

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

PRINTED: 12/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 241 SS=D	<p>483.15(a), DIGNITY AND RESPECT OF INDIVIDUALITY</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 medical record review, observation and interview, it was determined the facility failed to protect the dignity of a resident who was lying on her bed wearing only a diaper for 1 of 30 (Resident #23) sampled residents observed during the stage 1 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #23 revealed the resident was admitted 11/30/06 with diagnoses including Cerebral Artery Occlusion with Infarction, Diabetes Mellitus, Schizophrenia, Vascular Dementia with Depression, Malayan Filariasis and Joint Contracture of Multiple Joints. The annual Minimum Data Set (MDS) assessment dated 9/18/14 Resident #23 was assessed with moderate impaired cognitive status and documented no problem behavior had been observed during the assessment period. The annual MDS dated 9/18/14 documented Resident #23 was totally dependent for Activities of Daily Living including bed mobility, transfer, locomotion, dressing and personal hygiene.</p> <p>Observations on the 300 hallway on 12/1/14 at 10:28 AM, revealed a staff member exited Resident #23's room carrying dirty linen, leaving the door to the hallway open.</p> <p><i>accident POC 12/17/14 JPPH</i></p>	F 241	<p>F 241</p> <ol style="list-style-type: none"> 1. CNA responsible for resident #23 on 12/1/14 was in-serviced by DON regarding dignity and respect with a focus on ensuring resident is properly covered / dressed. 2. A quality round was performed to monitor for any additional resident who may have been affected by alleged deficient practice. 3. The staff was in-serviced on resident's rights including privacy, dignity, proper dress, covering residents during / after care, and privacy curtains. 4. DON / designee will make daily quality rounds to monitor for dignity / respect issues. Any concerns noted will be addressed at the time of discovery and reported to the QAPI Committee and follow up. QAPI Committee will monitor facility compliance and make recommendations as needed. 	12/15/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 12/17/14
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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 faxed 12/17/14 so

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F 241 Continued From page 1

Observations in Resident #23's room on 12/1/14 at 10:30 AM, revealed the privacy curtain was partially pulled between the A and B bed; Resident #23's bare feet on the bed were visible from the open door. Upon entering the room, Resident #23 was observed lying on her back, wearing only a diaper. The only bed linen present was a bottom sheet on the bed.

Observations on the 300 hallway beside the doorway to Resident #23's room on 12/1/14 at 10:35 AM, revealed personnel from an outside laboratory service knocked on Resident #23's door, walked into the room, spoke with Resident #23, obtained a blood specimen and left the room.

Observations in Resident #23's room on 12/1/14 at 10:50 AM, revealed Resident #23 remained lying on the bed wearing only a diaper. The only bed linen present was a bottom sheet on the bed. A folded diaper was observed on the floor between the right side of the bed and the bedside table. There was no other bed linens or clothing observed on Resident #23's bed, the bedside table or on the floor near the bed.

During an interview in Resident #23's room on 12/1/14 at 10:50 AM, Resident #23 stated, "I need some clothes on."

F 241

F 246 SS=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

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

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F 246	<p>Continued From page 2 the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to accommodate a resident's need when the call light was not placed within a resident's reach at all times for 1 of 44 (Resident #23) residents observed during the survey.</p> <p>The findings included: Review of the facility's call lights policy documented, "...be sure to position the call light conveniently for the resident to use... be sure call lights are place on the bed at all times..."</p> <p>Medical record review for Resident #23 documented an admission date of 11/3/06 with diagnoses including Cerebral Artery Occlusion with Infarction, Diabetes Mellitus, Schizophrenia, Vascular Dementia with Depression, Malayan Filariasis and Joint Contracture of Multiple Joints.</p> <p>Review of Resident #23's care plan dated 11/26/14 documented, "...keep call light in reach and encourage to use... frequent checks throughout q [every] shift..."</p> <p>Observations in Resident #23's room on 12/1/14 at 3:10 PM, 12/1/14 at 4:30 PM and on 12/2/14 at 7:53 AM, revealed Resident #23 in bed lying on her right side facing the window, the call light was tied to the left upper side rail at the head of the bed out of the resident's reach.</p>	F 246	<p>F 246</p> <ol style="list-style-type: none"> Resident # 23 now has her call light in reach. A quality round was completed to monitor for any other call lights out of place; corrections made as needed. Staff was in-serviced on where all call light should be placed and kept at all times. DON/designee will monitor facility compliance via daily rounds. Any issues noted will be addressed at the time of discovery and reported to QAPI Committee for follow up. QAPI Committee will monitor facility compliance and make recommendations as needed. 	12/15/14

