

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

...is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations.

PRINTED: 08/21/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>ALB 33 2012</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a homelike environment by not removing the plates off of trays when serving the residents during 2 of 2 (8/13/12 and 8/14/12) dining observations.</p> <p>The findings included;</p> <p>1. Observations in the R200 hall dining room on 8/13/12 beginning at 11:28 AM, revealed plates were not taken off the meal tray</p> <p>2. Observations in the R400 hall dining room on 8/14/12 beginning at 4:30 PM, revealed resident plates were not taken off their meal trays.</p> <p>Observations in the B400 hall dining room on 8/14/12 beginning at 5:00 PM, revealed all meals were served to the 13 residents in the dining room on their meal trays.</p> <p>3. During an interview in the Director of Nursing's (DON) office on 8/16/12 at 1:45 PM, the DON confirmed that plates are not taken off trays except for on R1 occasionally.</p>	F 252	<p>F-Tag #252</p> <p>A. Beginning September 4, 2012 plates will be removed from trays when serving residents in all unit day rooms and resident rooms for all units.</p> <p>B. Policy # 3.06 Tray Pass has been updated to reflect new process for meal delivery which instructs staff to remove plate, utensils, drinks, and all bowls from the serving tray and place them directly on the table. All residents have the potential to be affected</p> <p>C. Beginning August 30, 2012 all licensed nurses and certified technicians will be in-serviced on Policy #3.06 Tray Pass.</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> Understand the need for creating a home-like environment for residents. Understand techniques for proper food handling and set-up of meal trays. <p>D. The PCM, Charge Nurse, Director of Nutrition, Dietitians or Manager of Quality will audit the staff during tray pass to ensure all interventions are in place for a home-like environment for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.</p>	9/14/12
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p><i>acceptable pcc 8/31/12</i></p>	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *8-30-12*

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 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 interview, it was determined the facility failed to accurately assess hospice services for 1 of 29 (Resident #33) sampled residents with assessments of the 31 included in the stage 2 review.	F 278	F-Tag #278 A. On August 15, 2012 the Resident Assessment Manager (RAM) completed a modification assessment on a Significant Change MDS dated July 15, 2012 to correct noted miscoding of Section O0100K2 (Hospice Care) for one resident with incorrect MDS. The MDS was transmitted and accepted August 15, 2012. (See Attachment A) B. To identify additional potentially affected residents the RAM will perform an audit of all residents receiving hospice care to ensure proper MDS coding is in place by August 27, 2012. Any deficiencies noted will be immediately corrected. C. Effective August 17, 2012, the Resident Assessment Manager began reviewing the Hospice roster before auditing each MDS assessment prior to closing the assessment. On August 24, 2012 all UAC's were in-serviced on Policy #42.05 Care Plan. The RAM will then notify the responsible UAC with any discrepancies noted to correct any missed information before submission of assessment. (See Attachment B) Learning Objectives: <ul style="list-style-type: none"> Understand the need for accurate MDS coding, Understand systems and processes in place to alert users to any discrepancies. 	9/14/12	

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F 278	Continued From page 2 The findings included: Medical record review for Resident #33 documented an admission date of 12/20/11 with diagnoses of Status Post Cerebral Vascular Accident (CVA), Dementia, Adult Failure to Thrive, Hypertensive Heart and Kidney Disease with Heart Failure, Chronic Renal Disease Stage III, Congestive Heart Failure and Osteoarthritis. Review of the Minimum Data Set (MDS) dated 7/15/12 documented a significant change in section O special treatments, procedures and programs. Hospice was not checked. Review of a Physician's order dated 7/13/12 documented, "...admit to [name of Hospice] program with dx [diagnosis] of AFT [Adult Failure to Thrive]..." During an interview in the unit assessment coordinator's office on 8/15/12 at 8:20 AM, Nurse #8 was asked about hospice not being checked on the significant change MDS. Nurse #8 stated, "...MDS was for hospice but was overlooked..."	F 278	D. The RAM, UAC, PCM or Charge Nurse will audit the records of all residents receiving hospice care to ensure it is appropriately coded on the MDS monthly for at least 3 months. The threshold for compliance in the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	F-Tag #279 A. On August 16, 2012 the Resident Assessment Manager (RAM) completed a modification assessment on a Quarterly MDS dated June 3, 2012 to correct miscoding of Section N0300 (Injections). The MDS was transmitted and accepted August 24, 2012. A care plan was developed to address the Deep Vein Thrombosis (DVT) to include the use of the Lovenox and signs and symptoms for licensed staff to observe on August 17, 2012. (See Attachment C & D)	9/14/12	

