

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

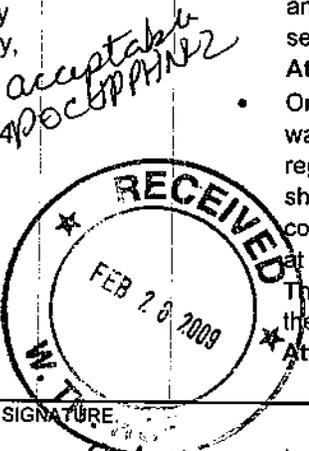
PRINTED: 02/18/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2009
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 000	INITIAL COMMENTS The annual re-certification and licensure survey was conducted on 2/2/09 through 2/5/09.	F 000	The plan of corrections is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations.	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on policy reviews, medical record review and interviews, it was determined the facility failed to resolve grievances related to lost clothing or smoking for 2 of 30 (Residents #24 and 26) sampled residents. The findings included: 1. Review of the facility's resident concerns and grievances policy documented "1. All significant residents concerns and grievances about the quality of care, services or behavior of other residents shall be directed to Quality, Advocacy and Risk Management...2. It is the duty of every employee to report such problems to the Quality, Advocacy and Risk Management..." 2. Medical record review revealed Resident #24 was admitted to the facility on 12/11/08 with diagnoses that included Cerebrovascular Accident, Hypertension, and Diabetes Mellitus Type 2. During an interview in Resident #24's room on 2/4/09 at 9:15 AM, Resident #24 voiced a concern over missing clothes. Resident #24	F 166	F 166 – Lost Clothing A. <ul style="list-style-type: none"> On 2/4/09 after trying to locate the lost clothing of resident #24 RN #2 immediately contacted laundry department to see if the misplaced items could be located. On 2/4/09 RN#2 also checked medical record for Resident #24 and found 2 inventory sheets for the resident, but none for list of admission clothing. (See Attachment 1) A grievance form was completed and filed by the Social Worker and sent to Risk Management. (See Attachment 2) On 2/5/09 an Educational in-service was given to nursing staff members regarding personal inventory sheets/personal items list to be completed and placed on the chart at admissions for each resident. The in-service was completed by the PCM on the B2 unit. (See Attachment 3) 	3/10/09



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Barbara Morrison</i>	TITLE <i>Acting Director</i>	(X6) DATE <i>2/25/09</i>
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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 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 166 Continued From page 1
stated, "I have a lot of clothes missing and they reach in my closet to take my clothes that are to be cleaned. I had three outfits that my sister bought for me and they were labeled and they are missing. I have reported this to the nurse and I want to file a theft report."

During an interview at the B2 nurses' station on 2/4/09 at 2:05 PM, Registered Nurse (RN #2) stated if a family member brings in belongings they take the belongings down to the front desk to be inventoried."

During an interview in Resident #24's room on 2/4/09 at 2:15 PM, Resident #24, RN #2 and Social Worker #1 were in a discussion of what took place with regards to the missing clothes. Resident #24 stated, "When I came here I had a bag of clothes and a pillow case filled with clothes. The bags came in with me on the ambulance ride. The staff accepted my clothes and put my name on it. I also had more clothes that did not have my name on it and someone took them and they never came back. This was reported to a nurse." RN #2 attempted to argue with Resident #24 and tell him when he came to the facility he had no clothes and he was wearing a hospital gown. Resident #24 stated, "My sister did not take my clothes. My clothes were lost in your establishment. [Named] CNT [Certified Nurse Technician #6] can tell you I had clothes." Resident #24 then obtained a receipt from his bedside table documenting the purchase of the 3 outfits that his sister had bought him and some were missing. RN #2 told Resident #24 on many occasions that he never had any clothes when he was admitted and that he always wore a hospital gown. Resident #24 was visibly upset about not being believed and started speaking in a louder

F 166

- All clothing has been found that was listed on the resident's personal inventory sheets.
- The resident had a receipt for the clothing that was brought to the facility upon admission. The clothing that was listed on the resident's store receipt has been found with the exception of one pair of pants. This pair of pants will be replaced by BLTC. A replacement pair of trousers was ordered by the Facilities Management Director on 2/23/09. (See Attachment 4)

B.

- An audit of each medical record on each unit will be conducted by the Medical Data Specialist (MDS) and supervised by the Patient Care Manager (PCM) unit to determine if personal inventory sheets are present for each resident. The MDS will compile a list of those residents that need inventory sheets completed. Once the list has been compiled the PCM will assign staff members to complete the inventory sheets for those that are missing. These inventory sheets will be completed by the MDS, CNT's, LPN's, Clothing Coordinator or Laundry Manager. The completed inventory sheets will be placed on the resident's chart.

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F 166 C.

- Upon admission all items for each resident are logged onto an inventory sheet by either the Resident Clothing Coordinator, Information Desk, PCM, Charge Nurse, Medical Data Specialist or by the CNT assigned to the resident.
- The PCM, Charge Nurse or Medical Data Specialist will audit the medical records of all newly admitted residents within 7 days of admission to BLTC to ensure that the inventory sheets have been completed and included in the resident's medical record.
- BLTC Education Department will educate Resident Clothing Coordinator, Information Desk, PCM, Charge Nurse or Medical Data Specialist staff regarding personal inventory sheets to be completed upon admission, readmissions and with any new items brought to residents. These items will also be sent to laundry to be labeled. Education to be completed by 2/25/09.
- Additionally, RN#2 will be educated on Customer Service by the Director of Employee Relations or DON/ADON and will apologize to the resident for the

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F 166

misunderstanding. RN#2 will attend manager training series to include topics such as Effective Communication, Managing Differences. These sessions are taught monthly by Director of Employee Relations beginning February 2009.

D.

- An audit of a 20% sample of new admission charts for inventory sheets will be conducted weekly by the Medical Data Specialist, Charge Nurse or Patient Care Manager. When the audits are 95% compliant for 4 consecutive weeks audits will be performed monthly. Once 95% compliance for 3 consecutive months is reached the audits will be completed quarterly. When the audits have been 95% compliant for 2 consecutive quarters the audits will be completed on an as needed basis at the discretion of the Director of Nursing. Results of the audits will be reported to Quality Council.

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voice. Social worker #1 repeatedly reassured Resident #24 that she did believe him, that he would be able to file a grievance with the risk management department, and she would make a copy of the receipt for the 3 outfits that his sister bought him. Resident #24 was apologetic to the Surveyor for being upset and stated, "I had to get my point across because no one believes me."

During an interview at the B2 nurses' station on 2/4/09 at 2:40 PM, CNT #6 stated, "His [Resident #24] sister did send new clothes up here, sent down to be labeled, have not seen them since ...happened about two weeks ago."

During an interview at the 2B nurses' station on 2/5/09 at 8:10 AM, RN #2 confirmed they were unable to find an admission inventory sheet for Resident #24.

3. Review of the facility's Smoking Policy dated 1/03 and reviewed/revise through 9/08 documented the following information: "Effective 8/6/07, residents may smoke outdoors with supervision only. Supervision may be provided by family or other visitors if they are deemed responsible and are age 18 or older. Administration may also approve supervision by sitters or private security guards...Residents with mental capacity who are reported to be in noncompliance with any part of this policy will be counseled and asked to explain the reason for the policy violation...Residents found to be in violation of this policy are subject to the following corrective measures: "Violation ...that cause grave safety concerns, such as smoking in the room, may result in involuntary discharge...Other violations not reaching the level of an immediate safety concern will be dealt with by an

F 166

F166- Smoking

- A.
- The Facility has and continues to have a smoking policy that it believes balances the Facility's responsibility to protect residents from the harmful effects of smoking and dangers of smoking related accidents with the desire of certain Residents to continue smoking after their admission to the Facility.
 - The Facility prohibited Resident #26 from continuing smoking because the Resident was noncompliant with the facility's smoking policy on at least six occasions, which are documented as smoking infractions in violation of the Facility's smoking policy. (See Attachment 5)

