POC #2 Acceptable 1/20/15

2014-12-22 10:46 DC0547PM13501 8652125642 >> 4238923709 P 5/36

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445205	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA		STREET ADDRESS, CITY, STATE, ZIP CODE: 6249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to notify the physician of the presence of pressure ulcers for one resident	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #14's physician and responsible party were updated on resident condition on 12/5/2014 by the nursing supervisor. Treatment orders were received. Resident #14 was assessed by the physician on 12/10/2014 new orders noted. LPN #2 was in serviced by the Director of Clinical Services on 12/10/2014 on notification to physician and responsible party of change in condition.	1/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 12/15/15

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

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	445205		12/09/2014

NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA

STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421

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F 157	Continued From page 1 (#14) of three residents reviewed for pressure ulcers. The facility's failure to notify the physician of the presence of the pressure ulcers resulted in Actual Harm to resident #14. The findings included: Resident #14 was admitted to the facility on September 3, 2004, with diagnoses including Chronic Obstructive Bronchitis, Glaucoma, Dysphagia, Muscle Weakness, Parkinson's Disease, and Alzheimer's Disease. Medical record review of a Nurse's note signed and dated on August 25, 2014, at 12:00 p.m. by Licensed Practical Nurse (LPN) #2 revealed, "...Res's (resident's) heels broke down. On R (right) heel stage 2 [partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed] measuring at 1 cm (centimeter) x (times) 1 cm without bleeding/odor. On L (left) heel stage 2 measuring at 0.50 cm x 0.50 cm without bleeding/odor...Heels to be elevated when in bed. Will continue with POC (Plan of Care) per M.D.'s (medical doctor) orders..." Continued review revealed no documentation the physician had been notified of the pressure ulcers. Medical record review of Weekly Skin Integrity Reviews dated September 3, 10, 17, and 24, 2014; October 5, 11, 24, 2014; November 5, and 12, 2014 (skin assessments for November 19 and 26 were blank); and December 3, 2014, all documented the presence of pressure ulcers to the resident's right and left heels. Continued review revealed no documentation the physician had been notified of the pressure ulcers.	F 157	2. All current residents have the potential to be affected by this citation. A review of current resident's medical records by the interdisciplinary team (Director of Clinical Services, and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records, and or Executive Director, to determine physician and responsible party notification was completed 12/29/2014-12/31/14. The results of the audit no new issues identified. Licensed nurses were in-serviced on 12/22/2014-1/09/2015 on notification to physician and responsible party for change in condition by the Director of Clinical Services and/or Nursing Supervisor. The Director of Clinical Services, Nursing Supervisor /and or Education Coordinator will provide orientation for all new hires on notification of MD, family and/or responsible party on notification and changes of residents condition. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of 10 resident medical records five times a week for two months, three times a week for two months, two times a week for one month then one time a week for one month and/or substantial compliance is obtained. 3. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee	1/12/15

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NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA		STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	

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F 157	Continued From page 2 Medical record review of Weekly Nursing Progress Notes dated September 17 and 24, 2014; October 11 and 24, and November 12, 2014, all documented the presence of pressure ulcers on the resident's heels. Continued review revealed no documentation the physician had been notified of the pressure ulcers. Medical record review of Physician's orders from August 2014, through November 2014, revealed no physician's orders for the treatment of the identified pressure ulcers. Medical record review of the Physician's progress notes revealed no documentation indicating the physician or nurse practictioner had been notified of the resident's pressure ulcers. Medical record review of a Nurse's note signed and dated on December 5, 2014, by the Wound Care Nurse revealed, "...2. Unstg [unstageable] slough and or eschar [non-living tissue , slough may be soft and moist, eschar may be soft or hard and may appear scab-like]-noted to L heel 3 x 2.9 cm 100 percent necrotic [non-living tissue covering ulcer] with zero drainage or odor noted. 3. Unstg noted to R heel. Area measures 9 cm x 10 cm. 100 percent necrotic with zero drainage or odor. Both areas tx (treatment) orders received and noted. Family and NP (Nurse Practictioner) aware..." Interview with the Director of Nursing (DON) on December 9, 2014, at 1:35 p.m., in the Conference Room, confirmed the DON had not been made aware of the presence of the pressure ulcers until December 5, 2014. Continued interview confirmed neither the nurse practitioner nor the physician had been notified of	F 157	by the Director of Clinical Services until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Social Services, Maintenance Director and Minimum Data Assessment Nurse.	1/12/15

