

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

FORMAL REVIEW
OMB NO. 0938-0391

RECEIVED

JAN 04 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445118

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

12/10/2015

NAME OF PROVIDER OR SUPPLIER

ASHTON PLACE HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3030 WALNUT GROVE RD
MEMPHIS, TN 38111

(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 000 INITIAL COMMENTS

F 157 SS=D 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.

F 000

F 157

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Ashton Place Health and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F157

How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

The Medical Director was notified of Resident # 158's blood sugars found during survey on 12-28-15.

1-10-2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
George Murchow

TITLE
CEO-Administrator

(X6) DATE
12-30-15

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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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, the facility failed to ensure a physician was notified of elevated blood glucose levels for 1 of 51 (Resident 158) residents included in the stage 2 review.</p> <p>The findings included:</p> <p>An "After Hours Call Guidelines" policy documented, "...Please refer to the guide below before making an after-hours call to the provider... Specific Abnormal Labs... Glucose... Notify if glucose greater than 300..."</p> <p>Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnoses of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.</p> <p>Physician's orders for October, November, and December 2015 documented, "...NOTIFY PROVIDER IF BLOOD SUGAR IS... GREATER THAN 300... HYPERGLYCEMIA PROTOCOL / SLIDING SCALE INSULIN: WE ARE UTILIZING A NO SSI [sliding scale insulin] COVERAGE PROTOCOL SINCE IT IS A REACTIVE</p>	F 157	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All diabetic residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will audit twenty residents utilizing the Insulin/Physician Notification Audit 3x/week for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure proper physician notification for blood sugars outside of ordered parameters. All licensed nursing staff will be in-serviced by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) on the Insulin</p>		

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F 157	<p>Continued From page 2</p> <p>RESPONSE TO ELEVATED BGS [blood glucoses]. THE USE OF RAPID ACTING OR SHORT ACTING INSULIN ORDERED BY THE PROVIDER IN RESPONSE TO ELEVATED BG [blood glucose] > [greater than] 300 IS REACTIVE APPROACH TO TREATING HYPERGLYCEMIA... ONLY THOSE SEEING AN ENDOCRINOLOGY FOR BRITTLE DIABETES MAY FOLLOW THE PROTOCOL FOR THE USE OF SSI COVERAGE..."</p> <p>Review of Resident #158's diabetic monitoring logs for October 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <ul style="list-style-type: none"> a. 322 on 10/1/15 at 9:00 PM. b. 334 on 10/3/15 at 9:00 PM. c. 323 on 10/8/15 at 9:00 PM. d. 486 on 10/11/15 at 9:00 PM. e. 318 on 10/12/15 at 6:30 AM. f. 332 on 10/12/15 at 9:00 PM. g. 306 on 10/13/15 at 9:00 PM. h. 349 on 10/19/15 at 9:00 PM. i. 350 on 10/24/15 at 9:00 PM. j. 343 on 10/25/15 at 9:00 PM. k. 307 on 10/28/15 at 6:30 AM. l. 302 on 10/28/15 at 9:00 PM. m. 350 on 10/30/15 PM. <p>Review of Resident #158's diabetic monitoring logs for November 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <ul style="list-style-type: none"> a. 308 on 11/8/15 at 6:30 AM. b. 350 on 11/15/15 at 9:00 PM. c. 343 on 11/22/15 at 6:30 AM. d. 335 on 11/22/15 at 9:00 PM. e. 325 on 11/28/15 at 9:00 PM. f. 319 on 11/29/15 at 6:30 AM. 	F 157	<p>Administration Policy which covers documentation and notification of physician when outside of parameters by 1-10-16.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (administrator, Assistant Director of Nursing, or Staff Development Coordinator) will present to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson -- Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) the results of the Insulin</p>		

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F 157	Continued From page 3 Review of Resident #158's diabetic monitoring logs for December 2015 revealed the following blood sugars results greater than 300 with no physician notification per policy or as ordered: a. 315 on 12/3/15 at 6:30 AM. b. 393 on 12/3/15 at 9:00 PM. c. 315 on 12/5/15 at 9:00 PM. d. 306 on 12/6/15 at 6:30 AM. e. 341 on 12/6/15 at 9:00 PM. f. 322 on 12/7/15 at 6:30 AM. Interview with the assistant director of nursing (ADON) on 12/10/15 at 12:51 PM, in the conference room, the ADON was asked what she expected the nurses to do when a blood glucose was outside of an ordered parameter. The ADON stated, "Doctor should be called."	F 157	/ Physician Notification Audits monthly x 4 months for further recommendations and/or follow up as needed.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	F164 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Staff are being in-serviced on the Quality of Life – Dignity Policy to ensure that all residents, including resident # 38, #146, and #158 are having their curtain pulled during personal care and staff are identifying themselves when knocking, asking permission to enter, and awaiting on permission prior to entering. Resident # 257 expired on 12-8-15.	1-10-2016

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F 164	<p>Continued From page 4 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure privacy was maintained for 4 of 51 (#38, 146, 158, and 255) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. The facility's "Privacy" policy documented, "...You have the right to personal privacy, including privacy in accommodations, medical treatment... personal care, visits..." 2. Medical record review revealed Resident #38 was admitted to the facility on 8/28/14 with diagnoses of Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Hypothyroidism, and Chronic Kidney Disease. <p>Interview with Resident #38 on 12/8/15 at 8:28 AM, in Resident #38's room, Resident #38 was asked do staff provide you privacy when they work with you, changing your clothes or providing treatment. Resident #38 stated, "No, it only takes</p>	F 164	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of all staff in all departments will be in-serviced on the Quality of Life – Dignity Policy by 1-10-16 by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) which indicates that staff will knock and request permission prior to entering a residents room and will close window blinds/shades and pull room curtains when providing personal care. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will complete a</p>	
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F 164	<p>Continued From page 5</p> <p>one person to help me and sometimes there will be 2 or 3 people come in. They don't always pull the curtain."</p> <p>3. Medical record review revealed Resident #146 was admitted to the facility on 6/5/12 with diagnoses of Osteoarthritis, Chronic Pain, Borderline Personality Disorder, Dementia with Behaviors, Mood Disorder, Personality Disorder, Hypertension, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Reflux Disease, Diabetes Mellitus, and Polyneuropathy.</p> <p>Interview with Resident #146 on 12/7/15 at 3:12 PM, in Resident #145's room, Resident #146 was asked do the staff provide you privacy when they work with you. Resident #146 stated, "I have to tell people to pull the curtain or close the door when they are working with me."</p> <p>4. Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.</p> <p>Observations in Resident #158's room on 12/7/15 at 11:57 AM and 4:08 PM, on 12/8/15 at 8:27 AM, 10:14 AM, 2:30 PM and 5:06 PM, on 12/9/15 at 9:45 AM and 1:00 PM, and on 12/10/15 at 8:50 AM, revealed the privacy curtain did not provide full visual privacy for Resident #158's bed.</p> <p>Observations in Resident #158's room on 12/10/15 at 8:59 AM, during perineal care,</p>	F 164	<p>dignity audit on twenty random residents twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure staff knock and gain permission prior to entering a resident's room and pull the curtain and window blinds/coverings prior to performing personal care.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) will present the results of the Dignity Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director;</p>	
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F 164	Continued From page 6 Certified Nursing Assistant (CNA) #1 knocked on the resident's door. CNA #3 stated, "Personal Care." CNA #1 entered the resident's room without waiting for permission. Resident #158 was uncovered when her door was opened to the hallway. 5. Medical record review revealed Resident #255 was admitted to the facility on 11/25/15 with diagnoses of Hypertension, Reflux Disease, Benign Prostatic Hyperplasia, Diabetes Mellitus, Hyperlipidemia, Parkinson's Disease, and Depression. Observations on 12/7/15 at 9:15 AM, outside Resident #255's room, revealed Resident #255 laying in bed with only a brief and socks with the door open. 6. Interview with the Director of Nursing (DON) on 12/9/15 at 4:35 PM, in the DON's office, the DON was asked what does she expect her staff to do to ensure residents' privacy. The DON stated, "Knock before entering, close the door and pull the curtain. We also have trouble with family members and other residents." The DON was asked what was done to prevent families and residents from going into rooms while care was being provided. The DON stated, "I've had to educate the families myself, and it is a constant battle to keep residents out."	F 164	Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 4 months for recommendations and/or follow up as needed.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166	<u>F166</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	1-10-2016

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F 166	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Social Worker's (SW) job description, review of grievance report/logs, review of an incident report, medical record review, and interview, the facility failed to fully investigate and resolve grievances voiced by 2 of 51 (Residents #158 and 180) residents included in the stage 2 sample. The findings included: 1. Review of the facility's grievance policy documented, "...Social Services will oversee the implementation of the facility grievance procedure... The Social Services Director will coordinate the facility system for collecting grievances and tracking those grievances for timely and appropriate response..." 2. Review of the facility's SW job description documented, "...Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint..." 3. Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.	F 166	Resident # 158's grievance was addressed on 12-30-15. Resident # 180's grievance was addressed on 12-22-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by 1-10-16 by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all	

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F 166	<p>Continued From page 8</p> <p>Review of a grievance report for Resident #158 dated 6/29/15 at 1:58 PM documented, "...CNA [Certified Nursing Assistant] changing diaper but use no soap/water... CNA's complain a lot... wants to know how much in patient trust account... The CNA was trying to get her point across and CNA reported she did not want anyone to write her up... The resident did not obtain a CNA name.</p> <p>There was no evidence that the family was notified and there is no signature identifying who completed the grievance resolution and the Chief Executive Officer did not sign the form.</p> <p>Interview with the Administrator on 12/9/15 at 12:50 PM, in the conference room, the Administrator stated, "There is no more information [on the concern dated 6/29/15]."</p> <p>4. Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Reflux Disease, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Hypertension, Hemiplegia, Disorder of Kidneys, Dysphagia, Gastrostomy and Cerebrovascular Disease with Cognitive Defects.</p> <p>Review of the grievance log from 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Review of a nurses note dated 11/22/15 documented, "...RP [responsible party] visited [sign for and] informed staff that property, DVD [digital video disc] player was missing. Incident report completed. Administration aware..."</p>	F 166	<p>grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property. 100% of all staff in all departments will be in-serviced on the facility's Abuse Policy which includes what misappropriation of residents property is and that this is reportable to the state. In-servicing will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16.</p>	

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F 166	<p>Continued From page 9</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player... Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Resident Condition at Time of Incident... Mental: Alert & [and] Oriented x [times] 1 Narrative of incident... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Interview with CNA #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long it was missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with SW #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the grievance log would be where missing personal items would be documented. SW #1 stated, "Yes, that is the bulk of our grievances."</p> <p>Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW office, SW #1 was asked for the documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the</p>	F 166	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 3 months for further follow up and/or recommendations as needed.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	

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F 166	<p>Continued From page 10</p> <p>Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone related to the missing DVD player. SW #1 stated, "I have not interviewed any staff." SW #1 was asked what is an acceptable period of time for an investigation for missing personal items. SW #1 stated, "Couple of days."</p> <p>Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked for the incident report dated 11/22/15 that documented the missing DVD player. The DON stated, "I don't have that, we have to put those in the computer and it may be on the floor, let me call and see if it is in an office somewhere. The DON called the B Wing 2nd floor and asked someone if they had the report. The DON stated, she is going to look for it to see if she has that, we are supposed to give those to Social Services. I will keep looking to see if I have it or it is in the computer." The DON was asked what would Social Service do when they receive an incident report for resident's missing items. The DON stated, "We usually replace the item, we don't have to but within reasonable monetary value we will." The DON was then asked if the SW should do an investigation. The DON stated, "Yes, they should investigate, do interviews."</p> <p>There was no investigation documentation provided and the SW was unable to tell the process or what she had done to investigate the missing DVD player.</p>	F 166		

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F 224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of an incident report, review of grievance logs, medical record review, and interview, the facility failed to ensure 1 of 51 (Resident #180) residents was free from misappropriation of personal property.</p> <p>The findings included:</p> <p>Review of the facility's abuse policy documented, "...Every resident has the right to be free from misappropriation of property... Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belonging's... designated for exclusive use by the resident..."</p> <p>Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease, Dysphagia and Gastrostomy.</p> <p>Resident #180's annual Minimum Data Set</p>	F 224	<p><u>F224</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 180's grievance was handled on 12-22-15 and the facility replaced the Digital Video Disc player.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected</p>	1-10-2016

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F 224	<p>Continued From page 12</p> <p>(MDS) assessment with an assessment reference date (ARD) of 3/27/15 and a quarterly MDS assessment with an ARD of 9/26/15 documented a Brief Interview for Mental Status (BIMS) of 2 indicating Resident #180 was moderately impaired cognitively.</p> <p>Nurse's note dated 11/22/15 documented, "...RP [responsible party] visited [sign for and] informed staff that property, DVD [Digital Video Disc] player was missing. Incident report completed. Administration aware..."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player... Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Resident Condition at Time of Incident... Mental: Alert & [and] Oriented x [times] 1 Narrative of incident and description of injuries... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Review of the grievance logs from 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long it was missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with Social Worker (SW) #1 on 12/9/15 at 8:45 AM, in the social services' office, SW #1</p>	F 224	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) by 1-10-16 to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances</p>	
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Continued From page 13
was asked for the documentation and investigation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log, but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 was asked what was an acceptable period of time for investigation. SW #1 stated, "Couple of days." SW #1 was asked if she would report misappropriation to the state. SW #1 stated, "I would not be the one to do that."

Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked for the incident report dated 11/22/15 that documented the missing DVD player. The DON stated, "I don't have that. We are supposed to give those to Social Services." The DON was asked what would social service do when they receive an incident report for resident's missing items. The DON stated, "We usually replace the item. We don't have to but within reasonable monetary value we will." The DON was asked, should the social worker do an investigation? The

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are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 3 months for further follow up and/or recommendations as needed.