3/10/09

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F 166	Continued From page 3 incremental approach...first violation will require counseling with the resident ... and a letter explaining the violation and the policy rules...second violation...will require further counseling with the resident, a letter explaining the policy rules...After these first two violations the facility may take steps to ensure compliance that may include increased monitoring, searching the resident's room and belongings for smoking materials, and restriction of smoking privileges... Continued violation...may require that the resident make one of the following choices...must cease all smoking behavior at [the named facility]. (The medical staff and Social Services will provide reasonable support, as requested.) Or if the resident chooses to continue smoking, involuntary discharge proceedings will commence due to the threat towards the safety of others in the facility...Residents who choose the first option will be required to contract with the facility to cease smoking. The contract will also state that the resident understands any future smoking behavior will result in a return to involuntary discharge proceedings." Medical record review revealed Resident #26 was admitted to the facility on 10/13/06 with diagnoses including Cerebral Vascular Accident (CVA) with Left Hemiparesis and Speech Impairment, Dysphagia, Hypertension, Diabetes Mellitus, Anemia, Hypercholesterolemia and Palliative Care. Review of the Physician's History and Physical dated 11/18/08 documented "Psych [Psychiatric]: Anxiety; Tobacco abuse - nicotine withdrawal..." Review of the Physician's orders dated 11/18/08 documented the following: "D/C [discontinue] Paxil; Wellbutrin 150 mg [milligrams] po [by mouth] q [every] day x [times] 3 days - then Wellbutrin 150 mg po bid [two times a day] @ [at]"	F 166	<ul style="list-style-type: none"> On November 18, 2008, the Facility offered Resident # 26 access to smoking cessation medication (Wellbutrin) to assist with the resident's efforts to stop smoking. Resident #26 remains on the Wellbutrin regimen. (See Attachment 6) Additionally, the Facility offered Resident #26 access and referral to psychiatric services to address and respond to any effects that the requirement to stop smoking may have had on Resident's psycho-social well-being. This referral was offered on February 18, 2009 by the Social Worker, but Resident #26 refused to access or use the services that were offered. (See Attachment 7) On February 24, 2009 BLTC's social worker offered resident #26 an additional smoking cessation product Chantix. Resident #26 also declined this additional support to stop smoking offered by the Facility. (See Attachment 8) In response to the survey statement of deficiencies from February 5, 2009, the Facility will offer Resident #26 an additional opportunity to file a grievance requesting his smoking privileges be reinstated. The Facility will specifically advised Resident #26 of this opportunity, supplementing the previous ability Resident #26, and all other residents, had and continue to have express 	
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F 166	<p>Continued From page 4</p> <p>0800 & [and] 1600 - smoking cessation - 1st dose tonight @ 1600." Review of the annual Minimum Data Set (MDS) dated 2/28/08 documented Resident #26 with no short or long term memory impairments, independent regarding decision-making skills and no mood or behavior problems. Review of "Section I: Disease Diagnoses" documented Resident #26 had an Anxiety disorder. Review of the Quarterly MDS dated 11/19/08 documented Resident #24's cognitive and mood/behavior status was unchanged. The plan of care dated 11/18/2008 through 3/1/09 documented "MOOD: Resident has a history of depression and is at risk for reoccurrence, particularly with recent loss of smoking privileges. INTERVENTIONS: Resident will be encouraged to attend and participate in unit activities." Review of the plan of care dated 2/27/08 through 3/1/09 for Resident #26 documented "SMOKING - Potential for injury related to smoking. [smokes with supervision per new policy]. GOALS: Resident will adhere to new policy with supervision with no noted injuries. Thru [through] next review. INTERVENTIONS: All smoking material will be given to charge nurse; Requires yellow arm band to wrist; Alert Nursing Administration of any noncompliance per policy and Smoke in designated areas only". The Disciplines listed to oversee these Interventions included, LN [Licensed Nurse], CNT and SS [Social Services]. The plan of care failed to include an intervention for supervised smoking.</p> <p>Review of the Mini Mental State Examination for Resident #26 dated 10/15/07 documented a total score of 30. On 12/12/08 the exam was repeated with a score of 27/28. The highest score possible was 30. Areas tested were orientation, registration, attention and calculation, recall and</p>	F 166	<p>complaints about Facility services or rules. The Director of Risk Management or the Quality Manager will assist the resident in completing a grievance form if needed. This will be offered by 3/2/09.</p> <ul style="list-style-type: none"> The social worker will offer Resident #26 the opportunity to schedule a meeting to discuss Resident #26 and smoking behaviors and any grievances he may file. This meeting will include Resident #26, Administrator, ADON or DON, Patient Care Manager, Social Worker, Risk Manager, and Medical Director and/or attending Medical Staff if available. The meeting will be scheduled by 3/6/09 if the resident agrees. The purpose of the meeting will be to determine whether Resident #26 can commit to following the Facility's smoking policy without infraction and whether the resident should be allowed to resume smoking privileges. If Resident #26's smoking privileges are reinstated, the resident and the Facility will outline Resident #26's commitment to compliance with the facility's smoking policy and set forth Resident #26's agreement to act consistent with that policy. If smoking privileges are reinstated Resident #26's compliance with the smoking policy will be evaluated for compliance with the Facility's rules. If additional non-compliance with the Facility's smoking policy occurs, the Facility 	
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F 166	<p>Continued From page 5</p> <p>language. Review of the interdisciplinary progress notes date 10/22/08; 11/7/08; 11/18/08 at 2:00 PM; 11/18/08 at 10:30 PM; 11/20/08 and 11/22/08 documented Resident #26 "attempted to smoke, had smoking material on his person or expressed the urge to smoke." Review of the Social Services Progress Notes dated 11/11/08 at 11:15 AM, documented "Resident has expressed interest in discharge though he does not demonstrate independence with ADL's [activities of daily living]..."</p> <p>During the group interview in the recreation hall, on 2/3/09 from 2:00 PM to 3:00 PM, Resident #26 stated, "Only rule is about smoking privileges." Resident #26 stated, "It was hard to get someone on my floor to go down and smoke. Used to bring own cigarettes and would go smoke with another floor. Two to three months ago."</p> <p>During an interview in the 300 hall of the Ribeiro building, on 2/4/09 at 4:00 PM, Resident #26 was asked, "Is there anything that would make this facility more comfortable for you?" Resident #26 stated, "Not really, except for the smoking situation." When asked, "Do they make efforts to resolve your problems?" Resident #26 stated, "Basically yes, except the smoking." When questioned about the smoking situation, Resident #26 confirmed, "When I first came here I could go smoke unsupervised. Then they changed it to a technician had to go. Then it was changed to, I could only go down with a group, not by myself. You can ask for someone to take you down. If no one can, then you can't go smoke. In a week this could be once or twice a week. Now on this floor, a lot of the techs don't smoke, so we don't have anyone to take us. I wasn't the only one carrying</p>	F 166	<p>will require Resident #26 to discontinue his smoking on the Facility campus.</p> <p>B</p> <ul style="list-style-type: none"> The Director of Risk Management or the Quality Manager will contact the Patient Care Managers on each unit to ensure that complaints about the consistency of smoking times are forwarded to Director of Risk Management for consideration as a patient grievance. The Quality Manager reviewed the grievance log to determine the number of smoking grievances received in the last seven months (June 2008 - January 2009). Two residents voiced grievances related to smoking schedules during the time period of June 2008 - January 2009, both residents have been discharged. <p>C</p> <ul style="list-style-type: none"> The Facility's Administrator and Risk Manager have reviewed the smoking policy. Individual patient care units will continue to develop smoking schedules that fit their unit needs. The Risk Manager will revise the policy to reflect that the Facility commits to allowing current residents who smoke to smoke at least once daily, unless there are extenuating circumstances beyond the facility's control. The Risk and/or Quality Manager will discuss the revised smoking policy with each resident who smokes. 	
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F 166	<p>Continued From page 6</p> <p>cigarettes and a lighter on me and going to smoke unsupervised. Then when the tech started going with me and the group, then I had to stop carrying my lighter and cigarettes. So, they'd catch me with them and I'd have to sign a affidavit. I signed it, hoping I'd get my privileges back. I don't care if they come and search my belongings." At this point there were tears in his eyes. "I'm not perfect. I just want to smoke and I have to find someplace else to go to live and I don't want to. I like it here. It tears me up to be downstairs and see the others come down to smoke. I have to leave here to go someplace else to smoke. Sometimes I call someone to come pick me up to take me out, so I can smoke. Sometimes I catch the Access bus to take me to a mall, so I can buy a lighter and cigarettes and smoke there. When I get ready to come back, I have to throw those cigarettes and lighter away. That bus costs me three dollars every time and the cost of the cigarettes and lighter. It's uncalled for. I'm on a fixed income. I don't have that kind of money. That money comes out of my monthly money. I said I'm sorry, I broke the rules, if you'd only give me my privileges back. I won't break the rules again. I've smoked for 40 to 50 years. You just can't stop it like that. I told them I would follow the rules. They said, 'You said that before and broke the rules again.' I said, 'I know.' I begged them for another chance, but nothin' materialized."</p> <p>During an interview in the Administrator's office suites on 2/5/09 from 12:13 PM to 12:55 PM, the Administrator, the Risk and Quality Management and Resident Advocate, Social Worker #2 and Social Worker #3 confirmed the facility has no formal assessment tool to determine the safety competency level of a smoker. A Mini Mental</p>	F 166	<ul style="list-style-type: none"> • The Risk Manager will attend the next scheduled Family Council meeting on March 4, 2009 to discuss and update the Council on the revised smoking policy. • The Risk Manager will attend the next scheduled Resident Council Meeting to discuss and update the Council on the revised smoking policy. • The Risk Manager will solicit volunteers from nursing and departments outside of nursing to assist with smoking supervision. The Risk Manager or Quality Manager will create a schedule of volunteer staff to assist the Facility with escorting residents who smoke to the smoking area and/or supervising those residents. • Each volunteer assisting with the resident smoking will be in-serviced by the Risk Manager and/or Quality Manager. The in-service will include a review of the revised smoking policy and safety measures when supervising resident smoking. <p>D</p> <ul style="list-style-type: none"> • Quality Manager will analyze grievances received each month to determine if Residents express any particular problems with smoking times and frequency as a whole or on a given unit. 	
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F 166	<p>Continued From page 6</p> <p>cigarettes and a lighter on me and going to smoke unsupervised. Then when the tech started going with me and the group, then I had to stop carrying my lighter and cigarettes. So, they'd catch me with them and I'd have to sign a affidavit. I signed it, hoping I'd get my privileges back. I don't care if they come and search my belongings." At this point there were tears in his eyes. "I'm not perfect. I just want to smoke and I have to find someplace else to go to live and I don't want to. I like it here. It tears me up to be downstairs and see the others come down to smoke. I have to leave here to go someplace else to smoke. Sometimes I call someone to come pick me up to take me out, so I can smoke. Sometimes I catch the Access bus to take me to a mall, so I can buy a lighter and cigarettes and smoke there. When I get ready to come back, I have to throw those cigarettes and lighter away. That bus costs me three dollars every time and the cost of the cigarettes and lighter. It's uncalled for. I'm on a fixed income. I don't have that kind of money. That money comes out of my monthly money. I said I'm sorry, I broke the rules, if you'd only give me my privileges back. I won't break the rules again. I've smoked for 40 to 50 years. You just can't stop it like that. I told them I would follow the rules. They said, 'You said that before and broke the rules again.' I said, 'I know.' I begged them for another chance, but nothin' materialized."</p> <p>During an interview in the Administrator's office suites on 2/5/09 from 12:13 PM to 12:55 PM, the Administrator, the Risk and Quality Management and Resident Advocate, Social Worker #2 and Social Worker #3 confirmed the facility has no formal assessment tool to determine the safety competency level of a smoker. A Mini Mental</p>	F 166	<ul style="list-style-type: none"> All grievances will be reviewed and responded to in a timely manner with the target being within seven business days. Any grievances related smoking will be reported monthly to the Risk Management Committee. Grievances regarding smoking will be reviewed weekly for resolution. The compliance threshold will be that 95% of grievances are addressed in a timely manner. When 95% compliance is achieved for four consecutive weeks, the Risk Manager or Quality Manager will then conduct monthly audits of 50% of resident grievances related to smoking. When 95% compliance is achieved for three consecutive months audits will be conducted quarterly. When 95% compliance is achieved for 2 consecutive quarters audit will be done at the discretion of the Director of Risk Management. Results of the audits will be reported monthly in the Risk Management and Quality Committees. 	
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F 166	Continued From page 7 State Examination is used instead. Based on the test results, it is decided if a smoker is safe to smoke. Smoking is a privilege and taking the residents out is voluntary. If the techs are busy, we try to use volunteers from other services. When questioned, "Are you saying that when the staff is not available, they might not get to go out?" Their reply was "Yes." During an interview in the 300 hall Ribeiro building, on 2/5/09 at 2:50 PM, CNT #7 confirmed, "No, I have never seen [Resident #26] smoking in his room. No, I have never smelled smoke coming from [Resident #26's] room." During an interview in the Patient Care Manager's office on 2/5/09 at 2:52 PM, RN #4 stated, "No, I have never seen [Resident #26] smoking in his room. No, I have never smelled smoke coming from [Resident #26's] room."	F 166		
F 246 SS=E	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and group interviews, it was determined the facility failed to accommodate the needs of the residents related to access or answering call lights for 5 of 30 (Residents #3, 4, 12, 14 and 23) sampled residents and for eight Random Residents (RR	F 246	F246 Call light availability and responsiveness A. • On 2/2/09 Resident #1 was given an adaptive call light. On 2/2/09 Resident #2 call light was put within reach by licensed staff member. On 2/2/09 Resident #7 was given call light which was attached to his clothing. On 2/2/09 Resident #8 call light was attached to his wheelchair within resident's reach. On 2/2/09 Resident #9 was placed on resident's wheelchair within resident's reach. On 2/2/09 Resident #10 call light was attached to resident's pillow within resident's reach. On 2/2/09 the adaptive call light for Resident #3 was placed on resident's bed and attached to his pillow within reach. On 2/3/09 the call light for Resident #12 was placed within resident's reach while in the bed and in the geri chair. On 2/3/09 the call light for resident #14	3/10/09