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F 157	Continued From page 3 the pressure ulcers from August 25, 2014, until December 5, 2014. Further interview with the DON confirmed the pressure ulcers had increased in size and stage since initially identified in August. Interview with LPN #2 on December 9, 2014, at 3:20 p.m., in the Wound Care Nurse's office, confirmed the LPN had identified the presence of pressure ulcers on the resident's heels on August 25, 2014. Continued interview confirmed LPN #2 had "...forgot..." to notify the Wound Care Nurse or physician of the presence of the pressure ulcers. The facility's failure to notify the physician of the presence of the pressure ulcers resulted in Actual Harm to resident #14.	F 157		1/12/15
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on facility policy reviews, observations and interviews, the facility failed to maintain a sanitary environment by failing to clean two bathrooms of twenty bathrooms observed and failing to prevent a persistent strong odor of urine on one hall (rooms 122 to 129) out of five halls observed. The findings included: Review of the facility's policy titled, "5-Step Daily Patient Room Cleaning", revealed that daily	F 253	1. Bathroom between 201 and 203 was cleaned on 12/8/2014 by the Environmental Services Director. Bathroom between 205 and 207 was cleaned on 12/8/2014 by the Environmental Services Director. The area in front of West Wing nurses station was cleaned 12/8/2014 by the Environmental Services Director. 2. All residents have the potential to be affected by this citation. Observations of resident bathrooms for cleanliness and odors were completed 12/29/2014 by the Environmental Services Director no issues identified.	

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F 253	Continued From page 4 cleaning was to include, "Horizontal Surfaces disinfected...using a solution of properly diluted germicide...damp mop...The commode includes the tank, the seat, the bowl and the base...using a separate rag and a germicide solution, wipe every area of the commode...". Review of the facility policy Equipment dated May 2014 revealed "...all equipment is routinely cleaned and maintained..." Observation on December 7, 2014 at 10:30 a.m., of the bathroom shared between residents room numbers 201 and 203, revealed the toilet seat had dried brown debris on the seat. Observation on December 8, 2014, at 4:10 p.m., of the bathroom shared between residents room numbers 201 and 203, revealed the toilet seat had dried brown debris on the seat. Observations on December 7, 2014, at 10:39 a.m., of the bathroom shared between residents room numbers 205 and 207, revealed the toilet seat had dried brown debris on the seat. Observations on December 8, 2014, at 4:14 p.m., of the bathroom shared between residents room numbers 205 and 207, revealed the toilet seat had dried brown debris on the seat. Interview with Registered Nurse (RN) #1, in the East Wing hall, on December 8, 2014, at 4:15 p.m., confirmed the toilet seats between room numbers 201 and 203, and between rooms 205 and 207 were both soiled with dried brown debris. Further interview revealed housekeeping staff are to clean the bathrooms each day and the soiled toilet seats should have been cleaned	F 253	3. The Environmental Services Director in serviced the Housekeeping staff on cleaning and disinfecting of resident rest rooms and hallways 12/30/2014-1/09/2015. The Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) and/or Executive Director, Environmental Services Director will perform Quality Improvement monitoring of 10 resident bathrooms for cleanliness and 10 resident rooms and/or halls for odors five times a week for two months, three times a week for two months, two times a week for one month, one time a week for one month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director for 6 months and or until substantial compliance is obtained. The Quality Assurance/Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators. Wound Care Nurse, Education Coordinator, Medical Director, Social Services, Maintenance Director, Environmental Services Director, and Minimum Data Assessment Nurse.	1/12/15

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	445205		12/09/2014

NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA

STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421

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F 253	Continued From page 5 immediately. Observation of the West Wing Nursing Unit on December 7, 2014, at 2:00 p.m., and 4:00 p.m., revealed a strong persistent odor of urine. Observation of the West Wing Nursing Unit on December 8, 2014, at 7:30 a.m., 11:00 am, 2:05 p.m., and 4:38 p.m., revealed a strong persistent odor of urine. Observation of the West Wing Nursing Unit on December 9, 2014, at 7:40 a.m, 10:00 am, and 1:38 p.m., revealed a persistent stronge urine odor. Interview with Housekeeper #1 in the West Wing Hallway, outside of room 129, on December 8, 2014, at 7:38 a.m., confirmed the presence of a persistent stronge odor of urine. Further interview confirmed there was a chronic problem with urine odors on this hall. Interview with the administrator on December 9, 2014, at 2:05 p.m., in the administrator's office, confirmed the presence of a persistent strong odor of urine on the West Wing.	F 253		1/12/15
F 278 SS=G	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	F 278	1. Resident #14 was assessed by the physician on 12/10/2014, new orders noted. Minimum Data Assessment Nurse was in serviced by the Regional Director of Clinical Services on completing the MDS using the medical record, staff interview and resident interview on 12/30/2014.	

