alerted the staff or made recommendations that the Ativan was unjustified in the absence of behaviors. A telephone interview was held with the consultant pharmacist on 03/14/11 at 12:31 PM. She stated when an antianxiety medication was changed from an as needed basis to a routine schedule, she expected to see documentation indicating the resident's behaviors had increased and were unrelieved or uncontrolled by the as needed dosage. At times, the pharmacist added, if an as needed medication was used almost routinely, the physician would make the medication routine. The pharmacist added if the as needed medication had only been used 4	F 428	will be completed by the medication nurse every shift. • Nurse Notes will be written to support behaviors on the monitoring or if greater explanations are necessary. AIMS tests will be completed by the nurse on initiation of a psychoactive drug, every 6 months or if condition changes. The Pharmacy consultant reviews the resident's drug regimen monthly and makes recommendations to the physician and to the nurse. These recommendations will be monitored by the DON for timely responses. Care plans for residents receiving psychoactive drugs will include non-pharmacological approaches to care needs. Documentation of behaviors and administration of psychoactive drugs will be reviewed by the IDT at the weekly standards of care (SOC) meeting. The physician will be notified of any concerns. Nurses failing to document behaviors will be identified, re-in serviced or disciplined as necessary.	
			The 24 hour nursing report, physician orders, resident change of condition forms and incident reports will be reviewed at the daily clinical meeting by the DON/ADON and/or MDS nurse. Licensed nurses and C.N.A.'s have been in-serviced by the DON on 2-10-11 on the	

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F 428	<p>Continued From page 75</p> <p>times in 9 months and there were sporadic documentation of exhibited behaviors, she would not expect to see an increase in the antianxiety agent. The pharmacist reviewed her notes for Resident # 39, made during her 12/04/10, 01/05/11, 02/04/11 and 03/03/11 monthly pharmacy record review and stated she did not question the increase in the resident's Ativan. The pharmacist stated it was just an oversight.</p> <p>2. Resident #10's additional dose of a routine Ativan without a rationale was not addressed by the pharmacist.</p> <p>On 1/5/11 the Consultant Pharmacist Note documented that Resident # 10 was receiving Ativan 0.5 mg 2 tabs PRN (as needed) q am (every morning) for extreme agitation, Ativan 0.5 mg 1 tab PRN q am for mild agitation, and Ativan 1 mg q hs (every bedtime). The Pharmacist note also wrote, no behaviors documented on the Nurses Notes/ no behaviors documented on the Documentation of Behavior Sheets. The note communicated to discontinue all PRN Ativan.</p> <p>On 2/5/11 the Consultant Pharmacist noted that all PRN Ativan had been discontinued on 1/24/11. A new physician's order was written on 1/24/11 for Resident #10 for Ativan 0.5 mg q am and Ativan 1mg q hs. The Pharmacist note did not address the rational for the change in medication from a PRN dose of Ativan to a routine dose of Ativan 0.5 mg q a.m. after PRN Ativan had been discontinued. There was no additional documentation from review of the Nurses Notes</p>	F 428	<p>following topics: "identifying and documenting resident behaviors. Assessing residents for pain that may increase resident behaviors. The regulations requiring justification for use of this category of drugs. AIMS testing, what it is and why it is done."</p> <p>4. monitoring to ensure continued compliance:</p> <ul style="list-style-type: none"> Behavior monitoring forms will be monitored weekly times 4 weeks by the DON/ADON or MDS nurse. <p>Physician orders for new orders for psychoactive medications or an increase in dosages or frequency will be reviewed by the IDT at the daily clinical meeting. Questions pertaining to these orders will be referred to the physician for clarification. Clarification orders and nurses notes will be written as necessary.</p> <p>The night nurses will monitor the behavior forms for documentation nightly for 30 days and review findings with DON.</p> <p>The DON will review the results of the audits with the QA committee monthly for 3 months. The QA committee will adjust this plan based on patterns and trends.</p> <p>Date of compliance: 4/10/11</p>	

