

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

PRINTED: 04/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

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MAY 02 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NASHVILLE COMMUNITY CARE &amp; REHABILITATION AT BORDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218</b>
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F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to promote dignity of residents when 3 of 29 staff members (Hospitality Aide (HA)#1, Licensed Practical Nurse (LPN) #8) and Certified Nursing Assistant (CNA) #3 referred to residents as a "feeder".</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>The facility's "Quality of Life - Dignity" policy documented, "...Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs..."</li> <li>Observation and interview on 4/6/16 at 4:55 PM, in the Ruberio 1 dining room revealed a resident was moved to another table. HA #1 was asked why resident was moved, and HA #1 stated, "She is a feeder."</li> <li>Observations on 4/6/16 at 5:14 PM, in the Ruberio 1 dining room revealed CNA #3 was standing outside of the Ruberio 1 dining room and yelled out to staff in the dining room, "the feeders against the wall".</li> <li>Observations on 4/6/16 at 6:10 PM, on the</li> </ol>	F 241	<ol style="list-style-type: none"> <li>The Residents of Bordeaux are spoken to in a manner that enhances their dignity and demonstrates respect by utilizing his or her name of choice. Residents will not be labeled (i.e., feeder, sweetie, honey, etc.).</li> <li>All residents have the potential to be affected by this alleged deficiency.</li> <li>Education will be provided to the staff regarding dignity and respect with a focus on: Respecting resident's by addressing the resident with a name of choice, avoiding the use of labels for residents such as "feeders", or hollering information across a room.</li> <li>Newly hired staff members will be oriented during orientation. The Department Head Team will monitor meal pass to ensure compliance with maintaining dignity and respect and will provide immediate feedback and remedial education as indicated.</li> <li>The Director of Nursing/Designee will be responsible for this process. She will ensure education is provided. Monitoring will take place daily for 30-days, then twice weekly for 30-days, and monthly thereafter.</li> </ol>	5/6/16
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Autony M...</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/29/16</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 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.

*This same POC was emailed 4/29/16 JP*

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F 241	Continued From page 1 Ruberio 1 south hall, LPN #8 was heard to say, "have so many feeders".	F 241	Results of monitoring will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision for a period of 3-months and quarterly thereafter.	
F 252 SS=D	5. Interview with CNA #3 on 4/6/16 at 5:56 PM, on Ruberio 1 hall, CNA #3 was asked whose 5 trays were still on the meal cart. CNA #3 stated, "All the feeders."  483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b>  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents had a homelike dining experience when there was not sufficient staff present to ensure the meal trays were passed in a timely manner on 1 of 5 (Ruberio 1 hall) halls during two meal observations.  The findings included:  Observations on Ruberio 1 (R-1) on 4/4/15, revealed the meal cart arrived at 11:36 AM, and the last tray was served at 12:24 PM, with a total of 48 minutes to complete tray pass.  Observations on R-1 on 4/6/16, revealed dining started at 4:55 PM, and the last tray was served at 6:15 PM, with a total of 1 hour and 20 minutes to complete tray pass.	F 252	1.The Dining Program on Ruberio-1 has been enhanced to ensure there is adequate staff for dependent diners, tray delivery that ensures meals are received at the appropriate temperature, and a more relaxed, homelike environment is provided.  2.The Dining Program on Ruberio-1 was observed for performance improvement purposes by the formed QAPI Dining Sub-Committee to evaluate and gather data related to this alleged deficiency.  3.The dining program on Ruberio-1 has been restructured and includes 2-seating's to provide a more relaxed experience. The new process will enable staff adequate time to provide attention, comfort, and dignity to each resident. The overall goal will be an enhanced dining program that meets the individual needs of each resident. 4.Education has been provided to the staff on Ruberio-1 regarding the new dining process and their individual roles in it. Newly hired staff members will be educated related to the dining program during orientation.  5.The Assistant Director of Nursing/Registered Dietitian/Designee will be responsible for this process. They will chair the QAPI Sub-Committee and execute the Performance Improvement Plan. They will observe dining daily for 1-week after the new process is initiated, then twice weekly for 30-days, and monthly thereafter.	5/6/16