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F 246	<p>Continued From page 3</p> <p>During an interview in Resident #23's room, Resident #23 was asked if she could push her call light to call someone. Resident #23 was lying on her right side, turned her head and looked over her left shoulder and stated, "I can see it [call light], but I can't reach it."</p> <p>During an interview in the hallway on 12/2/14 at 4:10 PM, the Director of Nursing (DON) was asked what she expected her staff to do regarding call lights and positioning of the call lights. The DON stated, "I expected them to have all resident's call lights within reach at all times." The DON was asked if it is acceptable to have Resident #23's call light tied to the left side rail at the head of the bed when the resident is contracted on the left side, lying on her right side and can't reach the call light. The DON stated, "The staff should put her call light on her right side where she can get to it at all times."</p> <p>During an interview in Resident #23's room on 12/3/14 at 9:09 AM, Certified Nursing Assistant (CNA) #1 was asked where she was supposed to place the residents' call lights. CNA #1 stated, "The call lights are supposed to be in arm/hands reach. We are trained to put it [call light] where they can reach it. CNA #1 was asked where Resident #23's call light should be placed since her left arm is contracted. CNA #1 stated, "I would place it as good as possible to her good arm."</p> <p>During an interview on the 300 hall on 12/3/14 at 9:19 AM, Nurse #1 was asked where the residents' call lights are supposed to be placed. Nurse #1 stated, "The call lights should be within reach." Nurse #1 was asked where Resident</p>	F 246		
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F 246	<p>Continued From page 4</p> <p>#23's call light should be placed since she she is contracted on the left side. Nurse #1 stated, "The call light for Resident #23 should be placed on her right side, put it on the unaffected side."</p> <p>During an interview in the 300 hall day room on 12/3/14 at 9:35 AM, CNA #3 was asked where she was expected to place residents' call lights. CNA #3 stated, "I hook mines to the bed or to the pillow case or whatever is close to the resident. If up in chair I hook to their clothes." CNA #3 was asked where to place the call light for Resident #23. CNA#3 stated, "I hook it on her non affected side."</p> <p>During an interview at the nurse's station on 12/3/14 at 9:45 AM, Nurse #2 was asked about her understanding or knowledge regarding placement of call lights. Nurse #2 stated, "They should be within reach at all times." The surveyor asked Nurse #2 if the resident was contracted or had a stroke on one side, where would she expect the call light to be placed. Nurse #2 stated, "I would expect it to be on the unaffected side so they can use it." Nurse #2 was asked where she would expect the call light for Resident #23 to be placed since she had a contracture on the left side. Nurse #2 stated, "I would expect to see it on her right side so she can use it." Nurse #2 was asked how she monitored for placement of call lights, and stated, "In the morning when I first get here, I go make rounds and check. I also meet with my CNA's and remind them about call lights. I also do random checks as I am giving meds and up and down the hall."</p> <p>During an interview in the 200 hall day room on 12/3/14 at 10:30 AM, the surveyor asked CNA #2 about the facility's policy on placement of call</p>	F 246		

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F 246	Continued From page 5 lights. CNA#2 stated, "If a resident is up in the chair, I clip it to the chair so they can reach it. If they are in the bed, I clip it to their pillow cover or their clothes."	F 246		
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 policy review, medical record review and interview, it was determined the facility failed to revise the comprehensive care plan related to use of rollator walker and wound status and treatment for 2 of 28 (Residents #10 and 54) sampled residents included in the stage 2 review.	F 280		