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F 224	Continued From page 14	F 224		
F 225 SS=D	<p>DON stated, "Yes, they should investigate, do interviews."</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	F 225	<p>F225</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 180's grievance was handled on 12-22-15 and the facility replaced the Digital Video Disc player.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p>	1-10-2016

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F.225	<p>Continued From page 15 appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of an incident report, review of grievance logs and interview, the facility failed to report and investigate an allegation of misappropriation for 1 of 51 (Resident #180) residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's abuse policy documented, "...Every resident has the right to be free from... misappropriation of property... The facility has developed and instituted policies and procedures for... misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences... The facility reports alleged violations, conduct, and investigation of all alleged violations, to the proper authorities and takes necessary corrective actions..."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222 [Resident #180's room]... Property Involved: DVD [digital video disc] player... Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Narrative of incident... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Review of the grievance logs from 7/3/15 to</p>	F 225	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) by 1-10-16 to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party,</p>	

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F 225	<p>Continued From page 16 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack of Coordlnation, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease, Dysphagia and Gastrostomy.</p> <p>Resident #180's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/27/15 and a quarterly MDS assessment with an ARD of 9/26/15 documented a Brief Interview for Mental Status (BIMS) of 2 indicating Resident #180 was moderately impaired cognitively.</p> <p>Review of a nurse's note dated 11/22/15 documented, "...4:00 PM RP visited [sign for and] informed staff that property, [Resident #180's] DVD player was missing. Incident report completed. Administration aware of incident..."</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long the DVD player had been missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with Social Worker (SW) #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the grievance log would be where missing personal items would be. SW #1 stated, "Yes,</p>	F 225	<p>and reported to state if there is misappropriation of residents property. Investigations will be comprehensive which will include interviewing staff members as appropriate.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records</p>	

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Continued From page 17
that is the bulk of our grievances."

Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW's office. SW #1 was asked for the documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log, but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 did not answer the question about a room search. SW #1 was asked what an acceptable period of time for investigation would be. SW #1 stated, "Couple of days." SW #1 was asked if she would report misappropriation to the state. SW #1 stated, "I would not be the one to do that."

F 225

Director.) monthly x 3 months for further follow up and/or recommendations as needed.

F 244

483.15(c)(6) LISTEN/ACT ON GROUP

F 244

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F 244 SS=E	Continued From page 18 GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes and interview, the facility failed to follow up on the resident council's concerns for 3 of 6 (9/10/15, 10/8/15 and 11/12/15) months of resident council meeting minutes reviewed. The findings included: 1. Review of the typed resident concerns prepared for the resident council meeting in September 2015 revealed, "...Old Business... List follow-up on last month's minutes and identify staff person responsible... Resident continue to have call light response time issues... New business... Resident suggested more activities such as a domino table and bridge. Some resident suggested more days for Bingo... Residents are reporting there is still a lack in supplies such as gloves, diapers and bed pads. Residents report CNA [Certified Nursing Assistants] take diapers from their room for other residents... Residents complained of food coming to their rooms cold... Residents report they are not being changed as often as they should. Social services will meet with CNA/Nurses, Dietary and Central Supply to develop a remedy to the issues reported..." The facility was unable to provide	F 244	F244 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident Council Meeting grievances from September 2015 through November 2015 are being addressed by the facility and will be in compliance by 1-10-16. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Resident Council Minutes from September 2015 – November 2015 are being reviewed for grievances and will be completed by 1-10-16.	1-10-2016

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F 244	<p>Continued From page 19 documentation of follow up to the voiced grievances in the meeting.</p> <p>2. Review of the typed resident concerns prepared for the resident council meeting in October 2015 revealed, "...Old Business... List follow-up on last month's minutes and identify staff [person responsible... The call lights are not being answered in a timely fashion... New Business... Residents report not receiving towels, sheets, and pads. Staff has to pull from floor. Staff continues to run out of diapers, especially on weekends. CNAs continue to be rude... The quality of care is poor. Housekeeping is buffing in rooms at night.. CNA have poor work performance and poor customer service. Resident report having issues getting money from Business Office and report poor customer service. Some residents are unaware how many days they are receiving therapy. Some residents reports not having showers or having them late due to no shower aides. Resident reports trays are late and food is cold and nasty..." The facility was unable to provide documentation of follow up to the voiced grievances in the meeting.</p> <p>3. Review of the typed resident concerns prepared for the resident council meeting in November 2015 revealed, "...Old Business... List follow-up on last month's minutes and identify staff person responsible... Resident states that call lights are being answered but staff just comes to see what you need cut light off then don't give them what they need..." The facility was unable to provide documentation of follow up to the voiced grievances in the meeting.</p> <p>4. Interview with Social Worker (SW) #2 in her office 12/10/15 at 6:20 PM, in SW #2's office, SW</p>	F 244	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>All Social Workers and Activities personnel will be in-serviced on the Grievance Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) by 1-10-16 to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property. Resident Council</p>	

PRINTED: 12/23/2015
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F 244	Continued From page 20 #2 was asked how she follows up on the concerns of the Resident Council. SW #2 stated, "I follow-up with the Administrator and he sends it out to the staff to address." SW #2 was asked about the recommendation made in the Resident Council meeting on 9/10/15 for social services to meet with the CNA/Nurse, Dietary and Central Supply to develop a remedy to the issues reported at this meeting, SW #2 confirmed that follow-up information was not reported back to the Resident Council.	F 244	Meeting Minutes will be reviewed/audited monthly x 3 months by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Social Worker) to ensure grievances voiced during the monthly Resident Council Meeting are addressed in a timely fashion per the Grievance Policy guidelines.	
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 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the resident's call lights were within reach for 3 of 51 (Residents #171, 180, and 202) residents included in the stage 2 review. The findings included: 1. Medical record review revealed Resident #171 was admitted to the facility on 7/16/13 and readmitted on 6/23/14 with diagnoses of Quadriplegia, Schizophrenia, Muscle Weakness, Acute and Chronic Respiratory Failure, Reflux	F 246	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit and the monthly Resident Council Meeting Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson -- Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director;	

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F 246	<p>Continued From page 21 Disease, Contracture, and Convulsions.</p> <p>Observations on 12/8/15 at 8:41 AM, in Resident #171's room, revealed Resident #171 in bed with the call light on the floor under the head of the bed out of Resident #171's reach.</p> <p>2. Medical Record review for Resident #180 documented an admission date of 3/18/14 and readmission date of 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Lack of Coordination, Hemiplegia, Cerebrovascular Disease with Cognitive Defects, Aphasia, Reflux Disease, Hypertension, Hemiplegia, Dysphagia and Gastrostomy.</p> <p>Observations on 12/7/15 at 12:14 PM, in Resident #180's room revealed Resident #180's call light was laying on his roommate's bed by the door, out of Resident #180's reach.</p> <p>3. Medical record review revealed Resident #202 was admitted to the facility on 3/4/15 and readmitted on 8/17/15 with diagnoses of Nontraumatic Intracerebral Hemorrhage, Obstructive Hydrocephalus, Aphasia, Muscle Weakness, Hypertension, Atrial Fibrillation, Dysphagia, and Hemiplegia.</p> <p>Observations on 12/7/15 at 2:49 PM and on 12/8/15 at 8:03 AM, in Resident #202's room, revealed Resident #202's call light was laying on the floor, out of Resident #202's reach.</p> <p>4. Interview with the Administrator and the Director of Nursing on 12/10/15 at 9:30 AM, in the main foyer, the Administrator and the Director of Nursing were asked if was appropriate for the residents call lights to be on the floor or out of</p>	F 246	<p>Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 3 months for further follow up and/or recommendations as needed.</p> <p>F246</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 171, 180, and 202's call lights are being placed within reach when resident is in the bed.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p>	1-10-2016

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F 246 F 247 SS=D	<p>Continued From page 22 reach. The Administrator stated, "No."</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, the facility failed to give advanced notice of a room change for 1 of 11 (Resident #38) residents who were interviewed about a room or roommate change.</p> <p>The findings included: The facility's "Room to Room..." policy documented, "...a resident will be provided with an advanced notice of the room transfer... Prior to the room transfer, the resident, his or her roommate... and the resident's representative will be provided with information concerning the decision to make the room transfer..."</p> <p>Medical record review revealed Resident #38 was admitted to the facility on 8/28/14 with diagnoses of Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Hypothyroidism, and Chronic Kidney Disease.</p> <p>Admission/Readmission nurses notes dated 8/28/14 documented resident in room 381.</p> <p>Consultant Pharmacy communication to the</p>	F 246 F 247	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of all staff in all departments are to be in-serviced by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) on the Answering Call Light Policy which addresses call lights being in reach when resident is in the bed by 1-10-16. A Room Rounds Audit will be conducted by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) twice weekly on all residents x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure call lights are within reach when residents are in bed.</p>	1-10-2016

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F 247

Continued From page 23
Physician dated 3/4/15 documented resident in room 280-1

Nurse's notes dated 5/6/15 documented, "...Resident and all belongings transferred to 236-1..."

Physician's telephone order dated 5/7/15 documented, "...Transfer to semi prt [private] room..."

Physician's telephone order dated 5/12/15 documented, "...Transfer to... [room] 105..."

Physician's telephone order dated 6/15/15 documented, "...Inhouse transfer to room 234-1..."

Interview with Resident #38 on 12/8/15 at 8:29 AM, in Resident #38's room, Resident #38 was asked if he had been moved to a different room or had a roommate change in the last nine months. Resident #8 stated, "Yes, I've been moved about three times." Resident #38 was asked if he was given notice before a room change or a change in roommate. Resident #38 stated, "No."

Interview with Social Worker (SW) #1, on 12/9/15 at 1:35 PM, in the SW's office, SW #1 was asked if the resident that is being moved is informed. SW #1 stated, "We definitely tell the resident that's being moved."

F 247

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

The results of the Room Rounds Audit will be presented by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Administrator) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 4 months for further recommendations and/or follow up as needed.

F 250
SS=D

The facility was unable to provide documentation
Resident #38 was notified of the room changes.
483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

F 250

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F 250	<p>Continued From page 24</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a job description, policy review, review of a grievance report, review of grievance logs, review of an incident report, medical record review, and interview, the facility failed to ensure the social worker immediately, thoroughly and completely investigated grievances related to care and complaints of misappropriation of personal property for 2 of 51 (Resident #158 and 180) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the Social Worker's (SW) job description documented, "...Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint..." 2. Review of the facility's grievance policy documented, "...Social Services will oversee the implementation of the facility grievance procedure... The Social Services Director will coordinate the facility system for collecting grievances and tracking those grievances for timely and appropriate response..." 3. Medical record review revealed Resident #158 	F 250	<p><u>F247</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 38 was informed on 12-28-15 that going forward if he were to experience any further room changes that he will be notified in advance.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Social Worker #1 is no longer employed at facility effective 12-11-15. All Social Workers and licensed nurses will be in-serviced on the Notification of Change</p>	1-10-2016
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F 250	<p>Continued From page 25</p> <p>was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Mood Disorder, Chronic Pain Syndrome, Vitamin D Deficiency, Chronic Kidney Disease, Hypokalemia, Vascular Dementia, Hypertension, Major Depressive Order, Insomnia, and Headache.</p> <p>Review of a grievance report for Resident #158 dated 6/29/15 at 1:58 PM documented, "...CNA [Certified Nursing Assistant] changing diaper but use no soap/water... CNA's complain a lot... wants to know how much in patient trust account... The CNA was trying to get her point across and CNA reported she did not want anyone to write her up... The resident did not obtain CNA name CNA's do not tell me their name... Action taken to resolve concern... research who had [Resident #158] between 3-11..."</p> <p>Review of the grievance log dated 6/29/15 documented, "...CNA changed diaper w/o [without] using soap/water. CNA complained a lot... Researched who took care of her during the times of 3 p [PM] -11 p..."</p> <p>The facility was unable to provide documentation the family was notified and there was no signature identifying who completed the grievance resolution.</p> <p>Interview with the Administrator on 12/9/15 at 12:50 PM, in the conference room, the Administrator stated, "There is no more information [on the concern dated 6/29/15]."</p> <p>4. Medical Record review revealed Resident</p>	F 250	<p>Policy which includes notification of physician, resident and/or responsible party within 24 hours of a room change. In-servicing will be conducted by the Director of Nursing or designee</p> <p>(Administrator, Assistant Director of Nursing, Staff Development Coordinator, Unit Managers) by 1-10-16. A Room Change Audit will be completed by the Director of Nursing or designee</p> <p>(Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) 3x/week x 4 weeks, weekly x 4 weeks, then monthly x 2 months to ensure documentation and proper notification of residents and/or responsible party and physicians are done for any impending room changes.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The results of the Room Change Audit will be presented by the Director of Nursing or designee</p>	

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F 250	<p>Continued From page 26</p> <p>#180 was admitted to the facility on 3/18/14 and was readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease, Dysphagia and Gastrostomy.</p> <p>Review of the grievance logs dated 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Review of a nurses note dated 11/22/15 documented, "...RP [responsible party] visited [sign for and] informed staff that property, DVD [digital video disc] player was missing. Incident report completed. Administration aware of incident."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player... Incident Reported by: Family member/RP... Associate Involved: Unknown... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long the DVD player had been missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with SW #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the</p>	F 250	<p>(Administrator, Assistant Director of Nursing, or Staff Development Coordinator) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 4 months for further recommendations and/or follow up as needed.</p>	

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F 250	<p>Continued From page 27</p> <p>grievance log would be where missing personal items would be. SW #1 stated, "Yes, that is the bulk of our grievances."</p> <p>Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW's office, SW #1 was asked for the documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put it in the log, but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 did not answer the question about searching rooms of other residents. SW #1 was asked what is an acceptable period of time for investigation. SW #1 stated, "Couple of days."</p> <p>Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked if the SW should do an investigation for missing personal property. The DON stated, "Yes they should investigate. Do interviews."</p> <p>The facility was unable to provide documentation of an investigation for the missing DVD player.</p>	F 250	<p>F250</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 158's grievance was addressed on 12-30-15. Resident # 180's grievance was addressed on 12-22-15.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Social Worker # 1 is no longer employed with facility effective 12-11-15 All Social Workers will be in-serviced on the Grievance Policy by 1-10-16 by the Director of Nursing or designee</p>	1-10-2016