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F 278	Continued From page 6 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, the facility failed to assess the presence of pressure ulcers on the Minimum Data Set (MDS) for one resident (#14) of three residents reviewed for pressure ulcers of 34 sampled residents. The facility's failure to assess the presence of pressure ulcers resulted in Actual Harm to resident #14. The findings included: Medical record review of resident #14's Care Plan dated February 12, 2014, revealed the resident was at risk for the development of pressure ulcers related to cognitive status and fragile skin.	F 278	2. Residents with wounds have the potential to be affected by this citation. An audit of the last 60 days of MDS's to verify that if a resident has a wound it was captured on the current MDS by the Director of Clinical Services, Nursing Supervisor and/or Minimum Data Assessment Nurse on 12/29/2014-1/2/2015. Results of the audits revealed one inaccurate assessment and modification to the assessment was completed on 12/30/2014. 3. The Minimum Data Assessment Nurse's were in served by the Regional Director of Clinical Services on accurate completion of MDS's using the medical record, staff and resident interview 12/30/14. The Director of Clinical Services will perform Quality Improvement Monitoring of accuracy of the MDS three times a week for two months, two times a week for two months and one time a week for two months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director for 6 months and or until substantial compliance is obtained. The Quality Assurance/Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Education Coordinator, Medical Director, Social Services, Maintenance Director, Environmental	1/12/15

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F 278	Continued From page 7 Medical record review of a Nurse's note signed and dated on August 26, 2014, at 12:00 p.m. by Licensed Practical Nurse (LPN) #2 revealed, "...Res's (resident's) heels broke down. On R (right) heel stage 2 [partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed] measuring at 1 cm (centimeter) x [times] 1 cm without bleeding/odor. On L (left) heel stage 2 measuring at 0.50 cm x 0.50 cm without bleeding/odor...Heels to be elevated when in bed. Will continue with POC (Plan of Care) per M.D.'s (medical doctor) orders..." Medical record review of Weekly Skin Integrity Reviews dated September 3, 10, 17, and 24, 2014; October 5, 11, 24, 2014; November 5, and 12, 2014 (skin assessments for November 19 and 26 were blank); and December 3, 2014, all documented the presence of pressure ulcers to the resident's right and left heels. Medical record review of Weekly Nursing Progress Notes dated September 17 and 24, 2014; October 11 and 24, and November 12, 2014, all documented the presence of pressure ulcers on the resident's heels. Medical record review of the most recent Quarterly MDS dated October 12, 2014, revealed the resident was at risk for the development of pressure ulcers, and had no documentation of the presence of pressure ulcers. Medical record review of a Nurse's note signed and dated on December 5, 2014, by the Wound Care Nurse revealed, "...2. Unstg [unstageable] slough and or eschar [non-living tissue , slough may be soft and moist, eschar may be soft or hard and may appear scab-like]-noted to L heel 3	F 278	Services Director, and Minimum Data Assessment Nurse.	1/12/15

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	445208		12/09/2014

NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA

STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421

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F 278	Continued From page 8 x 2.9 cm 100 percent necrotic with zero drainage or odor noted. 3. Unstg noted to R heel. Area measures 9 cm x 10 cm. 100 percent necrotic [non-living tissue covering ulcer] with zero drainage or odor..." Interview with the MDS Nurse on December 9, 2014, at 2:23 p.m., in the Conference Room, revealed the MDS Nurse was not aware of the presence of pressure ulcers on resident #14's heels. Continued interview revealed the MDS Nurse used the weekly wound reports, not the Weekly Skin Integrity reviews or weekly Nursing progress Notes, to assess if a resident had any pressure ulcers. Further interview revealed the MDS Nurse was not aware of the nurse's notes which documented the presence of the pressure ulcers. Continued interview confirmed the last Quarterly MDS was inaccurate and did not document the presence of pressure ulcers on the resident's heels. The facility's failure to assess the presence of pressure ulcers resulted in Actual Harm to resident #14.	F 278		1/12/15
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to brush the teeth for one resident (#1) of thirty four sampled resident's	F 312	1. Resident # 1 had teeth brushed and oral care provided by the Certified Nurses Aide on 12/9/2014. 2. All residents have the potential to be affected by this citation. An audit of current resident's mouths by direct observation was performed by the Director of Clinical Services/ and or East and West Unit Supervisors with a certified nursing assistant with no issues identified.Nurse Practitioner/ Physicians' orders on oral care was completed by the Director of Clinical Services, East and West Unit Coordinators. on 12/31/2014.	

