

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

MAR 19 2010

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 03/03/2010
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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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(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
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F 225 SS=D	<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 appropriate corrective action must be taken.</p>	F 225	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, Ashton Place Rehab and Care Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>	
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acceptable POC 3/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robertson, LNHA</i>	TITLE <i>CEO Administrator</i>	(X6) DATE <i>3-16-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure that a thorough investigation was completed for an injury of unknown origin, and failed to report the injury to the state agency for 1 of 30 (Resident #12) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Abuse/ Neglect/ Mistreatment: Guidelines for Prevention/Identification/Investigation" documented "Policy... It is the policy of this facility that residents have the right to be free from abuse... If, however, an incident occurs that may be considered abuse/neglect/mistreatment, the management staff will complete an investigation and notify the appropriate regulatory agency, according to the state guidelines and timeframes (may not exceed a maximum of 5 days after notification of the incident/occurrence)... Identification... The facility will be proactive in identifying occurrences, patterns and/or trends that may constitute possible/potential abuse or neglect... Investigation... The facility will thoroughly investigate, under the direction of the CEO [Chief Executive Officer], all injuries of unknown origin... to determine if abuse or neglect was involved... If the investigation finds that there is probable abuse, neglect or misappropriation of resident property, the CEO or DNS [Director of Nursing Services] must notify the State Regulatory Agency within five (5) days... Reporting and Response to Alleged Incidents... Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be</p>	F 225	<p>Ashton Place Rehab and Care Center will continue to ensure that all alleged violations, including injuries of unknown source are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Ashton Place will continue to investigate thoroughly any alleged violations and maintain appropriate documentation of such investigation. Ashton Place will continue to require incident reports be completed by Charge Nurse for any resident incident, including injuries of unknown origin, and Charge Nurse will also obtain statements from staff involved with care regarding the alleged incident.</p> <ol style="list-style-type: none"> 1. The Director of Nursing Services will continue to receive resident incident reports within 24 hours of incident and be contacted immediately to conduct an investigation. 2. The Director of Nursing Services or Designee will review incident reports on a daily basis on weekdays and will review these reports with the clinical management team in the clinical meetings. The Director of Nursing Services or Designee will continue to report to the State Regulatory Agency within five days of the date of incident for instances of abuse, neglect, misappropriation, and injuries of unknown origin. 3. The center's nursing staff to be inserviced by the Director of Nursing or Designee regarding the 	4/1/10
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F 225	<p>Continued From page 2</p> <p>thoroughly investigated, documented and reported to the proper authorities... The nursing or administrative supervisor assumes responsibility for immediate notification of the DNS and the CEO... The CEO, or designee, shall take the following actions to assure that the investigation is conducted appropriately: A. If the incident has resulted in an injury or is suspected to be the result of a sexual assault, the resident should be transferred to the emergency department... C. An immediate investigation into the alleged incident, during the shift it occurred on is initiated as follows: 1. Interview the resident or other witnesses. 2. Interview the staff member implicated. Have the employee document their knowledge/version of the incident in a written narrative that is dated and signed. 3. Interview all staff on that unit. Interview staff witnesses or other available witnesses. Witnesses are to document their knowledge of the incident in a written narrative, signed and dated. The CEO, or designee, will contact the State Regulatory Office and notify them of all the information present at that time. The Federal Regulations state that the facility has five (5) days to notify the State Regulatory Agency, but must follow the state guidelines on the time frames and complete the specific forms as required... Attachment A... Facility Investigation Guidelines and Forms... The purpose of this investigation is to address all types of abuse... 