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F 428	Continued From page 76 or Documentation of Behavior Sheets for the months of January 2011- March 10, 2011 that indicated a rationale for an additional dose of routine Ativan. The Assistant Director of Nurses reported during an interview on 3/10/11 at 9:54 a.m., that she did not know why Resident #10's, as needed dose of Ativan, was changed to a routine daily dose. Review of the documentation with the ADON did not reveal a rationale for the additional routine dose of Ativan.	F 428		
F 497 SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497	F 497 1. No residents were identified in this citation. 2. All residents have the potential to be affected by alleged deficient practice. Therefore currently employed C.N.A's in-service hours were audited and in-services were given to all staff in order to meet the 12 hour minimum by the facility ADON/SDC (Staff Development Coordinator). 3. Measures and systems in place to prevent reoccurrence of alleged deficient practice are: <ul style="list-style-type: none"> • A competency check list was initiated for each C.N.A. And a schedule of monthly check offs and in-services for the year was developed. • The SDC will log attendance hours after each scheduled in-service on each employees individualized attendance record. • Those employees who are identified by the SDC as lacking in-service hours will be notified by the SDC that they need to meet the requirements or they cannot continue to work. • Monthly in-services will be scheduled and posted. 	
	This REQUIREMENT is not met as evidenced by: Based on review of the facility's inservice record for Certified Nursing Assistants (CNA) and staff interview, the facility failed to ensure twelve hours of required training was done by forty-nine (49) of forty-nine (49) employed CNA's.			

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F 497	Continued From page 77 The findings include: The facility provided a listing/ ledger for all training and the number of hours that had been provided over the past year for the CNA's. Review of the facility's training records for documented inservices that were provided for the Certified Nursing Assistants from March 2010-March 2011, revealed that all forty-nine (49) employed CNA's records indicated they had received less than the required twelve (12) hours of annual training. During an interview on 3/11/11 at 3:00 p.m., the Assistant Director of Nurses (ADON) stated she was responsible for the staff education. She and Nurse # 7 confirmed the ledger submitted contained all of the training topics and hours and those annual performance evaluations for CNA's were presently not being done.	F 497	4. Monitoring to ensure continued compliance will include: <ul style="list-style-type: none"> DON will audit records of attendance and skills check off lists weekly times 4 weeks and then monthly. The DON will report findings at the monthly QA meeting. For 3 months. The QA committee will adjust this plan based on trends and patterns. Compliance Date 4/10/11	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		

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F 520	<p>Continued From page 78</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a physician was an active participating member of the Quality Assurance and Assessment Committee.</p> <p>The findings include:</p> <p>Interview with the Administrator on 3/10/11 at 4:12 p.m. revealed she was the coordinator of the Quality Assurance and Assessment (QAA) Committee. She reported the committee members consisted of the Director and Assistant Director of Nursing, Environmental Director, Social Work Director, Central Supply, Rehabilitation, Activities and Dietary Manager. The QAA committee met monthly and quarterly. She further stated that quarterly meetings consisted of the Medical Director. The direct care staff and the Pharmacist Consultant are not attending the QAA meetings as of yet. Review of the attendance records revealed that the Medical Director attended a QAA meeting on 1/6/11. The documentation for QAA attendance was only from July 2010- January 2011. There was no evidence that a physician had participated in any other quarterly QAA Committee meetings. The</p>	F 520	<p>F 520</p> <ol style="list-style-type: none"> No residents were identified with this citation. Residents residing in the facility have the potential to be affected by the deficient practice. The facility has contracted with a new medical director on 3/1/11. <p>The facility medical director or a physician from his practice will participate in the facility's quality assurance committee meetings on at least a quarterly basis.</p> <p>The medical director will receive a copy of the dates of the QA meeting at least 30 days prior to the meeting so that he can attend the meetings. This notice will be mailed by the DON.</p> <p>The administrator will follow-up with a phone call approximately one week prior to the meeting date to ensure participation.</p> <p>If the medical director has a conflict and cannot participate in that scheduled meeting he will arrange to have a physician from his practice participate on his behalf.</p> <p>Attendance will be verified by signature on the QA signature attendance page.</p> <p>4. This attendance will be monitored by the administrator at each meeting for one year. If there is an issue regarding attendance, the facility administrator will contact the corporate medical director to call the facility medical director and resolve the issue.</p> <p>Compliance date:4/10/11</p>	

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F 520	Continued From page 79 Administrator verified that the physician's attendance and participation had been a problem in the past. She reported that did not have a formal way of involving the physician in the QAA process when they were not in attendance. The Administrator shared that the QAA Committee was not presently addressing issues or concerns related to wandering residents and/or elopements. She stated, " We talk about everything."	F 520			