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F 250 F 254 SS=D	<p>Continued From page 28</p> <p>The SW was unable to explain how she had investigated this incident.</p> <p>483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION</p> <p>The facility must provide clean bed and bath linens that are in good condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, the facility failed to provide linen that was clean and in good condition to meet the needs of 2 of 51 (Residents #79 and 256) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Departmental (Environmental Services) - Laundry and Linen" policy documented, "...Reprocess any linen that is not visibly clean upon completion of the cycle..." 2. Observations in Resident #79's room on 12/9/15 at 4:26 PM, revealed a fitted sheet with multiple holes along the left side of the sheet. 3. Observations in Resident #256's room on 12/7/15 at 12:48 PM and 12/8/15 at 8:51 AM, revealed black stains on the blanket. <p>Interview with alert and oriented Resident #256 on 12/7/15 at 12:48 PM, in Resident #256's room, Resident #256 was asked if he received assistance with bathing. Resident #256 stated, "The blanket has blackberry stains on it from last week."</p>	F 250 F 254	<p>(Administrator, Assistant Director of Nursing, or Staff Development Coordinator) to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property. 100% of all staff in all departments will be in-serviced on the facility's Abuse Policy which includes what misappropriation of residents property is and that this is reportable to the state. In-servicing will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16.</p>	

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2015
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F 254	Continued From page 29	F 254	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.	
F 280 SS=E	<p>4. Interview with the Administrator on 12/10/15 at 9:05 AM, in the Administrator's office, the Administrator was asked about the condition of the linen. The Administrator stated, "When staff sees a hole, it should be ragged out."</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of care plan attendance records, medical record review, and interview, the facility failed to revise the care plan related to pressure ulcers, nutrition, status of nothing by mouth (NPO) and/or failed to invite the</p>	F 280	<p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 3 months for further follow up and/or recommendations as needed.</p>	

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F 280	Continued From page 30 resident or family member to the care plan meeting for 4 of 51 (Residents #24, 109, 158, and 202) residents included in the stage 2 review. The findings included: 1. Review of the facility's "Care Plans - Comprehensive" policy documented, "...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's, medical, nursing, mental and psychological needs is developed for each resident... Care Plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s)... Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..." 2. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia, Delirium, Depression, Hypertension, Peripheral Vascular Disease, Reflux Disease, Stage 3 Pressure Ulcer, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract. The care plan dated 8/5/15 documented, "...Actual Alteration in skin integrity: Pressure Ulcer related to Pressure Stage 3 Site (R) [right] Ischlal..." Documentation revealed the wound was resolved on 9/7/15. Interview with the Minimum Data Set (MDS)	F 280	<u>F254</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 79 and # 256's bed linens were changed on 12-11-16. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. . What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of all laundry personnel, Certified Nursing Assistants, and licensed nurses to be in-serviced on discarding linen that is stained or have holes, removing soiled linen when discovered and replace with clean linen, launder soiled linen, and report to the Administrator or	1-10-2016

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F 280	<p>Continued From page 31</p> <p>Coordinator on 12/10/15 at 2:20 PM, in the MDS office, the MDS Coordinator was shown the care plan that documented pressure ulcer to R Ischium and was asked if this was a current care plan. The MDS stated, "No, it is not."</p> <p>2. Medical record review revealed Resident #109 was admitted to the facility on 7/2/10 and readmitted on 3/21/14 with diagnoses of Complications of a Vascular Prosthetic Device/Graft, Muscle Weakness, and End Stage Renal Disease.</p> <p>The care plan dated 7/14/14 and revised on 10/28/15 documented, "...Resident is non-compliant with diet and fluid restriction..."</p> <p>The facility was unable to provide documentation to substantiate Resident #109's non-compliance with her diet and fluid restriction.</p> <p>3. The facility's "Resident/Family Participation - Assessment/ Care Plans" policy documented, "...The resident and his/her family, and/or the legal representative... are invited to attend and participate in the resident's assessment and care planning conference... The Social Worker Director or designee is responsible for contacting the resident's family and for maintaining records of such notices..."</p> <p>The care plan attendance records for 3/24/15 and 9/16/15 did not document that Resident #158 was invited to her care planning meeting on 3/24/15 and 9/6/15. The facility was unable to provide documentation that Resident #158 or her family was invited to her care planning conferences on 3/24/15 and 9/16/15.</p>	F 280	<p>Director of Nursing when linen has been discarded so new batches can be ordered. In-servicing will be conducted by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16. A Linen Audit will be conducted by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) 3x/week x 4 weeks, weekly x 4 weeks, then monthly x 2 months looking for holes and stains on linen, what was done, and any further in-servicing that needs to be completed.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator) will present the results of the Linen Audit to the Quality Assurance</p>	

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F 280	<p>Continued From page 32</p> <p>Interview with Resident #158 on 12/7/15 at 3:40 PM, in Resident #158's room, Resident #158 was asked if the staff included her in decisions about her medicine, therapy, or other treatments. Resident #158 stated, "No."</p> <p>4. Medical record review revealed Resident #202 was admitted to the facility on 3/4/15 and readmitted 8/17/15 with diagnoses of Intracerebral Hemorrhage, Obstructive Hydrocephalus, Aphasia, Muscle Weakness, Hypertension, Atrial Fibrillation, Hemiplegia, Dysphagia, and Dysarthria.</p> <p>The care plan dated 3/17/15 documented, "...Offer fluids at meals, medication pass, snacks, and activities... Keep fluids within easy reach and assist as needed..."</p> <p>The nutritional progress note dated 11/17/15 documented, "...Diet: NPO..."</p> <p>The care plan was not updated to reflect Resident #202's NPO status.</p> <p>Interview with the 2nd floor unit manager (UM) on 12/10/15 at 8:56 AM, at the C wing nurses' station, the UM was asked if the care plan correctly reflected the resident's status. The UM stated, "No, she gets nothing by mouth."</p>	F 280	<p>Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p> <p><u>F280</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>	1-10-2016
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282	<p>Care plan for Resident # 24 was updated on 12-28-15 to reflect that wound was resolved; Care plan for Resident # 109 was updated on 12-28-15 to reflect current compliance</p>	

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F 282	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow interventions for meal intake documentation, diet and/or pressure ulcer treatment for 3 of 51 (Residents #24, 180, and 257) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia, Delirium, Depression, Hypertension, Peripheral Vascular Disease, Reflux Disease, Stage 3 Pressure Ulcer, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract. <p>a. The care plan dated 10/2/15 documented, "...Diet as ordered..."</p> <p>The Physician's telephone order dated 12/7/15 documented, "...Change diet texture to mechanical soft per RP [Responsible Party]'s request..."</p> <p>Observation on 12/9/15 at 8:05 AM, in Resident #24's room revealed Resident #24 lying in bed when her breakfast tray was brought into her. Resident #24's breakfast consisted of orange juice, scrambled eggs, sausage, biscuit with jelly, oatmeal and a glass of water. The meal was not the texture of mechanical soft.</p> <p>Observations on 12/9/15 at 5:47 PM, in Resident #24's room revealed Resident #24 in bed with</p>	F 282	<p>status; Documentation for Resident # 158 will show that resident and family was invited for a care plan conference and will document if they declined to attend and reason if known. Family and/or resident will sign when they do attend; Care Plan for resident #202 was updated on 12-22-15 to reflect their current intake status. A care plan meeting was held on 12-28-15 for resident # 158 and she signed she attended.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected. 100% of resident care plans will be audited for accuracy of their intake status, wound status, and compliance status by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16.</p>	

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F 282	<p>Continued From page 34</p> <p>dinner tray with a glass of water, french fries, hotdog on bun, and beans. The meal was not the texture of mechanical soft.</p> <p>Observations on 12/10/15 at 7:59 AM, in Resident #24's room, revealed Resident #24's breakfast tray consisted of scrambled eggs, oatmeal, biscuit with jelly, sausage, orange juice, water, and milk. The meal was not the texture of mechanical soft.</p> <p>Interview with the Registered Dietician (RD) on 12/10/15 at 12:55 PM, in the RD's office, the RD was asked about Resident #24's dietary status. The RD stated, "Recently changed to mechanical soft texture on the 12/7/15. The RD was shown a diet slip dated 12/9/15 and was asked if a mechanical soft diet had been ordered, where would the change be reflected on the slip. The RD stated, "Under the texture on the diet slip." The RD was asked if she would expect a hot dog to be on a mechanical soft regular diet. The RD stated, "I would expect to see it cut up."</p> <p>Interview with the RD and the Dietary Manager (DM) on 12/10/15 at 1:15 PM, in the RD's office, the DM was asked is she considered a hotdog to be acceptable for a resident that was on a mechanical soft diet. The DM stated, "We grind our hot dogs." The DM was asked if you would expect the resident to receive a mechanical soft texture. The DM stated, "It should reflect the latest order."</p> <p>b. The care plan dated 10/2/15 documented, "...Monitor/document meal intake..."</p> <p>The meal intake reports for November and December 2015 did not document the dinner</p>	F 282	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of licensed nursing staff , Minimum Data Set Nursing staff, and Social Workers will be in-serviced on the Resident/Family Participation – Assessment Care Plans Policy which indicates notices to be sent for care plan conferences, signatures obtained for those who attend, and documentation of refusal to attend and reason if known. 100% of licensed nursing staff including Minimum Data Set Nursing staff will be in-serviced on the Comprehensive Care Plan Policy. All in-servicing will be completed by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16. A Care Plan Audit for new orders will be conducted 5x/weekly in morning stand up meeting x 3 months to determine if a resident change has been indicated, care plan updated, and appropriate notification has</p>	

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F 282	<p>Continued From page 35 intake on 11/5/15, 11/19, 11/26, 11/30/15 and 12/2, 12/3, and 12/9/15.</p> <p>Interview with the Director of Nursing (DON) on 12/10/15 at 11:00 AM, in the DON office, the DON was shown the care plan that documented a goal to monitor/document food intake. The DON verified there was no documentation of food intake on these days. The DON was asked would you expect the meal intake to be documented on these days. The DON stated, "It should."</p> <p>c. The care plan dated 10/16/14 and updated 12/8/15 documented, "...Pressure ulcer: Stage IV [4] - sacral area... Administer treatments as ordered by physician and document..."</p> <p>The treatment record" dated September 2015, October 2015 and November 2015 documented "...CLEANSE SACRAL W [wound] / [with] W/C, [wound cleanser] PAT DRY, APPLY SILVER COLLAGEN & [and] COVER W/ DRY DRSG [dressing] DAILY & PRN [as needed]."</p> <p>The treatment records revealed no documentation of dressing changes on 9/21/15, 10/17/15, or 11/28/15.</p> <p>Interview with the DON on 12/9/15 at 3:50 PM, in the DON's office, the DON confirmed treatments on 9/21/15, 10/17/15, and 11/28/15 were not documented as being done.</p> <p>2. Medical record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted 4/28/14 with diagnoses of Disorder of the Kidney and Ureter, Diabetes Mellitus, Hemiplegia, Cerebrovascular Disease, Hypertension, Aphasia, Hemiplegia, Dysphagia,</p>	F 282	<p>occurred. Social Workers to keep a log indicating when care plan conference notices are sent to families, a copy of such, and a signature is to be obtained from the resident and/or responsible party or documentation if they fail to attend and reason (if known) on the care plan meeting form.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Minimum Data Set Coordinator) will present the results of the Care Plan Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety</p>	

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F 282	Continued From page 36 Reflux Disease, Symbolic Dysfunction, and Gastrostomy. The care plan dated 3/27/15 documented, "...Diet (pleasure tray) as ordered..." Observations on 12/8/15 at 6:05 PM, in Resident #180's room revealed resident did not receive a pleasure tray. Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:10 PM, at the B wing nurses' station, CNA #1 confirmed Resident #180 was not served a pleasure tray. 3. Medical record review revealed Resident #257 was admitted to the facility on 11/24/15 with diagnoses of Adenocarcinoma of the Prostate with Metastases to the Bone, Failure to Thrive, Hearing Loss, Left Facial Nerve Palsy, General Weakness, Constipation, Pressure Ulcer of Sacrum, and Congenital Fusion of the Cervical Spine. The care plan dated 11/30/15 documented, "...Monitor/document meal intake..." The meal intake record did not document the food intake on 11/26/15, 11/30/15, 12/2/15, and 12/3/15 for the dinner meal. Interview with the DON on 12/10/15 at 11:00 AM, in the DON office, the DON confirmed there was no documentation of Resident #257's meal intake on 11/26/15, 11/30/15, 12/2/15, and 12/3/15.	F 282	Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. <u>F282</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #24's diet was communicated to the Dietary Manager on 12-11-15 and is now receiving a mechanical soft diet. Their intake is being recorded by Certified Nursing Assistants electronically and wound treatments are being documented as ordered by licensed nursing staff. Intake and wound treatments are being monitored via audits as listed below. Resident #180 is now receiving a pleasure tray as ordered and was communicated to dietary on 12-11-15 and with staff on 12-14-15. Resident # 257 is having their meal intake documented by Certified Nursing Assistants electronically and is being monitored via an audit as listed below.	1-10-2016
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	<p>Continued From page 37</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure physician orders were followed for applying geri-sleeves, administering medications, notifying the physician of abnormal blood sugars or obtaining sliding scale insulin order before administering the insulin for 4 of 51 (Residents #24, 158, 179, and 257) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. A "Documentation of Medication Administration" policy documented, "...A nurse... shall document all medications administered to each resident on the resident's medication administration record... Administration of medication must be documented immediately after (never before) it is given... Documentation must include... Signature and title of the person administering the medication..." 2. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Major Depressive Disorder, Hypothyroidism, Hypertlipidemia, Hypocalcemia, Hypertension, Dementia, Malaise, Delirium, Periphera Vascular Disease, Reflux, Stage 3 	F 309	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of Certified Nursing Assistants and licensed nursing staff to be in-serviced on the Meal Documentation Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16. 100% of licensed nursing staff and Dietary Personnel to be in-serviced on communicating a residents diet change and ensuring they receive the correct diet. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) are to print out the meal/fluid intake compliance report daily Monday through</p>	