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F 312	Continued From page 9 reviewed. The findings included: Resident #1 was admitted to the facility on October 24, 2012, with diagnoses including Hypertension, Cerebrovascular Accident, Falls, Dementia and Diarrhea. Medical record review of the quarterly Minimum Data Set (MDS) assessment dated November 15, 2014, revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS) assessment indicating the resident was cognitively intact. Medical record review of a physician order dated October 9, 2013, revealed "...Teeth should be brushed after each meal-floss between teeth before bedtime/if possible after the evening meal..." Medical record review of the care plan updated September 10, 2014, revealed the resident had an activities of daily living (ADL) self care performance deficit and required assistance by one staff member for personal oral hygiene care. Further review revealed the teeth were to be brushed after meals and flossed before bedtime. Interview with the resident on December 7, 2014, at 3:40 p.m., in the resident's room confirmed the resident had not had the teeth brushed that day. Interview with the resident on December 9, 2014, at 10:35 a.m., in the west hallway outside the resident's room confirmed it had been "months" since staff assisted the resident with teeth brushing. Further interview confirmed the resident	F 312	3. Licensed Nurses and Certified nurses assistants were in-serviced by the Director of Clinical Services, East and West Unit Coordinators, and or Education Coordinator on providing oral care to residents 12/22/2014-1/09/2015. The Director of Clinical Services and/or East and West Unit Coordinators will conduct Quality Improvement monitoring of oral care on 10 dependent residents five times a week for two months, three times a week for two months, two times a week for one month and one time a week for 1 month and/or until substantial compliance is obtained. 4. The results of the audits will be reported to the Quality Improvement Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Education Coordinator, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.	1/12/15

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NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA		STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421	

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F 312	Continued From page 10 had not had the teeth brushed on December 8, 2014, nor December 9, 2014, after breakfast. Interview with Certified Nurse Aide (CNA) #1 on December 9, 2014 at 10:45 a.m., at the west nurse station confirmed the resident's teeth had not been brushed that day. Further interview confirmed the CNA was not aware of the physicians order to brush the resident's teeth after each meal and to floss before bed. Interview with Licensed Practical Nurse (LPN) #1 on December 9, 2014 at 10:50 a.m., at the west nurse station confirmed confirmed the LPN was not aware of the physicians order to brush the resident's teeth after each meal and to floss before bed. Continued interview confirmed the resident's teeth had not been brushed that day.	F 312		1/12/15
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to identify and initiate treatment of pressure ulcers from August 25, 2014, to December 5, 2014, for one resident	F 314	1. Resident #14's physician and responsible party were updated on resident condition on 12/5/2014 by the nursing supervisor. Treatment orders were received. Resident #14 care plan was updated on 12/5/2014. Resident #14 was assessed by the nurse practitioner physician on 12/10/2014. LPN #2 was in serviced by the Director of Clinical Services on 12/10/2014 on notification to physician and responsible party of change in condition.	

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F 314	Continued From page 11 (#14) of three residents reviewed for pressure ulcers. The facility's failure to identify and treat the pressure ulcers resulted in unstageable pressure ulcers and Actual Harm to resident #14. The findings included: Resident #14 was admitted to the facility on September 3, 2004, with diagnoses including Chronic Obstructive Bronchitis, Glaucoma, Dysphagia, Muscle Weakness, Parkinson's Disease, and Alzheimer's Disease. Medical record review of the resident's Care Plan dated February 12, 2014, revealed the resident was at risk for the development of pressure ulcers related to cognitive status and fragile skin. Continued review of the resident's care plan revealed interventions to include "...document change in skin color, turgor...weekly skin checks by licensed nurse...report any red areas to nurse immediately...heel protectors in place while in bed..." Medical record review of a Nurse's note signed and dated on August 25, 2014, at 12:00 p.m. by Licensed Practical Nurse (LPN) #2 revealed, "...Res's (resident's) heels broke down. On R (right) heel stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed without slough) measuring at 1 cm (centimeter) x (by) 1 cm without bleeding/odor. On L (left) heel stage 2 measuring at 0.50 cm x 0.50 cm without bleeding/odor...Heels to be elevated when in bed. Will continue with POC (Plan of Care) per M.D.'s (medical doctor) orders..." Medical record review of Weekly Skin Integrity	F 314	2. Residents with wounds have the potential to be affected by this citation. The Charge Nurse on The East and West Units completed the skin assessments on current residents 12/9/2014 with no other issues identified. 3. The Director of Clinical Services in serviced licensed nurses on completing a weekly skin assessment on residents and if an area is identified on notifying physician for orders and follow up with responsible party and to notify the Director of Clinical Services and/or Unit Coordinator 12/22/2014-1//09/2015. Certified Nurse Assistants were in serviced on notifying nurse of any issues with skin that they identified during performing activities of daily living 12/22/2014-1/09/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of wounds to ensure treatment in progress 10 residents five times a week for two months, three times a week for two months, two times a week for one month and one time a week for one month and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of the completion of weekly skin assessments of 10 residents five times a week for two months, three times a week for two months, two times a week for one month and one time a week for one month and/or until substantial compliance is obtained.	1/12/15