DHSR CONSTRUCTION Fax: 919-733-6592

Apr 12 2011 11:31am P004/Q07

PRINTED: 04/11/2011
 5:00 PM 0001

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 08081 42 CFR 483.70(a) By observation on 3/28/11 at approximately noon the building construction was non-compliant, specific findings include the back wall of laundry was damaged.	K 012	K012 On April 5, 2011, the back wall of the laundry was repaired, and partially replaced by a contract construction company. These repairs, and the specified area will be monitored and observed by the Environmental Director on a weekly basis to ensure the area remains in compliance with Life Safety Code standards. This weekly monitoring shall continue for a period of three months, ending July 5, 2011.	4/5/11	
K 028 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and fire-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 08081 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the hazardous area was non-compliant, specific findings include both corridor doors to laundry did not close and latch tightly in their frames.	K 029	K 029 On April 4, 2011 the doors mentioned above were repaired to ensure proper closure and latch functioning by the facility maintenance department. These doors will be monitored weekly for proper operation by the Environmental Director. These weekly inspections will continue for 3 months ending on July 4, 2011. At that time monthly inspections will d be completed by the Environmental Director to ensure the doors remain in compliance.	4/29/11	

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

Judy A Carter

(X6) DATE
4-13-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution or other safeguards provide sufficient protection to the patients. (See Instructions.) Except for n following the date of survey whether or not a plan of correction is provided. For nursing home 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.

It is determined that disclosure 90 days re-disclosure 14

SPS

DHSR CONSTRUCTION Fax:919-733-8592

Apr 12 2011 11:31am P005/007
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856
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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
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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038	K 038 The company hired a contract construction company to install a sidewalk attaching to the above mentioned exits. The sidewalks will extend from the exit doors to a public way. Installations of the sidewalks has begun, and the estimated completion date is April 19, 2011. At the time of completion, the areas will be inspected by the facility Environmental Director to ensure work is complete with life safety building codes. With this being a fixed permanent installation, it will not be necessary to continue to monitor the area for completion/compliance, however the area will be monitored by the Environmental Director weekly for a period of three months to ensure no chipping or cracking occurs with the concrete. Weekly inspections to end June 19, 2011 and monthly inspections by the	4/19/11
K 047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the following exit access was observed as noncompliant: specific findings include exit access was not a solid path (easily maintained in inclement weather) to a public way (exit from 245, 249, 221, and the dining room)</p>	K 047		
K 047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p>	K 047		4/4/11
K 052 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the exit and directional sign was non-compliant, specific findings include an exit sign in dining room was not functioning properly.</p>	K 052		
K 052 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance</p>	K 052		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345374	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856
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K 052	Continued From page 2 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K047 On April 4, 2011 new Exit/direction signs were purchased and installed by the facility maintenance department. These Exit signs are high definition LED lighting signs. These Exit signs are tied in with the emergency lighting system. All facility exit signs will be monitored daily for a period of three month ending July 4, 2011. At that time weekly inspections of facility exit signs will be conducted by the Environmental Director.	4/15/11
K 069 SS=D	This STANDARD is not met as evidenced by: Surveyor: 08681 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the fire alarm system did not comply with NFPA 70 & 72, specific findings include documentation for smoke detector sensitivity was not available. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		
K 076 SS=D	This STANDARD is not met as evidenced by: Surveyor: 08681 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the cooking facilities did not comply with NFPA 96, specific findings include grease filters in the kitchen protective hood system was not properly installed. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	K 076		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 348374	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2011
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27858		
(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	
K 076	Continued From page 3 (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 This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 3/29/11 at approximately noon the full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage near the fire alarm panel)	K 076	K 069 New grease filters have been ordered for hood system. These will be in within the next 10 days. We will be in compliance with NFPA 96. They are the correct size and will be installed per manufacturer's directions. This will be monitored x1 by the Environmental director then on a routine monthly bases. This will be completed by May 5, 2011. K 076 We have moved our oxygen cylinders and concentrators to a larger room away from the fire alarm panel. As you enter this room all the full tanks and concentrators will be on th left side of the door and the empty ones will be on the right , all secured per regulation. Appopriate signage will be in place indicating full and empty containers. This will be monitored daily times 3 months by the maintenance department. Then the Environmental Director will monitor monthly on an ongoing basis.	4/13/11	