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F 252	Continued From page 2 Interview with the Director of Nursing (DON) and the Clinical Nurse Consultant (CNC) on 4/7/16 at 6:45 PM, in the DON's office, the DON and CNC were asked if it was acceptable for a resident to receive their tray an hour and 20 minutes after tray service began. The CNC stated, "It's difficult."	F 252	5.Results of the process will be reported to QAPI Committee monthly for 3-months and quarterly thereafter for review and recommendations.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.	F 278	1.Resident #222 has a corrected MDS dated 4/7/16 that appropriately reflects a chronic disease with a life expectancy of less than 6-months.  2. An audit of the clinical records on 4/28/16 of the three (3) residents currently receiving hospice services was conducted to ensure the coding of their assessments is reflective of a chronic disease with a life expectancy of less than 6-months.  3.The MDS Coordinator will provide re-education to the nurses in the MDS department related to coding with a focus on coding specifically for residents with a life expectancy of less than 6-months.  4.The MDS Coordinator will audit the MDS's for hospice residents for the next 3-months to ensure they are coded accurately. If indicated remedial education will be provided.	5/6/16	

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F 278	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess a resident for prognosis for life expectancy of 6 months or less for 1 of 17 (Resident #222) residents reviewed of the 28 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #222 was admitted to the facility on 10/23/15 with diagnoses of Coronary Artery Disease, Cerebral Vascular Accident with Right Sided Hemiparesis, End Stage Vascular Dementia, Schizophrenia, and Hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 1/27/16 documented Resident #222 had no prognosis for a life expectancy of 6 months or less, and received hospice services while a resident at the facility.</p> <p>The comprehensive care plan dated 10/30/15 documented, "...Resident is diagnosed with terminal condition... End-Stage of Vascular Dementia... currently receiving Hospice services..." The care plan was reviewed 1/27/16 and documented, "...Cont [continue] POC [plan of care]... Resident is followed by Hospice..."</p> <p>The current physician's orders signed 3/29/16 documented, "Order Date... 10/23/2015... HOSPICE SERVICES..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 4/6/16 at 3:00 PM, in the administrative hallway, LPN #1 was asked whether the quarterly</p>	F 278	<p>5.The MDS Director/Designee will be responsible for this process. He will provide the education and audit 100% of the hospice MDS's over the next 3-months. He will also audit 1-MDS for each of his 3-member team's MDS's monthly for 3-months providing education as indicated. He will report the findings of his audits to the QAPI Committee monthly for 3-months and quarterly thereafter.</p>	

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F 278	Continued From page 4	F 278		
F 279 SS=D	<p>MDS dated 1/27/16 was accurate related to the prognosis. LPN #1 stated, "It was error."</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's 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 medical record review, observation and interview, the facility failed to develop a care plan for dental status for 1 of 17 (Resident #103) sampled residents reviewed of the 28 residents included in the stage 2 review.</p> <p>The findings included:  Medical record review revealed Resident #103</p>	F 279	<p>1. Resident #103 has a current oral assessment, was seen by the dentist on 4/12/16, and has a care plan that addresses his need for assistance with oral hygiene.</p> <p>2. Current residents have had a dental assessment completed by nursing. Dental follow-up will be scheduled with the dentist as indicated. Care plans have been developed that reflect oral hygiene needs.</p> <p>3. Education was provided to the licensed nurses related to dental assessment completion expectation for every admission and annually; care plan development based on assessment, and the steps to take to obtain routine and emergency dental care if indicated. Newly hired nurses will be educated related to dental assessments and care plan development during orientation.</p> <p>4. Annually and with each new admission an audit will be complete to ensure they are completed and reflective of each resident's needs.</p>	5/6/16

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F 279	<p>Continued From page 5</p> <p>was admitted to the facility on 9/10/15 with diagnoses of Dysphagia, Diabetes, Epilepsy, Hypertension, Peripheral Neuropathy, Cerebrovascular Accident with Hemiplegia, Vascular Dementia, Bipolar, Arthritis, Edema, Muscle Weakness, Hyperlipidemia, Hypothyroidism, Osteoporosis, Depression, and Psychosis.</p> <p>The quarterly Minimum Data Set (MDS) dated 1/12/16 documented Resident #103 required extensive staff assistance for personal hygiene.</p> <p>The comprehensive care plan last reviewed on 2/27/16 did not address Resident #103's need for assistance with oral hygiene.</p> <p>Observations on the B4 hall, on 4/5/16 at 8:47 AM and 4/6/16 at 9:14 AM, revealed Resident #103 had several missing teeth.</p> <p>Interview with the Director of Nursing (DON) on 4/7/16 at 4:09 PM, in the conference room, the DON was asked whether Resident #103 had any missing or broken teeth. The DON stated, "He has some [teeth] missing." The DON was asked whether Resident #103's dental status should be addressed on the care plan. The DON stated, "Yes."</p>	F 279	<p>5. The Assistant Director of Nurses/Social Services/Designee will be responsible for this process. They will ensure assessments are completed upon admission and annually. They will facilitate the development of a comprehensive care plan. They will also assist the resident/family in making dental appointments and transportation arrangements as necessary.</p> <p>6. Any findings will be recorded and reported to the Quality Assurance Committee monthly for 3-months and quarterly thereafter. Completion date 5/6/16</p>		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition</p>	F 322	<p>1. Resident #32 has the placement of his percutaneous endoscopy gastrostomy (PEG) tube verified by checking gastric residual volume (GRV) before each feeding, and prior to medication administration.</p>	5/6/16	