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F 246	<p>Continued From page 8 #1, 2, 3, 7, 8, 9, 10 and 13).</p> <p>The findings included:</p> <p>1. Observations during the initial tour on 2/2/09 beginning at 8:45 AM revealed the following:</p> <p>a. RR #1 was in bed and called out for help because she needed pain medication. RR #1 was unable to press the call light due to contractures to the hands. During an interview in RR #1's room on 2/2/09 at 9:10 AM, Registered Nurse (RN #1) confirmed RR #1 was unable to press the call light and needed an adaptive call light.</p> <p>b. RR #2 was in a reclining chair in his room. The call light was on the bed out of RR #2's reach. During an interview in RR #2's room on 2/2/09 at 10:00 AM, Licensed Practical Nurse (LPN #1) confirmed the call light was out of RR #2's reach.</p> <p>c. RR #7's call light was on the floor beside the bed and out of RR #7's reach.</p> <p>d. RR #8's call light was hanging off the back of the bed, touching the floor and out of reach RR #8's reach.</p> <p>e. RR #9's call light was hanging off the back of the bed, touching the floor and out of RR #9's reach.</p> <p>f. RR #10's call light was behind the bed on the floor and out of RR #10's reach.</p> <p>2. Observations in Resident #3's room on 2/2/09 at 9:40 AM, revealed Resident #3's call light was clipped to a piece of tube on the wall, out of Resident #3's reach.</p> <p>During an interview on 2/2/09 at 9:40 AM, Certified Nursing Technician (CNT #1) confirmed Resident #3 could use the call light, but the call light was out of Resident #3's reach.</p>	F 246	<p>was replaced with a touch pad call light and was placed next to resident and clipped to bed within resident's reach. On 2/4/09 Resident #14 touch pad light was place within reach by the RN. On 2/4/09 Resident #23 call light was moved from the right side of the bed to the left by the CNT. On 2/4/09 Resident #23 call light cord was unwrapped from the right siderail and placed within reach by the RN. On 2/4/09 Resident #13 call light was placed within reach and clipped to mattress.</p> <p>B</p> <ul style="list-style-type: none"> Interviews will be conducted with competent residents by the Patient Care Manager (PCM's), Charge Nurse, Medical Data Specialist, or Social Worker regarding the availability of call lights, call light responsiveness, accommodation of needs and customer service. A sweep of the entire facility for call light availability and responsiveness will be done by the Medical Data Specialists, Unit Assessment Coordinators or Charge Nurse on each unit. Any deficiencies identified will be corrected immediately and reported to the Patient Care Manager 	
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F 246	<p>Continued From page 9</p> <p>3. Observations in Resident #4's room on 2/3/09 at 2:00 PM, Resident #4 activated the call light to say he needed to be cleaned up. A staff member answered the call light and stated, "Someone will be there." At 2:20 PM, Resident #4 activated the call light again to request help. Resident #4 activated the call light again. CNT #5 entered Resident #4's room at 2:45 PM and told Resident #4 as soon as she finished completing paperwork, she would be back to clean him.</p> <p>During an interview in Resident #4's room on 2/3/09 at 3:15 PM, Resident #4 stated he was cleaned of the incontinent episode at 3:10 PM.</p> <p>4. During the group interview in the recreation hall, on 2/3/09 at 2:00 PM, there were ten residents present that were deemed to be alert and oriented by the facility. Seven of the 10 alert and oriented residents in the group interview stated that staff did not answer the call lights in a timely manner. The residents also stated at meal time when the trays were being delivered or picked up and residents needed assistance they "are told they will have to wait" and may have to wait as long as an hour to receive the assistance needed.</p> <p>5. Observations in RR #3's room on 2/4/09 at 9:50 AM, revealed RR #3 lying in bed in with the adaptive call light clipped to the pillow, out of RR #3's reach.</p> <p>During an interview in RR #3's room on 2/4/09 at 9:50 AM, Licensed Practical Nurse (LPN #2), confirmed RR #3 was unable to access the call light.</p>	F 246	<ul style="list-style-type: none"> • Grievances will be developed by the staff member conducting the interview for significant or chronic concerns that are identified or those that cannot be resolved immediately. The PCM's will be responsible for the investigation of the grievances. Copies will be sent to Risk Management. <p>C.</p> <ul style="list-style-type: none"> • DON, ADON, Patient Care Manager (PCM), Nursing Supervisor, or Nurse Educator or Clinical Instructor will in-service the CNTs and licensed nurses on proper placement of call lights and prompt response times. Learning Objectives: <ul style="list-style-type: none"> ▪ Call light availability and responsiveness ▪ Call light placement not be wrapped around side rails. They should be clipped to bedding or pillows within resident reach when resident is in a geri chair, wheelchair or stationary chair. ▪ Location of clips on the units ▪ Maintaining Resident Dignity and Respect ▪ Customer Service ▪ ADC assistance during meals 	
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F 246 Continued From page 10

6. Observations in Resident #12's room on 2/3/09 at 8:10 AM, revealed Resident #12 in bed tilted to the right side, restless, throwing the covers back and asked for help in getting out of bed. Further observations revealed the call light was clipped to the left side of the bed near the top of the mattress and Resident #12 was attempting and unsuccessful in reaching the call light.

During an interview in Resident #12's room on 2/3/09 at 8:15 AM, Registered Nurse (RN #1) confirmed the call light was out of Resident #12's reach.

Observations and an interview in Resident #12's room on 2/3/09 at 2:50 PM, revealed Resident #12 in a reclined gerichair with the call light out of Resident #12's reach. Resident #12 stated she was "tired and want to go to bed."

During an interview in Resident #12's room on 2/3/09 at 2:50 PM, RN #5 confirmed that Resident #12 had been up much of the day and the CNT would be in the room "in a few minutes" to put her to bed. RN #5 also confirmed that Resident #12 could not reach the call light.

7. Observations and an interview in Resident #14's room on 2/3/09 at 9:07 AM, revealed Resident #14 was in bed with the call light on the right side of the bed clipped above her head and out of her reach. When Resident #14 was asked if she would like her call light she said "Yes."

During an interview in Resident #14's room on 2/3/09 at 9:08 AM, LPN #6 confirmed Resident #14's call light was out of reach. LPN #6 placed the call light in Resident #14's right hand, but Resident #14 she was unable to grip or hold it,

F 246

- PCM, Charge Nurse, Nursing Supervisor will make rounds on unit weekly to ensure call lights are properly placed for easy access.
- CNTs will be held responsible to ensure call lights are within reach at all times. LPNs will observe during daily rounds for call light placement and prompt response to resident requests

D

- A 20% sample of residents will be audited by the PCM weekly for call light availability and responsiveness, ADL assistance during meal time, and customer service weekly. When 95% compliance is observed for 3 consecutive week's audits will be completed monthly. When 95% compliance is achieved for 2 consecutive quarters the audit will be discontinued. Results of the audit will be reported at Quality Council.

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F 246	<p>Continued From page 11</p> <p>due to hand contractures. The call light slipped out of Resident #14's hand. LPN #6 stated, "We will get you a touch pad light."</p> <p>Observations in Resident #14's room on 2/4/09 at 12:15 PM, revealed the touch pad call light was located on the right side of the bed above Resident #14's head. The touch pad was not within Resident #14's reach.</p> <p>During an interview on 2/4/09 at 12:15 PM, RN #1 confirmed the touch pad was not within Resident #14's reach. RN #1 then placed the touch pad within Resident #14's reach. Resident #14 demonstrated the ability to activate the light.</p> <p>8. Observations in Resident #23's room on 2/3/09 at 9:40 AM, revealed Resident #23's call light was wrapped around the right side rail near the head of Resident #23's bed. The call light was hanging below the mattress. Resident #23 attempted to reach the call light.</p> <p>During an interview in Resident #23's room on 2/3/09 at 9:40 AM, Resident #23 stated, "Where is it [call light], I can't reach it."</p> <p>Observations and an interview in Resident #23's room on 2/4/09 at 8:45 AM, Resident #23's call light was wrapped around the right side rail near the head of Resident #23's bed. Resident #23 attempted to reach for her call light and stated, "I can't reach it [call light]."</p> <p>During an interview in Resident #23's room on 2/4/09 at 8:47 AM, RN #1 confirmed the call light was out of Resident #23's reach. RN #1 placed the call light in the Resident #23's hand.</p>	F 246		
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F 246 Continued From page 12
Observations in Resident #23's room on 2/4/09 at 10:13 AM, revealed Resident #23's was tilted to the left. Resident #23's call light was clipped to the right side of the bed tucked under the pillow, out of Resident #23's reach. Resident #23 attempted to reach for the call light but could not find it.

During an interview in Resident #23's room on 2/4/09 at 10:13 AM, CNT #2 confirmed the call light was out of Resident #23's reach. CNT #2 placed the call light within Resident #23's reach. Resident #23 demonstrated that she was able to turn the call light on when she was able to reach it.

Observations and an interview in Resident #23's room on 2/4/09 at 1:00 PM, revealed Resident #23's call light was wrapped around the right side rail toward the head of the bed. Resident #23 was asked if she could reach her call light. Resident #23 stated, "They [staff] moved it again "

During an interview in Resident #23's room on 2/4/09 at 1:00 PM, RN #1 confirmed the call light was out of Resident #23's reach. RN #1 removed the call light from the side rail and placed it in Resident #23's hand.

9. Observations in RR #13's room on 2/4/09 at 10:25 AM, revealed RR #13's touch pad call light was clipped above RR #13's head, out of her reach.

During an interview in RR #13's room on 2/4/09 at 10:25 AM, CNT #4 confirmed the call light was out of RR #13's reach.

F 246

F248

A

- Resident #11 and #26 were informed of changes made to the location of the pool table on 2/24/09 by the assigned social worker. Resident #26 states however, that he was not in attendance at the Resident Council meeting held during the survey. (See Attachment 9)

3/10/09

F 248
SS=D
483.15(f)(1) ACTIVITIES

F 248

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F 248	<p>Continued From page 13</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes, observations, the group interview, and individual interviews, it was determined the facility failed to ensure 2 of 10 (Random Resident #11 and Sampled Resident #26) alert and oriented residents in the group interview were provided with activities to meet their individual needs related to the pool table not being accessible to residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Resident Council Meeting" minutes dated 12/10/08 documented "The pool table is pushed to the back. Residents want to know if it is possible that it can be moved." 2. During the group interview in the recreation hall near the Floor 1 Cafeteria on 2/3/09 at 2:00 PM, Random Resident #11 and Sampled Resident #26 expressed concerns that the pool table in the Recreation Hall was unavailable for resident use. The resident stated money had been donated to the facility and the men had requested a pool table for their use. <p>Observations in the recreation hall on 2/3/09 at 2:00 PM, revealed the pool table was located against the wall and unavailable for resident use.</p>	F 248	<p>B.</p> <ul style="list-style-type: none"> • A called Resident Council Meeting will be scheduled by 3/10/09. • Residents will be informed of policy development and plans related to relocation and movement of resident pool table by the Director of Social Services and Recreation at the meeting. <p>C</p> <ul style="list-style-type: none"> • The Director of Social Services and Recreation will formulate a policy regarding location and movement of the pool table and in-service Recreation Coordinators on the policy. The policy will be forwarded to the Director of Facilities Management who will in-service Facilities and Environmental Services staff including Housekeepers, and Environmental Services Techs. • The objective of this in-service is to ensure that staff: <ul style="list-style-type: none"> ▪ Is aware of the concern related to accessibility of the pool table for residents and ▪ Why limited movement of the pool table is important, and ▪ Their responsibilities in returning the pool table back to a location accessible for residents. 	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2009
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 248 Continued From page 13

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 review of resident council meeting minutes, observations, the group interview, and individual interviews, it was determined the facility failed to ensure 2 of 10 (Random Resident #11 and Sampled Resident #26) alert and oriented residents in the group interview were provided with activities to meet their individual needs related to the pool table not being accessible to residents.

The findings included:

1. Review of the facility's "Resident Council Meeting" minutes dated 12/10/08 documented "The pool table is pushed to the back. Residents want to know if it is possible that it can be moved."
2. During the group interview in the recreation hall near the Floor 1 Cafeteria on 2/3/09 at 2:00 PM, Random Resident #11 and Sampled Resident #26 expressed concerns that the pool table in the Recreation Hall was unavailable for resident use. The resident stated money had been donated to the facility and the men had requested a pool table for their use.

Observations in the recreation hall on 2/3/09 at 2:00 PM, revealed the pool table was located against the wall and unavailable for resident use.