1. If the resident is injured, provide all the necessary medical treatment and stabilize his/her health... 2. If the resident is able, conduct an interview about the incident. The resident should be interviewed at least three (3) times... The purpose of three separate interviews is to determine if the story is consistent -- DO NOT automatically discount a resident with dementia or other cognitive impairment. All staff</p>	F 225	<p>following topics: abuse policy, including injury of unknown origin; incident report completion including staff and resident statements; intervention utilization; documentation of incidents; notification to supervisor regarding incidents of unknown origin, abuse, neglect, and misappropriation.</p> <p>4. The Clinical Team will continue to review incident reports daily on weekdays with the Director of Nursing or Designee. The Clinical Team will also review monthly Clinical Indicator Report for trends noted. The results of this review and report will be reviewed at the Quality Assurance Committee monthly for the next three months to ensure substantial compliance.</p>	
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F 225	<p>Continued From page 3</p> <p>on the unit at the time the incident occurred must be interviewed and a written statement is to be obtained... Witnesses to the Incident... 1. The Social Worker, CEO and/or the DNS should interview other potential residents (potential victims) within 24- [to] 48 hours of the alleged incident... Nursing/Medical Staff 1. Interview anyone who treated the resident. 2. Ask them to prepare and sign a statement. Employees should be instructed to write a summary of the occurrence prior to the end of their shift. If they did not notice anything, they need to document that on the statement..."</p> <p>Medical record review for Resident #12 documented an admission date of 5/14/07 with diagnoses of Psychosis, Anemia, Alzheimer's Disease, Schizophrenia, Dementia, Osteoarthritis, Congestive Heart Failure, Osteoporosis and Peripheral Vascular Disease. Review of the most recent quarterly Minimum Data Set dated 12/2/09 documented the resident has long and short term memory problems, is moderately impaired with daily decision making skills, is totally dependent for all activities of daily living and for transfers, is non-ambulatory and is bedfast all or most of the time. Review of Resident #12's Care Plan dated 9/10/09 and reviewed on 12/10/09 documented "...Altered thought process with impaired cognition and communication as evidenced by problem understanding others as seen by short and long term memory problem and impaired decision making... Episodes of disorganized speech, easily distracted, and mental status varies throughout the course of the day...Bedfast..."</p> <p>Review of Resident #12's nurses' notes dated 9/17/09 documented "...At 840/A [8:40 AM] --</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>Noted raised area c [with] light bruising on Left side of forehead when CNA [Certified Nursing Assistant] bringing resident from shower. Res [resident] stated she bumped it this morning but couldn't remember on what. Res remained up in W/C [wheelchair] at 11AM [11:00 AM] noted swelling moving over & [and] down forehead Call to [named nurse practitioner] notified and stated to get skull series..."</p> <p>Review of an incident report dated 9/17/09 documented the incident occurred at 7:40 AM in Resident #12's room. The report further documented "...Level of Consciousness: Alert -- Disoriented..." There was only one narrative stated attached to the incident report, written by the CNA, which stated that she (CNA) noticed the swelling after bringing the resident from the shower room. There were no other interviews documented with any other staff or residents.</p> <p>Observations in Resident #12's room on 3/1/10 at 9:45 AM and 3:15 PM and on 3/2/10 at 7:55 AM, revealed Resident #12 up in a gerichair at the bedside. Resident #12 was alert, confused and difficult to understand.</p> <p>During an interview in the conference room on 3/3/10 at 4:00 PM, the DNS was asked what should happen when an injury of unknown origin is identified. The DNS stated, "...the CNA would tell the charge nurse... the charge nurse should go to the room and do an assessment... and get a statement from the resident... if they [resident] can't tell them what happened... do an investigation..." The surveyor asked the DNS what she would do to investigate an incident. The DNS stated, "...I'd interview resident... staff members... roommate... check the MDS</p>	F 225			