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F 322	<p>Continued From page 6 demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure 1 of 6 (Licensed Practical Nurse (LPN #5) nurses checked placement of the percutaneous endoscopy gastrostomy (PEG) tube before administering medications to 1 of 3 (Resident #32) sampled residents receiving medication via a PEG tube.</p> <p>The findings included:</p> <p>Review of the facility's "Medication Administration Enteral Tubes" documented, "...8. Verify tube placement... aspirate stomach contents with syringe..."</p> <p>Observations on 4/7/16 at 12:20 PM, in Resident #32's room, revealed LPN #5 inserted a syringe into the PEG tube but did not aspirate stomach contents. LPN #5 flushed the PEG tube, administered medications, flushed the PEG tube</p>	F 322	<p>2.The facility realizes that all PEG-Tube residents have the potential to be affected by this alleged deficiency.</p> <p>3.Education was provided to the LPN #5 related to checking GRV by actually pulling back gastric contents prior to each medication administration. Education will be provided to the licensed nurses related to gastrostomy feeding and be provided with a copy of the guideline steps for their review. Each nurse will be observed with utilizing a Gastrostomy Feeding Competency Checklist. Newly hired licensed nurses will be educated during orientation and have a completed competency checklist completed.</p> <p>4.The Staff Development Coordinator, Director of Nursing, Designee will be responsible for this process. They will ensure that education is completed and competency is determined for each licensed nurse. Following education they will conduct one competency each week for 30-days, then two in 30-days, then one in 30-days and randomly thereafter.</p>		

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F 322	Continued From page 7 again and then removed the syringe. LPN #5 failed to check placement of the PEG tube prior to administering medications to Resident #32.  Interview with the Director of Nursing (DON) on 4/7/16 at 2:30 PM, in the DON's office, the DON was asked do you expect the nurses to actually pull back (aspirate) stomach contents when checking PEG placement. The DON stated, "Yes."	F 322	5.Results of the process will be reported to QAPI Committee monthly for 3-months and quarterly thereafter for review and recommendations.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on review of the Geriatric Medication Handbook, medical record review, observation and interview, the facility failed to ensure a resident was free from a significant medication error when 1 of 6 nurses (Licensed Practical Nurse (LPN) #4) failed to administer insulin within the proper time frame related to meals for Resident #196, who received an insulin injection. The failure to provide a significant snack or substantial meal within appropriate time of insulin administration resulted in a significant medication error.  The findings included:  Review of the Geriatric Medication Handbook, eleventh edition, page 41 documented, "DIABETES: INJECTABLE MEDICATIONS... Humalog... Rapid-Acting Insulin Analog...	F 333	1.Resident #196 had no observed side effects from the delay in meal provision. The resident is having insulin administered within the proper time frame related to meals.  2.The facility realizes that all residents receiving insulin have the potential to be affected by this alleged deficiency.  3.Education was provided to LPN #4 related to meal provision within the appropriate time frame following insulin administration. Education related to diabetes and insulin will be provided to the licensed nurses and will include the following information from the National Institute of Diabetes and Digestive Kidney Diseases: The types of insulin (rapid-acting, short-acting, intermediate acting, long acting, and pre-mixed types), brand names, onset, peak, and duration for each type.	5/6/16