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F 309	<p>Continued From page 38</p> <p>Pressure Ulcer to Sacrum, Stage 4 Pressure Ulcer of Sacral Area, Anorexia, Osteoporosis, Paraplegia, and Cataracts.</p> <p>Physician's orders for July 2015 documented, "...GERISLEEVES TO BIL [Bilateral] ARMS TO PREVENT BRUISING & [and] SCRATCHING..."</p> <p>Observations on 12/9/15 at 8:05 AM, 10:45 AM, 1:57 PM, and 5:47 PM, and on 12/10/15 at 7:59 AM, in Resident #24's room, revealed Resident #24 had no gerisleeves on her arms.</p> <p>Interview with the Director of Nursing (DON) on 12/10/15 at 3:05 PM, in the conference room, the DON was asked if she would expect a resident who has a physician's order for geri-sleeves to bilateral arms to prevent bruising and scratching to have them in place. The DON stated, "Um huh."</p> <p>3. An "After Hours Call Guidelines" policy documented, "...Please refer to the guide below before making an after-hours call to the provider... Specific Abnormal Labs... Glucose... Notify If glucose greater than 300 or less than 60..."</p> <p>Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnoses of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.</p> <p>Review of Resident #158's October 2015</p>	F 309	<p>Friday. Any staff member who failed to document meal intake is to come back in and document within 72 hours. A Dietary Audit for Meal Observation is to be completed on 20 random residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure residents are receiving correct diet ordered. A Treatment Audit is to be completed 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months looking for holes in the Treatment Administration Record.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>Results of the Meal Intake Compliance, Dietary Meal Observation, and Treatment Audits are to be presented by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator) to the Quality Assurance Performance Improvement Committee (Members of the Quality</p>	

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F 309	<p>Continued From page 39</p> <p>physician's orders documented Vitamin B Complex 1 by mouth (PO) daily, Levemir 15 units subcutaneously (SQ) twice daily (BID) and Vitamin D 2 50,000 units PO weekly.</p> <p>Review of Resident #158's Medication Administration Record (MAR) for October 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Vitamin B Complex on 10/17/15 at 9:00 AM. b. Levemir 15 units subcutaneously (SQ) on 10/18/15 at 9:00 AM. c. Vitamin D 2 50,000 units PO weekly on 10/23/15 at 9:00 AM.</p> <p>Review of Resident #158's November 2015 physician's orders documented Levothyroxine 100 micrograms (mcg) PO daily, Omeprazole 40 milligrams (mg) PO before breakfast, Fluticasone 50 mcg 2 sprays each nostril daily, Phos-Nak Packet 1 PO daily, Carvedilol 12.5 mg PO BID and Multivitamin 1 PO daily.</p> <p>Review of Resident #158's MAR for November 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Levothyroxine 100 mcg on 11/26/15 and 11/28/15 6:00 AM. b. Omeprazole 40 mg PO before breakfast on 11/28/15 at 6 AM. c. Fluticasone 50 mcg 2 sprays each nostril on 11/30/15 at 9:00 AM. d. Phos-Nak Packet 1 PO on 11/30/15 at 9:00 AM. e. Carvedilol 12.5 mg PO on 11/30/15 at 5:00 PM. f. Multivitamin 1 PO on 11/30/15 at 6:00 PM.</p>	F 309	<p>Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p> <p>F309</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #24 is wearing geri-sleeves as of 12-28-15. Resident #158's physician was notified on 12-28-15 of non-documentation of medications being administered. No adverse reactions have been noted. Physician was notified of blood sugars noted to have been</p>	1-10-2016

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F 309	<p>Continued From page 40</p> <p>Review of Resident #158's December 2015 physician's orders documented Provide Gold 30 milliliters (ml) PO daily, Xifaxin 550 mg PO BID, Levemir 20 units SQ BID, and Levothyroxine 100 mcg PO daily.</p> <p>Review of Resident #158's MAR for December 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <ul style="list-style-type: none"> a. Provide Gold 30 ml on 12/2/15 and 12/4/15 at 9:00 AM. b. Xifaxin 550 mg on 12/5/15 and 12/6/15 at 9:00 AM and 5:00 PM. c. Levemir 20 units on 12/7/15 and 12/10/15 at 9:00 AM. d. Levothyroxine 100 mcg on 12/8/15 and 12/9/15 at 6:00 AM. <p>Physician's orders for October, November, and December 2015 documented, "...NOTIFY PROVIDER IF BLOOD SUGAR IS LESS THAN 60 OR GREATER THAN 300... HYPERGLYCEMIA PROTOCOL / SLIDING SCALE INSULIN: WE ARE UTILIZING A NO SSI [sliding scale Insulin] COVERAGE PROTOCOL SINCE IT IS A REACTIVE RESPONSE TO ELEVATED BGS [blood glucoses]. THE USE OF RAPID ACTING OR SHORT ACTING INSULIN ORDERED BY THE PROVIDER IN RESPONSE TO ELEVATED BG [blood glucose] > [greater than] 300 IS REACTIVE APPROACH TO TREATING HYPERGLYCEMIA... ONLY THOSE SEEING AN ENDOCRINOLOGY FOR BRITTLE DIABETES MAY FOLLOW THE PROTOCOL FOR THE USE OF SSI COVERAGE..."</p> <p>Review of Resident #158's diabetic monitoring logs for October 2015 revealed the following</p>	F 309	<p>out of range on 12-28-15. Resident #179's physician was notified on 12-28-15 for non-documentation of medications. No adverse reactions have been noted. Resident # 257 expired 12-8-15.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>All licensed nurses will be in-serviced by the Director of Nursing or Designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) on the Insulin Administration Policy by 1-10-16. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will audit twenty residents utilizing the</p>	
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F 309	<p>Continued From page 41</p> <p>blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <ul style="list-style-type: none"> a. 322 on 10/1/15 at 9:00 PM. b. 334 on 10/3/15 at 9:00 PM. c. 323 on 10/8/15 at 9:00 PM. d. 486 on 10/11/15 at 9:00 PM. e. 318 on 10/12/15 at 6:30 AM. f. 332 on 10/12/15 at 9:00 PM. g. 306 on 10/13/15 at 9:00 PM. h. 349 on 10/19/15 at 9:00 PM. i. 350 on 10/24/15 at 9:00 PM. j. 343 on 10/25/15 at 9:00 PM. k. 307 on 10/28/15 at 6:30 AM. l. 302 on 10/28/15 at 9:00 PM. m. 350 on 10/30/15 PM. <p>On 10/11/15 at 9:00 PM a BG was 486 and sliding scale insulin of 5 units was administered.</p> <p>The facility was unable to provide a physicians order for the sliding scale dose of insulin that was administered on 10/11/15.</p> <p>Review of Resident #158's diabetic monitoring logs for November 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <ul style="list-style-type: none"> a. 308 on 11/8/15 at 6:30 AM. b. 350 on 11/15/15 at 9:00 PM. c. 343 on 11/22/15 at 6:30 AM. d. 335 on 11/22/15 at 9:00 PM. e. 325 on 11/28/15 at 9:00 PM. f. 319 on 11/29/15 at 6:30 AM. <p>Review of Resident #158's diabetic monitoring logs for December 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <ul style="list-style-type: none"> a. 315 on 12/3/15 at 6:30 AM. 	F 309	<p>Insulin/Physician Notification Audit 3x/week for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure proper physician notification for blood sugars outside of ordered parameters. 100% of licensed nurses will be in-serviced on the Medication Administration Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) which discusses how to properly document medications that are administered by 1-10-16. A Medication Documentation Audit will occur on 20 random residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months looking for any non-documentation issues for medications and geri-sleeves and further follow up that may need to occur.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p>	

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Continued From page 42
 b. 393 on 12/3/15 at 9:00 PM.
 c. 315 on 12/5/15 at 9:00 PM.
 d. 306 on 12/6/15 at 6:30 AM.
 e. 341 on 12/6/15 at 9:00 PM.
 f. 322 on 12/7/15 at 6:30 AM.

Interview with the assistant director of nursing (ADON) on 12/10/15 at 12:51 PM, in the conference room, the ADON was asked what she expected the nurses to do when a blood glucose was outside of an ordered parameter. The ADON stated, "Doctor should be called."

4. Medical record review revealed Resident #179 was admitted to the facility on 10/19/15 with the diagnoses of Convulsions, Symbolic Dysfunction, Muscle Weakness, Constipation, and Lung Mass.

Review of Resident #179's MAR for 11/22/15 revealed the following medications were not documented as given as ordered by the physician: Polyethylene Glycol 17 grams (GM) PO daily, Bisacodyl enteric coated (EC) 5 mg PO daily, and Docusate Sodium 100 mg PO daily.

5. Medical record review revealed Resident #257 was admitted to the facility on 11/24/15 with diagnoses of Adenocarcinoma of the Prostate with Metastases to the Bone, Failure to Thrive, Hearing Loss, Left Facial Nerve Palsy, General Weakness, Constipation, Pressure Ulcer of Sacrum, and Congenital Fusion of the Cervical Spine.

A physician's order dated 12/7/15 documented, "...Start Morphine ER [extended release] 10 mg q [every] 12 hours PO..."

Review of the MAR revealed Morphine ER 10 mg

F 309

The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator) will present the results of the Insulin/Physician Notification Audit and the Medication Documentation Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson - Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.

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F 309	<p>Continued From page 43 was not given as scheduled on 12/8/15 at 6:00 AM.</p> <p>Review of Resident #257's November 2015 physician's orders documented Hydrocodone Acetaminophen (APAP) 5-325 PO every 6 hours, Vigamox 0.5 percent (%) eye drops 1 drop to left eye every 4 hours, and Occular lubricant to left eye every 4 hours.</p> <p>Review of Resident #257's MAR for November 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Hydrocodone APAP 5-325 PO on 11/30/15 at 4:00 AM, 12/4/15 at 6:00 PM and on 12/7/15 at 12:00 PM.</p> <p>b. Vigamox 0.5% eye drops 1 drop to left eye on 11/26/15 and 11/27/15 at 9:00 PM.</p> <p>c. Occular lubricant to left eye on 11/26/15, 11/27/15, and 11/28/15 at 1:00 AM, and on 11/26/15, 11/27/15, 11/28/15, 11/29/15, and 11/30/15 at 5:00 AM.</p> <p>Review of Resident #257's December 2015 physician's orders documented Muclnex 600 mg PO BID, Hydrocodone APAP 5-325 PO every 6 hours, and Vigamox 0.5% eye drops 1 drop to left eye every 4 hours.</p> <p>Review of Resident #257's MAR for December 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Muclnex 600 mg on 12/7/15 at 5:00 PM.</p> <p>b. Docusate Sodium 100 mg on 12/4/15 at 5:00 PM.</p> <p>c. Hydrocodone APAP 5-325 on 12/4/15 at 6:00 PM and on 12/7/15 at 12:00 PM.</p>	F 309		

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F 309	Continued From page 44 d. Vigamox 0.5% eye drops 1 drop to left eye on 12/4/15 at 10:00 PM.	F 309		
F 314 SS=D	5. Interview with the DON on 12/10/15 at 4:10 PM, in the DON's office, the DON confirmed the medications were not given as ordered by the physician. The DON was asked if she would expect medications to be given as ordered by the physician. The DON stated, "They should." 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 policy review, medical record review, observation, and interview, the facility failed to provide care and treatment as ordered to promote healing for 2 of 8 (Residents #24 and 257) residents reviewed with pressure ulcers. The findings included: 1. The "Pressure Ulcer Risk Assessment" policy documented, "...A pressure ulcer risk assessment will be completed upon admission... quarterly... and with significant changes... Skin Assessment. Skin will be assessed for the presence of	F 314	F314 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 24's wound measurements were completed again on 12-15-15 after the survey. Resident #24 also had a skin assessment completed on 12-17-15 after survey. A dressing change order was obtained on 12-8-15 and then changed again on 12-15-15. Resident #24 is receiving dressing changes as ordered, the last of which was done on 12-30-15. Resident # 257 expired on 12-8-15. How the facility will identify other residents having the potential to be affected by the same deficient practice.	1-10-2016

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F 314	<p>Continued From page 45</p> <p>developing pressure ulcers on a weekly basis... Monitoring... Nurses will conduct skin assessments at least weekly... the following information should be recorded in the resident's medical record utilizing facility forms... The date and time and type of skin care provided..."</p> <p>2. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia without Behavioral Disturbance, Delirium, Major Depressive Disorder, Hypertension, Peripheral Vascular Disease, Reflux Disease, Pressure Ulcer Sacral Area Stage 3, Pressure Ulcer of Sacral Area Stage 4, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract.</p> <p>a. The wound assessment report documented, "...Date of Assessment 8/4/2015 Wound Type Pressure Ulcer Wound Location Sacrum... Stage 4 Measurements Length - 2.90 cm [centimeters] Width - 2.50 cm Depth - 0.10cm..."</p> <p>A second wound assessment report documented, "...Date of Assessment 8/4/2015 Wound Type Pressure Ulcer Wound Location Sacrum... Stage 4 Measurements Length - 2.70 cm Width - 1.70 cm Depth - 0.30 cm..."</p> <p>Review of the wound assessment report revealed 2 assessments with different measurements for the same date and the same wound.</p> <p>Interview with the Director of Nursing (DON) on 12/10/15 at 11:00 AM, in the DON office, the DON was shown the wound assessment report for the Stage 4 pressure wound on the sacrum and was asked if there should be 2 assessments</p>	F 314	<p>All residents with wounds have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of licensed nurses are to be in-serviced by 1-10-16 on the Pressure Ulcer Treatment Policy and the Pressure Ulcer Risk assessment Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Nurse, or Unit Managers) which includes how often skin and wound assessments should occur, documentation requirements for wound documentation, and ensuring resident is clean and dry for wounds in the sacral/perineal area. A Skin Audit will be completed on residents receiving treatments 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers).</p>		