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F 280	<p>Continued From page 6</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Care Plan Committee/Team " policy documented "...Care plans revised as changes in the resident's condition dictates..." Medical record review for Resident #10 documented an admission date of 1/19/13 with a readmission date of 9/29/14 with diagnoses of Hypothyroidism, Vascular Dementia, Anxiety State, Depression, Hypertension, Congestive Heart Failure, Atrial Fibrillation, Pain in Limb, Mental Disorder, Fracture Up End Humerus and General Osteoarthritis. <p>Review of the care plan initiated 1/26/13, last revised 11/20/14, documented, "Problem Onset: 01/26/2013 Impaired mobility; self care deficit... Resident requires extensive assist of one for transfers and ambulation per rollator walker... Resident is able to ambulate per rollator walker and extensive assist on one..."</p> <p>During an interview on the hall by the Minimum Data Set (MDS) office on 12/3/14 at 10:27 AM, the previous Director of Nursing (DON) was asked if Resident #10 used a rollator walker. The previous DON stated, "No."</p> <p>During an interview in the group room on 12/3/14 at 10:40 AM, the MDS Coordinator was asked if Resident #10 used a rollator walker. The MDS Coordinator stated, "No." The MDS Coordinator was asked if the care plan had been updated to reflect the resident no longer ambulated with rollator walker. The MDS Coordinator stated, "No."</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> Care plans for residents # 10 and #54 have been reviewed as needed Audit was completed to ensure care plans of other residents with walkers and treatments are current and reflect resident's status Scheduled and documented care plan meetings weekly to ensure care plans are accurate. MDS coordinator and nursing staff have been in-serviced regarding requirement of updating care plan. DON / designee will monitor facility compliance via daily rounds. Any issues noted will be addressed at the time of discovery and reported to QAPI Committee for follow up. QAPI Committee will monitor facility compliance and make recommendations as needed. 	12/15/14

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F 280	<p>Continued From page 7</p> <p>During an interview in the DON office on 12/3/14 at 2:10 PM, the previous DON was asked if the care plan related to the use of the rollator walker should be updated. The previous DON stated "Should be updated."</p> <p>3. Medical record review for Resident #54 documented an admission date of 3/10/11 with diagnoses of Debility, Alzheimer's Disease, Chronic Kidney Disease, Protein - Calorie Malnutrition, Depression and Esophageal Reflux. Review of the care plan dated 11/6/14 documented, "Problem Onset: 11/06/14 stage II pressure area to left buttock..."</p> <p>Review of Resident #54's nurses' note dated 11/13/14 documented, "Upon further assessment [symbol for with] wound rep [representative], wound margins and appearance, will classify area as a stage III as of today. Treatment changed..."</p> <p>Review of a physician's order dated 11/13/14 documented, "...D/C [discontinue] previous treatment to L [left] buttock... Clean L buttock [symbol for with] wound cleanser or NS [normal saline], pat dry, apply collagen and border dressing daily for stage III treatment..."</p> <p>The care plan was not revised to reflect the change in the staging or the treatment of Resident #54's pressure wound.</p> <p>During an interview at the nurse's station on 12/3/14 at 1:31 PM, the MDS Coordinator was asked if Resident #54's care plan should have been updated to include the change in the wound staging and treatment. The MDS Coordinator stated, "Yes ma'am, it should have been."</p>	F 280		
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F 282
SS=D

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to follow the care plan for assessment and documentation of pain for 1 of 14 (Resident #23) sampled residents reviewed of the 28 residents included in the stage 2 review.

The findings included:

Review of the facility's "Using the Care Plan" policy documented, "...Daily care and documentation must be consistent with the resident's care plan..."

Medical record review for Resident #23 revealed an admission date of 11/30/06 with diagnoses including Cerebral Artery Occlusion with Infarction, Diabetes Mellitus, Schizophrenia, Vascular Dementia with Depression, Malayan Filariasis and Joint Contracture of Multiple Joints.

Review of the November 2014 physician's recertification orders documented an order with a start date of 10/21/14 for a Fentanyl transdermal film pain patch administered topically every 72 hours for pain control.