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F 333	<p>Continued From page 8</p> <p>ONSET... 15 min [minutes]... TYPICAL ADMINISTRATION/COMMENTS 15 minutes prior to meals..."</p> <p>Medical record review revealed Resident #196 was admitted to the facility on 2/1/16 with diagnoses of Dependence on Renal Dialysis, End stage Renal Disease, Heart Failure, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease.</p> <p>Review of physician's order dated 3/28/16 documented "Humalog... inject 10 units Sub-Q [subcutaneously] three times daily with meals..."</p> <p>Observations in Resident #196's room on 4/6/16 at 5:25 PM, revealed LPN #4 administered 10 units of Humalog subcutaneously. Resident #196 then went to the B2 activity room.</p> <p>Observations in the B2 activity room on 4/6/16 at 6:04 PM is when Resident #196 took the first bite of food.</p> <p>Interview with LPN #4 on 4/7/16 at 2:40 PM, in B hall, LPN #4 was asked, how long after administering Humalog insulin should a resident receive their meal. LPN #4 stated, "Immediately."</p> <p>Interview with the Director of Nursing (DON) on 4/7/16 at 2:30 PM, in the DON's office, the DON was asked how long after a resident receives Humalog insulin should it be until the resident receives their meal or a significant snack. The DON stated, "Within 30 minutes."</p> <p>Humalog is a fast acting insulin. Resident #32 should have received a significant snack or substantial meal within 15 minutes after receiving</p>	F 333	<p>Education will also include monitoring of residents post insulin administration and standards of practice to the timing of meals or significant snack provision after insulin is administered.</p> <p>4. Newly hired licensed nurses will be educated during orientation and have a completed competency checklist completed.</p> <p>5. The Staff Development Coordinator/Director of Nursing/Designee will be responsible for this process. They will ensure education is conducted and standards of practice are maintained related to insulin administration and meal or significant snack provision. They will monitor the provision of nursing services related to diabetes management over the next 3-months and quarterly thereafter reporting their findings to the QAPI Committee for review and recommendations. Completion date 5/6/16</p>	

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F 333	Continued From page 9 the Humalog insulin.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, the facility failed to ensure food was stored and served under sanitary conditions as evidenced by open buckets with the presence of chemicals in the food preparation (prep) area, food items with no date when they were opened, liquid items stored past their expiration date, baking pans stacked wet nested (water between the pans), and staff touching food with their bare hands. This had the potential to affect 24 residents receiving thickened liquids, and 205 residents receiving meal trays from the kitchen of the total census of 234.  The findings included:  1. The facility's "Food Storage" policy stated, "...All containers must be legibly and accurately labeled... Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food... Leftover food is	F 371	1.The open buckets with chemicals in the food preparation area have been removed, open food items are dated when opened, expired liquid items have been removed, baking pans are not wet nested, and staff do not touch food with their bare hands. The buckets of chemicals are now on a mobile cart. After cleaning the cart can be removed from the food preparation area.  2.The facility realizes that all residents have the potential to be affected by this alleged deficiency. An audit was conducted post survey by the Registered Dietitian (RD), the Dietary Manager (DM), and the Chief Executive Officer (CEO) to validate sanitation, and infection control practices were maintained.  3.Education was provided to the members of the dietary department by the Registered Dietitian related to kitchen sanitation, infection control and focused on the following: All containers must be legibly and accurately labeled.	5/6/16

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F 371	<p>Continued From page 10</p> <p>stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated... Rewrap packages of frozen food which have been opened..."</p> <p>Observations in the kitchen on 4/4/16 beginning at 10:35 AM, revealed the following:</p> <ul style="list-style-type: none"> <li>a. 1 - red bucket and 1- green bucket with soapy water sitting under the food prep table.</li> <li>b. 1 - opened box of mixed vegetables, stored in the freezer.</li> <li>c. 1 - opened box of tater tots, stored in the freezer.</li> <li>d. 1 - meat item wrapped in plastic wrap with no open date.</li> <li>e. 2 - opened bags of meat no open date stored in the freezer.</li> <li>f. 6 - 46 ounce (oz) containers of thickened orange juice stored in the stock room past the expiration date of 3/18/15.</li> <li>g. 6 - 46 oz thickened sweetened tea with lemon flavor stored in the stock room past the expiration date of 10/6/15.</li> <li>h. 6 - 46 oz honey-like consistency sweetened tea with lemon flavor stored in the stock room past the expiration date of 11/12/15.</li> <li>i. 2 - 46 oz honey-like consistency sweetened tea with lemon flavor stored in the stock room past the expiration date of 2/17/16.</li> <li>j. 1 - 46 oz thickened orange juice stored in the dairy refrigerator past the expiration date of 3/18/16.</li> <li>k. 4 - 46 oz honey-like consistency sweetened tea with lemon flavor stored in the dairy refrigerator past the expiration date 11/12/15.</li> <li>l. 4 shallow baking pans stacked wet nested.</li> </ul> <p>Interview with the Dietary Manager (DM) on</p>	F 371	<p>Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food. Leftover food is to be stored in covered containers and wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Newly hired staff members will be oriented during orientation.</p> <p>4. The Registered Dietician/Chief Executive Officer/Designee will conduct a sanitation checklist daily for 5-days analyzing the results and providing feedback and/or remedial education as indicated. The checklist will then be completed twice weekly for 30-days, then weekly for 30-days, and monthly thereafter.</p> <p>5. Education will be provided to the nursing staff related to infection control and sanitation during meal pass. This will include the expectation that staff maintains hand hygiene, uses utensils, deli tissue, dispensing equipment to avoid bare hand contact of ready to eat foods. Newly hired staff members will be oriented during orientation.</p>		