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F 314	<p>Continued From page 46 on 8/4/15 with different measurements. The DON stated, " No."</p> <p>Review of the skin body assessment / nurses note revealed skin assessments on 9/22/15, 9/24/15, 10/15/15, and 11/3/15 and 11/5/15. Weekly skin assessments were not documented.</p> <p>The treatment record dated 12/1/15 to 12/31/15 documented "...Clean sacral wound c [with] w/c [wound cleanser] pat dry apply Silver Alginate and dry dsq [dressing] [sign for change] daily & [and] PRN [as needed]. There was no physician's order for a dressing change.</p> <p>Interview with the DON on 12/10/15 at 2:25 PM, in the DON office, the DON was asked how often the skin and body assessments are to be done. The DON stated, "Nurses do body assessments weekly." The DON was asked if weekly skin assessments should have been done on Resident #24. The DON stated, "Yeah."</p> <p>b. The wound assessment report documented, "...Date of Assessment 8/4/2015 Wound Type Pressure Ulcer Wound Location Right Buttock; Ischial Stage 3 Measurements Length - 0.80 cm Width - 0.50..."</p> <p>The wound assessment report documented, "...Date of Assessment 8/18/2015 Wound Type Pressure Ulcer Wound Location Right Buttock; Ischial Stage 3 Measurements Length - 1.0 cm Width - 1.0..."</p> <p>Weekly wound assessments were not documented after 8/4/15 through 8/18/15.</p> <p>Interview with the DON on 12/10/15 at 11:00 AM,</p>	F 314	<p>This audit includes ensuring weekly skin assessments, weekly wound measurements, physician notification for orders or treatment changes, and ensuring resident is clean and dry with appropriate interventions in place.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The results of the Skin Audit will be presented by the Director of Nursing or designee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator;</p>	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2015
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F 314	<p>Continued From page 47</p> <p>In the DON's office, the DON was asked would you expect an assessment to be done for the wound from 8/4/15 to 8/18/15. The DON stated, "There should be."</p> <p>Observations during wound care on 12/10/15 at 9:15 AM, in Resident #24's room, revealed that prior to starting wound care, the sacral wound had no dressing covering it, but a urine saturated brief was over the wound. Licensed Practical Nurse (LPN) #8 pulled Resident #24's soiled brief away from the wound but left the urine saturated brief on the resident during wound care.</p> <p>Interview with the DON on 12/10/15 at 11:00 AM, in the DON's office, the DON was asked if she would expect a dressing to be on a stage 4 sacral wound prior to a dressing change. The DON stated, "Yes." The DON was asked if she would expect to find a resident to be left in a brief saturated in urine when doing a dressing change. The DON stated, "No." The DON was asked if she would expect a resident who is incontinent and needed incontinent care to have this performed prior to wound care. The DON stated, "Yes."</p> <p>Review of a physician order dated 9/21/15 documented, "...Cleanse sacral wound c wound cleanser. Pat dry. Apply silver Collagen. Cover c [with] dry drsg [dressing] daily / PRN [as needed].</p> <p>The treatment records for September, October, and November 2015 documented, "...CLEANSE SACRAL W [wound] / [with] W/C, [wound cleanser] PAT DRY, APPLY SILVER COLLAGEN & [and] COVER W/ DRY DRSG DAILY & PRN."</p> <p>Review of the treatment record revealed no</p>	F 314	<p>Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p>	

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AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445118

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

12/10/2015

NAME OF PROVIDER OR SUPPLIER

ASHTON PLACE HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3030 WALNUT GROVE RD
MEMPHIS, TN 38111

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

F 314

Continued From page 48
documentation of dressing changes on 9/21/15,
10/17/15, or 11/28/15.

F 314

3. Medical record review revealed Resident #257
was admitted to the facility on 11/24/15 with
diagnoses of Adenocarcinoma of the Prostate
with Metastases to the Bone, Left Hearing Loss,
Failure to Thrive, Left Facial Nerve Palsy, and
Congenital Fusion of the Cervical Spine.

Review of a physician order dated 11/25/15
documented, "...Clean sacral wound c W/C. Pat
dry apply Santyl and dry dsq. [Sign for change]
daily & PRN..."

The treatment record dated November 2015
documented, "Clean Sacral Wound c w/c pat dry.
apply Santyl and dry dsq [sign for change] daily &
PRN..."

Review of the November 2015 treatment record
revealed no documentation of dressing changes
on 11/28/15 and 11/29/15.

Interview with LPN #8 on 12/9/15 at 3:30 PM, in
the staff education office, LPN #8 nurse was
asked if the dressing change on 11/28/15 and
11/29/15 should be signed out. LPN #8 stated,
"Have prn treatment nurses every other weekend
and then another treatment nurse rotating every
other weekend and on this weekend she did not
show up. I was not notified the other treatment
nurse [prn] was working on the medication cart
and did some treatments on Sunday." LPN # 8
was asked if the dressing changes were
performed. LPN #8 stated, "No they weren't."

Interview with the DON on 12/9/15 at 3:50 PM, in
the DON office, the DON was shown the

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F 314	Continued From page 49 treatment record where the dressing changes were not signed out on 11/28/15 and 11/29/15 and was asked if the treatments should be signed out. The DON stated, "Yes."	F 314		
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 policy review, medical record review, observation and interview, the facility failed to elevate the head of bed (HOB) for 1 of 3 (Resident #143) residents reviewed with a tube feeding. The findings included:	F 322	F322 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 143 expired 12-26-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving tube feedings have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of licensed nursing staff and Certified Nursing Assistants will be in-serviced by 1-10-16 on the Enteral Feedings – Safety	1-10-2016

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F 322	Continued From page 50 Review of the facility's "Enteral Feedings - Safety Precautions" policy documented, "...Always elevate the head of the bed at least 30 - [to] 45 [degrees] during tube feeding and at least 1 hour after..." Medical record review revealed Resident #143 was admitted to the facility on 4/12/12 with diagnoses of Gastrostomy, Dysphagia, Encephalopathy, Chronic Kidney Disease, Convulsions, Hypertension, Knee Contracture, Osteoporosis, Dysphagia, Congestive Heart Failure, Coronary Artery Disease, and Malaise. Physician's orders dated 12/3/15 documented, "...Keep HOB elevated 30-45 degrees..." The care plan dated 3/31/14 documented, "...HOB 30 degrees or per doctors orders..." Observations in Resident #143's room on 12/7/15 2:47 PM, on 12/8/15 at 8:37 AM, 10:00 AM, and 4:20 PM and on 12/9/15 at 7:50 AM, revealed Resident #143 flat on his back with the feeding of Fiber source HN infusing at 95 cc/hr. Interview with the Director of Nursing (DON) on 12/9/15 at 9:58 AM, in the minimum data set (MDS) office, the DON was asked if was appropriate for a resident receiving a tube feeding to be positioned flat on his back. The DON stated, "No." The DON was asked if she expected her staff to follow the physician's orders. The DON stated, "Yes ma'am." The DON confirmed Resident #143 was on his back on 12/9/15.	F 322	Precautions Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers). This policy indicates that the residents head of bed should be elevated 30-45 degrees during tube feeding and at least one hour after. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will utilize the Enteral Feeding Audit and audit 15 random residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months for correct bed positioning. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing or designee (Assistant Director of Nursing or Staff Development Coordinator) will present the results of the Enteral Feeding Audit to the Quality Assurance Performance Improvement Committee (Members of the	
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 51 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure staff supervised 4 of 19 (Residents # 11, 71, 85 and 194) residents who were observed smoking and failed to ensure toxic chemicals and razors were securely stored in 3 of 8 (B wing shower, C wing shower and 300 hall spa) shower rooms. The findings included: 1. Review of the facility's "Resident Smoking Policy and Agreement" policy documented, "...The facility will keep all cigarettes and lighters for patients who wish to smoke... Staff will supervise and assist smokers at designated times..." a. Medical record review revealed Resident #11 was admitted to the facility on 8/6/15 with diagnoses of Fractured Femur, Occipital Condyle Fracture of the Heel, Fractured Right Tibia, and Fracture Left Tibia. The quarterly Minimum Data Set (MDS) dated 11/5/15 documented a Brief Interview for Mental	F 323	Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed. <u>F323</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 11 was assessed for smoking on 12-28-15. Resident # 11, 71, 85, and 194's cigarettes and lighters were obtained and locked up on 12-11-15. Toxic chemicals were locked up in shower rooms B and C on 12-10-15. Razors were locked up on 12-10-15 in 300 hall	1-10-2016

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F 323	<p>Continued From page 52 Status (BIMS) score of 13 which indicated no cognitive impairment.</p> <p>A safe smoking evaluation dated 8/8/15 documented, "...NON-SMOKER..."</p> <p>Observations on 12/8/15 at 3:45 PM, on the smoking patio, revealed Resident #11 taking her cigarettes out of her personal bag.</p> <p>The facility failed to keep all cigarettes and lighters for patients who wish to smoke as per policy.</p> <p>b. Medical record review revealed Resident #71 was admitted to the facility on 2/23/07 and readmitted on 12/6/13 with diagnoses of Peripheral Vascular Disease, Diabetes Mellitus Type 2, Vitamin D Deficiency, Hyperlipidemia, Atherosclerotic Heart Disease of Native Coronary Artery, Mood Disorder, Psychosis, Cataracts, Chronic Obstructive Disease, Hypertension, Osteoarthritis, Contracture of the Knee, Muscle Wasting and Atrophy, Osteoporosis, Muscle Weakness, Enlarged Prostate with Lower Urinary Tract Symptoms, Lack of Coordination, Malaise, Dysarthria, Anarthria, Complete Traumatic Amputation of Right Lower Leg, and Complete Traumatic Amputation of Left Lower Leg.</p> <p>The quarterly MDS dated 10/9/15 documented a BIMS score of 9, which indicated moderate cognitive impairment.</p> <p>Review of a safe smoking evaluation dated 10/23/15 revealed Resident #71's summary of evaluation included that resident must be supervised by staff, volunteer, or family member at all times when smoking, and resident must</p>	F 323	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected. All residents signed a smoking policy stating they would abide by the rules on 12-11-15. A room search for cigarettes and lighters was completed by the Social Worker on 12-11-15. Random checks ensuring chemicals and razors are locked was initiated 12-11-15.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of staff in all departments will be in-serviced on the Storage of Supplies Policy by 1-10-16. 100% of staff will be in-serviced on the Smoking Policy for Residents by 1-10-16. All in-servicing will be done by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, Staff</p>	

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F 323	<p>Continued From page 53 wear smoking apron at all times.</p> <p>Observations on 12/9/15 at 2:10 PM, on the smoking patio, revealed Resident #71 smoking unattended.</p> <p>Staff failed to supervise smokers as per policy.</p> <p>c. Medical record review revealed Resident #85 was admitted to the facility on 6/16/09 with diagnoses of Diabetes Mellitus, Diabetic Polyneuropathy, Hypoglycemia, Hypercalcemia, Hyperkalemia, Mood Disorder, Major Depressive Disorder with Severe Psychotic Symptoms, Insomnia, Chronic Pain, Glaucoma, Vision Loss in Both Eyes, Hypertension, Reflux Disease, Osteoarthritis, Hip Pain, Muscle Weakness, Osteoporosis, End Stage Renal Disease, Hyperparathyroidism of Renal Origin, Abnormal Gait and Mobility, Anorexia, Noncompliance with Medical Treatment and Regimen, and Renal Dialysis Dependent.</p> <p>The quarterly MDS dated 10/29/15 documented a BIMS score of 15, which indicated no cognitive impairment.</p> <p>Review of a safe smoking evaluation dated 7/29/15 revealed Resident #85's vision was inadequate and resident was not able to light a cigarette safely with a lighter due to resident being blind. Summary of evaluation was that resident must be supervised by staff, volunteer, or family member at all times when smoking. Resident must wear smoking apron at all times.</p> <p>Observations on 12/9/15 at 2:10 PM, on the smoking patio, revealed Resident #85 smoking unattended.</p>	F 323	<p>Development Coordinator, Unit Managers). The Maintenance Director or designee (Maintenance worker, Housekeeper, Housekeeping supervisor, or Unit Managers) will complete a Shower Room/Spa Audit 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months looking for toxic chemicals and razors that are not locked. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will audit smoke breaks and off times to ensure smokers are not smoking un-supervised. All residents who are smokers will also be in-serviced on the Smoking Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-15. The residents that smoke will be educated that facility may check periodically to determine if residents have any smoking articles in violation of our smoking policies. Staff shall confiscate any such articles, and shall notify the Charge Nurse/Unit Manager that they have done so. Charge</p>	

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F 323	<p>Continued From page 54</p> <p>Staff failed to supervise smokers as per policy.</p> <p>d. Medical record review revealed Resident #194 was admitted to the facility on 4/17/15 with diagnoses of Cerebrovascular Disease, Hemiplegia One Side, Hyperlipidemia, Major Depressive Disorder, Blindness in One Eye, and Hypertension.</p> <p>The quarterly MDS dated 10/23/15 documented a BIMS score of 15, which indicated no cognitive impairment.</p> <p>Review of a safe smoking evaluation dated 10/23/15 revealed Resident #194's summary of evaluation included that resident must be supervised by staff, volunteer, or family member at all times when smoking.</p> <p>Observations on 12/8/15 at 3:45 PM, on the smoking patio, revealed Resident #194 unsupervised, lighting her own cigarette from the cigarette she was smoking.</p> <p>Interview with Activity Assistant #1 on 12/8/15 at 4:07 PM, in the courtyard, Activity Assistant #1 was asked if it was acceptable for any of the residents to keep their own smoking paraphenalia. Activity Assistant #1 stated, "No ma'am, it's off limits."</p> <p>The facility failed to keep all cigarettes and lighters for patients who wish to smoke as per policy. Staff failed to supervise smokers as per policy.</p> <p>2. Observations during initial tour on 12/8/15 beginning at 9:30 AM revealed toxic chemicals</p>	F 323	<p>Nurse/Unit Manager to notify the Director of Nursing for noncompliance. Residents that are noncompliant with the facility smoking policy will be re-educated about the policy and the plan of care will be updated for noncompliance. Repeated noncompliance may result in the loss of smoking privileges and the issuance of a 30 day discharge notice.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator) will present the results of the Smoking and Chemical Audits to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of</p>	

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F 323	<p>Continued From page 55 and razors stored insecurely in the following areas:</p> <p>a. B wing shower room - disinfectant cleaner stored in an unlocked cabinet.</p> <p>Interview with the Administrator on 12/10/15 at 8:05 AM, in the B shower room, the Administrator was asked if it was appropriate for chemicals to be stored in an unlocked cabinet and unattended. The Administrator stated, "No, it's not"</p> <p>b. C wing shower room - disinfectant cleaner sitting on heating ventilation air conditioning unit.</p> <p>c. 300 hall spa - 6 unused razors and 1 used razor unsecured in a cabinet.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 12/10/15 at 5:00 PM in the conference room, the ADON was asked if it was acceptable for razors to be stored in the shower room unattended. The ADON stated, "No."</p>	F 323	<p>Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p>	
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p>	F 325	<p>F325</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #24 began receiving diet as ordered on 12-10-15. Resident #64 is being assisted with meals.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p>	1-10-2016