- F 248
- A sign stating "Contact Facilities Management or Environmental Services (with phone numbers) to move the pool table if it is not accessible to residents or if repair services are needed" will be placed in the Recreation Hall.
 - Monitoring of the placement of the pool table in reference to its position and need for repairs will be done weekly.
 - A log for weekly monitoring will be maintained in the Resident Recreation Hall for recording of pool table placement after large events. The log sheet will be maintained by one of the following: Recreation Coordinators, Social Service Secretary or Director of Recreation and Social Services as appropriate.
 - Recreational staff will also check placement after activities that are held in that area (i.e., the Grill, Sports and Games, etc) to assure that the table is returned to its correct location if moved.
 - If pool table needs to be moved for any reason, Recreation or Environmental Services staff will be instructed to notify the Director of Recreation and the Director of Environmental Services. Plans to move the pool table back to its original location will be done immediately.

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F 248 Continued From page 14

3. Observations in the recreation hall on 2/4/09 at 9:15 AM, revealed the pool table against the wall and unavailable for resident use.

During an interview in the Social Services Office on 2/4/9 at 12:25 PM, Social Worker #2 stated, "Crime stoppers donated money for residents and the men wanted a pool table. It doesn't appear that anyone really wanted to use it." Social Worker #2 stated, "It's [pool table] not accessible; I can get that taken care of."

F 253 SS=D 483.15(h)(2) HOUSEKEEPING/MAINTENANCE

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, it was determined the facility failed to maintain a sanitary and orderly environment as evidenced by unlabeled bed pans, bath basins and urine drainage bag, a dusty fan and a soiled and stained feeding pump in 1 of 7 (300 hall) halls.

The findings included:

1. Observations in Resident #14's room (322 B) on 2/3/09 at 9:10 AM, revealed a fan was covered with a thick build up of lint and dust.

During an interview in Resident #14's room (322 B) on 2/3/09 at 9:10 AM, Licensed Practical Nurse (LPN #6) confirmed the fan was dusty.

2. Observations in the bathroom room of room

F 248 D

- Placement of pool table will be monitored on a weekly basis after events that take place in the Recreation Hall.
- The pool table placement will be monitored by Director of Recreation, Recreation Secretary or Recreation Coordinators on a weekly basis to assure it is in the correct location. When 95% compliance is achieved for 3 consecutive week monitoring will occur monthly. When 95% compliance is achieved for 3 consecutive months monitoring will be done quarterly. When 2 consecutive quarters of 95% compliance is achieved monitoring will be done at management discretion.

F253

Dirty Feeding Pumps;
Basins/Bedpans/Urinals

A.

- On 2/4/09 Room 322 bathroom bedpans were replaced, labeled and stored properly by the Patient Care Manager.
- On 2/2/09 Res. #3 feeding pump was cleaned at the time the deficiencies were found.
- On 2/2/09 Resident #11, Room 301B was issued new bedpan and was basin. These were labeled and placed in bathroom holding rack. Resident #11 urine drain bag was labeled by PCM and properly stored.

3/10/09

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F 253	<p>Continued From page 15</p> <p>322 on 2/4/09 at 5:30 PM, revealed two fracture bedpans and one regular bedpan in plastic bags with no names to identify who the bed pans belonged to.</p> <p>During an interview in the bathroom room of room 322 on 2/4/09 at 5:30 PM, Certified Nursing Technician (CNT #3) confirmed the bedpans were not labeled as to who they belonged to.</p> <p>3. Observations in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, revealed two bed pans and two bath basins, all in plastic bags, stacked together on the floor. The bed pans and bath basins were not labeled with names. There was a stained and soiled urine drainage leg bag appliance, hanging on a wall rack, with no label as to who it belong to.</p> <p>Observations in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, CNT #4 picked the bed pans and bath basins up of the floor and put them in racks.</p> <p>During an interview in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, Registered Nurse #1 confirmed the bed pans, bath basins and the urine drainage bag were not labeled with names and should be discarded.</p> <p>4. Observations in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, revealed Resident #3's feeding pump was soiled with dried brown drips and stains.</p> <p>During an interview in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, the Assistant Director of Nursing, confirmed the feeding pump had dried brown drips and stains.</p>	F 253	<p>B.</p> <ul style="list-style-type: none"> Fans for resident #14 were removed and cleaned by Facilities Management staff on 2/3/09. All feeding pumps will be checked for cleanliness by the Patient Care Manager, Charge Nurse, Medical Data Specialist, Dietitian, or Director of Nutrition Services by 2/25/09. Any pumps found to be soiled were cleaned at that time. All resident bathrooms will be checked for dirty or unlabeled bedpans, basins, urinals by the Patient Care Manager, Charge Nurse, CNT, Unit Assessment Coordinator, ADON, DON, Medical Data Specialist by 2/25/09. Those found deficient will have items replaced, labeled and stored properly. The Facilities Management staff, Director, Housekeeper, Medical Data Specialist, Environmental Services Supervisor or Facilities Supervisor will check all resident rooms for fans by 3/6/09. Any found to be in need of cleaning will be cleaned. 	
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F 253 Continued From page 15

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During an interview in the bathroom room of room 322 on 2/4/09 at 5:30 PM, Certified Nursing Technician (CNT #3) confirmed the bedpans were not labeled as to who they belonged to.

3. Observations in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, revealed two bed pans and two bath basins, all in plastic bags, stacked together on the floor. The bed pans and bath basins were not labeled with names. There was a stained and soiled urine drainage leg bag appliance, hanging on a wall rack, with no label as to who it belong to.

Observations in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, CNT #4 picked the bed pans and bath basins up of the floor and put them in racks.

During an interview in Resident #11's bathroom (301 B) on 2/2/09 at 9:00 AM, Registered Nurse #1 confirmed the bed pans, bath basins and the urine drainage bag were not labeled with names and should be discarded.

4. Observations in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, revealed Resident #3's feeding pump was soiled with dried brown drips and stains.

During an interview in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, the Assistant Director of Nursing, confirmed the feeding pump had dried brown drips and stains.

F 253 C.

- In-service/Education will be done by the ADON, DON, Clinical Educator, Nursing Supervisors or the PCM's with the licensed nurses to address their roles in maintaining the cleanliness of feeding pumps. Education in-service will be completed by ADON, DON, Clinical Educator, Nursing Supervisor, or PCM with the CNT's and licensed staff regarding basins, bedpans, urinals and the protocols for proper labeling and storage. Learning Objectives:
 - How to clean a feeding pump
 - Schedule for cleaning a feeding pump
 - Policy regarding labeling of personal use items such as bedpans and urinals
 - Infection control implications of failure to appropriately label personal use items.
- Resident fans have been added to the Facilities Management monthly preventive maintenance checklist and the Facilities Management staff will monitor all resident rooms monthly for compliance.

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4. Observations in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, revealed Resident #3's feeding pump was soiled with dried brown drips and stains.

During an interview in Resident #3's room (307 B) on 2/2/09 at 9:40 AM, the Assistant Director of Nursing, confirmed the feeding pump had dried brown drips and stains.

F 253

D.

- Audits of a 20% sample of feeding pumps, bathrooms will be conducted weekly by the PCM's, Charge Nurse or Dietitian regarding cleanliness. When 95% compliance is achieved for 3 consecutive weeks audit will decrease to once per month x 3 months. When a 95% compliance rate is achieved for 3 months audits will decrease to one per quarter. If a 95% compliance rate is maintained for 2 consecutive quarters the audit will be discontinued.
- Documentation of the fan cleaning will be kept on file in the Facility Management department and reviewed by the Facility Management Director or Supervisor.

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F 274 SS=D	<p>483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to conduct a comprehensive assessment within 14 days of significant changes in the physical condition of 1 of 30 (Resident #3) sampled residents.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #3 was originally admitted to the facility on 9/12/08 and readmitted to the facility on 12/31/08, after a hospitalization for the surgical procedure of Colectomy with Ileostomy. Resident #3 had current diagnoses of Cerebrovascular Accident with Dysphagia, Aphasia and Gastrostomy Tube. The initial Minimum Data Set (MDS) dated 10/3/08 assessed Resident #3 with the following: a. Communication - Sometimes understood (ability is limited to making concrete requests and</p>	F 274	<p>F274 Resident Assessment</p> <p>A.</p> <ul style="list-style-type: none"> For resident #3 a significant change assessment was done on 02/04/2009, by the Unit Assessment Coordinator (UAC), to reflect the areas of change. (See Attachment10) A care plan conference to include interdisciplinary team was completed on 02/04/2009. Care plan was updated by the Unit Assessment Coordinator to reflect changes at that time. (See Attachment 11) <p>B.</p> <ul style="list-style-type: none"> Quarterly assessments completed from 01/01/2009 through 01/31/09 have been reviewed by Resident Assessment Manager to determine if a significant change assessment should have been completed. Also readmissions to facility over the past 90 days were reviewed by the Resident Assessment Manager to determine if a significant change assessment was warranted for any of the these residents. This was completed on 02/17/2009. The three residents identified as needing a significant change assessment were completed by 02/17/2009. 	3/10/09
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F 274	<p>Continued From page 17</p> <p>rarely or never understands);</p> <p>b. Bowel Continence -Totally incontinent with no Ostomy present;</p> <p>c. Nutritional Status - Weight 146 pounds with no significant weight loss in the previous 30 or 180 days;</p> <p>d. Activities - Time awake, both morning and afternoon with participation in activities 1/3 to 2/3 of the time;</p> <p>e. Ulcers - One Stage II Pressure Ulcer;</p> <p>f. Medications received - No antipsychotic medications within the previous 7 days.</p> <p>Review of the quarterly MDS dated 1/14/09 revealed the following changes in Resident #3's assessment:</p> <p>a. Communication - Improved to usually understood and usually understands - difficulty finding words or finishing thoughts and may miss some part/intent of the message;</p> <p>b. Nutritional status - Significant weight loss of 5 percent (%) or more in the last 30 days or 10% in the last 180 days;</p> <p>c. Activities - Awake only in the afternoon with participation in activities decreased to less than 1/3 of the time;</p> <p>d. Ulcers - None;</p> <p>e. Medications received - Antipsychotic medications on 6 of the previous 7 days.</p> <p>This MDS failed to identify that Resident #3 had an Ileostomy with an appliance which rendered him continent of bowel, upon readmission from the hospital on 12/31/08.</p> <p>During an interview in the conference room on 2/3/09 at 10:30 AM, Licensed Practical Nurse (LPN #2) stated it was her responsibility for ensuring the MDS was accurately completed. LPN #2 pointed to the quarterly 1/14/09 MDS and stated, "That should have been a significant</p>	F 274	<p>C.</p> <ul style="list-style-type: none"> • The Significant Change Policy has been reviewed with Unit Assessment Coordinators by the Resident Assessment Manager. • In-service training was conducted by the Resident Assessment Manager with the Unit Assessment Coordinators. Education on significant change criteria as documented in the RAI manual was reviewed. Learning Objectives were as follows <ul style="list-style-type: none"> ▪ Identification of the guidelines for determining a significant change in resident status to include: ▪ Conditions that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, in not "self-limiting" ▪ Impacts more than one area of the resident's health status and ▪ Requires interdisciplinary review and/or revision of the care plan ▪ Identification of guidelines for decline and improvement in resident condition ▪ Monitoring and time frame for assessment to be within fourteen days of recognition of change ▪ Identification of when a change in resident status is not significant ▪ Significant changes for residents with terminal conditions. 	
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F 274 Continued From page 17
rarely or never understands);
b. Bowel Continence -Totally incontinent with no Ostomy present;
c. Nutritional Status - Weight 146 pounds with no significant weight loss in the previous 30 or 180 days;
d. Activities - Time awake, both morning and afternoon with participation in activities 1/3 to 2/3 of the time;
e. Ulcers - One Stage II Pressure Ulcer;
f. Medications received - No antipsychotic medications within the previous 7 days.
Review of the quarterly MDS dated 1/14/09 revealed the following changes in Resident #3's assessment:
a. Communication - Improved to usually understood and usually understands - difficulty finding words or finishing thoughts and may miss some part/intent of the message;
b. Nutritional status - Significant weight loss of 5 percent (%) or more in the last 30 days or 10% in the last 180 days;
c. Activities - Awake only in the afternoon with participation in activities decreased to less than 1/3 of the time;
d. Ulcers - None;
e. Medications received - Antipsychotic medications on 6 of the previous 7 days.
This MDS failed to identify that Resident #3 had an Ileostomy with an appliance which rendered him continent of bowel, upon readmission from the hospital on 12/31/08.

