

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

45th 10/26/13

PRINTED: 09/13/2013
FORM APPROVED
OMB NO. 0938-0391

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| 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 09/11/2013 |
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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 159 SS=D | <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the</p> | F 159 | <p>Disclaimer</p> <p>Submission of this response and plan of correction is not a legal admission that deficiency exists or that this statement of deficiencies was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.</p> | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE 9-29-13

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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| NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1630 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130 | | |
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| F 159 | Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of personal funds accounts and interview, the facility failed to provide a quarterly statement for one resident (#31) of four residents reviewed. The findings included: Review of the personal funds account statements for resident #31 revealed the resident's quarterly fund statement was mailed to a family member who was not the Power Of Attorney (POA). Interview with resident's Power of Attorney on September 10, 2013, at 3:15 p.m., in the resident's room, revealed the resident had a personal funds account managed by the facility and the POA had never received a statement for the account funds. Interview with the administrative assistant on September 11, 2013, at 4:28 p.m., in the front office confirmed the resident's personal fund statement was sent to the incorrect family member. | F 159 | F159 SS=D 483.10 Facility Management of Personal Funds Residents with trust funds will receive a quarterly statement. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Quarterly statement was given to resident #31 by Administrative assistant on 9/23/13 and mailed to responsible party on 9-19-13. <u>Identification of Other Residents Potentially Affected:</u> Resident residing in the facility with resident trust accounts have potential to be affected. <u>Measures/Systemic Changes Implemented:</u> Administrative Liaison will audit 100% of the files to ensure residents received their quarterly statements. The business office liaison will review 5 Residents with trust account quarterly to ensure resident and/or POA received statement. Education to be completed with Administrative Liaison by Regional Liaison on policy and procedures for resident quarterly statements. <u>Monitoring:</u> These findings will be presented by Administrator in the monthly Quality Assurance Committee monthly x3 months which is attended by the Executive Director, Director of Nursing, Medical director, Social Services, Activity Director to determine compliance. | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically | F 272 | | 10/21/13 | |