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F 225	Continued From page 5 [Minimum Data Set]... talk to the charge nurse... anybody that might have seen her... every single shift prior to and the day of [the incident]... The DNS was asked if this was an incident that should have been reported. The DNS stated, "...Yes Ma'am..." The DNS was then asked if this incident was reported. The DNS stated that she would check and see, then returned to the conference room at 4:25 PM, and stated "...No, Ma'am..."	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a	F 278	Ashton Place strives to complete assessments which accurately reflect the resident's status. The facility will continue to ensure care plans, nurses notes and assessments are up to date as per guidelines. 1. The assessments for Resident #3 and for Resident #14 have been updated to reflect the residents current status/condition. 2. Chart audits will be completed for all current residents by MDS Nurse or Designee to ensure appropriate assessments and care plans are in place and that they are accurate. 3. The center's nursing staff will be inserviced by Director of Nursing or Designee regarding completing nursing assessments, nursing documentation, skin assessments, change in condition, MDS accuracy and 24-hour report utilization. 4. The Director of Nursing or Designee will complete 5 random chart audits per unit per week for the next three months to ensure the following items are in compliance: facesheet, nurses notes, treatment notes/assessments, physician order sheets, social service note, activity	4/1/10

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F 278	<p>Continued From page 6 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility failed to complete the Minimum Data Set (MDS) to accurately assess residents for a fracture or a pressure ulcer for 2 of 30 (Residents #3 and 14) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #3 documented an admission date of 2/8/06 with diagnoses of Dementia, Seizures, Diabetes, Dysphagia, Hypertension, Failure To Thrive, and Peripheral Vascular Disease. Review of Resident #3's quarterly MDS assessment dated 12/5/09 in section M1 ULCERS, documented zero in a, b, c and d subsections. Review of Resident #3's "SKIN CONDITION RECORD" dated 11/9/09 documented a "0.6cm [centimeter] x [by] 0.7cm scabbed, black area to the bunion of the left foot." During an interview in the MDS Coordinator's office on 3/3/10 at 9:55 AM, the MDS Coordinator stated, "...It's [pressure ulcer] not on the MDS being generated now either, I'll check on this..." 2. Medical record review for Resident #14 documented an admission date of 9/1/04 and a readmission date of 9/29/09 with diagnoses of Psychosis, Peripheral Vascular Disease, Failure to Thrive, Hypertension, Osteomyelitis, Decubitus Ulcer and Anemia. Review of the full MDS assessment form dated 1/30/10, documented Resident #14 had had a fracture in the last 180 	F 278	<p>note, dietary note, nursing assessments, accuracy of MDS and weekly skin assessments. The completed audits will be submitted to Director of Nursing Services or Designee for review weekly for the next three months. The results of this audit will be reported to the Quality Assurance Committee monthly for the next three months to ensure substantial compliance.</p>	

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F 278	Continued From page 7 days.	F 278		
F 280 SS=D	<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 medical record review and observations, it was determined the facility failed to revise the comprehensive care plan to reflect the resident's current status for the inability to</p>	F 280	<p>Ashton Place strives to complete comprehensive care plans which accurately reflect the resident's current status.</p> <ol style="list-style-type: none"> 1. The comprehensive care plan for Resident #12 has been revised to reflect their current status. 2. Chart audits will be completed for all current residents by MDS Nurse or Designee to ensure appropriate assessments and care plans are in place. 3. The center's nursing staff and IDT team will be inserviced by Director of Nursing Services or Designee regarding completing assessments, updating care plans to reflect current status and revisions as needed with resident changes, care plans and the timelines required of such. 4. The Director of Nursing or Designee will complete 5 random chart per unit per week for the next three months to ensure that accurate comprehensive care plans are in place. The completed audits will be submitted to Director of Nursing Services or Designee for review weekly for the next three 	4/1/10

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F 280	<p>Continued From page 8</p> <p>comprehend how to use a call light, her non-ambulatory status, that weekly weights had been discontinued and that antibiotics had been discontinued since November 2009 for 1 of 30 (Resident #12) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #12 documented an admission date of 5/14/07 with diagnoses of Psychosis, Anemia, Alzheimer's Disease, Schizophrenia, Dementia, Osteoarthritis, Congestive Heart Failure, Osteoporosis and Peripheral Vascular Disease. Review of a physician's order dated 11/13/09 documented "...Patient c [with] repeated fever/^ [elevated] temp. [temperature]. [Named physician] notified. New orders received... Levaquin 500 mg [milligrams] i [one] po [by mouth] qd [every day] X [times] 10 days..." Review of Resident #12's physician's order dated 2/12/10 documented "...D/C [discontinue] Weekly Weights..." Review of Resident #12's most recent quarterly Minimum Data Set dated 12/2/09 documented the resident has long and short term memory problems, is moderately impaired with daily decision making skills, is totally dependent for all activities of daily living and transfers, is non-ambulatory and is bedfast all or most of the time.</p> <p>Review of Resident #12's Care Plan dated 9/10/09 and reviewed on 12/10/09 documented "...Potential for weight loss... Monitor weight weekly... Altered thought process with impaired cognition and communication as evidenced by problem understanding others as seen by short and long term memory problem and impaired decision making... Episodes of disorganized speech, easily distracted, and mental status</p>	F 280	<p>months. The results of this audit will be reported to the Quality Assurance Committee monthly for the next three months to ensure substantial compliance.</p>	