During an interview in the conference room on 2/3/09 at 10:30 AM, Licensed Practical Nurse (LPN #2) stated it was her responsibility for ensuring the MDS was accurately completed. LPN #2 pointed to the quarterly 1/14/09 MDS and stated, "That should have been a significant

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Other:

- Residents with the potential of significant changes in condition will be identified by unit assessment coordinator and interdisciplinary team member during morning rounds. The Unit Assessment Coordinators will place identified residents on the significant change log to be monitored. The Resident Assessment Manger will review significant change logs weekly for a period of one month. A significant change assessment will be completed by the Unit Assessment Coordinators within 14 days of being identified if criteria are met.
 - Unit Assessment coordinators will complete a Significant Change in Condition screen on each quarterly assessment for one month. The screen will be reviewed by Resident Assessment Manager.
- D.
- The Resident Assessment Coordinator will conduct a quality assurance audit of 20% quarterly assessments, comparing the two most recent assessments, maintaining a 95% compliance rate for a period of three months. The audit will review the significant change logs, the significant change screen tool and documentation of decision to complete an assessment and

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b. Bowel Continence -Totally incontinent with no Ostomy present;

c. Nutritional Status - Weight 146 pounds with no significant weight loss in the previous 30 or 180 days;

d. Activities - Time awake, both morning and afternoon with participation in activities 1/3 to 2/3 of the time;

e. Ulcers - One Stage II Pressure Ulcer;

f. Medications received - No antipsychotic medications within the previous 7 days.

Review of the quarterly MDS dated 1/14/09 revealed the following changes in Resident #3's assessment:

a. Communication - Improved to usually understood and usually understands - difficulty finding words or finishing thoughts and may miss some part/intent of the message;

b. Nutritional status - Significant weight loss of 5 percent (%) or more in the last 30 days or 10% in the last 180 days;

c. Activities - Awake only in the afternoon with participation in activities decreased to less than 1/3 of the time;

d. Ulcers - None;

e. Medications received - Antipsychotic medications on 6 of the previous 7 days.

This MDS failed to identify that Resident #3 had an ileostomy with an appliance which rendered him continent of bowel, upon readmission from the hospital on 12/31/08.

During an interview in the conference room on 2/3/09 at 10:30 AM, Licensed Practical Nurse (LPN #2) stated it was her responsibility for ensuring the MDS was accurately completed. LPN #2 pointed to the quarterly 1/14/09 MDS and stated, "That should have been a significant

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presence of significant change MDS in the medical record as well as applicable care plans. Results of audits will be reported to Quality Council monthly until compliance has reached 95% for 3 consecutive months and will then be reported quarterly. Once compliance of 95% has been reached on two consecutive quarterly reports Resident Assessment Manager will monitor as needed. Results of audits will be reported to Quality Council.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2009
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 274	Continued From page 18 change [MDS]."	F 274		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT	F 278	F 278	
	The assessment must accurately reflect the resident's status.		A.	
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.		<ul style="list-style-type: none"> Resident #3's MDS was reviewed and modified to reflect current status of resident by Unit Assessment Coordinator on 02/03/2009. (See Attachment 10) 	3/10/09
	A registered nurse must sign and certify that the assessment is completed.		B.	
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.		<ul style="list-style-type: none"> An audit was completed on all comprehensive assessments completed between 01/01/2009 - 02/09/2009 focusing on section H of MDS for accuracy. This was completed 02/09/2009 by the Resident Assessment Coordinator (with no discrepancies noted). 	
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.			
	Clinical disagreement does not constitute a material and false statement.			
	This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to ensure the accuracy of the comprehensive assessment for 1 of 30 (Resident #3) sampled residents.			

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F 274	Continued From page 18 change [MDS]."	F 274		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to ensure the accuracy of the comprehensive assessment for 1 of 30 (Resident #3) sampled residents.	F 278	C. • An In service was conducted by the Resident Assessment Coordinator on 02/11/2009 with all Unit Assessment Coordinators regarding the correct coding on the MDS. This included the RAI manual criteria for assessment of all areas on the comprehensive assessment. Objectives included: <ul style="list-style-type: none"> ▪ Instruction on physically assessing the resident prior to completion of the MDS. ▪ Review of medical record information during the look back period and ensure coding is being done accurately to reflect that information. ▪ Instruction given on completing a comparative analysis with the current assessment and the last MDS components. ▪ Instruction on analysis of significant changes and whether these were considered to be expected or a significant improvement or decline for the resident. ▪ Instruction on significant change criteria versus acute 	

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NAME OF PROVIDER OR SUPPLIER

BORDEAUX LONG TERM CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
1414 COUNTY HOSPITAL RD
NASHVILLE, TN 37218

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F 274	Continued From page 18	F 274		
F 278	change [MDS]."			
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT	F 278		
	<p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to ensure the accuracy of the comprehensive assessment for 1 of 30 (Resident #3) sampled residents.</p>		<p>expectation of the resident returning to their baseline.</p> <ul style="list-style-type: none"> ▪ Instruction was given on what action to take if it is determined that a significant change assessment is warranted, ex: significant change in condition r/t decline is warranted – the following steps would be taken: <ul style="list-style-type: none"> > Significant change assessment completed. > Complete revision of the resident's care plan to reflect current status of the resident. > UAC to make referrals as warranted, ex: Restorative, Specialized Therapies, Dietary, Social Services, etc. 	

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F 274	Continued From page 18 change [MDS]."	F 274		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to ensure the accuracy of the comprehensive assessment for 1 of 30 (Resident #3) sampled residents.	F 278	D • The Resident Assessment Manager or the Unit Assessment Coordinators will audit section H of the MDS for accuracy for 3 months maintaining a 95% compliance rate. Once a 95% accuracy rating has been met for 3 consecutive months the review will be done quarterly. When 95% accuracy has been maintained for 2 consecutive quarters audit will be done periodically as needed. Any assessment identified to be inaccurate will be modified to correctly reflect the resident.	

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F 278	<p>Continued From page 19</p> <p>The findings included:</p> <p>Medical record review revealed Resident #3 was originally admitted to the facility on 9/12/08. Resident #3 was initially admitted to the facility with diagnoses including Post Cerebrovascular Accident, Asthma and Tracheostomy secondary to Chronic Respiratory Failure. Resident #3 was readmitted to the facility on 12/31/08, after a two week hospitalization for the surgical procedure of Colectomy with Ileostomy. Review of the quarterly Minimum Data Set (MDS) dated 1/14/09 revealed the section for bowel continence, assessed Resident #3 as "4" (bowel incontinence all or almost all of the time.) The quarterly MDS dated 1/14/09 failed to identify that Resident #3 had an Ileostomy, with an appliance which rendered him continent of bowel.</p> <p>During an interview in the conference room, on 2/3/09 at 10:30 AM, Licensed Practical Nurse #2 confirmed the quarterly MDS dated 1/14/09 was an inaccurate.</p>	F 278		
F 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to ensure hospice services were provided for 2 of</p>	F 309	<p>F 309</p> <p>A.</p> <ul style="list-style-type: none"> Care plans for resident #12 and #20 have been reviewed and updated to reflect interdisciplinary coordination between BLTC and hospice on 2/3/2009 by the Unit Assessment Coordinator (UAC). Care plans also reflect interdisciplinary care provided by both entities. Hospice care plans were also updated to reflect financial responsibility for care for any hospice related diagnosis. (See Attachment 12) 	3/10/09