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F 279	<p>Continued From page 3</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to develop a comprehensive care plan for the new diagnosis of deep vein thrombosis and the use of the medication Lovenox for 1 of 29 (Resident #61) sampled residents with care plans of the 31 included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Care Plan" policy documented, "...Care Plans are to be updated as needed by the interdisciplinary team to resolve problems which no longer exist and to include new problems, goals and interventions. Copies of the Physician Orders will be screened by the Resident Assessment Department as a cross check to assure all new problems have been addressed..."</p> <p>Medical record review for Resident #61 documented an admission date of 12/15/11 with diagnoses of Diabetes Mellitus, Parkinson's Disease, Dementia, Anorexia, Hypertension, Protein-Calorie Malnutrition and Deep Vein Thrombosis. Review of the Physician orders dated 5/1/12 at 8:30 PM documented, "...Start</p>	F 279	<p>B. Unit Assessment Coordinators (UAC) will cross reference electronic medication administration records (EMAR's) with the physician's orders to assure that Sections N0300 (Record # of injections), N0410E (Record number of medications) and (anticoagulants received in past 7 days) are accurately coded beginning on August 27, 2012. Upon identifying Section N0410E (anticoagulants), the UAC will proceed with developing or updating the care plan if indicated.</p> <p>Effective August 27, 2012, the PCM, UAC, RAM, CN will audit all medical records for residents with a diagnosis of DVT to ensure the care plan is present and appropriately reflects goals and interventions as applicable. Unit Assessment Coordinators and Resident Assessment Manager will audit all resident medical records that receive Lovenox to cross reference with their weekly MDS due list for accuracy of coding of Sections N0300 and N0410E.</p> <p>C. Nursing staff will receive in-service training beginning August 30, 2012 regarding education on the signs and symptoms of DVT referencing Policy # 03.79. In addition, staff will be educated regarding potential side effects of Lovenox referencing Policy #3.25 Administration of medication.</p>	9/14/12	

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F 279	<p>Continued From page 3</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to develop a comprehensive care plan for the new diagnosis of deep vein thrombosis and the use of the medication Lovenox for 1 of 29 (Resident #61) sampled residents with care plans of the 31 included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Care Plan" policy documented, "...Care Plans are to be updated as needed by the interdisciplinary team to resolve problems which no longer exist and to include new problems, goals and interventions. Copies of the Physician Orders will be screened by the Resident Assessment Department as a cross check to assure all new problems have been addressed..."</p> <p>Medical record review for Resident #61 documented an admission date of 12/15/11 with diagnoses of Diabetes Mellitus, Parkinson's Disease, Dementia, Anorexia, Hypertension, Protein-Calorie Malnutrition and Deep Vein Thrombosis. Review of the Physician orders dated 5/1/12 at 8:30 PM documented, "...Start</p>	F 279	<p>Learning Objectives:</p> <ul style="list-style-type: none"> Understand the need to develop accurate care plans. Review of MD orders daily to ensure accurate care plans. Utilize morning rounds and weekly Medical Director rounds to acquire information regarding new medication order or medication changes. Identify signs and symptoms related to Lovenox <p>D. The RAM, UAC, PCM or Charge Nurse will audit the records of all residents with a diagnosis of DVT to ensure it is appropriately care planned with diagnosis and anticoagulant therapy monthly for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.</p>	9/14/12
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F 279	Continued From page 4 Lovenox 50 mg [milligrams] sq [subcutaneous] q [every] 12 hr [hours] (DVT [Deep Vein Thrombosis] right upper extremity)..." Review of the care plan updated 6/6/12 did not document the new diagnosis of DVT or the use of Lovenox injections.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it	F 280	F-Tag #280 A. Resident care plan was reviewed by QI Manager on August 17, 2012 to review and reflect correct intervention in place. An in-service began on August 17, 2012 with the unit Patient Care Manager (PCM), Unit Assessment Coordinator (UAC) and all licensed nurses working for this particular unit on the development of a care plan with an immediate intervention in relation for each fall occurrence. (See Attachment E) B. Effective August 17, 2012 in order to identify any additional residents that have the potential to be affected by this practice the RAM, UAC, PCM, Charge Nurse, Nursing Supervisor or Quality Manager began auditing the residents that have had falls in the last 30 days beginning August 27, 2012 to determine if appropriate interventions have been implemented to provide optimal safety for these residents. Any deficiencies found will be corrected at the time they are found.	9/14/12	