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
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F 325	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow a therapeutic diet as ordered, and initiate interventions to prevent weight loss for 2 of 4 (Residents #24 and 62) residents reviewed for nutrition of the 51 residents included in the stage 2 review. The findings included: 1. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia, Delirium, Depression, Hypertension, Peripheral Vascular Disease, Reflux Disease, Stage 3 Pressure Ulcer, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract. The care plan dated 10/2/15 documented, "...Reduce the risk for decline in nutritional / hydration / electrolyte and weight status... Approaches... Diet as ordered... Offer, encourage, assist w [with] / supplements, snacks, fluids, meals as ordered... The Physician's order dated 7/1/15 through 7/31/15 documented, "...Regular, Fortified Foods w/all meals... yogurt w/all meals... ice cream with all meals (tid) [three times daily]..." The Physician's telephone order dated 12/7/15 documented, "...Change diet texture to mechanical soft per RP's [responsible party] request..."	F 325	All residents have the potential to be affected. An audit of residents diets against what is on the dietary slip will be completed by 1-10-15. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of Certified Nursing Assistants and licensed nurses will be in-serviced on the Meal Assistance Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-15. This policy indicates that staff may not leave a resident until they are finished assisting them with their meal unless there is an emergency that requires your immediate help. If a resident's tray is removed prior to them being able to eat, another tray is to be obtained. 100% of dietary staff, licensed nurses, and Certified Nursing Assistants will be in-serviced on the Resident Nutrition Services policy by the Director of Nursing or designee (Registered Dietitian, Assistant Director of Nursing, Staff	

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F 325	<p>Continued From page 57</p> <p>Observations on 12/9/15 at 8:05 AM, in Resident #24's room revealed Resident #24's breakfast consisted of orange juice, scrambled eggs, sausage, biscuit with jelly, oatmeal and a glass of water. Her diet slip documented a regular diet with fortified foods (yogurt and ice cream). There was no yogurt or ice cream on her tray and the texture of the food was not a mechanical soft diet.</p> <p>Observations on 12/9/15 at 5:47 PM, in Resident #24's room revealed Resident #24's dinner tray consisted of a glass of water, french fries, hotdog on bun, and beans. The meal tray did not have fortified foods such as ice cream or yogurt, and the texture of the food was not a mechanical soft diet.</p> <p>Observations on 12/10/15 at 7:59 AM, in Resident #24's room, revealed Resident #24's breakfast tray consisted of scrambled eggs, oatmeal, biscuit with jelly, sausage, orange juice, water, and milk. There was no yogurt or ice cream on her tray and the food was not the texture of a mechanical soft diet.</p> <p>Interview with the Registered Dietician (RD) on 12/10/15 at 12:55 PM, in the RD's office, the RD was asked about Resident #24's dietary status. The RD stated, "Recently changed to mechanical soft texture on the 7th... fortified foods with all meals... yogurt with all meals... ice cream with all meals..." The RD was shown a diet slip dated 12/9/15 and was asked if a mechanical soft diet had been ordered, where would the change be reflected on the slip. The RD stated, "Under the texture on the diet slip." The RD was asked if she expected to see yogurt and ice cream on all of Resident #24's meal trays. The RD stated, "Yes." The RD was asked if she would expect a hot dog</p>	F 325	<p>Development Coordinator, or Unit Managers) by 1-10-15. This policy indicates that nursing personnel will ensure that residents are served the correct food tray. Prior to serving the food tray, the Nurse Aide must check the tray card to ensure that the correct food tray is being served to the resident. If there is doubt, the Nurse Supervisor will check the written physician's order. If an incorrect meal has been delivered, nursing staff will report it to the Dietary Manager so that a new food tray can be issued. The Director of Nursing or designee (Registered Dietitian, Assistant Director of Nursing, or Unit Managers) will conduct a random Meal Observation audit of 30 residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure residents are being assisted with dining and are receiving the correct, therapeutic diet as ordered.</p>	

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F 325	<p>Continued From page 58</p> <p>to be on a mechanical soft regular diet. The RD stated, "I would expect to see it cut up."</p> <p>Interview with the RD and the Dietary Manager (DM) on 12/10/15 at 1:15 PM, in the RD's office, the DM was asked is she considered a hot dog to be acceptable for a resident that was on a mechanical soft diet. The DM stated, "We grind our hot dogs. The DM was asked if you would expect the resident to receive a mechanical soft texture. The DM stated, "It should reflect the latest order." The DM was asked how would you know by looking at the meal tray if a food was fortified. The DM stated, "It is usually a milk shake or something extra or could be mashed potatoes or pudding." The DM was asked if you would expect these foods to be on a tray if resident is on fortified foods. The RD stated, "Um huh."</p> <p>2. Medical record review revealed Resident #64 was admitted to the facility with diagnoses of Muscle Weakness, Diabetes Mellitus, Anemia, Alzheimer's Disease, Insomnia, Cataract, Hypertension, Cerebrovascular Disease, Osteoarthritis, Osteoporosis, and Dysphagia.</p> <p>The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/15 documented, "...No weight loss or gain..." The quarterly MDS with an ARD of 11/13/15 documented, "...weight loss... not on a physician's-prescribed weight loss..."</p> <p>The care plan dated 8/14/15 documented, "...Resident at nutritional risk... Offer, encourage, assist w [with] /supplements, snacks, fluids, meals as ordered..."</p>	F 325	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing or Administrator) will present the results of the Meal Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson - Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p>	

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F 325	Continued From page 59 The Physician's orders dated 11/8/15 documented, "...Diet: Pureed, Nectar Thick... Ensure BID [twice daily]... Magic Cup TID [three times daily] w/meals..." Observations of Resident #62's lunch tray on 12/10/15 at 12:45 PM, on the meal cart, revealed a spoon stuck into the pureed dressing. There was no sign that the resident had eaten or drank anything because the piles of pureed food was as it was served. There was a shake with the lid still on the glass, 2 unopened cartons of thicken tea, and pudding with a lid that was still sealed on the bowl. The resident's meal consisted of pureed peas, bread, turkey, dressing, mighty shake, pureed desert, and 2 cartons of nectar thick tea. Interview with Certified Nursing Assistant (CNA) #3 on 12/10/15 at 1:35 PM, in the conference room, CNA #3 was asked how much did Resident #62 eat today (12/10/15). CNA #3 stated, "She ate 15 percent. She didn't eat anything but her dressing. Someone called me to the front desk and when I got back, her tray had been removed." CNA #3 was asked if it would have been appropriate to have gone to the kitchen and get the resident another lunch tray. CNA #3 stated, "Yes ma'am." Interview with the DON on 12/10/15 at 3:15 PM, in the conference room, the DON was asked what she expected her staff to do if a resident's tray was picked up and they had not eaten much of the food. The DON stated, "They should offer them a snack or another tray."	F 325		
F 361 SS=F	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS	F 361		

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F 361	<p>Continued From page 60</p> <p>The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.</p> <p>If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.</p> <p>A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a job description, policy review, review of an online order confirmation, observation and interview, the facility failed to ensure a qualified dietician provided oversight of the facility kitchen by planning, managing, and implementing dietary service activities as evidenced by food outdated food, opened food without an open date, wet nesting of pans, dusty and rusty ceiling lights, dusty ceilings, dirt build up under the steam table, lack of appropriate hair restraints worn by staff, chemicals in the food preparation area and failed to ensure a sufficient amount of emergency food supply was on hand at all times. The facility had a census of 170 with 156 of those residents receiving a meal tray from the kitchen.</p> <p>The findings included: Review of the facility's signed Dietitian job</p>	F 361	<p>F361</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>An Emergency 3 day food supply for both residents and staff was received on 12-11-15 and matched the emergency menu. Outdated food and undated food was thrown out on 12-7-15. Wet nesting of pans was corrected on 12-7-15. Cleaning and repairing of the dusty and rusty ceiling lights and dusty ceilings will be completed by 12-31-15. Steam table will be replaced by 1-10-16. Hair restraints are being worn and beard guards were ordered on 12-7-15. Chemicals in the food preparation area was corrected on 12-8-15.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p>	1-10-2016

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F 361

Continued From page 61
description documented, "...The primary purpose of your job is to plan, develop, and direct the overall operation of the Food Service Department..."

The facility's "Dietary Considerations for Residents" policy documented, "...A minimum of food and water to last for three days shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees, and visitors during a crisis or disaster situation..."

Review of a online order confirmation dated 12/8/15 with a delivery date of 12/11/15 documented, the following items were ordered for the emergency food supply:

- a. A case thick honey apple juice.
- b. A case Nectar thick apple juice.
- c. A case puree ham.
- d. A case ham shank.
- e. Two cases applesauce.
- f. Two cases applesauce in apple juice.
- g. Two cases green beans.
- h. Two cases pinto beans.
- i. Two cases diced beets.
- j. Two cases carrots.
- k. Two cases assorted cookies.
- l. A case saltine crackers.
- m. Two cases chicken and (&) dumpling.
- n. Two cases apple juice.
- o. Two cases orange juice.
- p. Two cases pineapple juice.
- q. Three cases mayonnaisse packets.
- r. Two cases sweet green peas.
- s. Three cases creamy peanut butter.
- t. Two cases pineapple tidbits.
- u. Two cases banana pudding.

F 361

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

100% of dietary personnel will be in-serviced on the dietary Sanitization Policy, Employee Hygiene and Sanitary Practices Policy, Storage of Pots, Dishes, Flatware, and Utensil Policy, Refrigerators and Freezers Policy, Food Prep Policy and the Dietary Considerations for Residents Policy by the Registered Dietitian or Dietary Manager by 1-10-16. A dietary audit will be completed by the dietary manager twice weekly x 3 months looking for undated/unlabeled food, steam table clean and free of debris buildup, expired food, chemicals in food prep area, cookware/utensils/equipment not stored wet, and ceiling lights/ceiling free from dust and rust, and ensuring there is a 3 day supply of emergency food on hand.

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F 361	<p>Continued From page 62</p> <p>v. Two cases chocolate pudding. w. A case puree beef stew. x. A case puree seasoned chicken. y. A case puree vegetables carrots & peas. z. Two case ravioli beef in meat sauce bite size. aa. Two cases vegetable soup. bb. Two cases deluxe beef stew. cc. Two cases mixed vegetables. These food items were not in stock for the emergency food supply.</p> <p>As the surveyor started comparing the emergency menu with food on hand, the Certified Dietary Manager (CDM) stated, "Probably don't have any vegetables. Probably don't have a lot of stuff."</p> <p>Interview with the Registered Dietician (RD) on 12/10/15 at 1:50 PM, in the conference room, the RD was asked what her responsibility was related to the kitchen. The RD stated, "Oversight, oversee the kitchen, cleanliness, everything related to regulation." The RD was asked about the lack of food in the emergency supply. The RD stated, "We have a new Dietary Manager, she just hadn't got there."</p> <p>Interview with the Administrator on 12/10/15 at 5:00 PM, the Administrator was asked when the emergency food supply would be in the facility. The Administrator stated, "We get delivery 2 times a week on Tuesdays and Fridays."</p> <p>The facility failed to ensure food was prepared and served in a sanitary manner as evidenced by outdated food, opened food without an open date, wet nesting of pans, dusty and rusty ceiling lights, dusty ceilings, dirt build up under the steam table, lack of appropriate hair restraints worn by staff</p>	F 361	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The result of the Dietary Audit will be presented by the Dietary Manager or designee (Administrator, Director of Nursing, Assistant Director of Nursing) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed.</p>	

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F 361	Continued From page 63 and chemicals in the food preparation area.	F 361		
F 371 SS=F	Refer to F371. 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 prepared and served in a sanitary manner as evidenced by outdated food, opened food without an open date, wet nesting of pans, dusty and rusty ceiling lights, dusty ceilings, dirt build up under the steam table, lack of appropriate hair restraints worn by staff and chemicals in the food preparation area. The facility had a census of 170 with 156 of those residents receiving a meal tray from the kitchen. The findings included: 1. Observations during kitchen tour on 12/7/15 beginning at 10:20 AM, revealed the following: a. 15 - 6 ounce (oz) containers of fat free strawberry yogurt stored past the use date of 12/4/15.	F 371	F371 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. An Emergency 3 day food supply for both residents and staff was received on 12-11-15 and matched the emergency menu. Outdated food and undated food was thrown out on 12-7-15. Wet nesting of pans was corrected on 12-7-15. Cleaning and repairing of the dusty and rusty ceiling lights and dusty ceilings will be completed by 12-31-15. Steam table will be replaced on 1-10-16. Hair restraints are being worn and beard guards were ordered on 12-7-15. Chemicals in the food preparation area was corrected on 12-8-15. How the facility will identify other residents having the potential to be affected by the same deficient practice.	1-10-2016

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F 371	<p>Continued From page 64</p> <p>b. 36 - 4 oz containers of strawberry banana yogurt stored past the use date of 11/30/15.</p> <p>c. A 1/2 gallon of buttermilk stored past the use by date of 11/28/15.</p> <p>d. Two 20 oz opened loaves of light bread without an open date.</p> <p>e. Seven 20 oz loaves of light bread stored past the use best by date of 12/5/15.</p> <p>f. Two 11 oz packages of opened hamburger buns without an open date.</p> <p>g. Four 11 oz packages of hot dog buns stored past the use best by date of 11/14/15.</p> <p>Interview with the Certified Dietary Manager (CDM) on 12/7/15 at 10:20 AM, in the kitchen, the CDM was asked about the expired foods and foods without an open date. The CDM stated, "I can't believe it, that's the milkman. I have to watch them [bread men] or they will bring me out of date stuff." The CDM stated, "I've told them and told them they have to date stuff when they open it."</p> <p>2. Review of the facility's "Storage of Pots, Dishes, Flatware, Utensils" policy documented, "...Pots, dishes, and flatware are stored in such a way to prevent contamination by splash, dust, pests, or other means... Air dry pots..."</p> <p>Observations in the kitchen on 12/7/15 at 10:25 AM revealed the following:</p> <p>a. A stack of 7 baking sheets stored wet nested and some had flour remnants on them.</p> <p>b. 12 deep pans stacked wet nested.</p> <p>c. A hole in the wall next to the ice machine.</p> <p>d. Ceiling and ceiling lights were dusty and/or rusty.</p> <p>e. Underneath the steam table had thick dirt in the edges.</p>	F 371	<p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of dietary personnel will be in-serviced on the dietary Sanitization Policy, Employee Hygiene and Sanitary Practices Policy, Storage of Pots, Dishes, Flatware, and Utensil Policy, Refrigerators and Freezers Policy, Food Prep Policy and the Dietary Considerations for Residents Policy by the Registered Dietitian or Dietary Manager by 1-10-16. A dietary audit will be completed by the Dietary Manager twice weekly x 3 months looking for undated/unlabeled food, steam table clean and free of debris buildup, expired food, chemicals in food prep area, cookware/utensils/equipment not stored wet, and ceiling lights/ceiling free from dust and rust.</p>	

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F 371	Continued From page 65 3. Review of the facility's "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy documented, "...Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness... Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens..." Observations on 12/7/15 at 10:50 AM, revealed Dietary Staff (DS) #1 with a surgical mask on his chin with facial hair on the sides of his face and moustache uncovered. Observations on 12/7/15 at 10:50 AM, revealed DS #2 also had surgical mask covering the facial hair on his chin with facial hair on the sides of his face uncovered. The CDM turned around and told the dietary staff to "Put 2 masks on if you have to." 4. Review of the facility's "Poisonous and Toxic Materials" policy documented, "...Only poisonous and toxic materials that are required to maintain kitchen sanitation shall be permitted in the pot washing and dishwashing areas, but may not be stored or used in the presence of food..." Observations on 12/8/15 at 5:15 PM, revealed a green bucket sitting under the food preparation table with a sudsy liquid inside. Interview with the CDM on 12/8/15 at 5:15 PM, in the kitchen, the CDM was asked what was in the green bucket. The CDM stated, "It's just some sanitizer." The CDM was asked if it was	F 371	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The result of the Dietary Audit will be presented by the Dietary Manager or designee (Administrator, Director of Nursing, Assistant Director of Nursing) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed.	