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F 280	Continued From page 9 varies throughout the course of the day... Keep call light within reach... Potential for falls r/t [related to] decline in her adl [activities of daily living] function ability... Bedfast... Keep room and and pathway free of clutter... Keep call light within reach... Resident is risk for adverse side effects r/t use of Antibiotic aeb [as evidenced by] resident having dx [diagnosis] hx [history] of pneumonia..." Observations in Resident #12's room on 3/1/10 at 9:45 AM and 3:15 PM, and on 3/2/10 at 7:55 AM, revealed Resident #12 up in a gerichair at the bedside. Resident #12 resident was alert, confused and difficult to understand. Resident #12's Care Plan was not revised to reflect the resident's inability to comprehend how to use a call light, her non-ambulatory status, that the weekly weights were discontinued 2/12/10 and that antibiotics had been discontinued since November 2009.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on the policy review, medical record review and interview, it was determined the facility failed to follow physician's orders for nothing by mouth (NPO) status, vital signs and documentation of	F 309	Ashton Place will continue to strive to ensure each resident receives 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. 1. The center will continue to ensure physician orders are followed as written. Physician was notified regarding Res #1 and Res.# 15. Resident #17 now has bowel movements documented daily. 2. Chart audits will be completed for all current residents by Director of Nursing Services or Designee to ensure appropriate diets are in	4/1/10

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F 309	<p>Continued From page 10</p> <p>bowel movements for 3 of 30 (Residents #1, 5 and 17) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #1 documented an admission date of 1/11/05 and a readmission date of 1/4/10 with diagnoses that included Congestive Heart Failure, Anemia, Gastrostomy, Abdominal Mass, Degenerative Joint Disease, Dementia and Atherosclerotic Cardiovascular Disease. Review of Resident #1's physician's orders dated 1/4/10 documented Resident #1 was NPO. Review of Resident #1's nurse's notes dated 1/12/10 at 8:40 AM, documented a Certified Nursing Assistant (CNA) was observed feeding Resident #1.</p> <p>During an interview in the Director of Nursing Services' (DNS) office on 3/3/10 at 4:30 PM, Nurse #3 stated the CNA had mistaken Resident #1 for another resident.</p> <p>2. Medical record review for Resident #5 documented an admission date of 7/21/08 and a readmission date of 9/16/08 with diagnoses of Hypertension, Senile Delusion, Congestive Heart Failure, Failure to Thrive, Diabetes Mellitus, Anemia, Gastritis with Ulcer and Hypothyroidism. Review of Resident #5's physician's order dated 2/18/10 documented, "...B/P/HR [blood pressure and heart rate] daily x [times] 1 week then routine..." Resident #5's nurses' notes and vital sign flowsheet for 2/18/10 through 2/24/10, revealed there was no documentation of vital signs for 2/19/10, 2/20/10 and 2/21/10.</p> <p>During an interview in the conference room on 3/3/10 at 4:05 PM, the DNS was asked to provide</p>	F 309	<p>place and correct on the meal tickets, bowel movement documentation is compliant, communication between nurses and nursing assistants regarding resident condition, and vital signs being completed as ordered by physician.</p> <p>3. The center's nursing staff will be inserviced by Director of Nursing Services or Designee regarding daily documentation of bowel movements, verification of residents, diet slips, diet orders, and physician orders to include vital signs daily as ordered.</p> <p>4. The Director of Nursing or Designee will complete 5 random chart audits per unit per week for the next three months to ensure that there is substantial compliance with regards to physician orders. The completed audits will be submitted to Director of Nursing Services or Designee for review weekly for the next three months. The results of this audit will be reported to the Quality Assurance Committee monthly for the next three months to ensure substantial compliance.</p>		