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F 280	<p>Continued From page 5</p> <p>was determined the facility failed to revise the care plan to reflect new interventions for falls for 1 of 29 (Resident #119) sampled residents of the 31 included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #119 documented an admission date of 7/7/10 with diagnoses of Cerebral Vascular Accident with Dysphagia and Aphasia, Vascular Dementia, Schizophrenia, Benign Prostatic Hypertrophy, Dementia, Psychosis, Depression, Hypertension, Gastric Esophageal Reflux Disease, Asthma, Gastroparesis, Contractures of Left Upper Extremity, Percutaneous Esophageal Gastrostomy and Cardiomegaly. Review of the annual Minimum Data Set (MDS) dated 2/5/12 documented under Section J the resident had 1 fall since admission but no injury. Review of the quarterly MDS dated 7/22/12 documented in section J that the resident had 2 falls since the last assessment but no injury. Review of the care plan dated 2/6/12 until present documented falls on 2/6/12, 3/2/12, 4/4/12, 5/23/12, 6/11/12, 6/22/12, 7/31/12. with no injuries. There were no new interventions put in place for falls after the fall on 3/2/12.</p> <p>During an interview in the resident assessment office on the birmingham 2nd floor on 8/15/12 at 11:11 AM, Nurse #2 stated, "...They [staff] may not put new interventions in place... They keep the ones already in place."</p> <p>During an interview in the hallway outside room B228 on 8/15/12 at 2:15 PM, Nurse #3 stated, "...After each fall they [staff] put in a new</p>	F 280	<p>C. Effective August 17, 2012 any residents that have experienced falls during the week will have their medical records and incident reports with interventions presented during morning rounds occurring three (3) times a week. The Unit Charge Nurse or PCM will communicate during these meetings information related to the fall incidents to ensure it is addressed and appropriately added to the plan of care. The Nursing Supervisor will check the 24 hour report book after hours and during the weekends to ensure that any falls and the appropriate interventions are implemented and added to the care plan.</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> To understand the review of the care plan to ensure it has been appropriately updated as a result of a fall. To understand the guidelines for re-evaluation if the implemented intervention is not successful at increasing the safety level of the resident. Licensed nurses will understand that new interventions are applied immediately following a fall. <p>D. The RAM, UAC, PCM or Charge Nurse will audit the records of all residents who have experienced a fall in the last 30 days to ensure appropriate interventions are employed and identified on the care plan. This will be done monthly for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.</p>	<p>9/14/12</p>
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F 280	Continued From page 6 intervention. They try to monitor him more frequently..." Nurse #3 was asked about any new interventions put in place for the falls that had occurred after 3/2/12. Nurse #3 stated "...may have exhausted all the interventions." During an interview in the unit assessment coordinator's office on 8/15/12 at 4:55 PM, Nurse #4 stated, "[Resident #119] has every intervention available..."	F 280			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined 1 of 10 nurses (Nurse #5) observed administering medications failed to ensure proper placement of a percutaneous endoscopy gastrostomy (PEG) tube before administering medications to 1 of 2 (Resident #25) sampled residents observed receiving medications via PEG tube. The findings included: Medical record review documented an admission date of 9/28/11 with diagnoses of Hypertension,	F 322 F-Tag 322	A. On August 24, 2012 the Patient Care Manager (PCM) for B4 reviewed with Nurse #5 Section 21.d of policy #3.25 Administration of Medication. In addition, nurse #5 was observed by the PCM for tube placement and medication administration via PEG tube for resident #23 and met standards. (See Attachment F) B. There are three residents on B4 with PEG tubes. Resident #25 was the only resident with a PEG tube cared for by nurse #5. Nurse #5 will periodically be audited regarding placement of PEG tubes prior to administration of medications C. Licensed nursing staff will be in-serviced on Policy 3.25 Medication Administration and perform return demonstrations beginning August 30, 2012. Learning Objectives: <ul style="list-style-type: none"> Licensed nursing staff will understand proper techniques for verifying PEG tube placement Licensed nursing staff will understand correct process for medication administration 	9/14/12	