Review of the care plan initiated 7/5/13, last reviewed 11/26/14 documented, "...Pain

F 282

1. A pain assessment has been completed for resident # 23.
2. An audit was completed to identify other residents who may have been missing a quarterly pain assessment.
3. Nurses were in-serviced to document pain scale every shift and with PRN medication, pre and post pain assessment. Pain management flow sheet incorporated into MAR. resident with scheduled pain medication now has pre and post pain assessments.
4. DON / designee will audit charts during the weekly care plan meeting (following assessment schedule) to ensure completion of quarterly "at risk" assessments, including pain. Any concerns noted will be addressed at the time of discovery and reported to the QAPI Committee for follow up. QAPI Committee will monitor facility compliance and make recommendations as needed.

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F 282	Continued From page 9 assessment quarterly and prn [as needed]." The facility was unable to provide documentation of Resident #23 pain assessment being completed for the scheduled pain medication since 11/26/14. The care plan was not followed for completing pain assessments. During an interview in the conference room on 12/3/14 at 1:51 PM, the previous Director of Nursing (DON) was asked to review Resident #23's November 2014 and December 2014 medication administration record. The previous DON verified there had been no pain assessment documented for Resident #23 since 11/26/14.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to follow the policy and care plan for completing pain assessments for 1 of 28 (Resident #23) sampled residents included in the stage 2 review. The findings included: Review of the facility's "Pain Management" policy documented, "...any resident receiving scheduled	F 309	F 309 1. Resident #23's MAR was updated to reflect pain monitoring every shift and a pain assessment has been completed for resident also. 2. An audit was completed to identify other residents who may have been missing a quarterly pain assessment and every shift pain monitoring on their MAR.	

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F 309

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medications for pain, will have their pain assessed at least daily pain assessed using a scale of 1- [to] 10 and recorded on the medication administration record... The licensed nurse will screen the resident for pain a) on admission/readmission. b) with quarterly, annual and/or significant change Minimum Data Set (MDS) assessment and c) as needed with condition change."

Medical record review for Resident #23 documented an admission date of 11/30/06 with diagnoses including Cerebral Artery Occlusion with Infarction, Diabetes Mellitus, Schizophrenia, Vascular Dementia with Depression, Malayan Filariasis and Joint Contracture of Multiple Joints.

Review of a physician's order dated 10/21/14 documented, "Fentanyl 12 MCG/HR [micrograms per hour] TRANSDERMAL FILM ER [extended release] 1 PATCH TOP [topically] Q [Every] 72 H [hour] PAIN..."

During an interview on the 300 hall on 12/3/14 at 9:19 AM, Nurse #1 was asked what is your policy or procedure for assessing/documenting residents for pain. Nurse #1 stated, "We assess resident on rounds and pm [as needed] for pain. If we give them a PRN pain medicine we complete a pain assessment and we also complete one quarterly."

During an interview at the nurse's station on 12/3/14 at 9:45 AM, Nurse #2 was asked what is the facility's pain policy. Nurse #2 stated, "We do pain assessments on admission, quarterly and if a resident requires a PRN pain medicine." Nurse #2 was asked where pain assessments would be documented. Nurse #2 stated, "On the MAR

F 309

F309

- Staff was in-serviced on resident's pain will be assessed every shift 6-2,2-10,10-6. Document on a scale of 0-10. PRN medications will have pre and post pain assessments, will be documented on the pain management flow sheet. Resident with schedule pain medications will be documented pre and post pain assessments on the pain management sheets.
- DON / designee will audit MAR's q week to determine compliance with every shift pain monitoring. DON / designee will audit charts during the weekly care plan meeting (following assessment schedule) to ensure completion of quarterly "at risk" assessments, including pain. Any concerns noted will be addressed at the time of discovery and reported to the QAPI Committee for follow up. QAPI Committee will monitor facility compliance and make recommendations as needed.

12/15/14

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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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 309	Continued From page 11 [medication administration records]."	F 309		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</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 food was protected from physical contaminants and other sources of contamination as evidenced by 2 of 2 unauthorized persons (Administrator and Certified Nursing Assistant (CNA) #1) entered the kitchen without a hair net and/or beard covering. The facility had a resident census of 44 with 2 residents currently under isolation precautions.</p> <p>The findings included:</p> <p>1. Review of the facility's "Dietary Services" policy documented, "...Measures are taken to prevent contamination of food products and therefore decrease the likelihood of food borne</p>	F 371	<p>F 371</p> <ol style="list-style-type: none"> 1. Administrator and CNA have been in-served regarding need to wear hair/beard covering while in kitchen. 2. No residents were affected by this alleged deficient practice. 	

