

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

PRINTED: 10/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2014
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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130
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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 000	INITIAL COMMENTS	F 000	<p>This Plan of Correction (POC) has been developed in compliance with State and Federal Regulation. This plan affirms Boulevard Terrace Rehabilitation and Nursing Center's intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency.</p> <p>F223</p> <p>i. <u>Immediate Corrective Action</u></p> <p>Upon notification, resident # 17 was assessed by a Licensed Nurse and no adverse observations resulted from alleged abuse. The Director of Nursing was notified 10/11/14 by a Licensed Nurse of the alleged incident and The DON initiated the investigation of employee statements.</p> <p>ii. <u>How other residents were identified to be at risk.</u></p> <p>Social Services interviewed residents with a BIMS score nine or greater that were cared for by the agency nurse to determine any other residents that were at risk. No other residents were identified for deficient practice during this time.</p>	
F 223 SS=D	<p>During the annual recertification and complaint investigation #34841 conducted on October 13-16, 2014, at Boulevard Terrace Rehabilitation and Nursing Home, no deficiencies were cited in relation to the complaint under 42 CFR PART 483.13, Requirements for Long Term Care. 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, facility document review, facility policy review, and facility contract review, the facility failed to ensure a resident was safe from abuse for one (#17) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #17 was admitted to the facility on January 30, 2013, with diagnoses including Hypertension, Diabetes Mellitus, Mild Dementia, Chronic Pain, Rheumatoid Arthritis, Macular Degeneration, and Gastroesophageal Reflux Disease.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 19, 2014, revealed the</p>	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronna White</i>	TITLE Administrator	(X6) DATE 12/12/2014
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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 223	<p>Continued From page 1</p> <p>resident had a score of 15 on the Brief Interview for Mental Status (score of 15 indicates resident is cognitively intact).</p> <p>Medical record review of the physician's orders dated July 27, 2014, revealed the resident was ordered Promethazine-DM syrup 6.25-15 mg (milligrams)/5 ml (milliliters) 5 ml Q6h (every 6 hours) prn (as needed) for cough.</p> <p>Medical record review of the care plan revised on July 23, 2014, revealed the resident was oriented to person and place; recognized caregivers; and was able to navigate to and from common areas in the environment.</p> <p>Interview with resident #17 on October 14, 2014, at 9:13 a.m., in the resident's room, revealed a nurse came into the resident's room on October 11, 2014, with medications. Continued interview revealed the nurse stated was from Corporate. Further interview revealed the nurse did not leave the resident's cough medicine, so the resident turned on the call light. Continued interview revealed the Certified Nurse Assistant (CNA) responded and stated would tell the nurse. Further interview revealed, after an hour had passed and the nurse had not brought the cough medicine, the resident walked toward the medication cart in the hall. Continued interview revealed the resident asked the nurse for the cough syrup, to which the nurse responded, "Get back to your room where you belong and wait your turn." Further interview revealed the resident went closer to the cart, pointed to the drawer where the medicine was, and the nurse slapped the resident's arm and told the resident to get away from the cart. Continued interview revealed there was a CNA who observed the exchange</p>	F 223	<p>III. <u>Systematic Changes</u></p> <p>Re-education by the Quality Improvement Consultant and the Nurse Educator was conducted on 10-16-2014, for the Licensed Nursing staff and Certified Nursing Assistants related to keeping residents safe from abuse and timely reporting of suspected abuse. NHA communicated 10/12/14 with the staffing Agency the requirements of keeping residents safe from abuse and timely reporting of suspected abuse. The Agency Nurse is not allowed back into the facility for any reason. Residents with a BIMS score of 9 or greater were interviewed by Social Services to verbalize feelings of safety and response to concerns. Resident satisfaction surveys will be conducted monthly times three months, then quarterly thereafter, asking the resident if they feel safe in the facility.</p>	
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F 223	<p>Continued From page 2 and wrote down everything as it occurred.</p> <p>Interview with the Administrator on October 15, 2014, at 9:25 a.m., in the Administrator's office, revealed there was no one from Corporate administering medications, but an agency nurse worked the night of October 11, 2014. Continued interview with the Administrator revealed there was a complaint the Director of Nursing (DON) was following up on concerning a resident who didn't feel they had received cough medicine in a timely manner.</p> <p>Review of a note dated October 11, 2014, at 12:15 a.m., sent to the DON by CNA #1, who worked the night of October 11, 2014, revealed resident #17 pressed the call light to ask for some cough medicine at 11:00 p.m., on October 11, 2014. Continued review of the note revealed CNA #1 told the nurse about the resident's request. Further review of the note revealed the resident pressed the call light again at 11:30 p.m., still requesting the cough syrup as well as something for headache. Continued review of the note revealed CNA #1 told the nurse again about the resident's request. Further review of the note revealed the resident got up and went out into the hall to ask for the medicine. Continued review of the note revealed the resident went toward the cart; the nurse pushed the resident's arm; and the nurse said not to touch the cart. Further review of the note revealed there was a lot of screaming going on between the resident and the nurse. Continued review of the note revealed CNA #1 stepped in between the nurse and resident and took the resident back to the room.</p> <p>Review of a note dated October 11, 2014, at 12:30 a.m., sent to the DON by Licensed</p>	F 223	<p>IV. <u>Monitoring/Quality Assurance Performance Improvement</u></p> <p>Results of resident interviews will be brought to the monthly Quality Assurance Performance Improvement Committee for review. Any aberrancies are discussed, action plans developed and implemented as indicated. The Quality Assurance Performance Improvement Committee consists of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and other Department Heads as determined.</p> <p>Compliance Date: November 30, 2014</p>	
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F 223	Continued From page 3 Practical Nurse (LPN) #1, revealed CNA #1 reported the incident to the LPN. Continued review of the note revealed resident #17 approached the agency nurse to ask for cough syrup and something for headache. Further review of the note revealed the agency nurse spoke loudly to the resident, telling the resident to go back into the room and wait their turn. Continued review of the note revealed the resident made several attempts to show the drawer where the cough syrup was, and the agency nurse pushed the resident away and told the resident to wait their turn. Further review of the note revealed LPN #1, who was located on another hall, could hear the agency nurse talking very loudly to resident #17. Continued review of the note revealed LPN #1 went to the resident's room, finding the resident very upset and crying, and stating the agency nurse gave the resident pills but refused to give the resident cough syrup and something for headache. Further review of the note revealed LPN #1 approached the agency nurse and asked if the medications could be given, to which the agency nurse responded, "not 'til I am ready to go down there." Continued review of the note revealed the agency nurse stated resident #17 swatted at the agency nurse and the move made the agency nurse mad. Continued review of the note revealed CNA #1 stated the CNA had to get between the agency nurse and the resident, otherwise the situation would have escalated to a higher level. Further review of the note revealed the DON was notified of the incident on October 11, 2014, at 12:15 a.m. Interview with the DON on October 15, 2014, at 1:20 p.m., in the dining room, confirmed the DON received the notes from CNA #1 and LPN #1, and the notes were turned over to the Administrator.	F 223			