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| F 272 | <p>Continued From page 2 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 272 | <p>F272 SS=D 483.20 Comprehensive Assessments</p> <p>Facility conducts initial and periodic comprehensive assessments of each resident's functional capacity.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice</u> Resident #95 and #83 have been assessed in place of missed MDS by licensed nursing staff and an accurate assessment for falls and weight loss and gain for resident #23 was completed by licensed nurse.</p> <p><u>Identification of Other Residents Potentially Affected:</u> Residents requiring MDS assessments and the potential for weight loss/gain and falls have the potential to be affected.</p> <p><u>Measures/Systemic Changes Implemented:</u> MDS Director to report in morning stand up MDS assessments that are due or past due. 100% audit of residents that are at risk for falls, weight loss, and weight gain by DON or designee. The at risk residents to be discussed at weekly at the at risk meeting. DM and licensed nursing staff re educated on accurate weights and nutrition supplements by DON or designee.</p> <p><u>Monitoring:</u> 10 MDS assessments to be audited weekly X4 weeks then monthly X3 by DON or designee. These findings will be presented by DON or designee in the monthly Quality Assurance Committee which is attended by the Executive Director, Director of Nursing, Medical director, Social Services, Activity Director and designees to determine compliance.</p> | 10/21/13 |
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| F 272 | <p>Continued From page 3-</p> <p>Based on medical record review and interview, the facility failed to complete a quarterly Minimum Data Set (MDS) for two residents (#95 and #83); and failed to accurately assess a fall and weight loss and gain for one resident (#23) for thirty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #95 was admitted to the facility on February 14, 2011, with diagnoses including Hypertension, Dementia with Lewy Bodies, Dementia with Behaviors, Osteoarthritis, and Macular Degeneration.</p> <p>Medical record review of a Quarterly MDS dated July 13, 2013, revealed, section C "Cognitive Patterns" and section D "Mood" were blank. Further record review revealed eleven out of twenty sections were not completed.</p> <p>Interview on September 11, 2013, at 9:30 a.m., in the conference room, with the Administrator, Director of Nursing and MDS Coordinator confirmed the MDS had not been completed.</p> <p>Resident #83 was admitted to the facility on March 25, 2013, with diagnoses including Dementia, Anxiety, Diabetes Mellitus Type II, Osteoarthritis, Epilepsy, Peripheral Neuropathy, and Hypertension.</p> <p>Medical record review of the resident's Quarterly Minimum Data Set (MDS) dated June 19, 2013, revealed the resident's cognitive status was not assessed.</p> <p>Interview with the Administrator, Director of</p> | F 272 | | |
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| F 272 | <p>Continued From page 4</p> <p>Nursing, and the MDS Coordinator on September 12, 2013, at 9:30 a.m., in the conference room confirmed the MDS was incomplete.</p> <p>Resident #23 was admitted to the facility on July 9, 2013, and after a fall resulting in fractures and hospitalization, was readmitted to the facility on July 22, 2013, with diagnoses including Fractured Right Elbow, Distal Right Radial Fracture, Fractured Right Hip, Peptic Ulcer Disease, Renal Insufficiency, Peripheral Neuropathy Affecting Hands and Feet, and Anxiety/Depression.</p> <p>Medical record review of the Admission Minimum Data Set (MDS) dated July 29, 2013, revealed the resident had no falls.</p> <p>Review of a facility document of an incident report with an incident date of July 14, 2013, revealed the resident was "...ambulating from the bed to closet...reports feeling "dizzy" and fell on floor... (Resident) stated hitting head, arm and hip..." Further review revealed the resident was taken by ambulance to the hospital.</p> <p>Review of the hospital history and physical with the admission date of July 14, 2013, revealed the resident had "...X-rays confirmed a right hip fracture as well as fractures of the right elbow and distal right radial fracture..."</p> <p>Interview on September 11, 2013, at 2:55 p.m., in the MDS office, with the MDS Coordinator, confirmed the facility failed to accurately assess the fall on the July 29, 2013, Admission MDS.</p> <p>Medical record review of the Weight Summary</p> | F 272 | | |
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| F 272 | Continued From page 5 documentation revealed the following resident weight in pounds (#) and the significant weight (significant weight change defined as a 5 percent gain or loss in 30 days, 7.5 percent gain or loss in 90 days) gain or loss in percent (%) and in pounds: August 14, 2013: weight 121.4#; a loss of 7.6% or 10# in 30 days (July 23, 2013); a gain of 17% or 17.6# in 90 days (June 5, 2013); July 30, 2013: weight of 122#, a gain of 18.2% or 18.8# in 30 days (July 8, 2013); a gain of 14.9% or 15.8# in 90 days (May 3, 2013); July 24, 2013: weight of 129.2#, a gain of 25.2% or 26# in 30 days (July 8, 2013); a gain of 21.7% or 23# in 90 days (May 3, 2013); July 23, 2013: weight of 131.4#; July 8, 2013: weight of 103.2#; June 5, 2013: weight of 103.8#; and May 3, 2013: weight of 106.2#. Medical record review of the Admission MDS dated July 29, 2013, revealed the resident weight was 129#, the weight loss was not physician prescribed and the resident was on a physician prescribed weight gain regimen. Medical record review of the Prospective Payment System (PPS) assessment dated August 3, 2013, revealed the resident's weight was 122# with no weight loss or gain. Medical record review of the PPS assessment dated August 17, 2013, revealed the resident's weight was 121#, with no weight loss or gain. | F 272 | | | |

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| F 272 | Continued From page 6 Interview on September 11, 2013, at 2:35 p.m., in the dietary office, with the Dietary Manager and the Registered Dietitian, confirmed the MDS dated July 29, 2013, was inaccurate regarding the weight loss and the physician weight gain regimen. Further interview confirmed the dietary department had not requested nutritional supplementation and there were no physician orders for nutritional supplements. Further interview confirmed the facility failed to accurately assess the significant weight gain on the August 3, 2013, PPS assessment and failed to address the significant weight loss and gain on the August 17, 2013, PPS assessment. | F 272 | | |
| F 279 SS=E | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | F 279 | F279 SS=E 483.20 Develop comprehensive care plans Facility develops, reviews, and revises comprehensive care plans for each resident. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice</u> For Residents #23, #27, #15, #31, #135, #17 care plans and kardexs were updated by IDT to reflect current interventions for falls, urinary incontinence, respiratory status, transfers, and dialysis status. <u>Identification of Other Residents Potentially Affected:</u> Residents requiring a comprehensive care plan for falls, urinary incontinence, respiratory status, transfers, and dialysis status have the potential to be affected. | 10/21/13 |