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F 309	Continued From page 11 documentation of daily BP and HR as ordered on 2/18/10. The DNS stated, "I don't see heart rate and blood pressure charted for 3 of the 7 days ordered." 3. Review of the facility's "Bowel Protocol" policy documented, "...1. Nursing staff document the resident's bowel movements each shift..." Medical record review for Resident #17 documented an admission date of 3/20/09 with diagnoses of Depression with Psychosis, Arthritis, Schizophrenic Affective Disorder, Hypertension, Peripheral Neuropathy, Reflux Esophagitis, Constipation, Osteoporosis and History of Breast Cancer. Review of Resident #17's physician's orders dated 2/13/10 documented, "...Please document all BM's [bowel movements] (type, or lack thereof) x [times] 1 week..." Review of Resident #17's Care Plan dated 1/8/10 documented, "...POTENTIAL FOR CONSTIPATION.... MONITOR BOWEL MOVEMENTS EVERY SHIFT AND RECORD... IF CONTINENT (ASK RESIDENT HOW MANY TIMES)". Review of the personal care records for Resident #17 dated September 2009, October 2009, November 2009, December 2009, February 2010 and March 2010 had no documentation of bowel movements recorded for each shift. During an interview in the G Hall on 3/3/10 at 4:15 PM, Nurse #1 stated, "...CNAs write on their ADL [Activities of Daily Living] sheets each shift. The letter 'C' would mean continent, but that wouldn't tell you anything..."	F 309		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364	Ashton Place will continue to strive to ensure each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 1. The Dietary Manager will complete a weekly test tray to ensure that all food items that	4/1/10

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F 364	Continued From page 12 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interviews, it was determined the facility failed to ensure food was palatable, by complaints that hot foods were cold and ice cream was melted for 4 of 7 (Halls C, E, F and G) halls, and complaints by 3 of 12 residents in the group interview. The findings included: Interviews during the initial tour on 3/1/10 revealed the following: a. Hall C at 9:40 AM, the Resident in room #274 complained eggs were cold. b. Hall F at 10:10 AM, the Resident in room #380 complained the food was cold when served. c. Hall G at 10:50 AM, the Resident in room #482 complained the food was not hot and the ice cream was melted when served. During a family member interview on Hall E on 3/2/10 at 8:32 AM, a resident's family member complained the bacon was not hot. During the group interview in the main dining room on 3/2/10 at 11:00 AM, 3 of 12 alert and oriented residents in the group complained that the foods were served cold and the ice cream was melted and "drinkable".	F 364	are being delivered to all residents are being served at proper temperatures. 2. Smart Therm pellets have been ordered to aid in maintaining appropriate food temperatures. 3. The center's dietary staff will be inserviced by the Dietary Manager or Designee regarding the following: appropriate food temperature ranges for each food item and for each food consistency; how to appropriately take food temperatures; what to do when items are not at appropriate temperatures; and equipment used to aid in serving at proper temperatures. 4. Dietary Manager or Designee will conduct Resident Food Committee monthly for the next three months in which residents' dietary services satisfaction will be reviewed including, but not limited to, food selection and quality, food temperatures, and resident choice meals. The results of this monthly committee will be reviewed in the Quality Assurance Committee monthly for the next three months, along with weekly test tray audits.	
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 13</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure food was prepared or stored under sanitary conditions as evidenced by dirty kitchen equipment; wet nesting of plates, glasses and trays; improper food holding temperatures; no covers over light fixtures to protect food from glass in case of breakage; an oscillating fan in the dish wash room; and peeling pipe covers over the rack holding clean trays.</p> <p>The findings included:</p> <p>1. Review of the facility's "Food Handling Guidelines" documented "...Hot Holding: foods should be held hot for serving at [or greater than] 150 [degrees]..." The "AM/PM COOK CLEANING SCHEDULE" documented "...2. CLEAN & [and] SANITIZE STOVE & GRIDDLE AFTER EACH SHIFT..."</p> <p>2. Observations during the initial tour of the kitchen on 3/1/10 beginning at 9:35 AM, revealed the following:</p> <p>a. Stove grease trap coated with dried food and grease.</p>	F 371	<p>Ashton Place continues to strive to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>1. The dietary department has revised their cleaning schedule to include more frequent cleaning of the grease trap, meat slicer, steam well and toaster. These will be checked daily by the Dietary Manager or Designee to ensure compliance with the revised cleaning schedule.</p> <p>2. Tray racks have been ordered to ensure all glasses are being dried and stored properly to</p>	4/1/10	