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F 223	Continued From page 4 Telephone interview with CNA #1 on October 16, 2014, at 10:29 a.m., revealed the CNA had told the agency nurse several times about resident #17 wanting cough medicine and something for headache.. Further interview with the CNA revealed when the resident pointed to the drawer on the medication cart where the cough medicine was usually kept, the agency nurse told the resident to back up and don't touch the cart. Continued interview revealed, when the resident reached toward the cart, the agency nurse swatted the resident's hand away. Further interview revealed the resident and agency nurse were hollering and screaming, so the CNA grabbed the resident, who was unsteady, and went to the resident's room. Interview with resident #17 on October 16, 2014, at 12:30 p.m., in the resident's room, revealed the resident verbalized the story again, with the same details as was verbalized during interview on October 14, 2014. Continued interview with the resident revealed, when the resident approached the medicine cart, the agency nurse stated, "...Get on back to your room and wait your turn..." and pointed down the hall toward the resident's room. Further interview revealed the resident told the agency nurse just wanted cough medicine and the agency nurse again said "...Get back to your room where you belong and wait your turn..." and pointed in the direction of the resident's room. Further interview revealed the resident pointed toward the drawer containing the cough syrup, and the agency nurse pushed the resident away. Continued interview revealed the agency nurse could have knocked the resident down when the resident's arm was slapped if the resident had not pulled the arm away. Further	F 223			

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F 223	Continued From page 5 interview revealed the resident was upset at the nurse's behavior and stated, "The person should not be in the position and act like that. If...treated me like that and I have my mind, how does...treat those who can't talk back." Review of the facility policy Abuse Prevention Policy and Procedure, dated 2012, revealed, "...Purpose...to review those practices and omissions, which if allowed to go unchecked, could lead to abuse. The scope of this program shall apply to the prevention and abuse committed by anyone...This facility shall not condone any acts of resident mistreatment...verbal...physical and/or mental abuse...by any...staff or other agencies...Abuse...the harmful treatment of people, ranging from rough handling to the use of insulting or coarse language...the willful infliction of...intimidation...or deprivation by an individual, including a caretaker, of goods and services...Mental Abuse...humiliation, intimidation, harassment, and threats of...deprivation...Physical Abuse...slapping...shoving...Verbal Abuse...saying or doing something with intent to frighten a resident or otherwise make him/her feel unsafe or insecure...Neglect...failure to fulfill a care-taking obligation to provide goods or services...denial of...health-related services...any employee suspected of abuse will be suspended as the incident is reported, pending outcome of the investigation..." Review of the contract between the facility and the agency who supplied the nurse, dated July 11, 2011, revealed the agency would "Responsibilities of [Agency]...match client service requests with temporary health care personnel who are properly screened and qualified in accordance with Standard Hiring	F 223		
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F 223	Continued From page 6 Practices...Responsibilities of [Facility]...Provide orientation which, at minimum, includes the review of policies and procedures regarding...patient rights..."	F 223		
F 225 SS=D	Interview with the Administrator on October 16, 2014, at 11:45 a.m., in the Administrator's office, revealed they did not feel the agency nurse was trying to cause harm to the resident, so abuse had not occurred. Further interview with the Administrator confirmed the agency nurse was allowed to complete the shift and was not removed from duty. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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).	F 225	I. <u>Immediate Corrective Action</u> The investigation for Resident #17 for alleged abuse was initiated 10/11/14 by the Director of Nursing obtaining employee statements. II. <u>How other residents were identified to be at risk.</u> Social Services interviewed residents with a BIMS score nine or greater that were cared for by the agency nurse to determine any other residents that were at risk. No other residents were identified for deficient practice during this time.	