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F 322	Continued From page 7 Chronic Kidney Disease, Dementia, Cerebrovascular Accident (CVA), Hemiplegia, Weight Loss, Gastrostomy and Seizure Disorder. Review of the Physician's orders dated 7/31/12 documented, "...Pepcid 20 mg [milligrams] per PEG BID [twice daily]... Keppra 1000 mg per peg BID... Lorazepam 0.5 mg per peg BID... PEG Tube Osmolite 1 cal [calorie] liq [liquid] enteral tube each shift @ [at] 76 ml [milliliters] / [per] hr [hour] x [times] 19 hrs [hours]... Flush tube with 95 ml/hr of H2O [water] from 2P- [to] 4P and 10P-12A..." Review of the care plan dated 5/25/12 documented, "...Feeding tube long term... TF [tube feeding] dependence d/t [due to] dysphagia following a CVA... Check placement gastric residuals per protocol..." Observations in Resident #25's room on 8/14/12 at 4:40 PM, revealed Nurse #5 aspirated the PEG tube with no visible gastric contents returned. Nurse #5 then injected a full 60 ml of air into the PEG tube without using a stethoscope to auscultate for placement as the air was injected. Nurse #5 did not bring a stethoscope into the room. Nurse #5 then gave Resident #25's medications per PEG tube. Nurse #5 failed to properly check the placement of the PEG tube prior to administering medications. During an interview in the patient care manager's office on the birmingham 4th floor, Nurse #6 stated, "...PEG placement should be verified by aspiration and by using a stethoscope to listen as you inject a small amount of air into the PEG tube... not a full 60 ml syringe..."	F 322	D. The PCM, Nurse Educator or Nurse Supervisor will perform medication pass audits on 20% of residents with PEG tubes monthly for at least 3 months. The threshold for compliance in the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.	9/14/12	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 8</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to implement new interventions to prevent falls for 1 of 6(Resident #119) sampled residents of the 6 residents reviewed with falls included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Falls and Restraints" policy documented "ACTIONS NECESSARY AFTER FALLS After a resident falls, a licensed nurse in charge of care must immediately put in place measurable interventions to prevent future accidents..."</p> <p>Medical record review for Resident #119 documented an admission date of 7/7/10 with diagnoses of Cerebral Vascular Accident with Dysphagia and Aphasia, Vascular Dementia, Schizophrenia, Benign Prostatic Hypertrophy, Dementia, Psychosis, Depression, Hypertension, Asthma, Gastro Esophageal Reflux Disease, Gastroparesis, Contractures of Left Upper Extremity, Percutaneous Endoscopy Gastrostomy and Cardiomegaly. Review of the annual Minimum Data Set (MDS) dated 2/5/12</p>	F 323	<p>F-Tag #323</p> <p>A. Resident care plan was reviewed by QI Manager on August 17, 2012 to review and reflect correct intervention in place. An in-service began on August 17, 2012 with the unit Patient Care Manager (PCM), Unit Assessment Coordinator (UAC) and all licensed nurses working for this particular unit on the development of a care plan with an immediate intervention in relation for each fall occurrence. (See Attachment E)</p> <p>B. Effective August 17, 2012 in order to identify any additional residents that have the potential to be affected by this practice the RAM, UAC, PCM, Charge Nurse, Nursing Supervisor or Quality Manager began auditing the residents that have had falls in the last 30 days beginning August 27, 2012 to determine if appropriate interventions have been implemented to provide optimal safety for these residents. Any deficiencies found will be corrected at the time they are found.</p> <p>C. Effective August 17, 2012 any residents that have experienced falls during the week will have their medical records and incident reports with interventions presented during morning rounds occurring three (3) times a week. The Unit Charge Nurse or PCM will communicate during these meetings information related to the fall incidents to ensure it is addressed and appropriately added to the plan of care. The Nursing Supervisor will check the 24 hour report book after hours and during the weekends to ensure that any falls and the appropriate interventions are implemented and added to the care plan.</p>	9/14/12	