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F 314	Continued From page 12 Reviews dated September 3, 10, 17, and 24, 2014; October 5, 11, 24, 2014; November 5, and 12, 2014 (skin assessments for November 19 and 28 were blank); and December 3, 2014, all documented the presence of pressure ulcers to the resident's right and left heels, and no description or measrements of the ulcers. Medical record review of Weekly Nursing Progress Notes dated September 17 and 24, 2014; October 11 and 24, 2014, and November 12, 2014, all documented the presence of pressure ulcers on the resident's heels, and no treatment for the pressure ulcers. Medical record review of Treatment Records from August 2014, through November 2014, revealed no treatment for the pressure ulcers with the exception of "...Heel protectors while in bed... " Medical record review of the most recent Quarterly Minimum Data Set (MDS) dated October 12, 2014, revealed the resident was severely cognitively impaired, was totally dependent for all Activities of Daily Living, was at risk for the development of pressure ulcers, and had no documentation of the presence of pressure ulcers. Medical record review of physician's orders from August 2014, through November 2014, revealed no physician's orders for the treatment of the identified pressure ulcers. Medical record review of Physician's progress notes revealed no documentation the physician was aware of resident #14's pressure ulcers. Medical record review of a Nurse's note signed	F 314	4. The results of the audits will be reported to the Quality Improvement Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Education Coordinator, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.	1/12/15

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F 314	Continued From page 13 and dated on December 5, 2014, by the Wound Care Nurse revealed, "...2. Unstg [unstageable] slough and/or eschar [non-living tissue , slough may be soft and moist, eschar may be soft or hard and may appear scab-like]- known but not stageable due to coverage of wound bed by slough and or eschar]noted to L heel 3 x 2.9 cm 100 percent necrotic [non-living tissue covering ulcer] with zero drainage or odor noted. 3. Unstg noted to R heel. Area measures 9 cm x 10 cm. 100 percent necrotic with zero drainage or odor. Both areas tx (treatment) orders received and noted. Family and NP (Nurse Practictioner) aware..." Medical record review of a physician telephone order dated december 5, 2014, revealed "...skin prep...to R [right] heel Q [every] day and prn [as needed]..." and "...skin prep to L [left] heel Q day and prn..." Review of the resident's Care Plan dated December 5, 2014, revealed the presence of unstageable pressure ulcers to both the right and left heels. Observation of resident #14 on December 9, 2014, in the resident's room, at approximately 4:00 p.m., with the Wound Care Nurse, revealed the presence of pressure ulcers to both the right and left heels. Continued observation of the resident confirmed the presence of the pressure ulcers which now had the appearance of Stage 2 ulcers, which had increased in size from the initial measurements as documented on August 25, 2014. Interview with the Wound Care Nurse on December 9, 2014, at 10:33 a.m., in the	F 314		1/12/15

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F 314	Continued From page 14 Conference Room, revealed the Wound Care Nurse had not been notified of the presence of the pressure ulcers until December 5, 2014, and confirmed had not been assessing, monitoring or treating the wounds. Continued interview confirmed the Wound Care Nurse was not aware of the documentation of the pressure ulcers on Weekly Skin Assessments, and confirmed the pressure ulcers had increased in size and stage since the wounds were initially identified on August 25, 2014. Continued interview revealed all residents with pressure ulcers are to be ordered a protein supplement to aid in wound healing. Continued interview confirmed the Wound Care Nurse had not ordered a protein supplement for the resident because the nurse was not aware of the presence of the pressure ulcers. Interview with the Director of Nursing (DON) on December 9, 2014, at 1:35 p.m., in the Conference Room, confirmed the DON was not made aware of the presence of the pressure ulcers until December 5, 2014. Continued interview confirmed the Nurse Practitioner nor the physician had been notified of the pressure ulcers. Further interview with the DON confirmed the pressure ulcers had increased in size and stage since initially documented in August. Interview with LPN #2 on December 9, 2014, at 3:20 p.m., in the Wound Care Nurse's office, confirmed LPN #2 had identified the presence of pressure ulcers on resident #14's heels on August 25, 2014. Continued interview confirmed LPN #2 had "...forgot..." to notify the Wound Care Nurse or physician of the presence of the pressure ulcers. The facility's failure to identify and treat the pressure ulcers resulted in Actual Harm to resident #14.	F 314		1/12/15

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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 -- (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 demonstrates that use of a naso gastric tube was unavoidable; and (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. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess for potential complications of a newly inserted feeding tube by monitoring the gastric residual volume for one resident (#116) of two residents with feeding tubes of thirty-four residents reviewed. The findings included: Resident #116 was admitted to the facility on October 10, 2014, from a hospital stay in a gero-psych unit with diagnoses including Dementia, Anxiety, Diabetes, and	F 322	1. Resident # 116 was not harmed related to this citation. Nurse #4 was in serviced on 12/09/14 on checking residuals with tube feedings as ordered by the physician by the Director of Clinical Services. 2. Residents with tube feedings have the potential to be affected by this citation. An audit of residents with feeding tubes was performed by the Director of Clinical Services and the East and West Unit Coordinators on 12/29/2014 with no other issues identified. 3. Licensed Nurses were In-serviced by the Director of Clinical Services, and the East and West Unit Coordinators on following physician orders for checking residual gastric volume and documenting those results on the medication administration record 12/21/2014-12/09/2014 The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Improvement monitoring of 5 residents with feeding tubes that require residual tube feeding documentation five times a week for one month, three times a week for two months, two times a week for two months and one time a week for two months and/or until substantial compliance is obtained.	1/12/15