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F 225	<p>Continued From page 7</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> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, review of facility documents, and facility policy review, the facility failed to conduct a thorough investigation of an allegation of abuse for one (#17) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #17 was admitted to the facility on January 30, 2013, with diagnoses including Hypertension, Diabetes Mellitus, Mild Dementia, Chronic Pain, Rheumatoid Arthritis, Macular Degeneration, and Gastroesophageal Reflux Disease.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 19, 2014, revealed the resident had a score of 15 on the Brief Interview for Mental Status (score of 15 indicates resident is cognitively intact).</p> <p>Medical record review of the physician's orders</p>	F 225	<p>III. <u>Systemic Changes</u></p> <p>The Quality Improvement Consultant and the Nurse Educator re-educated on 10-16-2014; Licensed Nurses, Certified Nursing Assistants, Administrator and Director of Nursing regarding prompt initiation and completion of investigative standard of suspected abuse. The Quality Improvement Consultant will monitor alleged abuse investigations weekly times four weeks, monthly times three months and then quarterly thereafter to ensure prompt and completed investigations of alleged abuse.</p> <p>IV. <u>Monitoring/Quality Assurance Performance Improvement</u></p> <p>Results of the investigation reviews will be presented to the monthly Quality Assurance Performance Improvement Committee for discussion and plan of action development as indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and other Department Heads as determined.</p>	
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November 30, 2014 for Able's 11/12/14 3:10 PM

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F 225	<p>Continued From page 8</p> <p>dated July 27, 2014, revealed the resident was ordered Promethazine-DM syrup 6.25-15 mg (milligrams)/5 ml (milliliters) 5 ml Q6h (every 6 hours) prn (as needed) for cough.</p> <p>Medical record review of the care plan revised on July 23, 2014, revealed the resident was oriented to person and place; recognized caregivers; and was able to navigate to and from common areas in the environment.</p> <p>Interview with resident #17 on October 14, 2014, at 9:13 a.m., in the resident's room, revealed a nurse came into the resident's room on October 11, 2014, with medications. Continued interview revealed the nurse stated was from Corporate. Further interview revealed the nurse did not leave the resident's cough medicine, so the resident turned on the call light. Continued interview revealed the Certified Nurse Assistant (CNA) responded and stated would tell the nurse. Further interview revealed, after an hour had passed and the nurse had not brought the cough medicine, the resident walked toward the medication cart in the hall. Continued interview revealed the resident asked the nurse for the cough syrup to which the nurse responded, "Get back to your room where you belong and wait your turn." Further interview revealed the resident went closer to the cart and pointed to the drawer where the medicine was, and the nurse slapped the resident's arm and told the resident to get away from the cart. Continued interview revealed there was a CNA who observed the exchange and wrote down everything as it occurred.</p> <p>Interview with the Administrator on October 15, 2014, at 9:25 a.m., in the Administrator's office, revealed there was no one from Corporate</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>administering medications, but an agency nurse worked the night of October 11, 2014. Continued interview with the Administrator revealed there was a complaint the Director of Nursing (DON) was following up on concerning a resident who didn't feel they had received cough medicine in a timely manner.</p> <p>Review of a note dated October 11, 2014, at 12:15 a.m., sent to the DON by CNA #1, who worked the night of October 11, 2014, revealed resident #17 pressed the call light to ask for some cough medicine at 11:00 p.m., on October 11, 2014. Continued review of the note revealed CNA #1 told the nurse about the resident's request. Further review of the note revealed the resident pressed the call light again at 11:30 p.m., still requesting the cough syrup as well as something for headache. Continued review of the note revealed CNA #1 told the nurse again about the resident's request. Further review of the note revealed the resident got up and went out into the hall to ask for the medicine. Continued review of the note revealed the resident went toward the cart; the nurse pushed the resident's arm; and the nurse said not to touch the cart. Further review of the note revealed there was a lot of screaming going on between the resident and the nurse. Continued review of the note revealed the CNA stepped in between the nurse and resident and took the resident back to the room.</p> <p>Review of a note dated October 11, 2014, at 12:30 a.m., sent to the DON by Licensed Practical Nurse (LPN) #1, revealed CNA #1 reported the incident to LPN #1. Continued review of the note revealed resident #17 approached the agency nurse to ask for cough syrup and something for headache. Further review of the</p>	F 225		
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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(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 225	<p>Continued From page 10</p> <p>note revealed the agency nurse spoke loudly to the resident, telling the resident to go back into the room and wait their turn. Continued review of the note revealed the resident made several attempts to show the drawer where the cough syrup was, and the agency nurse pushed the resident away and told the resident to wait their turn. Further review of the note revealed LPN #1 was located on another hall and could hear the agency nurse talking very loudly to resident #17. Continued review of the note revealed LPN #1 went to the resident's room, finding the resident very upset and crying, and stating the agency nurse gave the resident pills, but refused to give the resident cough syrup and something for headache. Further review of the note revealed LPN #1 approached the agency nurse and asked if the medications could be given, to which the agency nurse responded, "not 'til I am ready to go down there." Continued review of the note revealed the agency nurse stated resident #17 swatted at the agency nurse and the move made the agency nurse mad. Continued review of the note revealed CNA #1 stated the CNA had to get between the agency nurse and the resident, otherwise the situation would have escalated to a higher level. Further review of the note revealed the DON was notified of the incident on October 11, 2014, at 12:15 a.m.</p> <p>Interview with the DON on October 15, 2014, at 1:20 p.m., in the dining room, revealed the DON interviewed the resident on October 14, 2014. Continued interview with the DON revealed the only complaint received was a nurse was rude to a resident who wanted cough syrup. Further interview with the DON confirmed the DON received the notes from CNA #1 and LPN #1, and the notes were turned over to the Administrator.</p>	F 225		