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F 371	<p>Continued From page 11</p> <p>4/4/16 at 10:40 AM, in the kitchen prep area, the DM was asked what was in the red and green buckets. The DM stated, "Red bucket just soap and water, green bucket is sanitizer."</p> <p>Interview with the DM on 4/4/16 at 10:45 AM, in the freezer, the DM was asked what the meat wrapped in plastic was. The DM did not answer, but took the wrapped food and stated, "I will throw that away." The DM was asked what the 2 bags of meat in the opened bags were, and if they should be closed and dated. The DM stated, "Black bean burgers" and took the bags out of the freezer.</p> <p>Interview with the DM on 4/4/16 at 10:53 AM, in the stockroom, the DM was asked if it was acceptable to have expired juices stored on the shelves. The DM stated, "No."</p> <p>Interview with the DM on 4/4/16 at 10:58 AM, in the kitchen, the DM was asked if stacking wet pans was acceptable. The DM stated, "Wet nesting, no."</p> <p>Interview with the Registered Dietician (RD) on 4/7/16 at 3:00 PM, next to the conference room, the RD was asked if it was acceptable to have food items opened and not dated. The RD stated, "No, it's not." The RD was asked if it was acceptable to have expired juices stored in the stockroom and refrigerator. The RD stated, "No." The RD was asked if it was acceptable to have pans stacked wet-nested. The RD stated, "No." The RD was asked if it was acceptable to have chemicals around food. The RD stated, "No."</p> <p>2. Observations in Ruberio 2 dining room on 4/4/16 at 12:50 PM, revealed certified nursing</p>	F 371	<p>6. Dining services will be monitored on all units daily by Unit Managers and Nursing Supervisors for 5-days, then twice weekly for 30-days, then weekly for 30-days, and monthly thereafter. Remedial education will be provided as indicated.</p> <p>7. The Registered Dietician/Chief Executive Officer/Director of Nursing/Designee will be responsible for these processes. They will ensure education is provided, and monitoring with interventions as indicated are conducted. They will report their findings to the QAPI Committee monthly for 3-months and quarterly thereafter.</p>		

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F 371	Continued From page 12 assistant (CNA) #1 assisted Resident #53 with the lunch meal. CNA #1 picked up the roll with bare hands, cut the roll and placed butter in the roll, then placed the roll in Resident #53's mouth for a bite, then took the roll bare handed, and placed it back on the plate. CNA #1 continued to pick the roll up with bare hands during the entire meal.  Interview with the Director of Nursing (DON), on 4/7/16 at 6:00 PM, in the DON's office, the DON was asked if it was acceptable for staff to use bare hands to feed residents. The DON stated, "No, it is not acceptable."	F 371			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide care and services related to dental health for 1 of 4 (Resident #103) sampled residents with dental needs of the 28 residents included in the stage 2 review.	F 412	1. Resident #103 has a current oral assessment, was seen by the dentist on 4/12/16, and has a care plan that addresses his need for assistance with oral hygiene.  2. Current residents have had a dental assessment completed by nursing. Dental follow-up will be scheduled with the dentist as indicated. Care plans have been developed that reflect oral hygiene needs.  3. Education was provided to the licensed nurses related to dental assessment completion on admission and annually; care plan development based on assessment, and the steps to take to obtain routine and emergency dental care if indicated. Newly hired nurses will be educated related to dental assessments and care plan development during orientation.	5/6/16	