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F 322	Continued From page 16 Gastroesophageal Reflux Disease. Review of the Daily Skilled Nurse's Note dated November 21, 2014, at 6:00 p.m., revealed, "Arrived from hospital - peg [peroutaneous esophageal-gastric] feeding tube insertion...on Jevity [tube feeding formula] 240 ml [milliliters] bolus [interval feedings administered by the nurse]..." Review of the physician's telephone order dated November 21, 2014, revealed, "...Jevity 1.5 bolus 240 cc [cubic centimeters] (one can) every 6 hours...Hold bolus if residual [remaining gastric contents in stomach]greater than 240 cc...Check placement + residual prior to flushes..." Review of the Daily Skilled Nurse's Notes dated November 21, 2014, through December 9, 2014, revealed no record of residual gastric contents recorded. Interview with Licensed Practical Nurse (LPN) #4 on December 9, 2014, at 2:00 p.m., in the conference room, confirmed the LPN had cared for the resident at intervals from November 21, 2014, to December 9, 2014, and had not checked for residual gastric contents prior to administering a bolus feeding. Interview with the Director of Nurses on December 9, 2014, at 2:45 p.m., confirmed residual gastric contents had not been checked prior to administering bolus feedings from November 21, 2014, when the new PEG feeding tube was inserted, to December 9, 2014.	F 322	4. The results of the audits will be reported to the Quality Improvement Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Education Coordinator, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.	1/12/15
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 17 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 observation, review of facility policy, and interview, the facility failed to maintain a sanitary kitchen by not properly cleaning kitchen equipment and storing, dating, and labeling prepared food for one of one kitchen reviewed. The findings included: Observation with the Cook on December 7, 2014, at 9:35 a.m., in the kitchen, revealed a covered stand-up mixer with dried food particles on the bowl and beaters. Continued observation revealed two uncovered racks of dinner plates stored face up. Observation with the Cook on December 7, 2014, at 9:55 a.m., at the reach-in refrigerator, revealed no internal thermometer. Continued observation of the reach-in refrigerator, revealed the following items undated and unlabeled: one container of mixed lettuce salad, one container of diced hard boiled eggs, one container of diced cucumbers, one container of diced onions, one dish of sliced tomatoes, five peanut butter sandwiches, barbeque sauce in a drinking pitcher, salami	F 371	1. No resident was affected related to this citation. The stand up mixer was cleaned on 12/7/2014 by the Dietary Manager. The container of mixed lettuce salad, diced hard boiled eggs, diced cucumbers, diced onions were discarded on 12/7/2014 by the Dietary Manager. A dish of sliced tomatoes, five peanut butter sandwiches, a pitcher of barbeque sauce, salami slices and two containers of sliced oranges and three bologna sandwiches were discarded on 12/7/2014 by the Dietary Manager. Two bags of elbow macaroni, one box of lasagna noodles, one bag of bran and oat cereal and one bag of spiral macaroni were discarded on 12/7/2014 by the Dietary Manager. One bag of hash browns and a box of sausage patties were discarded on 12/7/2014 by the Dietary Manager. The cooling fans in the freezer and cooler were cleaned on 12/8/2014 by the Maintenance Director. A thermometer was placed in the reach in refrigeration on 12/7/2014 by the Dietary Manager. . 2. No residents were affected by this citation. Observations of dating, storing and labeling of food items and kitchen equipment were completed by the Dietary Manger on 12/30/2014-12/31/2014.	1/12/15

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F 371	Continued From page 18 slices, and two containers of sliced oranges. Further observation revealed three bologna sandwiches dated November 24 and one container of sliced mushrooms dated November 20. Observation with the Cook on December 7, 2014, at 10:00 a.m., in the dry storage area of the kitchen, revealed the following opened items: two bags of elbow macaroni, one box of lasagna noodles, one bag each of bran and oat cereal, and one bag of undated spiral macaroni. Observation with the Cook on December 7, 2014, at 10:10 a.m. of the walk-in freezer revealed one bag of opened hash browns. Continued observation revealed dust debris on three cooling fans. Observation with the Cook on December 7, 2014, at 10:15 a.m., in the walk-in cooler revealed one box of opened sausage patties. Continued observation revealed dust debris on two cooling fans. Review of the facility policy Food Handling Guidelines, dated May 2014, revealed "...food contact surfaces are sanitized and cleaned between different food preparation..." Continued review revealed "...avoid contamination by potentially harmful physical, biological, and chemical contamination..." Review of the facility policy Food Storage: Cold revealed "...accurate thermometer will be kept in each refrigerator and freezer...daily temperatures...recorded..." Review of the facility policy Sanitary Conditions,	F 371	3. The cooks, dietary aides were in serviced by the Dietary Manager on 12/31/2014-1/09/2015 on proper storage of food items, dating and labeling of food items, cleaning of equipment and maintaining a thermometer in reach in refrigerator. The Dietary Manager and/or Executive Director will perform Quality Improvement Monitoring of cleanliness of kitchen, storage, labeling and dating of food items documentation five times a week for one month, three times a week for two months, two times a week for two months and one time a week for two months and/or until substantial compliance is obtained. 4. The results of the audits will be reported to the Quality Improvement Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Education Coordinator, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.	1/12/15