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F 225	Continued From page 11 Interview with the Administrator on October 15, 2014, at 3:20 p.m., in the Administrator's office, revealed the DON talked to the agency nurse who stated told resident #17 would be there in a minute: Telephone interview with CNA #1 on October 16, 2014, at 10:29 a.m., revealed the CNA had told the agency nurse several times about resident #17 wanting cough medicine and something for headache. Further interview revealed, when the resident pointed to the drawer on the medication cart where the cough medicine was usually kept, the agency nurse told the resident to back up and don't touch the cart. Continued interview revealed when the resident reached toward the cart, the agency nurse swatted the resident's hand away. Further interview revealed the resident and agency nurse were hollering and screaming so the CNA grabbed the resident, who was unsteady, and went to the resident's room. Interview with resident #17 on October 16, 2014, at 12:30 p.m., in the resident's room, revealed the resident again verbalized the story as told during interview on October 14, 2014. Continued interview revealed, when the resident approached the medicine cart, the agency nurse stated, "...Get on back to your room and wait your turn..." and pointed down the hall toward the resident's room. Further interview revealed the resident told the agency nurse just wanted cough medicine and the agency nurse again said, "...Get back to your room where you belong and wait your turn..." and pointed in the direction of the resident's room. Further interview revealed the resident pointed toward the drawer containing the cough syrup, and the agency nurse pushed the resident	F 225			

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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130
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F 225	Continued From page 12 away. Continued interview revealed the agency nurse could have knocked the resident down when the resident's arm was slapped if the resident had not pulled the arm away. Further interview revealed the resident was upset at the nurse's behavior and stated, "The person should not be in the position and act like that. If...treated me like that and I have my mind, how does...treat those who can't talk back." Review of the facility policy Abuse Prevention Policy and Procedure, dated 2012, revealed, "...Any complaint, allegation, observation, or suspicion of resident abuse...whether physical, mental, or sexual is to be thoroughly reported, investigated, and documented in a uniform manner...the investigation is completed within 48 to 72 hours..." interview with the Administrator on October 16, 2014, at 11:45 a.m., in the Administrator's office, confirmed an abuse investigation was not conducted because the Administrator had discussed the incident with the DON and Corporate and they did not feel the incident qualified as abuse. Continued interview with the Administrator revealed they did not feel the agency nurse was trying to cause harm to the resident, so abuse had not occurred.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F 226 I. <u>Immediate Corrective Action</u> The investigation was initiated on 10/11/14 by the Director of Nursing which is the first step in following facility policy.	

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F 226	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, facility document review, and facility policy review, the facility failed to implement the facility policy for investigation of an allegation of abuse for one (#17) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #17 was admitted to the facility on January 30, 2013, with diagnoses including Hypertension, Diabetes Mellitus, Mild Dementia, Chronic Pain, Rheumatoid Arthritis, Macular Degeneration, and Gastroesophageal Reflux Disease.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 19, 2014, revealed the resident had a score of 15 on the Brief Interview for Mental Status (score of 15 indicates resident is cognitively intact).</p> <p>Medical record review of the physician's orders dated July 27, 2014, revealed the resident was ordered Promethazine-DM syrup 6.25-15 mg (milligrams)/5 ml (milliliters) 5 ml Q6h (every 6 hours) prn (as needed) for cough.</p> <p>Medical record review of the care plan revised on July 23, 2014, revealed the resident was oriented to person and place; recognized caregivers; and was able to navigate to and from common areas in the environment.</p> <p>Interview with resident #17 on October 14, 2014, at 9:13 a.m., in the resident's room, revealed a nurse came into the resident's room on October</p>	F 226	<p>ii. <u>How other residents were identified to be at risk.</u></p> <p>Social Services interviewed residents with a BIMS score nine or greater that were cared for by the agency nurse to determine any other residents that were at risk. No other residents were identified for deficient practice during this time.</p> <p>iii. <u>Systemic Changes</u></p> <p>The Quality Improvement Consultant and the Nurse Educator re-educated on 10-16-2014; Licensed Nurses, Certified Nursing Assistants, Administrator and Director of Nursing regarding prompt initiation and completion of investigative standard of suspected abuse. The Quality improvement Consultant will monitor alleged abuse investigations weekly times four weeks, monthly times three months, and quarterly thereafter to ensure prompt and completed investigations of alleged abuse.</p>		

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F 226	<p>Continued From page 14</p> <p>11, 2014, with medications. Continued interview revealed the nurse stated was from Corporate. Further interview revealed the nurse did not leave the resident's cough medicine, so the resident turned on the call light. Continued interview revealed the Certified Nurse Assistant (CNA) responded and stated would tell the nurse. Further interview revealed, after an hour had passed and the nurse had not brought the cough medicine, the resident walked toward the medication cart in the hall. Continued interview revealed the resident asked the nurse for the cough syrup, to which the nurse responded, "Get back to your room where you belong and wait your turn." Further interview revealed the resident went closer to the cart and pointed to the drawer where the medicine was, and the nurse slapped the resident's arm and told the resident to get away from the cart. Continued interview revealed there was a CNA who observed the exchange and wrote down everything as it occurred.</p> <p>Interview with the Administrator on October 15, 2014, at 9:25 a.m., in the Administrator's office, revealed there was no one from Corporate administering medications, but an agency nurse worked the night of October 11, 2014. Continued interview with the Administrator revealed there was a complaint the Director of Nursing (DON) was following up on concerning a resident who didn't feel they had received cough medicine in a timely manner.</p> <p>Review of a note dated October 11, 2014, at 12:15 a.m., sent to the DON by CNA #1, who worked the night of October 11, 2014, revealed resident #17 pressed the call light to ask for some cough medicine at 11:00 p.m., on October 11, 2014. Continued review of the note revealed CNA</p>	F 226	<p>IV. <u>Monitoring/Quality Assurance</u> <u>Performance Improvement</u></p> <p>Results of the investigation review will be presented to the monthly Quality Assurance Performance Improvement Committee for discussion and plan of action development as indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and other Department Heads as determined.</p> <p>Compliance date: November 30, 2014</p>	