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| F 279 | <p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to develop care plans to ensure the necessary care and services were provided for six residents (#23, #27, #15, #31, #135, #17) of thirty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #23 was admitted to the facility on July 9, 2013, and after a fall resulting in fractures and hospitalization was readmitted to the facility on July 22, 2013, with diagnoses including Fractured Right Elbow, Distal Right Radial Fracture, Fractured Right Hip, Peptic Ulcer Disease, Renal Insufficiency, Peripheral Neuropathy Affecting Hands and Feet, Diverticulosis, and Anxiety/Depression.</p> <p>Review of a facility incident report dated July 14, 2013, revealed the resident was "...ambulating from the bed to closet...reports feeling "dizzy" and fell on floor...(Resident) stated hitting head, arm and hip..." Further review revealed the resident was taken by ambulance to the hospital.</p> <p>Review of the hospital history and physical with the admission date of July 14, 2013, revealed the resident had "...X-rays confirmed a right hip fracture as well as fractures of the right elbow and distal right radial fracture..."</p> <p>Review of the facility document, MDS Kardex careplan, revealed the "Accidents-Fall Risk" section was not completed.</p> | F 279 | <p><u>Measures/Systemic Changes Implemented:</u> 100% audit of all care plans and Kardexes by DON or designee for accuracy for accuracy. Care plans and Kardexes to be updated during clinical start up meeting, during weekly at risk meeting and with each intervention by licensed nurse. Assessments to be updated quarterly and as needed by licensed nurses. Education with licensed CNAs and nurses on care plans and kardexes by MDS Director. Education with all licensed nurses on timely fall risk assessments and care planning respiratory status as needed by DON or designee.</p> <p><u>Monitoring:</u> 10 Care plans and kardexes to be audited X4 weeks for 1 month then monthly X3 by DON or Designee for accuracy. These findings will be presented in the monthly Quality Assurance Committee by DON or designee monthly which is attended by the Executive Director, Director of Nursing, Medical director, Social Services, Activity Director.</p> <p style="text-align: right;">10/21/13</p> | |
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| F 279 | <p>Continued From page 8</p> <p>Review of the medical record revealed the facility failed to update the care plan to address the resident's fall on July 14, 2013.</p> <p>Review of the facility policy Accidents/Incidents/Unusual Circumstances, dated 2010, revealed, "...1. Fall management program...Policy: It is the policy of the facility to provide residents with adequate supervision to minimize the risk of accidents. The facility will identify residents at risk for falls and implement interventions to minimize the occurrence of falls for those at risk...Procedure:...10. Care plans are updated and revised at every fall or incident..."</p> <p>Interview on September 11, 2013, at 1:57 p.m., in the MDS office, with the MDS Coordinator, confirmed the MDS Kardex was used by the Certified Nurse Aides to provide care to the resident. Further interview confirmed the MDS Kardex and care plan failed to include the fall precautions.</p> <p>Resident #27 was readmitted to the facility on August 27, 2013, with diagnoses including Dehydration, Schizophrenia, Dementia, Coronary Artery Disease with Coronary Artery Bypass Graft, Pacemaker Insertion, Hypertension, and Degenerative Joint Disease.</p> <p>Medical record review of the Nursing Admission Assessment dated August 27, 2013, revealed the resident was incontinent of urine both day and night time and voided large amounts (puddles/soaks, clothes, bed, floor).</p> <p>Medical record review of the care plan dated August 28, 2013, revealed urinary incontinence</p> | F 279 | | |
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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 279 | <p>Continued From page 9</p> <p>was not addressed as a problem for the resident.</p> <p>Interview with the Unit Manager on September 10, 2013, at 2:18 p.m., in the A - B nurses' station, confirmed the resident was incontinent of urine and the care plan did not address urinary incontinence.</p> <p>Resident #15 was admitted to the facility on March 22, 2013, with diagnoses including Obstructive Chronic Bronchitis with Exacerbation, Congestive Heart Failure, Generalized Anxiety Disorder, Pneumonia, Chronic Airway Obstruction, and Asthma.</p> <p>Observation and interview on September 11, 2013, at 6:40 p.m., with the resident, in the resident's room revealed the resident was able to verbalize without Shortness Of Breath (SOB) or use of oxygen. The resident revealed the oxygen was used occasionally when SOB.</p> <p>Medical record review of the hospital history and physical dated April 17, 2013, revealed the resident was admitted to the hospital for SOB, and diagnosed with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure, Exacerbation with Pneumonia.</p> <p>Review of the resident's care plan dated May 8, 2013, revealed no interventions to address the respiratory status.</p> <p>Interview and review of the care plan dated May 8, 2013, at 6:15 p.m., with the A-B Hall Unit Manager near the AB nursing desk confirmed no interventions for the resident's respiratory status were addressed on the care plan.</p> <p>Resident #31 was admitted to the facility on</p> | F 279 | | | |