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F 412	<p>Continued From page 13 The findings included:</p> <p>Medical record review revealed Resident #103 was admitted to the facility on 9/10/15 with diagnoses of Dysphagia, Diabetes, Epilepsy, Hypertension, Peripheral Neuropathy, Cerebrovascular Accident with Hemiplegia, Vascular Dementia, Bipolar, Hyperlipidemia, Hypothyroidism, Arthritis, Muscle Weakness, Osteoporosis, Edema, Depression, and Psychosis.</p> <p>The quarterly Minimum Data Set (MDS) dated 1/12/16 documented Resident #103 had a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment, and required extensive staff assistance for personal hygiene.</p> <p>The speech therapy (ST) note dated 2/4/16 documented, "...Reason for Referral... mechanical soft texture presents some confusion to resident regarding origin of food items and is not able to identify them... Dentition... partially edentulous with missing upper front teeth and on lower intermittently..."</p> <p>Observations on the B4 hall, on 4/5/16 at 8:47 AM and on 4/6/16 at 9:14 AM, revealed Resident #103 had several missing teeth.</p> <p>Interview with the Assistant Administrator on 4/6/16 at 4:36 PM, in the conference room, the Assistant Administrator was asked whether Resident #103 had received any dental consults while a resident at the facility. The Assistant Administrator stated, "I don't have anything."</p> <p>Interview with MDS Coordinator #2 on 4/7/16 at</p>	F 412	<p>4. Annually and with each new admission an audit will be conducted of the assessments and care plans to ensure they are completed and reflective of each resident's needs.</p> <p>5. The Assistant Director of Nurses/Social Services/Designee will be responsible for this process. They will ensure assessments are completed upon admission and annually. They will facilitate the development of a comprehensive care plan. They will also assist the resident/family in making dental appointments and transportation arrangements as necessary. Finally, they will report on the process to the QAPI Committee monthly for 3-months and quarterly thereafter.</p>		

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F 412	Continued From page 14 2:48 PM, in the conference room, MDS Coordinator #2 was asked how are dental assessments performed. MDS Coordinator #2 stated, "Floor nurses do them."  Interview with Licensed Practical Nurse (LPN) #3 on 4/7/16 at 3:15 PM, on the B4 hall, LPN #3 was asked whether the floor nurses perform dental assessments. LPN #3 stated, "No, we don't do them."  Interview with the Director of Nursing (DON) on 4/7/16 at 4:09 PM, in the conference room, the DON was asked whether Resident #103 had any missing or broken teeth. The DON stated, "He has some [teeth] missing."  The facility was unable to provide documentation that Resident #103 had been offered dental services.	F 412			
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.	F 431	1. Medication is securely stored according to the medication storage policy.  2. All residents have the potential to be affected by this alleged deficiency.	5/6/16	

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F 431	Continued From page 15  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.  This REQUIREMENT is not met as evidenced by: Based on policy review, observations, and interview, the facility failed to ensure medications were stored securely in 2 of 25 (Birmingham 4th floor crash cart and Rubiero 1 south hall medication cart) medication storage areas.  The findings included:  1. The facility's medication storage policy stated, "...The medication supply shall only be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications... Medications are to remain in these containers and stored in a controlled environment... Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access..."	F 431	3. Education was provided to LPN #8 regarding medication storage. Education was provided to the licensed nurses regarding medication storage and focused on the requirements to have medication rooms, cabinets, crash carts, and medication supplies remain locked when not in use or attended by persons with authorized access.  4. A random audit of medication and crash carts will be conducted on each unit daily for 1-week, then twice weekly for 30-days, then once weekly for 30-days, and monthly thereafter.  5. The Director of Nursing/Designee will be responsible for this process. She will ensure education is completed and audits are conducted as scheduled. When indicated remedial education and/or discipline will be provided. She will present the outcomes of the audits to the QAPI Committee monthly for a period of 3-months, and quarterly thereafter.		