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F 226	<p>Continued From page 15</p> <p>#1 told the nurse about the resident's request. Further review of the note revealed the resident pressed the call light again at 11:30 p.m., still requesting the cough syrup as well as something for headache. Continued review of the note revealed CNA #1 told the nurse again about the resident's request. Further review of the note revealed the resident got up and went out into the hall to ask for the medicine. Continued review of the note revealed the resident went toward the cart, the nurse pushed the resident's arm; and the nurse said not to touch the cart. Further review of the note revealed there was a lot of screaming going on between the resident and the nurse. Continued review of the note revealed CNA #1 stepped in between the nurse and resident, and took the resident back to the room.</p> <p>Review of a note dated October 11, 2014, at 12:30 a.m., sent to the DON by Licensed Practical Nurse (LPN) #1, revealed CNA #1 reported the incident to LPN #1. Continued review of the note revealed resident #17 approached the agency nurse to ask for cough syrup and something for headache. Further review of the note revealed the agency nurse spoke loudly to the resident, telling the resident to go back into the room and wait their turn. Continued review of the note revealed the resident made several attempts to show the drawer where the cough syrup was, and the agency nurse pushed the resident away and told the resident to wait their turn. Further review of the note revealed LPN #1 was located on another hall and could hear the agency nurse talking very loudly to resident #17. Continued review of the note revealed LPN #1 went to the resident's room, finding the resident very upset and crying, and stating the agency nurse gave the resident pills, but refused to give</p>	F 226		
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F 226	<p>Continued From page 16</p> <p>the resident cough syrup and something for headache. Further review of the note revealed LPN #1 approached the agency nurse and asked if the medications could be given, to which the agency nurse responded, "not 'til I am ready to go down there." Continued review of the note revealed the agency nurse stated resident #17 swatted at the agency nurse and the move made the agency nurse mad. Continued review of the note revealed CNA #1 stated the CNA had to get between the agency nurse and the resident, otherwise the situation would have escalated to a higher level. Further review of the note revealed the DON was notified of the incident on October 11, 2014, at 12:15 a.m.</p> <p>Interview with the DON on October 15, 2014, at 1:20 p.m., in the dining room, confirmed the DON received the notes from CNA #1 and LPN #1, and the notes were turned over to the Administrator.</p> <p>Interview with the Administrator on October 15, 2014, at 3:20 p.m., in the Administrator's office, revealed the DON talked to the agency nurse who stated told resident #17 would be there in a minute.</p> <p>Telephone interview with CNA #1 on October 16, 2014, at 10:29 a.m., revealed the CNA had told the agency nurse several times about resident #17 wanting cough medicine and something for headache. Further interview revealed when the resident pointed to the drawer on the medication cart where the cough medicine was usually kept, the agency nurse told the resident to back up and don't touch the cart. Continued interview revealed when the resident reached toward the cart, the agency nurse swatted the resident's hand away. Further interview revealed the resident and</p>	F 226		

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F 226	<p>Continued From page 17</p> <p>agency nurse were hollering and screaming, so the CNA grabbed the resident, who was unsteady, and went to the resident's room.</p> <p>Interview with resident #17 on October 16, 2014, at 12:30 p.m., in the resident's room, revealed the resident again told the story with the same details as verbalized on October 14, 2014. Continued interview revealed when the resident approached the medicine cart, the agency nurse stated, "...Get on back to your room and wait your turn..." and pointed down the hall toward the resident's room. Further interview revealed the resident told the agency nurse just wanted cough medicine and the agency nurse again said, "...Get back to your room where you belong and wait your turn..." and pointed in the direction of the resident's room. Further interview revealed the resident pointed toward the drawer containing the cough syrup, and the agency nurse pushed the resident away. Continued interview revealed the agency nurse could have knocked the resident down when the resident's arm was slapped if the resident had not pulled the arm away. Further interview revealed the resident was upset at the nurse's behavior and stated, "The person should not be in the position and act like that: If...treated me like that and I have my mind, how does...treat those who can't talk back."</p> <p>Review of the facility policy Abuse Prevention Policy and Procedure, dated 2012, revealed, "...Any complaint, allegation, observation, or suspicion of resident abuse...whether physical, mental, or sexual is to be thoroughly reported, investigated, and documented in a uniform manner...the investigation is completed within 48 to 72 hours...any employee suspected of abuse will be suspended as the incident is reported,</p>	F 226			

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F 226	Continued From page 18 pending outcome of the investigation..."	F 226		
F 246 SS=D	<p>Interview with the Administrator on October 16, 2014, at 11:45 a.m., in the Administrator's office, confirmed an abuse investigation was not conducted because the Administrator had discussed the incident with the DON and Corporate, and they did not feel the incident qualified as abuse. Further interview revealed the agency was notified the nurse was not to return to the facility. Further interview confirmed the agency nurse was allowed to complete the shift and was not removed from duty as the facility policy stated.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and facility policy review, the facility failed to place call lights within reach for two residents (#30, #64) of thirty-four residents reviewed.</p> <p>The findings included: Resident #30 was admitted to the facility on March 8, 2013, with diagnoses including</p>	F 246	<p>F246</p> <p>I. <u>immediate Corrective Action</u></p> <p>Resident # 30 and Resident # 64 have their call lights placed within reach upon notification on 10/15/14 by the certified nursing assistant.</p> <p>II. <u>How other residents were identified to be at risk.</u></p> <p>Administrator conducted a facility audit to ensure all call lights were in reach for all residents upon notification.</p>	