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PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 66 acceptable to have a bucket of sanitizer around food. The CDM stated, "It's just what we use to clean."	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Devices to attach narcotic boxes to the inside of the refrigerators was ordered on 12-18-15 and were repaired on 12-30-15. Insulin found expired in C wing medication room was disposed of on 12/9/15. B wing medication cart was locked on 12/9/15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. All stored medications were inspected for expiration by the Unit Managers and Director of Nursing on 12-11-15. A new insulin box was replaced on 12-11-15.	1-10-2016

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F 431	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure medications were properly stored as evidenced by unsecured refrigerator narcotic boxes, medications stored past their expiration dates, and/or medication cart was left unlocked, unattended and out of the nurse's sight in 8 of 15 (A wing medication room refrigerator, Memory care unit refrigerator, C wing front hall medication room refrigerator, C wing front hall medication room refrigerator, C wing back hall medication room refrigerator, B wing medication cart #1, B wing medication room refrigerator and E wing medication room refrigerator) medication storage areas. The findings included: 1. Review of the facility's "Storage of Medications" policy documented, "...The facility shall store all drugs and biologicals in a safe, secure and orderly manner... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others..." 2. Observations in the A wing medication room on 12/8/15 at 4:00 PM, revealed 7 Lorazepam stored in an unsecured box in the A wing medication room refrigerator. Interview with Licensed Practical Nurse (LPN) #1	F 431	What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of licensed nurses will be in-serviced on Storage of Medication Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Mangers) by Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and follow up as needed. 1-10-16 which indicates that narcotic boxes within a refrigerator must be secured, med carts locked when not in use, and outdated drugs will not be used. A Medication Storage audit looking for expired medications, unlocked medication carts, and secured narcotic boxes in refrigerators in medication rooms will be conducted by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) 3x/ week x 4 weeks, weekly x 4 weeks, then monthly x 2 months.	

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F 431	<p>Continued From page 68</p> <p>on 12/8/15 at 4:00 PM, LPN #1 was asked if the narcotic box was permanently attached to the refrigerator. LPN #1 stated, "No it is not."</p> <p>3. Observations in the memory care unit nurses' station on 12/8/15 at 4:10 PM, revealed 7 injectable Lorazepam stored in a narcotic box in the memory care unit nurses' station refrigerator. The memory care unit nurses' station door was unsecured and open.</p> <p>Interview with LPN #2 on 12/8/15 at 4:10 PM, in the memory care unit nurses' station, LPN #2 was asked if the narcotic box was permanently attached to the refrigerator. LPN #2 stated, "No, it is not."</p> <p>4. Observations in the C wing front hall medication room on 12/9/15 at 5:00 PM, revealed an unsecured small black narcotic box stored in the C wing front hall medication room refrigerator containing 14 Lorazepam injections.</p> <p>Interview with LPN #3 on 12/9/15 at 5:15 PM, in the C wing front hall medication room, LPN #3 was asked if the box was permanently affixed to the refrigerator. LPN #3 stated, "No."</p> <p>5. Observations in the C wing front hall medication room on 12/9/15 at 5:15 PM, revealed Lantus insulin, Novolin 70/30 insulin, Novolin insulin, Levimir insulin, Humalog insulin, Novolin R insulin, and Novolin N insulin stored in a locked kit. The box was labeled on the outside with an expiration date of 9/30/15. The insulin was stored past the expiration date of 9/30/15.</p> <p>Interview with LPN #3 on 12/9/15 at 5:15 PM, in the C wing front hall medication room, LPN #3</p>	F 431	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing or Staff Development Coordinator) will present results of the Medication Audit to the Quality Assurance Performance Improvement Committee (Administrator, Director of Nursing, Assistant Director of Nursing) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection</p>	

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F 431	<p>Continued From page 69 was asked if she could tell when the kit of insulin expired. LPN #3 stated, "9/30/15."</p> <p>6. Observations on the C wing back hall medication room on 12/9/15 at 5:20 PM, revealed 9 Lorazepam injectable's stored in an unsecured narcotic box in C wing back hall medication room refrigerator.</p> <p>Interview with LPN #4 on 12/9/15 at 5:20 PM in the C wing back hall, LPN #4 was asked if the box was permanently attached to the refrigerator. LPN #4 stated, "No, it is not."</p> <p>7. Observations on the B wing hall on 12/9/15 at 5:25 PM, revealed the B wing medication cart #1 was unlocked, unattended and out of sight of the nurses.</p> <p>8. Observations in the B wing medication room on 12/9/15 at 5:40 PM, revealed Lorazepam liquid oral concentrate and 7 vials of Lorazepam stored in an unsecured narcotic box in the B wing medication room refrigerator.</p> <p>Interview with LPN #6 on 12/9/15 at 5:40 PM, in the B wing medication room LPN #6 was asked if the narcotic box was permanently attached to the refrigerator. LPN #6 stated, "No."</p> <p>9. Observations in the E wing medication room on 12/9/15 at 5:50 PM, revealed 2 injectable Lorazepam stored in an unsecured narcotic box in the E wing medication room refrigerator.</p> <p>Interview with LPN #7 on 12/9/15 at 5:50 PM, in the E wing medication room, LPN #7 was asked if the narcotic box was permanently attached to the refrigerator. LPN #7 stated, "No."</p>	F 431		

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</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>	F 441	<p>F441</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>November infection tracking was completed on 12-11-15. Toilet paper in room 229 was disposed of on 12/7/15 and replaced on holder. Urinal in room 246 was discarded on 12/8/15 and replaced, labeled, and bagged. Briefs in room 219 were stored off the floor on 12/10/15. Wound care products in room 381 were removed from the bathroom floor on 12/7/15. Tiles in the B Wing Shower room and the room off of it were repaired on 12/21 /15. The black substance on top of the walls and ceiling were cleaned on 12-7-15. The faucet in C wing Shower Room was repaired on 12-28-15. Feces on the trash can were cleaned on 12-8-15. The clear bag of dirty clothes was removed on 12/8/15. The disinfectant cleaner was locked up on 12/8/15. The middle washing machine in the laundry room was repaired on 12-11-15. An outside contracted company is coming on 1-1-16 to pressure wash all shower rooms.</p>	1-10-2016	

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F 441	<p>Continued From page 71</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, observation and interview, the facility failed to track and trend infections and failed to prevent the potential spread of infection and cross contamination as evidenced by toilet paper sitting on the bathroom floor, unlabeled urinals and wound care products and briefs stored on the floor in 4 of 129 (Room #229, 246, 219 and 381) resident rooms/bathrooms and black and brown substance on the walls and ceiling, leaky faucet, feces on the edges of the trash can, clear trash bag with dirty clothes on the floor, disinfectant cleaner sitting on the heating, ventilation and air conditioner (HVAC) unit, dirty grout, dirt build up on wheels of a shower chairs. The facility failed to process linens so as to prevent the spread of infection in 1 of 3 washers.</p> <p>The findings included:</p> <p>1. Review of the facility's "Healthcare-Associated Infections, Identifying" policy documented, "...Healthcare-associated infections (HAIs) are those that are acquired during the delivery of healthcare across settings (hospitals, home health, in the facility), in contrast to those acquired prior to entering the healthcare setting but may persist after admission to the facility... When an infection is identified, the Infection Preventionist, with the input of the nursing staff and Attending Physician as needed... The committee will review the reports and identify the trends, patterns, or problems that might reflect the development of healthcare-associated infections..."</p> <p>Interview with the Director of Nursing (DON) on</p>	F 441	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected. All shower rooms were inspected on 12-11-15 for broken tiles, disrepair, and cleanliness.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of Certified Nursing Assistants, licensed nursing staff, laundry/housekeeping staff, and maintenance staff will be in-serviced on the Storage of Supplies Policy, Maintenance Work Order Policy, and the Cleaning and Disinfecting Environmental Surfaces Policy by 1-10-15. The Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, Maintenance Director, or Unit Managers) will conduct the in-servicing. A Shower Room Audit, Laundry Room Audit, and Room Rounds audit</p>	

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F 441	<p>Continued From page 72</p> <p>12/10/15 at 4:30 PM, in the conference room, the DON was asked how you could tell by looking at the "User Defined Assessment Summary" when there are trends. The DON stated, "We only track and trend the nosocomial infections." The DON was asked if November 2015 had been trended. The DON stated, "November has been tracked but not trended."</p> <p>2. Observations in room 229's bathroom on 2/7/15 at 9:30 AM, revealed a roll of toilet paper sitting on the floor next to the toilet.</p> <p>3. Observations in room 246's bathroom on 9/27/15 at 9:35 AM and on 12/8/15 at 2:30 PM, revealed an unlabeled urinal hanging from grab bar next to the toilet and a urinal was sitting in a bed pan which was sitting in a wash basin on the floor next to the toilet.</p> <p>Interview with the DON on 12/10/15 at 9:45 AM, the DON was asked if it was appropriate for urinals to be unlabeled and patient equipment sitting on the floor. The DON stated, "The equipment should be bagged and labeled and they shouldn't be on the floor."</p> <p>4. Observations in room 219 on 12/10/15 at 7:59 AM, revealed 4 packages of briefs sitting on the floor by the closet.</p> <p>5. Observations in room 381 on 12/7/15 at 11:31 AM, revealed a box of hydrophobic foam wound care products (one dressing kit was open), a box of Caniste and an opened Simplace dressing all sitting on the bathroom floor.</p> <p>Interview with the DON on 12/10/15 at 8:10 AM, in the main foyer, the DON was asked if it was</p>	F 441	<p>will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Maintenance Director, or Unit Managers) 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 looking for disrepair, cleanliness, and storage issues.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Maintenance Director) will present the findings of the Shower Room Audits, Laundry Room Audit, and Room Rounds Audits x 4 months to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities</p>	

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F 441	<p>Continued From page 73</p> <p>ever appropriate to store enteral feedings, briefs, or wound care products on the floor of a resident's room. The DON stated, "No."</p> <p>6. Observations during initial tour on 12/8/15 and beginning at 9:30 AM revealed:</p> <p>a. B Wing Shower - there was a chunk of the threshold tile in the shower, a chunk of tile off a wall corner wall. There was a room off of this shower that was being used as equipment storage, the tile was punched in around the emergency call light by the toilet and there was an unknown black and brown substance on the top of the walls and the ceiling.</p> <p>b. C Wing Shower Room - there was running water in the sink with the faucet unable to turn the water off, feces on the edges of the trash can, clear trash bag with dirty clothes on the floor, disinfectant cleaner sitting on the HVAC unit, grout dirty and dirt build up on wheels of a 6 shower chairs.</p> <p>7. Observations in the laundry on 12/8/15 at 10:15 AM, revealed Laundry Technician #1 working in the laundry. There were 3 machines in the laundry, the middle machine was in use and was leaking water from the front door.</p> <p>Interview with Laundry Technician #1 on 12/8/15 at 10:20 AM, in the laundry room, Laundry Technician #1 was asked about the washing machine. Laundry Technician #1 stated, "The middle machine leaks because the seal is broken."</p> <p>Observations in the laundry room on 12/9/15 at 10:00 AM, revealed 3 washing machines, the</p>	F 441	<p>Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.</p>	

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F 441	Continued From page 74 middle washer was running and water was pouring out the front door. Interview with Laundry Technician #1 on 12/9/15 at 10:00 AM, Laundry Technician #1 stated, "The machine that is leaking has a broken seal and that makes the water leak." Interview with the Administrator on 12/10/15 at 5:55 PM, in the main foyer, the Administrator was asked if he could provide an invoice showing the seal for the leaking washing machine. The Administrator stated, "No, there is not an invoice.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain 2 of 3 essential equipment (washing machines) in the laundry as evidenced by a washer leaking water and a washer out of order. One washer has been out of order for at least 2 months. The findings included: 1. Observations in the laundry on 12/8/15 at 10:15 AM, revealed Laundry Technician #1 working in the laundry. There were 3 machines in the laundry, one machine was out of service, the middle machine was in use and was leaking water from the front door.	F 456	<u>F456</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The washing machine out of order will be removed by 1-10-16. The washing machine that was leaking was repaired on 12-11-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. The Maintenance Supervisor inspected the washing	1-10-2016