Marty 9/24/13

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| F 279 | <p>Continued From page 10</p> <p>September 15, 2012, with diagnoses including Vascular Dementia with Depressed Mood, Hemiplegia Affecting Dominant Side due to Cerebrovascular Disease, Aphasia, and Degeneration Intervertebral Disc Site Unspecified.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated June 21, 2013, revealed the resident was dependent for transfers with a two person assist.</p> <p>Review of the resident's MDS Kardex Report (Kardex) identified by the Administrator on September 11, 2013, at 9:30 a.m., in the conference room as the current working care plan for nurses and aides, revealed, " ...Transfers: No ..."</p> <p>Interview with Certified Nurse Aide (CNA) #2 on September 11, 2013, at 12:48 p.m., in the resident's room confirmed the resident required the assistance of two persons for transfers.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on September 11, 2012, at 12:59 p.m., at the A-B Nurses Station, confirmed the resident required assistance of two persons for transfers.</p> <p>Interview with the Administrator and the Assistant Director of Nursing on September 11, 2013, at 1:24 p.m., at the A-B Nurses Station confirmed the information on the Kardex care plan was unclear, and the staff would not be able to determine from the Kardex how much assistance the resident needed for transfers.</p> <p>Interview with the CNA/Restorative Assistant on September 11, 2013, at 1:36 p.m., at the A-B</p> | F 279 | | |
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Gruffy 9/24/13

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| F 279 | <p>Continued From page 11</p> <p>Nurses Station, confirmed the resident transferred with extensive assist of two persons and on occasion utilized the lift for transfers. Continued interview confirmed the Kardex care plan did not reflect the resident's transfer status. Resident #135 was admitted to the facility on August 16, 2013, with diagnoses including Human Immunodeficiency Virus (HIV), Chronic Kidney Disease (CKD), Prostatitis, Dysphagia, Hypertension, and Urinary Tract Infection.</p> <p>Medical record review of the care plan dated August 16, 2013, initiated on August 19, 2013, revealed, "...the resident is risk for falls r/t (related to) unaware of safety needs...gait/balance problems..."</p> <p>Medical record review of the nursing progress notes revealed the resident had falls on August 18, 22, and September 11, 2013, with no injuries.</p> <p>Medical record review of the Minimum Data Set (MDS) Kardex Report (care plan for Certified Nursing Aides), not dated, revealed, "Accidents Fall Risk" section did not have "...Falls...Falls since admission or prior assessment..." completed. Further review revealed no documentation the resident had three falls or was at risk for further falls.</p> <p>Interview with the Administrator and the Director of Nursing, on September 11, 2013, at 2:30 p.m., in the conference room, confirmed the facility had initiated the Kardex system one week ago to assist new staff in knowing residents' care needs. Further interview confirmed the Kardex care plan was not completed.</p> <p>Resident #17 was admitted to the facility on May 17, 2013, with diagnoses including End Stage</p> | F 279 | | |
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Shirley 9/24/13

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F 279 Continued From page 12
Renal Disease, Diabetes, Muscle Weakness, Chronic Pain, Depressive Disorder, and Congestive Heart Failure.

F 279

Medical record review of the Dialysis Center orders dated August 26, 2013, revealed the resident went to dialysis on Monday, Wednesday, and Friday.

Medical record review of the resident's MDS Kardex Report (undated), revealed dialysis services was not addressed.

Interview with the Administrator and the Director of Nursing on September 12, 2013, at 2:30 p.m., in the conference room, confirmed dialysis was a significant care need and was not addressed on the Kardex care plan.