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F 246	<p>Continued From page 19</p> <p>Hypoglycemia, Osteoarthritis, Muscular Wasting, Chronic Pain, Peripheral Neuropathy, Hypertension, and Hemiplegic Affect.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated July 17, 2014, revealed the resident had highly impaired vision and required extensive assistance of one person for bed mobility.</p> <p>Observation on October 14, 2014, at 12:52 p.m., in the resident's room, revealed the resident was lying on the bed on the left side, and complained of leg pain. Continued observation revealed the resident's call light was positioned on the side rail on the right side of the bed.</p> <p>Interview with the resident on October 14, 2014, at 12:52 p.m., in the resident's room, confirmed the resident was not able to reach the call light on the right side of the bed.</p> <p>Review of the facility's policy Call Light Standard, undated, revealed, "...Be sure the call light is plugged in at all times and is placed so the resident may easily access the call light when needed..."</p> <p>Interview and observation of the resident, with the Director of Nurses (DON), in the resident's room, on October 15, 2014, at 1:00 p.m., confirmed when the resident was positioned on the left side, the resident would not be able to reach the call light on the right side of the bed.</p> <p>Resident #64 was admitted to the facility on November 22, 2011, with diagnoses including Traumatic Amputation of Left Lower Extremity Below the Knee, Diabetes, Chronic Pain,</p>	F 246	<p>III. <u>Systemic Changes</u></p> <p>The Nurse Educator re-educated Licensed Nurses and Certified Nursing Assistants on 10-16-2014, regarding the facility Call Light Standard. The Director of Nursing/designee will monitor call light placement three times a week for four weeks and then weekly for four weeks to ensure compliance.</p> <p>IV. <u>Monitoring/Quality Assurance Performance Improvement</u></p> <p>Results of the call light audit will be brought to the Quality Assurance Performance Improvement Committee to discuss and develop action plans if indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and Departments Head as determined.</p> <p>Compliance Date: November 30, 2014</p>	
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F 246	<p>Continued From page 20 Blindness Both Eyes, Hypertension, Peripheral Vascular Disease, and Major Depressive Disorder.</p> <p>Medical record review of the Quarterly MDS dated September 27, 2014, revealed the resident was cognitively intact; had severe vision impairment; had physical mobility impairment of upper and lower extremities on one side; required extensive assistance of one person for bed mobility and extensive assistance of 2 or more persons for transfers; and was not self-sufficient in a wheelchair.</p> <p>Observation on October 13, 2014, at 10:46 a.m., in the resident's room, revealed the resident seated in a wheelchair facing away from the bed, and the resident's call light was secured to the bed rail behind the resident.</p> <p>Observation on October 15, 2014, at 12:30 p.m., revealed the resident dressed in a gown, and seated in a wheelchair beside the bed, facing away from the bed. Continued observation revealed the resident appeared to be cold, evidenced by the shaking motions of the resident's body and clenched teeth. Continued observation revealed the resident's call light was secured to the bed rail behind the resident.</p> <p>Interview with the resident on October 15, 2014, at 12:30 p.m., in the resident's room; confirmed the resident was cold, stating, "Yes, my teeth are chattering." Continued interview confirmed the resident could not reach the call light.</p> <p>Interview with the DON on October 15, 2014, at 12:40 p.m., in the resident's room, confirmed the call light had not been placed within the resident's</p>	F 246		
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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(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 246	Continued From page 21 reach.	F 246			
F 278 SS=E	<p>Interview with the Administrator on October 15, 2014, at 3:30 p.m., in the conference room, confirmed the facility's expectation was for each resident's call light to be placed within the resident's reach.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278	<p>F 278</p> <p><u>I. Immediate Corrective Action</u></p> <p>The MDS Coordinator submitted a significant correction for resident #22 on 11-06-2014. Resident #107 discharged on 11-06-2014. MDS Coordinator completed a quarterly assessment on 10-24-2014 assuring accuracy on res #30.. The MDS Coordinator submitted a significate correction for resident # 6 on 11-06-2014.</p> <p><u>II. How other residents are identified to be at risk.</u></p> <p>All residing residents have the potential to be affected by alleged deficient practice. No other inaccurate MDS's were found by the MDS Coordinator on 11-05-2014 after a cursory review.</p>		