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F 323	Continued From page 9 documented under section J the resident had 1 fall since admission with no injury. Review of the quarterly MDS dated 7/22/12 documented in section J that the resident had 2 falls since the last assessment with no injury. Review of the care plan dated 2/6/12 until present documented falls on 2/6/12, 3/2/12, 4/4/12, 5/23/12, 6/11/12, 6/22/12, and 7/31/12 with no injuries. There were no new interventions put in place for falls after the fall on 3/2/12 During interview in the resident assessment office on 8/15/12 at 11:11 AM, Nurse #2 stated, "...They [staff] may not put new interventions in place. They keep the ones already in place..." During an interview in the hallway outside room B228 on 8/15/12 at 2:15 PM, Nurse #3 stated, "...After each fall they [staff] put in a new intervention. They try to monitor him more frequently..." Nurse #3 was asked about any new interventions put in place for the falls that had occurred after 3/2/12. Nurse #3 stated "...may have exhausted all the interventions." During interview in the unit assessment coordinator's office on 8/15/12 at 4:55 PM, Nurse #4 stated Resident #119 "...has every intervention available... Feels like they have tried all the interventions..."	F 323	Learning Objectives: <ul style="list-style-type: none"> To understand the review of the care plan to ensure it has been appropriately updated as a result of a fall. To understand the guidelines for re-evaluation if the implemented intervention is not successful at increasing the safety level of the resident. Licensed nurses will understand that new interventions are applied immediately following a fall. D. The RAM, UAC, PCM or Charge Nurse will audit the records of all residents who have experienced a fall in the last 30 days to ensure appropriate interventions are employed and identified on the care plan. This will be done monthly for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.	9/14/12	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371			

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F 371	Continued From page 10 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained when 11 of 33 certified nursing technicians (CNT #6, 10, 11, 13, 14, 15, 19, 20, 21, 23 and 24) failed to practice sanitary hand hygiene by touching the residents' environment and then prepared meal trays and fed residents, handled residents' food and straws with bare hands or placed contaminated trays back on the cart with unserved meal trays during dining observations. The findings included: 1. Review of the facility's "Tray Setup" policy documented, "Procedure... 6. Prior to beginning the meal tray pass, staff should clean their hands with soap and water. Staff should NOT wear gloves during meal tray service. Instead, between tray passes, staff should sanitize their hands using the Sani Wipes or Alcohol Foam. Staff members who have touched a resident during a tray pass must clean their hands with soap and water before the next tray pass. 7. Staff are to clean their hands with soap and water between touching a resident and opening food or liquid containers on tray... 10. If a straw is needed, it should be unwrapped and placed in a beverage being careful not to touch the end of the straw	F 371	F-Tag #371 A. Effective August 17, 2012, the Director of Nursing began in-servicing staff on appropriate hand hygiene during tray pass. Beginning August 30, 2012 employed Certified Nursing Assistance will be required to complete "Tray Set-Up" in-service with return demonstration. B. Policy # 3.06 Tray Pass has been updated to reflect the correct process for hand hygiene during meal deliveries. All residents have the potential to be affected. C. All licensed nurses and certified technicians will be in-serviced on Policy #3.06 Tray Pass and perform return demonstration beginning August 30, 2012. (See Attachment G) Learning Objectives: <ul style="list-style-type: none"> Understand the proper delivery and set-up of resident's meals Understand proper hand hygiene during delivery and set-up of resident meals. D. The PCM, Charge Nurse, DON, Director of Skilled Services, Nursing Supervisor, Nurse Educator or Quality Manager will audit tray passes of staff during four meal passes a week to ensure interventions are in place for proper hand hygiene for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.	9/14/12	

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F 371	Continued From page 11 that the resident will put in their mouth..." 2. Observations in the R400 hall dining room on 8/13/12 beginning at 12:20 PM, CNT #6 touched the resident's silverware with bare hands and touched the tip of the fork and spoon. 3. Observations in R400 dining room on 8/13/12 beginning at 12:20 PM, CNT#10 handled the straw with her bare hands when placing it in the resident's drink. 4. Observations in the R400 hall dining room on 8/13/12 beginning at 12:20 PM, CNT #11 moved her hair away from her face and continued to prepare the residents' tray. 5. Observations in the B400 hall dining room on 8/14/12 beginning at 5:00 PM, CNT #13 fed graham crackers and a sandwich to Resident #420 with her bare hands. 6. Observations in room 406B on 8/14/12 beginning at 5:00 PM, CNT #14 delivered a meal tray to room 406B, adjusted the bed manually, pulled the resident's shoulders over to reposition him in bed, applied a clothing protector on the resident after wearing it over her shoulder throughout setup of the tray. CNT #14 then set up the tray, including silverware and straw, handling all items with her bare unwashed hands. CNT #14 proceeded to room B422, opened the straw and handled it with her bare hands after tray setup. 7. Observations in room B429 on 8/14/12 beginning at 5:00 PM, CNT #15 delivered a tray, set up the tray, peeled the boiled egg with her	F 371			