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F 371	<p>Continued From page 12</p> <p>illness... proper attire... should include a hair covering... Beards must be covered..."</p> <p>2. Observations in the kitchen on 12/1/14 at 8:20 AM, revealed the Administrator in the kitchen with no hair covering and no beard covering.</p> <p>3. Observations in the kitchen on 12/1/14 at 8:25 AM, revealed CNA #1 entered the kitchen and got a cart. CNA #1 did not have a hair covering on.</p> <p>During an interview in the dining room on 12/1/14 at 8:30 AM CNA #1 was asked about going into the kitchen without a hair covering. CNA #1 stated, "They usually have the cart out here [indicating the dining room] but sometimes we have to go in to get one. No we don't use hairnets [when entering the kitchen]."</p> <p>4. During an interview at the nurses station on 12/2/14 at 2:50 PM, the previous Director of Nursing was asked about non dietary staff members entering the kitchen. The previous Director of Nursing stated, "Really they should not have to go into the kitchen to get a cart. No, they do not wear hairnets [when entering the kitchen]."</p> <p>During an interview in the nourishment room on 12/3/14 at 7:45 AM, the Certified Dietary Manager (DM) was asked about non dietary staff members being in the kitchen without hair coverings. The DM stated, "I don't allow anyone in the kitchen without a hair net, that was just an accident. Not to be in the kitchen without hair covering."</p>	F 371	<p>F 371</p> <p>3. Staff was in-serviced on wearing hair/facial nets while in kitchen. Only dietary and authorized staff is allowed in kitchen area.</p> <p>4. DSM/designee will make daily observations to determine no one is without a hair net/beard covering while in the kitchen. Any concerns noted will be addressed at the time of discovery and reported to the QAPI Committee will monitor facility compliance and make recommendations as needed.</p>	12/15/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	<p>Continued From page 13</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 policy review, medical record review and interview, it was determined the facility failed to maintain clinical records that were complete for pain assessments for 1 of 28 (Resident #23) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Pain Management" policy documented, "...any resident receiving scheduled medications for pain, will have their pain assessed at least daily pain assessed using a scale of 1- [to] 10 and recorded on the medication administration record... The licensed nurse will screen the resident for pain a) on admission/readmission. b) with quarterly, annual and/or significant change Minimum Data Set (MDS) assessment and c) as needed with condition change."</p> <p>Medical record review for Resident #23 documented an admission date of 11/30/06 with diagnoses including Cerebral Artery Occlusion</p>	F 514	<p>F 514</p> <ol style="list-style-type: none"> 1. Resident #23's MAR was updated to reflect pain monitoring every shift and a pain assessment has been completed for resident also. 2. An audit was completed to identify other residents who may have been missing a quarterly pain assessment and every shift pain monitoring on their MAR. 3. Staff was in-serviced on resident's pain will be assessed every shift 6-2,2-10,10-6. Document on a scale of 0-10. PRN medications will have pre and post pain assessments, will be documented on the pain management flow sheet. Resident with schedule pain medications will be documented pre and post pain assessments on the pain management sheets. 	

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F 514 Continued From page 14 with Infarction, Diabetes Mellitus, Schizophrenia, Vascular Dementia with Depression, Malayan Filariasis and Joint Contracture of Multiple Joints.

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During an interview at the nurse's station on 12/3/14 at 9:45 AM, Nurse #2 was asked what is the facility's pain policy. Nurse #2 stated, "We do pain assessments on admission, quarterly and if a resident requires a PRN pain medicine." Nurse #2 was asked where pain assessments would be documented. Nurse #2 stated, "On the MAR [medication administration records]."

The facility was unable to provide documentation of pain assessments after 11/26/14.

F 514

F 514

- DON / designee will audit MAR's q week to determine compliance with every shift pain monitoring. DON / designee will audit charts during the weekly care plan meeting (following assessment schedule) to ensure completion of quarterly "at risk" assessments, including pain. Any concerns noted will be addressed at the time of discovery and reported to the QAPI Committee for follow up. QAPI Committee will monitor facility compliance and make recommendations as needed.

12/15/14

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