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F 278	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, and review of facility fall investigations, the facility failed to ensure assessments were accurate for four residents (#22, #107, #30, and #6) of thirty-four residents reviewed. The findings included: Resident #22 was admitted to the facility on April 12, 2013, with diagnoses including Dementia, History of Falls, Parkinson's Disease, Muscle Weakness, Anxiety, Congestive Heart Failure, Depression, Schizophrenia, and Prostate Cancer. Medical record review of a Nursing Progress Note dated September 27, 2014, at 1:22 p.m., revealed the resident had been "...found on the floor by...bed..." Medical record review of the 60 day Prospective Payment System (PPS) assessment dated September 30, 2014, revealed the resident had not had a fall since admission or the prior assessment. Interview with the Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #1 and the MDS Coordinator on October 16, 2014, at 10:07 a.m., in the MDS office, confirmed the resident had fallen on September 27, 2014. Further interview confirmed the assessment dated September 30, 2014, was not accurate. Resident #107 was admitted to the facility on May 16, 2014, with diagnoses including Aftercare Healing of Traumatic Fracture of Hip, Personal	F 278	III. <u>Systemic Changes</u> The DON educated all department managers on how to accurately code the MDS to reflect the resident's status on 11-07-2014. The MDS coordinator will conduct and coordinate the assessment according to each individual resident's needs. Director of Nursing/designee will monitor the MDS weekly times four weeks, then monthly times four weeks to ensure accuracy of data coded. MDS coordinator will attend training session in February targeting accurate coding on MDS and will train facility staff accordingly. IV. <u>Monitoring/Quality Assurance Performance Improvement</u> Results of the MDS Accuracy audit will be brought to the Quality Assurance Performance Improvement Committee to discuss and develop action plans if indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and Departments Head as determined. Compliance date: 11/14/2014	
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F 278	<p>Continued From page 23</p> <p>History of Fall, Depression, Chronic Ischemic Heart Disease, Cerebrovascular Disease, Muscle Weakness, Diabetes Mellitus, Congestive Heart Failure, Pressure Ulcer, and Coronary Atherosclerosis.</p> <p>Medical record review of the Medication Administration Record (MAR) dated June 1-30, 2014, revealed the resident refused to take Paroxetine (anti-depressant) at 8:00 p.m., and Lactulose Solution (for constipation) at 8:00 p.m., from June 5 through 11, 2014, for a total of seven days.</p> <p>Medical record review of the 30 day PPS assessment dated June 11, 2014, revealed the resident refused care, including medication, for one to three days.</p> <p>Interview with the Social Worker on October 15, 2014, at 10:35 a.m., in the MDS office, confirmed the Social Worker was responsible for the section addressing the refusal of care on the PPS assessments. Further interview confirmed the June 11, 2014, assessment failed to accurately address the daily refusal of medications.</p> <p>Resident #30 was readmitted to the facility on July 3, 2014, with diagnoses including Hypoglycemia, Osteoarthritis, Muscular Wasting, Chronic Pain, Peripheral Neuropathy, Hypertension, and Hemiplegic Affect.</p> <p>Medical record review revealed the resident had been admitted to Hospice services on August 9, 2013, with diagnoses of Senile Dementia with Depressive Features.</p> <p>Medical record review of the Quarterly MDS</p>	F 278		
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F 278	<p>Continued From page 24 dated July 17, 2014, revealed no documentation the resident had a prognosis for life expectancy of less than six months.</p> <p>Interview with LPN #1 on October 15, 2014, at 2:30 p.m., in the MDS office, confirmed the MDS assessment was inaccurate.</p> <p>Resident #6 was re-admitted to the facility on December 23, 2013, with diagnoses including Acute Myocardial Infarction, Congestive Heart Failure, Cardiomyopathy, Dementia, Diabetes, Generalized Muscle Weakness, and Anxiety.</p> <p>Review of a fall investigation with an incident date of April 29, 2014, revealed the resident had an unwitnessed fall with no injury.</p> <p>Review of a fall investigation with an incident date of May 4, 2014, revealed the resident had a fall with no injury.</p> <p>Review of a fall investigation report with an incident date of May 6, 2014, revealed the resident had a fall with no injury.</p> <p>Review of a quarterly MDS dated July 11, 2014, revealed the resident had no falls since previous assessment.</p> <p>Interview with the MDS Coordinator on October 16, 2014, at 9:55 a.m., in the MDS office, confirmed the quarterly MDS dated July 11, 2014, was not accurate.</p>	F 278		
F 358 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on</p>	F 358		

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F 356	<p>Continued From page 25</p> <p>a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post accurate nurse staffing information as required.</p> <p>The findings included: Observation on October 13, 2014, at 8:55 a.m., in</p>	F 356	<p>F356</p> <p>I. <u>Immediate Corrective Action</u></p> <p>Current staffing information was posted upon identification 10/13/14 by the Nursing Home Administrator.</p> <p>II. <u>How other residents were identified to be at risk.</u></p> <p>No residents were at risk with this deficient practice.</p> <p>III. <u>Systemic Changes</u></p> <p>Re-education of the staffing coordinator was conducted by the Nursing Home Administrator on 10-17-2014 regarding the posting of daily current staffing information. DON/designee will monitor daily times four weeks, weekly times four weeks and then monthly thereafter.</p>	
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F 356 Continued From page 26
the front hallway, revealed the nursing staff information posted was for the nursing staff scheduled on October 10, 2014, and had not been updated to reflect the current nursing staff in the facility for October 13, 2014.

F 356

IV. Monitoring/Quality Assurance Performance Improvement

Results of the investigation review will be presented to the monthly Quality Assurance Performance Improvement Committee for discussion and plan of action development as indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and Department Head as determined

F 371 SS=F
Interview with the Administrator on October 13, 2014, at 8:55 a.m., in the front hallway, confirmed the nurse staffing information did not reflect the current nursing staff present; and confirmed the facility failed to post accurate nurse staffing.
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

F 371

ember 30, 2014

November

This REQUIREMENT Is not met as evidenced by:
Based on observation and interview, the facility failed to maintain three of three dietary food storage bins and one of one three drawer utensil storage bins in the dessert room and the convection oven in a sanitary manner.

F371

I. Immediate Corrective Action

Upon notification 10/13/14, 3 identified food storage bins, the convection oven interior and 1 three drawer storage container with utensils were cleaned by the Dietary Manager/staff.