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F 371	<p>Continued From page 14</p> <p>b. Meat slicer with meat particles on the lip of the guard. c. Grease in the water of one of the steam well pans. d. Toaster covered with greasy black and brown crumbs.</p> <p>During an interview in the kitchen on 3/1/10 beginning at 9:35 AM, the Dietary Manager (DM) stated, "...They [kitchen staff] clean the stove area every 2 days... [Meat slicer] cleaned after each use... It [Steam well pan] shouldn't [have grease in the water]... We tried to get off [bread crumbs from the toaster] and it won't come clean..."</p> <p>3. Observations in the kitchen on 3/2/10 at 9:30 AM, revealed the following: a. Glasses and trays wet nested. b. Plates stacked in the plate warmer wet nested.</p> <p>4. Observations in the kitchen on 3/2/10 at 11:55 AM, revealed the following hot food tray line temperatures: a. Turkey 140 degree Fahrenheit (F). b. Pureed meat 140 degrees F. c. Mechanical chopped meat 130 degrees F. d. Pureed green beans 130 degrees F. Fifty three trays had been served with the hot foods at the wrong temperature.</p> <p>During an interview in the kitchen on 3/2/10 at 12:25 PM, the DM stated, "...We're fixing to [reheat food] now. I'm sorry. I was so upset, I forgot to tell them [dietary staff to reheat the food]..."</p> <p>5. Observations in the kitchen on 3/2/10 at 1:03 PM, revealed the following:</p>	F 371	<p>avoid wet nesting. All plates will stay in tray rack until dry and then placed in plate warmer as recommended. Smart Therm System has been ordered to ensure appropriate food temperatures are maintained. Dietary Manager or Designee will do a weekly test tray audit to ensure food is being delivered at the appropriate temperature All light fixtures have protective covers in place. All wall fans have been added to the weekly and as needed cleaning schedule. Maintenance has repaired the pipe cover over the rack in the kitchen.</p> <p>3. Dietary staff will be inserviced by the Dietary Manager or Designee regarding the following: cleaning schedules; Smart Therm system and appropriate food temperatures; wet nesting and appropriate storage of dishes; maintenance requests and requisition forms.</p> <p>4. All results of daily cleaning schedule and sanitation rounds will be reviewed monthly in the Quality Assurance Committee for the next three months to ensure substantial compliance.</p>	