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F 371	<p>Continued From page 12</p> <p>bare hands, placed the egg into the serving bowl with her bare hands, opened the straw and handled it without washing her hands.</p> <p>8. Observations on B300 hall on 8/13/12 beginning at 11:15 AM, CNT #19 carried a meal tray into room 330 and placed the tray on the resident's overbed table. The resident refused the tray. CNT #19 picked up the tray and returned it to the tray cart which contained meal trays that had not been served.</p> <p>9. Observations in the R100 hall dining room on 8/13/12 beginning at 11:30 AM, CNT #20 handled the straw with bare hands when placing it in the resident's drink.</p> <p>10. Observations in the R100 hall dining room on 8/13/12 beginning at 11:30 AM, CNT #21 handled a baked potato while applying butter.</p> <p>11. Observations in the R100 hall dining room on 8/13/12 beginning at 11:30 AM, CNT #23 handled the straw with bare hands when placing it in the resident's drinks.</p> <p>12. Observations in the R100 hall dining room on 8/13/12 beginning at 11:30 AM, CNT #24 handled the straw with bare hands when placing it in the resident's drinks.</p> <p>13. During an interview in the Director of Nursing's (DON) office on 8/16/12 at 1:45 PM, the DON was asked about expectations of staff when serving meal trays. The DON stated, "Depend on what they've touched. If resident contact, at least use wipe and after three times must wash hands. Should not come in contact with food. Hold</p>	F 371			

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F 371	Continued From page 13 bread/food inside bag and butter it. They are not to touch food or silverware other than handle."	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F-Tag #431 A. On August 15, 2012 all medication carts on R1 and R4 found with expired medications were immediately inspected for any expired medications. Any expired medications found were removed, disposed of and new medications ordered where needed. B. To identify other residents potentially affected all medication carts within the facility were immediately checked on August 15, 2012 for any expired medications. Any medications found were removed, disposed of and new medications ordered where needed. C. Policy #6.69 "Medication Storage" will be reviewed and updated by DON and Pharmacy Consultant by August 29, 2012. All licensed staff will be in-serviced on the updated policy #6.69 Medication Storage August 30, 2012. Beginning the week of August 27, 2012 the Pharmacy Consultant will do weekly audits of the medication carts for expired medication and complete a "Medication Cart Expired Med Review Tool" and present findings to the PCM. Any expired medications will be disposed of and new medications ordered. (See Attachment H) Learning Objectives include: <ul style="list-style-type: none"> Understanding the importance of checking medication expiration dates and proper disposal of when expired. Understanding of proper disposal systems when expired medications are located and the process to reorder the medication. Ensuring that review of medication labels for expiration dates are routinely a part of the medication pass. 	<i>9/14/12</i>	

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F 431	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure medications were not stored past their expiration date in 4 of 25 (Ribeiro Building 4th floor North hall medication cart, Ribeiro Building 4th floor South hall medication cart, Ribeiro Building 1st floor East hall medication cart and Ribeiro Building 1st floor North hall medication cart) medication storage areas.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Medication Storage in the Facility" policy documented, "...Expired... medications... are immediately removed from medication carts and medication rooms, disposed of according to procedures for medication destruction, and reordered from the pharmacy..." 2. Observations and interview in Ribeiro Building 4th floor North hall medication cart on 8/15/12 at 8:30 AM revealed Clonidine 0.1 milligram (mg) tablets stored past the expiration date of 7/6/12. The dates on the expired medication was confirmed with the nurse responsible for this medication cart. 3. Observations and interview in Ribeiro Building 4th floor South hall medication cart on 8/15/12 at 8:30 AM, revealed Vistaril 25 mg capsules stored past the expiration date of 7/6/12 and a bottle of Nitroglycerin 0.4 mg sublingual tablets stored past the expiration date of 7/6/12. The dates on the expired medications was confirmed with the nurse responsible for this medication cart. 	F 431	<p>D. The Pharmacy Consultant, PCM or Charge Nurse will audit periodically during the month each medication cart to ensure there are not any expired medications present for least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.</p>	9/14/12	