The findings included:
Observation of the dietary department dessert room on October 13, 2014, at 9:20 a.m., and 12:28 p.m., with the Certified Dietary Manager

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F 371	Continued From page 27 present, revealed three of three food storage bins containing flour, sugar, and cornmeal, had dried debris and red colored stains on the exterior of the bins and lids. Further observation revealed one three drawer storage container with utensils had dried debris and stains on the exterior of the container. Observation of the dietary department on October 13, 2014, at 12:50 p.m. with the Certified Dietary Manager present, revealed the interior sides, door, and back of the convection oven was covered with brown colored debris. Interview with the Certified Dietary Manager on October 13, 2014, at 12:28 p.m., and 12:50 p.m., in the dietary department, confirmed the three food storage bins and the utensil storage bin in the dessert room and the convection oven interior were dirty.	F 371	ii. How other residents were identified to be at risk All residents are at risk for this identified deficient practice. The items identified were cleaned or replaced with new items. iii. Systemic Changes Dietary Manager re-educated dietary staff on 10-16-2014 regarding cleaning schedules for all identified equipment. The Dietary Manager/designee will monitor the cleaning schedules and actual cleaning of items three times a week for four weeks and then weekly for four weeks to ensure compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	iv. Monitoring/Quality Assurance Performance Improvement Results of the monitoring will be presented to the Quality Assurance Performance Improvement Committee to discuss and develop action plans as indicated. The Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and Department Head as determined. Compliance Date: November 30, 2014	

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F 441	<p>Continued From page 28</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure safe infection control practices were implemented for three residents (#39, #53, #56) of thirty-four residents observed.</p> <p>The findings included: Resident #39 was readmitted to the facility on March 17, 2014, with diagnoses including Dysphagia, Dementia, Convulsions, Alzheimer's Disease, and Gastrostomy Tube. Observation in the resident's room with the Director of Nurses (DON) on October 15, 2014, at</p>	F 441	<p>#441</p> <p>I. Immediate Corrective Action</p> <p>Resident #39 was cleaned of saliva by the Licensed Nurse immediately upon notification. No further adverse conditions were found. Resident #53 foley catheter bag was properly positioned by the Licensed Nurse upon notification. Resident # 56 trash was removed to an appropriate receptacle.</p> <p>II. How other residents were identified to be at risk.</p> <p>All residing residents have the potential to be affected by alleged deficient practice.</p>	

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F 441	<p>Continued From page 29</p> <p>10:30 a.m., revealed bubbles had formed on the resident's mouth from the resident exhaling through saliva pooled on the resident's lips. Continued observation revealed saliva had oozed from the left side of the resident's mouth, down the neck, and around the chin to the resident's chest. Continued observation revealed the DON wiped the resident's mouth, neck, and chest area using a moistened paper towel and ungloved hand to remove the saliva from the resident's skin.</p> <p>Review of the facility's policy Infection Control Program Plan, revised 2011, revealed, "...1. Gloves: Gloves should be worn whenever exposure to the following is planned or anticipated...Saliva, Mucous membranes..."</p> <p>Interview with the DON on October 15, 2014, at 3:30 p.m., in the A/B hallway, confirmed the facility's policy for infection control had not been implemented.</p> <p>Observation on October 13, 2014, at 9:45 a.m., in the room of resident #53, revealed the resident's foley catheter (for drainage of urine from the bladder) drainage bag was lying on the floor.</p> <p>Interview with Licensed Practical Nurse #3 on October 13, 2014, at 9:50 a.m., in the resident's room, confirmed the catheter bag was not to be lying on the floor and was to be secured to the bed.</p> <p>Observation on October 13, 2014, at 10:10 a.m., in the room of resident #56, revealed the garbage can in the room was overflowing onto the floor with trash and wet diapers.</p>	F 441	<p>III. Systemic Changes</p> <p>The Director of Nursing was re-educated by the Quality Improvement Consultant on October 15, 2014 as to Infection Control techniques (utilization of gloves) when providing resident care. LPN #3 was re-educated by the Nurse Educator October 15, 2014 on the proper placement of a foley catheter bag. NHA was re-educated by the Quality Improvement Consultant on October 15, 2014 as to proper disposal of trash and incontinence products. The Nurse educator conducted in-service education on October 16, 2014 to Licensed Nurses, Certified Nursing Assistants and the Nursing Home Administrator and Director of Nursing regarding proper infection control techniques of gloving during resident care; proper placement of foley catheter bag; and proper disposal of trash including incontinence devices.</p>	<p><i>PCC MS. AJR/11</i> <i>12/12/14 3:40pm</i></p>

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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 441	Continued From page 30 Interview with the Administrator on October 13, 2014, at 10:20 a.m., in the resident's room, confirmed the garbage can was overflowing with trash onto the floor and constituted an infection control risk.	F 441	<p>IV. Monitoring/Quality Assurance Performance Improvement</p> <p>Audit of resident care provision (mouth care) will be conducted by the DON/designee three times a week times 4 weeks and then weekly times 4 weeks to ensure compliance. An audit of foley catheter bag placement will be conducted by the DON/designee three times a week times four weeks and then weekly times four weeks to ensure compliance. An audit to identify proper trash removal and disposal will be conducted by the Housekeeping The</p> <p>Quality Assurance Performance Improvement Committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Maintenance Director, Activities Director, Social Service Director, Human Resources, and Department Head as determined.</p> <p>Supervisor three times a week for four weeks and then weekly for four weeks to ensure compliance. All audit results will be brought to the Quality Assurance Performance Improvement Committee for review and determination of compliance. Additional action plans will be developed for identified concerns.</p> <p>Compliance Date November 30th</p>	
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