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F 371	Continued From page 19 dated May 2014, revealed "...foods...held for more than 24 hours at a temperature of 41 degrees F (Fahrenheit) or less, will be labeled and dated with a "prepared date"(Day 1) and a "use by date"(Day 7)..." Review of the facility policy Food Storage-Dry Goods dated May 2014 revealed "...packaged...food items shall be kept clean, dry, and properly sealed...label and date container..." Review of the facility policy Equipment dated May 2014 revealed "...all equipment is routinely cleaned and maintained..." Interview with the Cook on December 7, 2014 at 10:25 a.m., in the kitchen confirmed the facility failed to maintain the cleanliness of the stand-up mixer and the cooling fans, to cover the dinner plates, monitor the thermometer of the reach-in refrigerator, and label, date, properly seal, and monitor expired prepared foods.	F 371		1/12/15
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain a closed dumpster for one of three dumpsters and to maintain a clean area free of debris for three of three dumpsters observed. The findings included:	F 372	1. No residents were injured related to this citation. The door on the dumpster was closed and the area around the dumpsters was cleaned on 12/7/2014 by the housekeeping manager. 2. Observations of the dumpster area completed on 12/29/2014 – 12/31/2014, by the Executive Director to assure dumpster area was properly maintained.	

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F 372	Continued From page 20 Observation with the Cook on December 7, 2014, at 10:20 a.m., at the dumpster area, revealed three dumpsters, with the door open to one dumpster. Further observation revealed trash on the ground surrounding the three dumpsters including two plastic cups, six disposable gloves turned inside out, and paper pieces. Review of facility policy Housekeeping In-Service, Proper Disposal of Garbage, undated, revealed "...clean up any garbage or debris that may fall out of garbage bags immediately..." Interview with the Dietary Manager, on December 7, 2014, at 2:30 p.m., at the west nursing station, confirmed the facility failed to maintain a clean dumpster area.	F 372	3. The housekeeping and dietary staff were in serviced by the Executive Director on 12/30/2014 and 12/31/2014, on maintaining the dumpster area in a clean and secure manner. The dietary manager/or housekeeping manager will perform Quality Improvement monitoring of the dumpster area three times a week for eight weeks, two times a week for eight weeks then one time a week for eight weeks and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	1/12/15
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	F 431		

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PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA		STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	

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F 431	Continued From page 21 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 observation and interview, the facility failed to label and store drugs in a safe and secure manner in one of two medication carts on the East Wing. The findings included: Observation of one of the two medication carts on the East Wing, on December 9, 2014 at 10:35 a.m. revealed two loose pills inside the top drawer of one medication cart. These two white pills had no label or container and had no identifiable markings on them. Interview with Licensed Practical Nurse (LPN) #1, in the East Wing Medication Room, on December 9, 2014, at 10:35 a.m., confirmed the two white pills were loose in the medication cart drawer. Further interview confirmed the two pills had no container or label, and medications must be	F 431	F431 1. No residents were affected by this citation. The unlabeled, non bottled pills were discarded on 12/9/2014 by a licensed nurse. 2. All residents have the potential to be affected by this citation. Observations of the medication carts on East and West wings observing for labeling and storage of medications on 12/10/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on storage of medications on the medication carts, this included making sure that resident names were on packaging on 12/31/2014-1/09/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication carts for proper storage and labeling of medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained.	1/12/15

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NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOGA	445205	STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421	12/05/2014

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F 431	Continued From page 22 stored in labeled containers.	F 431	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	1/12/15
F 441 SS=F	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 of disease and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 1. No residents were injured related to this citation. Housekeeper #1 was in serviced by the Environmental Services Director on proper disposal and transport of trash 12/10/2014. 2. All residents have the potential to be affected by this citation. Observations of housekeeping staff disposing of trash by the Environmental Services Director was completed on 12/30/2014-12/31/2014. No other concerns were identified during observation.	