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F 309	<p>Continued From page 20</p> <p>10 (Residents #12 and 20) sampled residents receiving hospice care.</p> <p>The findings included:</p> <p>1. Medical record review revealed Resident #12 was admitted to the facility 7/6/07 and had current diagnoses including Cerebrovascular Accident, Dysphagia with Gastrostomy Tube, Anxiety, Depression, Osteoarthritis, Bone and Joint Pain with Xray indicative of Knee Cancer, and Adult Failure to Thrive. Review of the initial nursing assessment done by hospice revealed Resident #12 was admitted to hospice care on 8/15/08 and included the following: self care deficits/functional limitations for transfers with assistance; bed-bound 90 percent (%) of the time; bathing; dressing; feeding; ambulation and continence. The Minimum Data Set (MDS) dated 12/23/08 assessed Resident #12 being totally dependent for transfers, assistance, bathing, dressing, feeding, ambulation and incontinent of bowel and bladder. Review of the current care plan for Activities of Daily Living (ADL) function revealed Resident #12 was to receive a "shower/full body bath/sponge bath" 2 times weekly, or more often if requested, and being "Bedfast at this time..." Further review of the care plan revealed it did not designate which care and services would be provided by the facility and which would be provided by the hospice entity. There was no documentation of revisions to denote that Resident #12 was to be assisted out of bed to a chair.</p> <p>Observations in Resident #12's room on 2/3/09 at 8:10 AM, revealed Resident #12 in bed tilted to the right side, restless, throwing the covers back and asked for help in getting out of bed. Further</p>	F 309	<p>B.</p> <ul style="list-style-type: none"> All hospice resident care plans will be reviewed by the Unit Assessment Coordinator (UAC) to determine whether the care plan reflects integrated care between hospice providers and BLTC. Any care plans that are deficient will be updated to reflect interdisciplinary care and financial responsibility related to DME and other services which should be provided by the hospice provider and/or BLTC. Hospice agencies will continue to be invited to attend the care plan conferences on a quarterly basis and encouraged to review and update care plans as needed. <p>C.</p> <ul style="list-style-type: none"> A meeting was held with the hospice agencies to review concerns cited by the state surveyors. Hospice representatives were advised to review care plans to ensure that care plans are accurate and denote the services which hospice provides and those provided by BLTC. This meeting was held on 02/12/09 here at BLTC. Hospice agencies will continue to receive notification of care plan conference on any patient that they service whenever this resident's plan of care is being reviewed. Continued input is encouraged on a regular basis to ensure coordination of care. Care plans will be reviewed on a quarterly basis by the interdisciplinary team and hospice provider for all residents receiving hospice services. Any questions related to coverage of care will be discussed at this time or as they 	
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F 309	<p>Continued From page 21</p> <p>observations revealed the call light was clipped to the left side of the bed near the top of the mattress and Resident #12 was attempting and unsuccessful in reaching the call light.</p> <p>Observations and an interview in Resident #12's room on 2/3/09 at 2:50 PM, revealed Resident #12 in a reclined gerichair with the call light out of Resident #12's reach. Resident #12 stated she was "tired and want to go to bed."</p> <p>During an interview in Resident #12's room on 2/3/09 at 2:50 PM, RN #5 confirmed that Resident #12 had been up much of the day and the Certified Nursing Technician (CNT) would be in the room "in a few minutes" to put her to bed. RN #5 also confirmed that Resident #12 could not reach the call light.</p> <p>During an interview in the conference room on 2/4/09 at 3:45 PM, Licensed Practical Nurse (LPN #2) confirmed she was responsible for ensuring the MDS and care plans were completed. LPN #2 confirmed Resident #12 did not have an integrated hospice care plan to determine which care and services hospice would provide.</p> <p>2. Medical record review revealed Resident #20 was admitted to the facility on 6/22/05 and had current diagnoses of Advanced Multiple Sclerosis, Paraplegia, Joint Contractures, and Muscle Spasms. The Annual MDS dated 1/8/09 included the following assessments: short term memory impairment, but no long term memory impairment; aware of the current season, location of own room, staff names and faces, and that he is in a nursing home; modified independence in daily decision making (some difficulty in new situations only); no indicators of delirium or</p>	F 309	<p>arise. All questions related to coordination of care services needed for a resident followed by hospice will be forwarded to the Social Services department for the Social Worker to follow up with the hospice agency.</p> <ul style="list-style-type: none"> The hospice policy will be updated to include care planning of services, notification of care plan conferences, and coordination of services by the Director of Social Services and Recreation. The Director of Social Services and Recreation will in-service the social workers on the updated policy. A copy of the policy will be forwarded to the Resident Assessment Manager for in-servicing Unit Assessment Coordinators and to the Director of Nursing and ADON for in-servicing of Patient Care Managers. The goal or objective of this education is to update staff on policy revision and to insure that there is appropriate documentation of care and care integration between BLTC and the hospice provider. Care plans for hospice residents will be reviewed quarterly per resident assessment schedule or as needed for any resident changes by the interdisciplinary team (IDT). IDT will be notified when a resident is admitted to hospice and when a resident is discharged from hospice per email notification from Social Services. Changes will be made to the care plan by the Social Worker to reflect this notification. 	
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F 309	<p>Continued From page 22</p> <p>disordered thinking; totally dependent upon staff for all activities of daily living including locomotion on the unit; locomotion off the unit did not occur; functional limitations included full loss of voluntary movement of the arm, hand, leg, and foot. The current facility care plan revealed it was not integrated with hospice and did not designate the care and services, including durable medical equipment (DME) which would be provided by hospice or the facility.</p> <p>Observations in Resident #20's room on 2/2/09 at 10:15 AM, revealed Resident #20 in bed with severely contracted hands. Resident #20 had no use of the right hand and the left hand was contracted and weak with very limited use.</p> <p>During an interview in Resident #20's room on 2/2/09 at 10:15 AM, Resident #20 revealed the batteries for the motorized wheelchair (w/c) needed to be replaced and he had been unable to be independent in the w/c for 6 months because the batteries were too expensive (\$400). Resident #20 revealed he had previously discussed this with the Director of Rehabilitative Services (DOR).</p> <p>Observations in the 300 B hallway on 2/2/09 at 1:00 PM, revealed a staff member wheeling Resident #20 in a gerichair.</p> <p>During an interview in the conference room on 2/4/09 at 9:00 AM, the DOR confirmed Resident #20's batteries were not working and the power w/c was not usable. The DOR stated the batteries had been cost prohibitive, but she had initiated procuring the batteries from a different supplier and expected their delivery this week.</p>	F 309	<ul style="list-style-type: none"> • Social Service Director will consult with hospice agencies quarterly to discuss any issues. If necessary, a meeting to further discuss any issues can be scheduled. Any problems or concerns will be forwarded to the appropriate staff member for follow-up. <p>D</p> <ul style="list-style-type: none"> • The Resident Assessment Manager will randomly review 20% of the hospice care plans monthly. When 95% compliance is reached for 3 consecutive months, the audit will occur quarterly. When 95% compliance has been reached for 2 consecutive quarters audits will be conducted at management discretion and reported to Quality Council. • Findings will be reported in Quality Council on a monthly basis by Resident Assessment. 	
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F 309	<p>Continued From page 23</p> <p>During a telephone interview in the conference room on 2/4/09 at 2:00 PM, the Director of Clinical Operations of the hospice provider stated hospice is responsible for supplying DME. The hospice has a contract with a company to provide batteries and could have them delivered by the end of this week.</p> <p>During an interview in the conference room on 2/4/09 at 3:45 PM, LPN #2 confirmed the facility care plan was not integrated with hospice and the care plan did not designate which care and services, including DME would be provided by hospice.</p> <p>During an interview in Resident #20's room on 2/4/09 at 5:15 PM, Resident #20 stated the batteries had been obtained and the power chair was "downstairs" having the new batteries installed at this time.</p>	F 309		
F 312 SS=D	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the shower schedule, review of the bath type detail report, observations, and interviews, it was determined the facility failed to perform personal and oral hygiene care for 1 of 30 (Resident #3) sampled residents.</p> <p>The findings included:</p>	F 312	<p>F312</p> <p>A.</p> <ul style="list-style-type: none"> • CNT #1 immediately placed call light in reach of resident #3 to ensure he was able to call for assistance when needed. 2/2/09 • CNT # 1 provided resident #3 with personal hygiene via bed bath and oral care per plan of care. Mint lip balm applied to resident # 3 lips. 2/2/09. 	3/10/09

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F 312	<p>Continued From page 24</p> <p>Medical record review revealed Resident #3 was originally admitted to the facility on 9/12/08 and readmitted to the facility on 12/31/08. Resident #3 had current diagnoses including Post Cerebrovascular Accident with Dysphagia, Aphasia, Hemiplegia, Gastrostomy Tube, Colectomy, Ileostomy and Right Eye Blindness. Review of the initial Minimum Data Set (MDS) dated 10/3/08 and the quarterly MDS dated 1/14/09 revealed Resident #3 was assessed as totally dependent upon staff for bed mobility, transfers, personal hygiene and bathing. Review of the care plan initiated 9/29/08 and reviewed with goals and interventions through 4/27/09 revealed Resident #3 was identified as dependent upon staff for all activities of daily living (ADL) with the goal of, "All needs will be met by staff daily, will be clean, dry, and odor free with privacy and dignity maintained at all times thru [through] next review date." The interventions included, "Call light in reach and answered promptly. Resident to have full body bath/sponge bath or shower at least two (2) times each week, or more often if requested by resident. Oral care daily."</p> <p>Observations and interview in Resident #3's room on 2/2/09 at 10:40 AM, revealed Resident #3 alone in his room, restless, pointing to his mouth with unintelligible speech. Resident #3's hair was oily and uncombed. He was wearing a hospital gown. The hospital gown and bed linens were crumpled and the bed was in disarray, including a body pillow lying over the sheets and on top of the resident. Resident #3's mouth was coated with a heavy buildup of dried yellow debris on his lips, tongue, and teeth. Resident #3's call light was clipped to tubing on the wall above the bed and out of his reach. Resident #3 was asked if he was</p>	F 312	<ul style="list-style-type: none"> Documentation shows Res. #3 was out of the facility 11/7/08 – 11/10/08 (returned on 11/10/08). Res. #3 was out of the facility 12/14/08 – 12/31/08 (returned on 12/31/08). Res. #3 was out of the facility 1/3/09 – 1/4/09 (returned on 1/4/09). Res. #3 was out of the facility 1/13/09 – 1/16/09 (returned on 1/16/09). Res. #3 was out of the facility a total of 35 days from 11/7/08 – 2/06/09 (93 days). Res. #3 was in the facility 58 days from 11/7/08 – 2/06/09. From 11/7/08 – 2/6/09 the Res. #3 received a bath or shower 67 times per the Care Tracker documentation. (See Attachment 13) <p>B.</p> <ul style="list-style-type: none"> All residents located on B3 were immediately assessed by the PCM to ensure their call lights were within reach and to ensure needs/wants could be communicated to staff. The PCM and the Nursing Supervisor ensured all call lights received a security clip to ensure correct placement was within reach of the resident. Touch call lights were acquired by the Nurses on the floor for residents that were unable to utilize button call lights. All residents on B3 were assessed for hygiene needs by the PCM to ensure proper hygiene and oral care was being given by the staff. A sweep of all units will be done by the PCM, Charge Nurse, Medical Data Specialist, UAC's or House Supervisor to assess call light availability, 	
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F 312	<p>Continued From page 25</p> <p>thirsty. Resident #3 stated, "Oh God, yes."</p> <p>Observations and interview in the hallway outside of Resident #3's room on 2/2/09 at 10:40 AM, Certified Nursing Technician (CNT #1) was made aware Resident #3 could not reach the call light and needed help. CNT #1 entered the room and confirmed the call light was out of Resident #3's reach. CNT #1 confirmed Resident #3's mouth was dry, and that he was difficult to understand him, and was dependent upon staff for all personal care needs.</p> <p>During an interview in Resident #3's room on 2/3/09 at 4:00 PM, Resident #3's Responsible Party (RP) was asked about the care provided by the facility's staff. The RP stated, "They do not shower him. I complained to a Tech [Technician] and Nurse, not sure who, he smelled, his back itches and he's not getting showered and they just told me he should get 2 [showers] a week. I don't think he ever gets a shower; I don't know if he's even had one since he's been here. His back's always itchy where he sweats."</p> <p>Observations in Resident #3's room on 2/3/09 at 4:00 PM, revealed the RP was scratching Resident #3's back while we were talking.</p> <p>Review of Resident #3's shower schedule, provided by RN #1, revealed Resident #3 was scheduled for showers every Tuesday and Friday. Review of Resident #3's "Bath Type Detail Report", also provided by RN #1, revealed Resident #3 received no showers in the month of 11/08, 1 shower in the month of 12/08, and 1 shower in 1/09.</p> <p>During an interview at the B3 nurses' station on</p>	F 312	<p>oral care and personal hygiene needs being met</p> <p>C.</p> <ul style="list-style-type: none"> ADON, DON, Patient Care Manager (PCM), Nursing Supervisor, Nursing Educator will in-service the nursing staff on proper placement of call lights and prompt response times on 2/3/09, 2/4/09, 2/9/09, 2/12/09 and is continuing. PCM/Charge nurse/Nursing supervisor will make rounds on unit weekly to ensure call lights are properly placed for easy access. CNTs will be held responsible to ensure call lights are within reach at all times. LPNs will observe during daily rounds for call light placement and prompt response to resident requests. PCM will interview competent residents weekly to ensure call lights are accessible and answered promptly. Grievances will be developed for significant or chronic concerns that are identified. The PCM will be responsible for the investigation of the grievances. 	
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F 312	<p>Continued From page 25</p> <p>thirsty. Resident #3 stated, "Oh God, yes."</p> <p>Observations and interview in the hallway outside of Resident #3's room on 2/2/09 at 10:40 AM, Certified Nursing Technician (CNT) #1 was made aware Resident #3 could not reach the call light and needed help. CNT #1 entered the room and confirmed the call light was out of Resident #3's reach. CNT #1 confirmed Resident #3's mouth was dry, and that he was difficult to understand him, and was dependent upon staff for all personal care needs.</p> <p>During an interview in Resident #3's room on 2/3/09 at 4:00 PM, Resident #3's Responsible Party (RP) was asked about the care provided by the facility's staff. The RP stated, "They do not shower him. I complained to a Tech [Technician] and Nurse, not sure who, he smelled, his back itches and he's not getting showered and they just told me he should get 2 [showers] a week. I don't think he ever gets a shower; I don't know if he's even had one since he's been here. His back's always itchy where he sweats."</p> <p>Observations in Resident #3's room on 2/3/09 at 4:00 PM, revealed the RP was scratching Resident #3's back while we were talking.</p> <p>Review of Resident #3's shower schedule, provided by RN #1, revealed Resident #3 was scheduled for showers every Tuesday and Friday. Review of Resident #3's "Bath Type Detail Report", also provided by RN #1, revealed Resident #3 received no showers in the month of 11/08, 1 shower in the month of 12/08, and 1 shower in 1/09.</p> <p>During an interview at the B3 nurses station on</p>	F 312	<ul style="list-style-type: none"> Weekly audits will be completed by PCM to ensure bath schedules are adhered to with 95% accuracy. If a resident refuses, the CNT will report to the nurse on duty and they will document any reason for noncompliance in the resident chart. All residents that are NPO and receive their nutritional support through means of Enteral feedings will be assessed for dry mouth and proper oral care will be given every shift per protocol. <p>D.</p> <ul style="list-style-type: none"> Weekly interviews with 20% competent resident sample will be completed by PCM to ensure staff reach at least a 95% compliance rate for 3 consecutive months. Once this is reached the audits will be done every quarter X 2 quarters with at least a 95% compliance rate, then audit as needed. Audits will be forwarded to DON/ADON for quality assurance purposes. Call light responsiveness will be reviewed monthly in Quality Council meetings. PCM will complete weekly bath audit of 20% of the residents to ensure showers/bed baths are being completed as scheduled maintaining at least a 95% compliance rate. Once this is reached the audits will be done every quarter X 2 quarters with at least a 95% compliance rate, then audit as needed. Audits will be forwarded to DON/ADON for quality assurance purposes. Audits will be reviewed in Quality Council Meetings monthly. 	
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<p>F 312</p> <p>F 315</p> <p>SS=D</p>	<p>Continued From page 26</p> <p>2/3/09 at 5:28 PM, RN #1 confirmed what was documented on the bath type detail report.</p> <p>483.25(d) URINARY INCONTINENCE</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 medical record review and interview, it was determined the facility failed to assess, maintain and restore as much normal bladder function as possible for 1 of 30 (Resident #23) sampled residents.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #23 was admitted to the facility on 1/6/09 with diagnoses including Cerebrovascular Accident, Aphasia, Hypertension, Coronary Artery Disease, Hypothyroidism and Tube Feeding. The admission Minimum Data Set (MDS) dated 1/12/09 assessed Resident #23 with short term memory impairment and no long term memory impairment. The 1/12/09 MDS revealed Resident #23 is frequently incontinent of urine with multiple episodes per day. Review of an incontinence assessment dated 2/2/09 revealed Resident #23 is incontinent of bladder, able to make self</p>	<p>F 312</p> <p>F 315</p>	<p>F-315 Urinary Incontinence:</p> <p>A</p> <ul style="list-style-type: none"> The urinary incontinence assessment was completed for Res. #23 on 2/2/09 by the Restorative Nurse and was signed by MD on 2/5/09. The resident will be referred to the specialized incontinence management clinic to specifically address her incontinence needs and to develop a program that will help her reach her optimal functioning ability. (See Attachment 14) <p>B</p> <ul style="list-style-type: none"> An in-service on timeliness and appropriate bowel & bladder assessment was presented to the Restorative Nurse by the DON. Restorative nurse received education including: <ul style="list-style-type: none"> Bowel & Bladder Policy Risk Factors facing the resident Urinary incontinence assessment form The Restorative Nurse and the Resident Assessment Manager reviewed comprehensive assessments completed between November 1, 2008 through February 2, 2009 to determine if Bowel and Bladder assessments were completed correctly. Any missed assessments were completed by the Restorative Care Nurse. 	<p>3/10/09</p>
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F 315	Continued From page 27 understood and is cooperative. Page 2 of the incontinence assessment was incomplete and not signed or dated by the Medical Doctor. During an interview in Resident #23's room on 2/4/09 at 12:50 PM, Resident #23 confirmed she feels the urge when she needs to go to the bathroom. Resident #23 also revealed when she asks to go to the bathroom she has been told that she can't go because she can't stand up and that she has a diaper on and does not need to go. During an interview at the B3 nurses' station on 2/4/09 at 5:20 PM, RN #1 confirmed the toileting assessment for Resident #23 was not initiated until 2/2/09 and the MD had not filled out the assessment to identify the type of incontinence and or treatment. RN #1 stated that Resident #23 has not received any treatment to improve the urinary continence status.	F 315	C • The Restorative Nurse will use the comprehensive assessment schedule as a guide to alert them to any Bowel & Bladder assessments that are due. • The Unit Assessment Coordinator (UAC) will review all assessments including Bowel and Bladder assessments prior to finalizing the comprehensive assessments. • If the Bowel and Bladder assessment cannot be located the UAC will notify the Restorative Nurse. D • A monthly audit will be conducted by the UAC (for 3 consecutive months) on 20% of residents who receive a comprehensive assessment during the month to determine if the annual Bowel & Bladder Assessment as completed by the Restorative Nurse. Results of the audit will be reported in Quality Council. When 95% compliance is achieved for 3 consecutive months, the audits will then be completed quarterly. When 95% compliance is achieved for 2 consecutive quarters, the audits will be completed at the discretion of the Director Nursing. Audit results will be reported in Quality Council.	
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (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 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and an interview, it was determined the facility	F 325		