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F 431	Continued From page 16  2. Observations on Birmingham 4th floor hallway, on 4/7/16 at 2:15 PM, revealed the unit's crash cart was left unlocked.  Interview with Licensed Practical Nurse (LPN) #6 on 4/7/16 at 2:16 PM, in the hallway beside the crash cart, LPN #6 was asked why the crash cart was unlocked. LPN #6 stated, "I had to order some Dextrose to replace in it."  3. Observations on Rubiero 1 on 4/6/16 at 6:16 PM, revealed the south hall medication cart was left unlocked, unattended and out of the view of the nurse. A side drawer in the cart had a clear plastic cup with a brown substance with green streaks in it. the cart remained unlocked for 15 minutes before Licensed Practical Nurse (LPN) #8 walked up to the cart and stated, "I left my cart unlocked."  Interview with LPN #8 on 4/6/16 at 6:31 PM on Rubiero 1, LPN #8 was asked if it was acceptable to leave the medication cart unlocked, unattended and out of view of a nurse. LPN #8 stated, "No."  Interview with the Director of Nursing (DON) on 4/6/16 at 7:20 PM, on Rubiero 1 hall, the DON was asked if it was acceptable to leave a medication cart unlocked, unattended and out of view of the nurse. The DON stated, "No it is not."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	1. Tracheostomy care is provided to Resident # 352 following standards of practice for infection control, and policy and procedure for trach care/hand hygiene.	5/6/16

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F 441	<p>Continued From page 17 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview, the facility failed to prevent the potential transmission of disease and/or infection when 2 of 29 staff members</p>	F 441	<p>Bedside table surfaces are sanitized when moved from one room to another.</p> <p>2. All residents have the potential to be affected by this alleged deficiency.</p> <p>3. Respiratory therapist #1 was educated and was observed providing tracheostomy care using a tracheostomy care checklist. Education related to tracheostomy care and hand hygiene was provided to the respiratory therapists (RT) and the licensed nurses. A competency demonstration/checklist was completed for each. Newly hired RT's and licensed nurses will be educated during orientation with return demonstration checklist completion.</p> <p>4. The Director of the Respiratory Program/Designee will conduct a tracheostomy competency observation weekly for 30-days, once every other week for 30-days, and monthly thereafter.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NASHVILLE COMMUNITY CARE &amp; REHABILITATION AT BORDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218</b>	
(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 441	<p>Continued From page 18 (Respiratory Therapist (RT) #1 and Certified Nursing assistant (CNA) #2) failed to perform proper hand hygiene during tracheostomy care or failed to disinfect a bedside table during dining.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. The facility's "Tracheostomy Care" policy documented "...5. Wash and dry hand thoroughly, put on sterile gloves."</li> <li>2. Medical record review revealed Resident #352 was admitted to the facility on 4/5/16 with diagnoses of Respiratory Failure, Dementia, Diabetes, and Hypertension.</li> </ol> <p>Observations revealed Respiratory Therapist (RT) #1 performing trach care on 4/7/16 at 5:10 PM, in Resident #352's room. RT #1 put on clean gloves, applied sterile gloves over the clean gloves, and performed the trach care. RT #1 did not change the clean gloves or wash hands during the procedure. RT #1 was not observed washing hands prior to trach care.</p> <p>Interview with RT #1 on 4/7/16 at 6:00 PM, RT #1 was asked when she washed her hands during the trach care. RT #1 stated "After." RT #1 was asked if she washed her hands before the trach care. RT #1 stated, "No."</p> <ol style="list-style-type: none"> <li>3. Observations on Ruberio 100 hall on 4/6/16 at 6:00 PM, revealed CNA #2 served supper trays. CNA #2 moved a bedside table out of room 107 to room 106 and placed the meal tray for 106 on the bedside table without sanitizing the table surface. At 6:15 PM, CNA #2 moved the bedside table from room 106 to room 108, and placed the meal tray on the table without sanitizing the table</li> </ol>	F 441	<ol style="list-style-type: none"> <li>5. Education was provided to the nursing staff related to infection control specific to equipment use between resident uses. The focus was on bedside tables at meal times. Newly hired staff will be provided this information during orientation.</li> <li>6. The Director of Respiratory Therapy/Director Of Nursing/Designee will be responsible for these processes. They will ensure training and competencies are completed and maintained as outlined. They will report on the process to the QAPI Committee monthly for a period of 3-months and quarterly thereafter. Completion 5/6/16</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  <b>NASHVILLE COMMUNITY CARE &amp; REHABILITATION AT BORDE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218</b>		
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F 441	Continued From page 19 surface.  Interview with the Director of Nursing (DON) on 4/7/16 at 6:00, in the DON office, the DON was asked if it was acceptable to move bedside tables from room to room to serve meals without sanitizing the the surface. The DON stated, "No, it is not acceptable."	F 441		

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