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F 431	Continued From page 15 4. Observations and interview on Ribeiro Building 1st floor East hall medication cart on 8/15/12 at 3:00 PM, Premarin vaginal cream stored past the expiration date of 7/22/12 and Lorazepam 0.5 mg tablets stored past the expiration date of 7/18/12. The dates on the expired medications was confirmed with the nurse responsible for this medication cart. 5. Observations in Ribeiro Building 1st floor North hall medication cart on 8/15/12 at 3:10 PM, revealed Clonidine 0.1 mg tablets stored past the expiration date of 7/6/12 and Promethazine 25 mg tablets stored past the expiration date of 7/5/12. The dates on the expired medications was confirmed with the nurse responsible for this medication cart.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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:	F 514	F-Tag #514 A. The original MD order had been changed to three times daily on April 18, 2012. The text "Bid" had not been removed from order name box in KNS. The order read Sinemet 25-100 tab, 2 tabs bid, oral, three times daily for Parkinson's disease. The resident had been receiving the correct dosage. The order was re-entered correctly as soon as it was discovered on August 15, 2012 B. Beginning the week of August 27, 2012, an audit will be conducted by the PCM, Charge Nurse, Nursing Supervisor, or Quality Manager to review other physician orders for any inaccuracies in the electronic record/chart orders. Any inaccuracies will be corrected immediately.	9/14/12	

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F 514	<p>Continued From page 16</p> <p>Based on medical record review and interview, it was determined the facility failed to ensure medical records were accurate for 1 of 19 (Resident #282) sampled residents of the 31 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #282 documented an admission date of 11/30/09 with diagnoses of Anemia, Anoxic Brain Damage, Dysphagia, Anemia, Hepatitis C, Dementia, Parkinson's, Osteoarthritis, Joint Contractures, Aphasia, Cocaine Abuse, Ethanol Abuse, Gastroesophageal Reflux, Pain, Depression, Psychosis, Constipation, Hypoglycemia, History of Falls, and Chronic Respiratory Failure. Review of the recertification Physician's orders dated 3/28/12 documented, "...Order Date... 2/19/12... MED [medication] - SINEMET 25-100 25 MG [milligram] -100 MG TAB [tablet] adm. [administer] 2 tabs bid [twice a day] (Carbidopa / Levodopa) Oral Twice daily..." Review of a physician's order dated 4/18/12 documented, "...Change Sinemet 25/100 mg [2] tabs po tid [three times a day]..." Review of the recertification Physician orders dated 4/27/12, 5/29/12, 6/26/12 and 7/30/12 documented, "...Order Date... 04/18/12... MED - SINEMET 25-100 25 MG-100 MG TAB adm. 2 tabs bid (Carbidopa/Levodopa) Oral Three times daily..." Review of a physician's progress note dated 4/18/12 documented, "...Trial of increasing Sinemet to 25/100 mg two tablets t.i.d. [three times a day] If there is no improvement whatsoever, he may be better not on any Sinemet at all..." Review of the medication administration records (MAR) dated from 3/1/12 through (-) 8/15/12 documented Resident #282</p>	F 514	<p>C. All Licensed Nurses and Medical Data Specialist will be in-serviced on the entry of physician orders into Keane beginning August 29, 2012.</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> Understand the importance of correctly entering physician orders into Keane Understand all steps involved to accurately build a physician's order for entry into Keane <p>D. The PCM, Charge Nurse, or Quality Manager will audit 20% of all new orders each month for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Quality Manager. Audit results will be reported monthly in Quality Council Committee.</p>	9/14/12	

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F 514	Continued From page 17 received Sinemet 25-100 mg tabs BID until 4/18/12. From 4/18/12 to present, Resident #282 received Sinemet 25-100 mg tabs TID. During an interview in the Director of Nursing's (DON) office on 8/15/12 at 3:55 PM, the DON was asked about the two different frequencies of the Sinemet on the recertification orders. The DON confirmed the recertification orders were inaccurate and stated, "...must have been an error, should just say tid here, that is how he is getting it on the MARs..."	F 514			