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F 325	<p>Continued From page 28</p> <p>failed to weigh a resident after a hospital return to ensure acceptable parameters of nutrition could be met for 1 of 30 (Resident #3) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Weight Management" policy documented "New Admissions: 1.) Residents admitted to the facility will be weighed daily by assigned nursing staff for the first two days. If there is over a 5 pound difference in the two weights, a third weight will be obtained to determine a reasonable baseline...If a resident is sent to the hospital and stays over 72 hours he/she will be treated as a new admission, receiving weights as indicated above."</p> <p>Medical record review revealed Resident #3 was originally admitted to the facility on 9/12/08 and readmitted to the facility on 12/31/08, after a hospitalization for the surgical procedure of Colectomy with Ileostomy. Resident #3 had current diagnoses including Post Cerebrovascular Accident with Dysphagia, Aphasia and Gastrostomy Tube. The initial Minimum Data Set (MDS) dated 10/3/08 assessed Resident #3's nutritional status of a weight of 146 pounds with no significant weight loss in the previous 30 or 180 days. Review of the quarterly MDS dated 1/14/09, under the section of nutritional status revealed a significant weight loss of 5 percent (%) or more in the last 30 days or 10% in the last 180 days. Review of Resident #3's MDS Tracking Forms documented "D/C [discharged] 12/07/08 - R/A [readmitted] 12/12/08; D/C 12/14/08 - R/A 12/31/08."</p> <p>Review of the form titled "Weights Detail Report"</p>	F 325 A.	<ul style="list-style-type: none"> • Resident #3 was out of the facility from 12/7/08 through 12/12/08 and again from 12/14/08 to 12/31/08, undergoing surgical procedure of colectomy with ileostomy. Significant weight change occurred during this time. Resident was out of the facility twice in January, 1/3/09 – 1/4/09, 1/13/09 – 1/16/09. • Since January resident #3's weight has steadily improved from 130.6 lbs to his current weight of 143.8 lbs. Throughout the resident's stay the resident has been monitored in the NAR (Nutritionally At Risk Committee) with numerous nutritional, pharmaceutical and medical interventions. (See Attachment 15) • The dietitian has evaluated the resident's weights and has determined that improvement is evidenced by desired weight increase as follows: (See Attachment 16) <ul style="list-style-type: none"> ▪ 1/19/09 – 130.6 lbs ▪ 2/3/09 – 135.5 lbs ▪ 2/8/09 – 138.8 lbs ▪ 2/14/09 – 141.2 lbs ▪ 2/23/09 – 143.8 lbs B. • The Director of Nutrition Services, Dietitians, and Clinical Diet Technician will review all new admissions for the last 60 days to see if weights have been obtained according to policy. The Director of Nutrition Services, Dietitian and Clinical Diet Technician will review the weights of those who were not weighed according to policy upon admission and determine if further 	3/10/09
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F 325	<p>Continued From page 28</p> <p>failed to weigh a resident after a hospital return to ensure acceptable parameters of nutrition could be met for 1 of 30 (Resident #3) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Weight Management" policy documented "New Admissions: 1.) Residents admitted to the facility will be weighed daily by assigned nursing staff for the first two days. If there is over a 5 pound difference in the two weights, a third weight will be obtained to determine a reasonable baseline...If a resident is sent to the hospital and stays over 72 hours he/she will be treated as a new admission, receiving weights as indicated above."</p> <p>Medical record review revealed Resident #3 was originally admitted to the facility on 9/12/08 and readmitted to the facility on 12/31/08, after a hospitalization for the surgical procedure of Colectomy with Ileostomy. Resident #3 had current diagnoses including Post Cerebrovascular Accident with Dysphagia, Aphasia and Gastrostomy Tube. The initial Minimum Data Set (MDS) dated 10/3/08 assessed Resident #3's nutritional status of a weight of 146 pounds with no significant weight loss in the previous 30 or 180 days. Review of the quarterly MDS dated 1/14/09, under the section of nutritional status revealed a significant weight loss of 5 percent (%) or more in the last 30 days or 10% in the last 180 days. Review of Resident #3's MDS Tracking Forms documented "D/C [discharged] 12/07/08 - R/A [readmitted] 12/12/08; D/C 12/14/08 - R/A 12/31/08."</p> <p>Review of the form titled "Weights Detail Report"</p>	F 325	<p>weights or reweights may be needed to established an accurate weight record. An accurate weight will be determined by the Dietitian.</p> <p>C.</p> <ul style="list-style-type: none"> The Weight Management policy will be updated to reflect a modification in the process to be used in obtaining and recording weights for new admissions. The names of new admissions will be placed on the 24h report. The Charge Nurse will be responsible for ensuring that the weights are obtained by noting on the 24hour report the following day. Charge Nurse will assure that the weight detail report from Care Tracker is attached to the 24h report to verify that weights are recorded in the medical record for each of the first 2 days after admission. All CNTS and licensed nurses will be in-serviced on the change of policy by the Director of Nutrition Service, Dietitians, Clinical Diet Technician, Nursing Supervisor, Clinical Educator, DON, ADON or Patient Care Managers by 3/10/09. Learning Objectives include: <ul style="list-style-type: none"> To understand the importance of obtaining two weights on new admissions to the facility in establishing a baseline Provide documentation of new admission weights in the 24hour report book, or provide a copy of Care tracker weight report verifying adherence to policy with a printout from Care tracker 		

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F 325	Continued From page 29 supplied by Registered Nurse (RN #1) on 2/3/09 at 5:00 PM documented Resident #3's weights (wt) as 11/10/08 wt 144.1 pounds (#), 11/30/08 wt 144.6#, 1/12/09 wt 133.6# and 1/19/09 wt 130.6#. Review of the current physicians orders dated 1/27/09 documented the tube feeding order of "2 Cal HN 84 cc [cubic centimeters] / [per] hr [hour] x [times] 17 hr" a day as the only source of nutrition. During an interview at the B3 nurses' station, on 2/3/09 at 5:25 PM, RN #1 confirmed Resident #3 was not weighed upon readmission, after a 2 week hospital stay. The first documented weight was 13 days after readmission, at which time a significant weight loss was documented. RN #1 confirmed the facility failed to follow it's own policy to weigh Resident #3 upon admission, and reweigh the second day after admission to establish a baseline weight so that interventions could be implemented if needed.	F 325 D.	<ul style="list-style-type: none"> 50% of the facility's new admissions will be reviewed retrospectively by the Director of Nutrition, Dietitians, or Clinical Diet Technician for documentation of admission weights in the medical record. Goal: 90% compliance. Once goal is met for 3 months consecutively, monitoring will be reduced to quarterly. When compliance is reached for 2 consecutive quarters audit will be conducted on management discretion. Audit results will be reported at Nutrition Committee and Quality Council. 		
F 328 SS=D	483.25(k) 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. This REQUIREMENT is not met as evidenced by:	F 328			

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F 328 Continued From page 30

Based on policy review, medical record review, observations, and interviews, it was determined the facility failed to ensure oxygen (O2) was administered according to the physician's orders for 1 of 1 (Resident #25) sampled residents receiving O2 therapy.