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F 371	Continued From page 15 a. Fourteen (14) light fixtures, containing 2 florescent bulbs each, with no protective covers to protect food from glass particles in case of breakage. b. A wall mounted fan, turned on, and oscillating between the dirty dish wash area and the clean dish wash area. c. A peeling pipe cover with strings hanging down over the rack holding clean trays.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to ensure the facility environment was sanitary as evidence of strong ammoniacal or fecal odors on 4 of 7 (Halls B, D, E and F) halls of the facility for 3 of 3 (3/1/10, 3/2/10 and 3/3/10) days of the survey. The findings included: Observations of the facility revealed strong ammoniacal odors in the following areas: a. On 3/1/10 at 9:00 AM and 5:10 PM - in Hall D between rooms 180 and 194. b. On 3/1/10 at 10:30 AM - in Hall F between rooms 380 and 392. c. On 3/1/10 at 10:55 AM - in Hall E outside room 286. d. On 3/2/10 at 9:15 AM - in Hall D from the elevator around to the patio exit.	F 465	Ashton Place will continue to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. The Director of Nursing Services, Housekeeping Supervisor or Designee will conduct environmental rounds at a minimum of at least twice per day to ensure an appropriate homelike environment is maintained for our residents, staff and the public. 2. Rooms and hallways to be deep cleaned as per schedule and more frequently as needed. 3. Director of Nursing Services or Designee will inservice staff on the following topics: infection control; turning and positioning; toileting schedules; reporting odors and minimizing odors; and proper handling of soiled linen and briefs. 4. The results of these environmental rounds will be	4/1/10

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F 465	Continued From page 16 e. On 3/3/10 at 3:40 PM - in Hall B from the elevator, between rooms 205 and 211 and to the nurses station.	F 465	referred to the Quality Assurance Committee monthly for the next three months for compliance and further recommendations.	
F 514 SS=D	Observations on B Hall on 3/1/10 at 3:15 PM, revealed a strong foul fecal odor between rooms 220 and 236. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interview, it was determined the facility failed to ensure medical records were complete and accurate for 1 of 30 (Resident #12) sampled residents. The findings included: Medical record review for Resident #12 documented an admission date of 5/14/07 with diagnoses of Psychosis, Anemia, Alzheimer's Disease, Schizophrenia, Dementia, Osteoarthritis,	F 514	Ashton Place will continue to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. A skin assessment has been corrected for Resident #12 to reveal the correct status of resident. 2. Chart audits will be completed for all current residents by Director of Nursing Services or Designee to ensure appropriate assessments and care plans are in place regarding skin integrity. 3. Director of Nursing Services or Designee to inservice nursing on the following: nursing documentation; and skin assessments. The Treatment Nurses to ensure IDT members receive wound	4/1/10

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F 514	<p>Continued From page 17</p> <p>Congestive Heart Failure, Osteoporosis, and Peripheral Vascular Disease. Review of Resident #12's skin body assessment forms dated 9/18/09, 9/25/09, 10/2/09, 10/9/09, 11/6/09, 11/13/09, 11/20/09, 11/27/09 and 12/4/09 documented "...Skin intact... No areas of skin impairment..." Review of another skin body assessment form dated 9/4/09, 9/8/09, 9/14/09, 9/22/09, 9/28/09 and 10/12/09, documented "...Eschar (L) [left] heel..." A hospital return skin body assessment dated 10/20/09 documented "...Eschar to (R) [right] and (L) heel... new area hospital return [right heel]..."</p> <p>Observations in Resident #12's room on 3/1/10 at 9:45 AM and 3:15 PM and on 3/2/10 at 7:55 AM, revealed Resident #12 up in a gerichair at the bedside. Resident #12 was alert, confused and difficult to understand.</p> <p>Observations in Resident #12's room on 3/2/10 at 3:35 PM, revealed there were no open areas on Resident #12's feet/heels.</p> <p>During an interview in the conference room on 3/3/10 at 3:10 PM, the Director of Nursing Services (DNS) was asked why there were two sheets for the same time period. The DNS stated, "...one is treatment nurse... one is charge nurse..." The DNS was asked who is responsible for completing the assessments. The DNS stated that the charge nurse completes them, unless there is skin breakdown and then the treatment nurse is responsible. The DNS also stated that "...she [charge nurse] must have considered the skin intact... [charge nurse] must not have been aware [of the wounds]..."</p>	F 514	<p>reports weekly, monthly, and as needed.</p> <p>4. Clinical Management Team or designee to audit 15 skin assessments per week and report findings to Director of Nursing Services. Results will be reviewed in weekly wound and weight meeting and referred to Quality Assurance Meeting monthly for the next three months to ensure substantial compliance.</p>	