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F 466	<p>Continued From page 75</p> <p>Interview with Laundry Technician #1 on 12/8/15 at 10:20 AM, in the laundry room, Laundry Technician #1 was asked about the washing machines. Laundry Technician #1 stated, "The machine out of service has been broken a couple of months due to a belt that would not spin, the middle machine leaks because the seal is broken."</p> <p>2. Observations in the laundry room on 12/9/15 at 10:00 AM, revealed 3 washing machines, 1 machine was out of order, the middle washer was running and water was pouring out the front door.</p> <p>Interview with Laundry Technician #1 on 12/9/15 at 10:00 AM, Laundry Technician #1 stated, "That machine is not working and has been broken around 2 months, it is the belt inside, the machine that is leaking has a broken seal and that makes the water leak."</p> <p>3. Interview with the Administrator on 12/10/15 at 9:05 AM, in the Administrator's office, the Administrator was asked about the washing machines. The Administrator stated, "We are attempting to get the 3rd washer back up."</p> <p>Interview with the Administrator on 12/10/15 at 5:55 PM, in the main foyer, the Administrator was asked if he could provide an invoice showing the seal for the leaking washing machine. The Administrator stated, "No, there is not an invoice."</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional,</p>	F 456	<p>machines on 12-11-15. There will be two remaining washers which can adequately handle the laundry load within the facility. The broken washer will be removed by 1-10-16.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of laundry/housekeeping personnel and maintenance personnel will be in-serviced by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator) on Maintenance Work Order Policy by 1-10-15. A Laundry Room Audit will be completed by the the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Maintenance Director, or Unit Managers) 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 looking for disrepair.</p> <p>How the facility will monitor its</p>	

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F 465	<p>Continued From page 76 sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure the environment was safe and sanitary as evidenced by tiles broken or missing, black and brown substance on the walls and ceiling, leaky faucet, feces on the edges of the trash can, clear trash bag with dirty clothes on the floor, disinfectant cleaner sitting on the heating, ventilation and air conditioner (HVAC) unit, dirty grout, dirt build up on wheels of a shower chairs and foul offensive odors in 2 of 8 (B wing shower room and C wing shower room) shower rooms, 3 of 8 (memory care unit hall, 100 hall, and D hall) halls.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Cleansing and Disinfection of Environmental Surface" policy documented, "...Environmental surfaces will be cleaned and disinfected according to current CDC [centers of disease control] recommendations for disinfection of healthcare facilities and the OSHA [occupational safety and health administration] Bloodborne Pathogens Standard..." Review of the facility's "7-Step Daily Washroom Cleaning" policy documented, "...Clean and Sanitize Sink and Tub... Use Germicide to clean the sink to be sure it is disinfected... Clean and Sanitize Commode - The commode includes the tank, the seat, the bowl and the base... Spot clean the walls... Use proper mop and germicide 	F 465	<p>corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Maintenance Director) will present the findings of the Laundry Room Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p>	

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F 465	Continued From page 77 solution to disinfect the floor... Be sure to run mop along edges and never push dirt into corners..." 2. Observations during initial tour on 12/8/15 and beginning at 9:30 AM revealed: a. B Wing Shower - there was a chunk of the threshold tile in the shower, a chunk of tile off a wall corner wall. There was a room off of this shower that was being used as equipment storage, the tile was punched in around the emergency call light by the toilet and there was an unknown black and brown substance on the top of the walls and the ceiling. b. C Wing Shower Room - there was running water in the sink with the faucet unable to turn the water off, feces on the edges of the trash can, clear trash bag with dirty clothes on the floor, disinfectant cleaner sitting on the HVAC unit, grout dirty and dirt build up on wheels of a 6 shower chairs. 3. Observations on the memory care unit hall outside of room 124 on 12/5/15 at 2:50 PM, revealed a strong offensive odor. 4. Observations on the 100 hall outside of room 194 on 12/7/15 at 2:25 PM, revealed a strong offensive odor. Observations on the 100 hall outside of room 182 on 12/7/15 at 2:30 PM, revealed a strong urine odor. 5. Observations on D hall on 12/8/15 at 7:20 AM and 12/9/15 at 11:15 AM, revealed a strong offensive odor.	F 465	F465 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Tiles in the B Wing Shower room and the room off of it were repaired on 12/21 /15. The black substance on top of the walls and ceiling were cleaned on 12-7-15. The faucet in C wing Shower Room was repaired on 12-28-15. Feces on the trash can was cleaned on 12-8-15. The clear bag of dirty clothes was removed on 12/8/15. The disinfectant cleaner was locked up on 12/8/15. Room 124 was deep cleaned on 12/16/15 and 12/23/15. Room 194 was deep cleaned on 12/14/15. Room 182 was deep cleaned on 12/16/15. Room 186 was cleaned 12/28/15 and again on 12/29/15. This room was what was causing the offensive odors on D hall. An outside contracted company is coming to pressure wash all shower rooms on 1-1-16.	1-10-2016

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F 465	Continued From page 78 6. Interview with the Administrator on 12/10/15 at 8:05 AM, in the B shower room, the Administrator confirmed the broken tiles was not safe. The Administrator was asked if it was appropriate to for chemicals to be unattended in the common areas or resident rooms. The Administrator stated, "No, it's not." Interview with the Administrator, Housekeeping Supervisor (HKS) and the Director of Nursing (DON) on 12/10/15 at 8:30 AM, the HKS was asked if he considered the shower rooms to be clean and sanitary. The HKS stated, "No." Interview with the Administrator on 12/10/15 at 9:15 AM, in the main foyer, the Administrator was asked if it was ever appropriate to have odors in the common areas. The Administrator stated, "No."	F 465	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of Certified Nursing Assistants, licensed nursing staff, laundry/housekeeping staff, and maintenance staff will be in-	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services: This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory tests as ordered by the physician for 1 of 51 (Resident #109) residents included in the stage 2 review. The findings included: Medical record review revealed Resident #109 was admitted to the facility on 7/2/10 and	F 502	serviced on the Storage of Supplies Policy, Maintenance Work Order Policy, and the Cleaning and Disinfecting Environmental Surfaces Policy by 1-10-15. The Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, Maintenance Director, or Unit Managers) will conduct the in-servicing. A Shower Room Audit and Room Rounds	

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F 502	<p>Continued From page 79 readmitted on 3/21/14 with diagnoses of Complications of a Vascular Prosthetic Device / Graft, Muscle Weakness, and End Stage Renal Disease.</p> <p>The Physician's orders dated 11/1/15 through 11/30/15 documented, "...LAB ORDERS... VIT [Vitamin] D [level] EVERY 6 MON [months] THIS DUE: APRIL, OCT... TSH [thyroid stimulating hormone] YEARLY DUE: OCT... ANNUAL TB [tuberculosis] SCREEN... CBC [complete blood coun]..."</p> <p>The facility was unable to provide documentation that a Vitamin D level, TSH, CBC and TB skin test had been done as ordered by the physician.</p> <p>Lab result form with collection date of 10/26/15 documented, "...THE FOLLOWING TEST(S) WERE REQUESTED AND NOT PERFORMED: CBC, TSH, VITAMIN D</p> <p>Lab result collection form dated 10/28/15, documented, "THE FOLLOWING TEST(S) WERE REQUESTED AND NOT PERFORMED... TSH, CMP [complete metabolic panel], VITAMIN D..."</p> <p>Consultant Pharmacist Communication to the Physician dated for review period of April 2015, documented, "...Please consider checking the following lab(s): CBC, CMP, TSH..."</p> <p>Interview with the Unit Manager on 12/10/15 at 5:46 PM, in the conference room, the Unit Manager was asked why the labs were not being followed through with. The Unit Manager stated, "Nurses told [named Laboratory] that dialysis would draw lab but didn't tell dialysis. Should write</p>	F 502	<p>audit will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Maintenance Director, or Unit Managers) 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 looking for disrepair, cleanliness, and storage issues.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Maintenance Director) will present the findings of the Shower Room Audits and Room Rounds Audits x 4 months to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities</p>	

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F 502 F 517 SS=F	Continued From page 80 on dialysis communication." 483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a online order invoice, observation and interview, the facility failed to ensure emergency food supplies were on hand at all times, as evidenced by an insufficient amount of food in the emergency food supply closet. The facility had a census of 170 with 156 of those residents receiving a meal tray from the kitchen. The findings included: The facility's "Dietary Considerations for Residents" policy documented, "...A minimum of food and water to last for three days shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees, and visitors during a crisis or disaster situation..." Review of a online order confirmation dated 12/8/15 with a delivery date of 12/11/15 documented, the following items were ordered for the emergency food supply: a. A case thick honey apple juice. b. A case Nectar thick apple juice.	F 502 F 517	Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed. F502 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #109 had a CBC done and was in the chart dated for 10-28-15 as ordered. Resident #109's TB skin test was indeed done on 3-19-15 and is not overdue. This is documented on the resident's immunization sheet. Resident #109's CMP and TSH were drawn on 12-11-15. Vitamin D for Resident #109 was discontinued on 12-31-15. How the facility will identify other residents having the potential to be affected by the same deficient practice.	1-10-2016

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F 517

Continued From page 81

- c. A case puree ham.
- d. A case ham shank.
- e. Two cases applesauce.
- f. Two cases applesauce in apple juice.
- g. Two cases green beans.
- h. Two cases pinto beans.
- i. Two cases diced beets.
- j. Two cases carrots.
- k. Two cases assorted cookies.
- l. A case saltine crackers.
- m. Two cases chicken and (&) dumpling.
- n. Two cases apple juice.
- o. Two cases orange juice.
- p. Two cases pineapple juice.
- q. Three cases mayonnaise packets.
- r. Two cases sweet green peas.
- s. Three cases creamy peanut butter.
- t. Two cases pineapple tidbits.
- u. Two cases banana pudding.
- v. Two cases chocolate pudding.
- w. A case puree beef stew.
- x. A case puree seasoned chicken.
- y. A case puree vegetables carrots & peas.
- z. Two case ravioli beef in meat sauce bite size.
- aa. Two cases vegetable soup.
- bb. Two cases deluxe beef stew.
- cc. Two cases mixed vegetables.

These food items were not in stock for the emergency food supply.

As the surveyor started comparing the emergency menu with food on hand, the Certified Dietary Manager (CDM) stated, "Probably don't have any vegetables. Probably don't have a lot of stuff."

Interview with the Registered Dietician (RD) on 12/10/15 at 1:50-PM, in the conference room, the RD was asked what her responsibility was related

F 517

All residents have the potential to be affected.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

All licensed nurses will be in-serviced by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-15 on the Transcription of Medical Orders Policy which states that staff are to complete lab slips for ordered lab studies, notify lab of order, and/or initiate process for blood draws and specimen transport. If ordered every month, every 3 months, every 6 months, etc...place labs on a calendar. Calendar is to be reviewed at the beginning of each month with lab slips filled out to be drawn during time frame. Labs to be reviewed by nursing management during the timeframe labs ordered to ensure labs are drawn. A Lab Audit will be completed by the Director of Nursing or designee (Assistant Director of Nursing, Staff

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F 517	<p>Continued From page 82</p> <p>to the kitchen. The RD stated, "Oversight, oversee the kitchen, cleanliness, everything related to regulation." The RD was asked about the lack of food in the emergency supply. The RD stated, "We have a new Dietary Manager she just hadn't got there."</p> <p>Interview with the Administrator on 12/10/15 at 5:00 PM, the Administrator was asked when the emergency food supply would be in the facility. The Administrator stated, "We get delivery 2 times a week on Tuesdays and Fridays."</p>	F 517	<p>Development Coordinator, or Omu Managers) ensuring labs are placed on the calendar and completed as ordered. This audit will be completed weekly x 4 months.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator) will present the Lab Audit results to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further recommendations and/or follow up as needed.</p>	

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F 502	Continued From page 80 on dialysis communication."	F 502		1-10-2016	
F 517 SS=F	<p>483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS</p> <p>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of a online order invoice, observation and interview, the facility failed to ensure emergency food supplies were on hand at all times, as evidenced by an insufficient amount of food in the emergency food supply closet. The facility had a census of 170 with 156 of those residents receiving a meal tray from the kitchen.</p> <p>The findings included: The facility's "Dietary Considerations for Residents" policy documented, "...A minimum of food and water to last for three days shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees, and visitors during a crisis or disaster situation..."</p> <p>Review of a online order confirmation dated 12/8/15 with a delivery date of 12/11/15 documented, the following items were ordered for the emergency food supply: a. A case thick honey apple juice. b. A case Nectar thick apple juice.</p>	F 517	<p><u>F517</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>An Emergency 3 day food supply for both residents and staff was received on 12-11-15 and matched the emergency menu.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of dietary personnel will be in-serviced on the Dietary Considerations for Residents Policy by the Registered Dietitian</p>		

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F 517	<p>Continued From page 81</p> <ul style="list-style-type: none"> c. A case puree ham. d. A case ham shank. e. Two cases applesauce. f. Two cases applesauce in apple juice. g. Two cases green beans. h. Two cases pinto beans. i. Two cases diced beets. j. Two cases carrots. k. Two cases assorted cookies. l. A case saltine crackers. m. Two cases chicken and (&) dumpling. n. Two cases apple juice. o. Two cases orange juice. p. Two cases pineapple juice. q. Three cases mayonnaise packets. r. Two cases sweet green peas. s. Three cases creamy peanut butter. t. Two cases pineapple tidbits. u. Two cases banana pudding. v. Two cases chocolate pudding. w. A case puree beef stew. x. A case puree seasoned chicken. y. A case puree vegetables carrots & peas. z. Two case ravioli beef in meat sauce bite size. aa. Two cases vegetable soup. bb. Two cases deluxe beef stew. cc. Two cases mixed vegetables. <p>These food items were not in stock for the emergency food supply.</p> <p>As the surveyor started comparing the emergency menu with food on hand, the Certified Dietary Manager (CDM) stated, "Probably don't have any vegetables. Probably don't have a lot of stuff."</p> <p>Interview with the Registered Dietician (RD) on 12/10/15 at 1:50 PM, in the conference room, the RD was asked what her responsibility was related</p>	F 517	<p>or Dietary Manager by 1-10-16. A dietary audit will be completed by the dietary manager twice weekly x 3 months making sure there is a 3 day emergency supply of food on hand.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The result of the Dietary Audit will be presented by the Dietary Manager or designee (Administrator, Director of Nursing, Assistant Director of Nursing) to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection</p>		

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

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111		
(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)	(X6) COMPLETION DATE	
F 517	Continued From page 82 to the kitchen. The RD stated, "Oversight, oversee the kitchen, cleanliness, everything related to regulation." The RD was asked about the lack of food in the emergency supply. The RD stated, "We have a new Dietary Manager she just hadn't got there." Interview with the Administrator on 12/10/15 at 5:00 PM, the Administrator was asked when the emergency food supply would be in the facility. The Administrator stated, "We get delivery 2 times a week on Tuesdays and Fridays.	F 517	Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed.		