The findings included:

Review of the facility's oxygen cylinder change out policy documented "...ALL OXYGEN CYLINDERS WILL BE CHANGE OUT AT 500 PSI [pounds per square inch] OR RED INDICATOR ON OXYGEN GAGE...1 NO TANK MAY BE USED THAT IS IN THE RED...2: IT IS THE RESPONSIBILITY OF NURSING, THERAPY AND ALL CARE GIVERS TO MONITOR AND NOTIFY RESPIRATORY THERAPY OF A TANK REACHING RED LINE..."

Medical record review for Resident #25 documented an admission date of 6/14/08 with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety, Respiratory Alkalosis, Diabetes Mellitus, Steroid Induced Hyperglycemia, Cardiac Dysrhythmias, Depressive Disorder, Adjustment disorder with Anxiety and Depressed Mood. The interdisciplinary progress notes dated 1/24/09 documented "Husband stated resident had syncope episode, not wearing O2. O2 replaced....O2 Sat [saturation] 98% [percent]. NP [Nurse Practitioner] notified ...being monitored closely." A physician's order dated 1/30/09 documented "O2 @ [at] 4 IPM [liters per minute] per NC [nasal cannula]."

During the group interview in the recreation hall on 2/3/09 at 2:00 PM, Resident #25 stated, "Sunday night I had trouble breathing and needed

F 328 F-328 Special Needs

A

- On 2/4/09 Res. # 25's oxygen E-tank was checked and changed out by the Respiratory Therapist. 3/10/09

B

- On 2/4/09 rounds were done by the Respiratory Therapist assessing the portable oxygen tanks throughout the facility. No deficiencies were noted.

C

- On 2/4/09 a policy was developed and implemented to address daily rounds and check process of the O2 tanks.
- On 2/5/09 an educational hand out was prepared by the Respiratory Therapy Manager to the Respiratory Care staff, Physical Therapist, Outpatient Therapy, Recreation Coordinator, Nursing.

Learning Objectives:

- On the new policy for changing out and monitoring portable oxygen tanks.
- To inform all staff they are responsible for monitoring the oxygen level with resident usage of these tanks.

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F 328	<p>Continued From page 31</p> <p>changing and the oxygen checked but no one came." Resident #25 stated her husband came to the facility and found the O2 tube had come a loose from the oxygen supply.</p> <p>Observations in the 2nd floor dayroom on 2/4/09 at 1:20 PM, revealed the O2 tank was attached to the back of Resident #25's wheelchair. The oxygen gauge setting on the tank was at the red "Refill" area.</p> <p>During an Interview in the 2nd floor dayroom on 2/4/09 at 1:22 PM, Licensed Practical Nurse (LPN #4) was asked about the oxygen tank setting. LPN #4 stated, "It's [O2 tank] empty, I'll get her another [O2 tank]."</p> <p>During an interview at the 2nd Floor Roberio nurses' station on 2/4/09 at 4:15 PM, LPN #5 was asked who was responsible for checking the portable oxygen tanks. LPN #5 stated, "Nurses on the floor should check about every 2 hours."</p>	F 328	<p>D</p> <ul style="list-style-type: none"> The DON, ADON, PCM, Charge Nurse or Nurse on duty will make weekly rounds and check all portable oxygen tanks, those in use and those in storage areas. This will be recorded on the Portable Oxygen Check Form. The PCM will do a weekly audit on a 20% sample of resident on their respective units that utilize portable oxygen tanks. This weekly audit will be continued with a target of at least 95% compliance rate. Once the 95% compliance rate has been reached for 3 consecutive months the audit will reduce to once per month. When a 95% compliance is achieved for 2 consecutive quarters the audits will be done at management discretion. Any deficiency found will be corrected at that time and deficiencies will be reported in Quality Council monthly. 	
F 465 SS=D	<p>483.70(h) OTHER ENVIRONMENTAL CONDITIONS</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and an interview, it was determined the facility failed to ensure the environment was clean, sanitary and free of odors on 1 of 7 (B3 West hall) halls.</p> <p>The findings included:</p>	F 465	<p>A</p> <ul style="list-style-type: none"> On 2/23/09 the Director of Environmental Services and ADON made walking rounds throughout Birmingham 3rd floor unit. It was noted that rooms B-301, B-313 and B-316 had an odor. (See Attachment 17) It has been determined that the floors in these rooms will be stripped and waxed. This will be completed by 3/2/09. 	3/10/09

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F 465	<p>Continued From page 32</p> <p>Observations of the B3 West hall on 2/2/09 between 10:15 AM and 10:30 AM revealed a strong odor of urine was present throughout the entire hall.</p> <p>Observations of the B3 West hall on 2/2/09 at 4:00 PM, revealed a foul odor at the nurses' station as well as down the halls of resident rooms 301 through 312 and 324 through 335.</p> <p>During an interview in the B3 West hall, on 2/2/09 at 10:25 AM, Licensed Practical Nurse (LPN #3) confirmed the presence of the strong urine odor on the entire hallway. During the interview it was revealed that housekeeping had already been up and mopped the floor but the odor prevailed.</p>	F 465	<ul style="list-style-type: none"> Environmental Services will also replace the privacy curtains with clean curtains when the rooms are stripped and waxed. Deodorant blocks will be placed in rooms B-301, B-313, and B-316 by 2/27/09. The catheter drainage bags for residents in B-310, & B-316 were changed on 2/2/09 	
F 514 SS=D	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and an interview, it was determined the facility failed to maintain complete and accurate medical records regarding resuscitation status for 1 of 30 (Resident #2) sampled residents.</p>	F 514	<p>B</p> <ul style="list-style-type: none"> The Patient Care Manager and Environmental Services Director will conduct rounds on each of the other units to determine if there are other rooms with odors in need of intervention. All rooms identified with odor issues will be deep cleaned and floors stripped, etc., to reduce these concerns. Monitoring will be ongoing on this unit (B3) weekly by the PCM, Charge Nurse, Nursing Supervisor, ADON or Environmental Services Director to determine any foul odors. Any odor will be addressed immediately. <p>C</p> <ul style="list-style-type: none"> The residents in B-313 and B-316 will have their catheter bags changed weekly to help contain the odors. Licensed nurses and CNTs will be educated by Clinical Instructor, Educator, PCM, DON, ADON or Nursing Supervisor regarding the maintenance and labeling of residents bedpans, urinals and catheter bags. Environmental Services staff will be educated by the Director of Environmental Services, 	

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F 465	Continued From page 32 Observations of the B3 West hall on 2/2/09 between 10:15 AM and 10:30 AM, revealed a strong odor of urine was present throughout the entire hall. Observations of the B3 West hall on 2/2/09 at 4:00 PM, revealed a foul odor at the nurses' station as well as down the halls of resident rooms 301 through 312 and 324 through 335. During an interview in the B3 West hall, on 2/2/09 at 10:25 AM, Licensed Practical Nurse (LPN #3) confirmed the presence of the strong urine odor on the entire hallway. During the interview it was revealed that housekeeping had already been up and mopped the floor but the odor prevailed.	F 465	Nurse Educator, Clinical Instructor or Director of Facilities Management regarding maintaining cleanliness of unit floors. <ul style="list-style-type: none">• Additionally all bedpans, urinals, and wash basins will be removed from plastic bags, labeled and replaced in wire racks on bathroom walls by CNT's, LPN's, and PCM on the unit.• All storage bags attached to the foot of the beds will be removed from the resident's rooms with completion date of 2/25/09.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and an interview, it was determined the facility failed to maintain complete and accurate medical records regarding resuscitation status for 1 of 30 (Resident #2) sampled residents.	F 514 D	<ul style="list-style-type: none">• The Patient Care Manager for B3, Assistant Director of Nursing or the Director of Environmental Services, will make weekly rounds on Birmingham 3 to check for unit cleanliness and to assure proper placement and labeling of bedpans and urinals and catheter bags. Results will be reported to Quality Council. When 95% compliance is reached for 4 consecutive weeks rounds will be conducted monthly. When 95% is reached for 3 consecutive months, rounds will be conducted quarterly. When 95% compliance is achieved for 2 consecutive quarters, rounds will be conducted at the discretion of the Director of Nursing.	

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F 514 3=D	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and an interview, it was determined the facility failed to maintain complete and accurate medical records regarding resuscitation status for 1 of 30 (Resident #2) sampled residents.</p>	F 514	<p>A</p> <ul style="list-style-type: none"> Resident #2 medical record was found to have incorrect advance directive status on the outside of the record. The incorrect advance directive sticker was placed on the outside of the chart. <p>B</p> <ul style="list-style-type: none"> There will be audits of all charts to determine if advance directives are in place and to ensure that all medical records have the correct sticker on the chart. Any resident that does not have current advance directives in place will be referred to medical director or medical staff for the unit 	3/10/09

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F 514	<p>Continued From page 33</p> <p>The findings included:</p> <p>Medical record review revealed Resident #2 was admitted on 6/30/05 and readmitted on 12/17/08 with diagnoses including Percutaneous Endoscopic Gastrostomy, Adult Failure to Thrive, Status Post Cerebrovascular Accident with Cognitive Deficits, and Vascular Dementia. Resident #2's care plan dated 12/4/08 documented "DNR [Do Not Resuscitate]/DNI [Do Not Intubate] per Advanced Directive and DO NOT Resuscitate Post Date: 12/7/07." Review of the Physician's orders for scope of treatment (POST) form dated 12/22/08 documented "Resuscitate CPR [Cardiopulmonary Resuscitation] but do not intubate." The recapitulation Physician orders dated 2/1/09 through (-) 2/28/09 documented "POST form: DNR/no CPR."</p> <p>Observation of Resident #2's medical record in the day room on floor 2 of the Birmingham building on 2/2/09 at 4:00 PM, revealed a DNR sticker on the front binder of the medical record.</p> <p>During an interview in the day room on floor 2 of the Birmingham building on 2/2/09 at 4:00 PM, Registered Nurse (RN #2) confirmed Resident #2 should be resuscitated and the recapitulation orders dated 2/1/09-2/28/09 were incorrect and the DNR sticker on the front of the chart should be removed.</p>	F 514	<ul style="list-style-type: none"> Any resident chart found to be deficient will have the correct sticker placed on the spine of the chart. <p>C</p> <ul style="list-style-type: none"> The PCM, Charge Nurse, Medical Data Specialist, Nurse or Unit Assessment Coordinator will do an audit of the medical record of all newly admitted residents within 24 hrs. of admission to BLTC to ensure the advance directives will be included in the resident's medical record and the appropriate advance directive status sticker is on the outside of the chart. The PCM, Charge Nurse, Licensed Nurse, Medical Data Specialist and Unit Assessment Coordinator will receive educational information regarding Advance Directives from Clinical Educator and Instructor <p>D</p> <ul style="list-style-type: none"> Audits of a 20% sample of resident charts will be conducted weekly by the Medical Data Specialist, Quality Manager or Charge Nurse regarding advance directives to assure the appropriate sticker is on the chart. When 95% compliance for 3 months is achieved the 	
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