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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow infection control practices to prevent cross contamination for four of thirty one residents reviewed while performing housekeeping duties in resident rooms. The findings included: Observation on December 7, 2014, between 9:45 a.m. and 8:55 a.m., in the west wing revealed housekeeper #1 collecting the trash in rooms 227, 229, and 231 without wearing gloves. Continued observation revealed the housekeeper did not wash or sanitize the hands prior to exiting each room. Observation on December 9, 2014 between 11:00 a.m. and 11:10 a.m., in the west wing revealed housekeeper # 1 collecting the trash and sweeping the floor in room 239 without wearing gloves. Continued observation revealed the housekeeper placed the garbage into the utility cart, swept the floor debris into the dust pan, touched the bottom of the dust pan, the cleaning cart, returned to the resident's room and placed a clean garbage bag into the trash can. The housekeeper then exited the room without washing or sanitizing the hands. Interview with housekeeper #1 on December 7, 2014, at 10:00 a.m., in the west wing hallway revealed "...I have been instructed to use gloves by my supervisors, but it's just not practical..." Continued interview confirmed the housekeeper	F 441	3. Housekeeping staff were in serviced by the Environmental Services Director on proper disposal and transport of trash 12/30/2014-1/09/2015. Environmental Services Director and/or the Executive Director will conduct Quality Improvement Monitoring of proper disposal and transport of trash five times a week for two months, three times a week for two months, two times a week for one month, one time a week for one month and/or until substantial compliance is obtained. 4. The results of the audits will be reported to the Quality Improvement Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Wound Care Nurse, Medical Director, Education Coordinator, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.	1/12/15

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F 441	Continued From page 24 was not wearing gloves while emptying trash in resident rooms, and the facility failed to follow infection control practices.	F 441		1/12/15
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: Based on medical record review, review of facility policy, and interview, the facility failed to maintain complete and accurate records for one resident (#5) of thirty-four residents reviewed. The findings included: Resident #5 was admitted to the facility on June 13, 2014, with diagnoses including Diabetes, Coronary Atherosclerosis, Obstructive Uropathy, and Chronic Renal Failure. Medical record review of results of blood test dated July 7, 2014, included a white blood count of 17.68, flagged as a high value on the	F 514	1. No resident was injured related to this citation. 2. All residents have the potential to be affected by this citation. Multiple residents' charts were reviewed for complete, timely, and accurate documentation by the Interdisciplinary team. (Director of Clinical Services and /or Nursing Supervisor, Business Office Manager, Social services, Activities, Medical Records) and or Executive Director, during 12/29/2015 – 12-31-2014 audits. 3. Licensed Nurses were In-serviced by Director of Clinical Services, East and West Unit Coordinators On maintaining complete, timely, and accurate medical records on all Residents in the facility 12/29/2014-1/09/2015. The Director of Clinical Services and/or Nursing Supervisor Will conduct Quality Improvement Monitoring of 10 medical records for Complete, timely and accurate Documentation five times a week for Two months, three times a week for two Months, two times a week for one Month, one time a week for one Month and/or until substantial compliance is obtained.	

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F 514	Continued From page 25 laboratory report. Further review of the report revealed a nurse had written on the bottom right corner "push fluids NP [Nurse Practitioner] notified 7-7-14 levaquin [an antibiotic] 500 mg [milligrams] QD [every day] x 10 days." Medical record review of a physician's telephone order dated July 7, 2014, revealed, "levaquin 500 mg QD x 10 days re: leukocytosis [an elevated white blood count indicative of an infectious process]..." Review of the facility policy "Physician Order for Medications" revealed, "...The Physician's Order must specify the date the order was obtained...and route of administration..." Review of the July medication administration record (MAR) revealed the telephone order was transcribed to the MAR without a route recorded. Medical record review of a nurse's note dated July 8, 2014, titled "Code Blue Documentation" revealed the resident was found without vital signs at 6:22 p.m., resuscitation efforts began, Emergency Medical personnel arrived, and (after consultation with the supervising physician at the Emergency Room) resuscitation efforts were stopped at 6:45 p.m. Review of the Discharge Summary revealed, "...expired in facility...7-8-14..." Medical record review of the Treatment Record revealed on the night shift (11 p.m.-7 a.m.) on July 8, 2014, and on July 9, 2014, on the day shift (7 a.m.- 3 p.m.) and the night shift, nurses documented the following treatments were administered to the expired resident: Safety checks every 15 minutes; Foley catheter care	F 514	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the director of clinical services for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, East and West Unit Coordinators, Medical Director, Social Services, Maintenance Director and Minimum Data Assessment Nurse.	1/12/15

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F 514	Continued From page 26 every shift; and a protective ointment to buttocks every shift. Interview with the Director of Nurses at 4:00 p.m., on December 8, 2014, in the conference room, confirmed neither the telephone order or the MAR included a route for the antibiotic administration, and the "push fluids" portion of the NP's order (written initially on the laboratory report) was not included in the physician's telephone order. Continued interview confirmed two of the staff nurses had continued to document administering treatments to resident #5 for more than twenty-four hours after the resident had expired, and the facility had failed to maintain complete and accurate records.	F 614		1/12/15