F 280
SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after

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| F 280 | <p>Continued From page 13 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update care plans to reflect the changing needs of the residents for two (#5, #7) of thirty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on September 9, 2012, with diagnoses including Dementia with Behavioral Disturbances, Depression, Diabetes Mellitus, Coronary Atherosclerotic Disease, and Hypertension.</p> <p>Review of a Psychiatry assessment dated May 16, 2013, revealed "...patient has severe, chronic mental illness, recurrent general anxiety, and history of schizoaffective disorder. Patient frequently decompensated with minor stressors requiring psych hospitalization (evaluation in a psychiatric hospital) due to suicidal comments. Patient has a long history of not getting along with staff and other residents. Can be very manipulative and demanding at times..."</p> <p>Continued review of the assessment revealed Suggested Behavioral Interventions for Staff Consideration:</p> <ol style="list-style-type: none"> 1. Visit with patient and encourage them to share memories and talk about their life to increase self-esteem. 2. Provide increased choices regarding care, schedules, etc, to increase feelings of control, independence, and/or to increase compliance. | F 280 | <p>F280 SS=D 483.20</p> <p>Right to participate in care planning and care plan revisions.</p> <p>Facility updates and revises comprehensive care plans with current interventions.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident #5 and #9 care plans were updated to reflect current interventions for recommendations and oral care by licensed nurse. Oral and dietary assessment completed on resident #9 by licensed nurse.</p> <p><u>Identification of Other Residents Potentially Affected:</u> Residents with recommendations and potential for oral concerns have the potential to be affected by the alleged cited deficient practice.</p> <p><u>Measures/Systemic Changes Implemented:</u> An oral assessment of all residents was conducted by Director of Nursing, and or designee. Updates and revisions completed as needed. Nurse Educator to reeducate Unit manager on timely recommendations. During Morning Meeting DON or designee will review recommendations that have occurred within the past month to ensure addressed timely. Re education with RD and DM on accurate Dietary screens by DON or Designee.</p> | 10/24/13 |
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| F 280 | <p>Continued From page 14</p> <p>3. Provide praise/reinforcement for appropriate behavior, increased compliance, activity, or interaction.</p> <p>4. Consistently correct inappropriate behavior.</p> <p>Medical record review of a psychology note dated July 30, 2013, revealed "...increased irritability, pain complaints, attention seeking behavior. Obsessed with smoke break times in addition to when meds (medications) will arrive. Need to consult with staff re (regarding) implementing behavior management strategies, of reinforcing positive behaviors and statements, increasing positive attention to decrease pain complaints and negative ways of increasing attention..."</p> <p>Medical record review of the care plan dated August 2, 2013, revealed no recommendation interventions from May 16, 2013, or July 30, 2013, had been incorporated into the behavior section.</p> <p>Interview with the Unit Manager on September 11, 2013, at 2:30 p.m., in the A - B Hall nurses' station, confirmed no recommendation interventions from May 16, 2013, or July 30, 2013, had been incorporated into the care plan. Continued interview with the Unit Manager revealed having the recommendations incorporated into the care plan would have been good to help staff deal with the resident's behavior.</p> <p>Resident #9 was admitted to the facility on July 16, 2013, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety.</p> <p>Observation and interview with the resident on</p> | F 280 | <p><u>Monitoring:</u> Pharmacy recommendations are discussed monthly during QA&A by DON or designee. 10 Care plans and kardexes to be audited X4 weeks for 1 month then monthly X3 by DON or Designee for accuracy. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> <p style="text-align: right;">10/21/13</p> | |

Duffy

9/24/13

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| F 280 | <p>Continued From page 15</p> <p>September 10, 2013, at 11:23 a.m., in the resident's room revealed the resident had six lower teeth, with heavy plaque, blackish in color. The resident stated "I have asked them for a long time to get someone to pull them but nobody does anything"</p> <p>Medical record review of the dietary screen dated July 17, 2013, revealed the resident does not have own teeth and has chewing and swallowing problems.</p> <p>Review of the resident's care plan dated March 20, 2013, revealed "...The resident has nutritional problem or potential nutritional problem r/t (related to) Diet restrictions..." with no approaches to address the dental needs.</p> <p>Interview on September 11, 2013, at 4:45 p.m., outside of the resident's room with the A-B Unit Manager confirmed the resident's dental status was not addressed on the resident's care plan.</p> | F 280 | | |
| F 282 SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide services in accordance with the resident's plan of care for three resident (#19, #9, #83) of thirty-seven residents reviewed.</p> | F 282 | | |

Shelby 9/24/13

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| F 282 | Continued From page 16 The findings included: Resident #19 was admitted to the facility September 25, 2012, with diagnoses including Vascular Dementia with Delusions, Dysphagia Oral Stage (difficulty swallowing), Diabetes, and Anemia. Observation with the Dietary Manager (DM) on September 10, 2013, at 1:25 p.m., in resident #19's room revealed Certified Nurse Assistant (CNA) #1 served the resident's lunch tray. Continued observation revealed the tray card showed a picture of a plate guard to be used with meals. Observation with the DM revealed the plate guard was not on the resident's lunch tray. The DM went to the kitchen and obtained one. When the DM returned the resident had put the dome on the plate and was "done". Continued observation revealed the resident had a large portion of the pureed ham, potatoes, and greens on the shirt. Medical record review of the Certified Nursing Assistant (CNA) kardex careplan for the resident revealed no indication of the resident's need for a plate guard. Medical record review of the resident's care plan dated October 5, 2012, revealed "...The resident has a potential for nutritional problem r/t (related to) Dementia, Therapeutic Diet, Diabetes...Provide plate guard with meals..." Interview on September 11, 2013, at 4:50 p.m., outside of the resident's room with the A-B Unit Manager confirmed the resident's care plan stated to use a plate guard and the care plan was | F 282 | F282 SS=D 483.20 Services by Qualified persons/per care plan. The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Residents #19 - dietary was educated on placing assistive devices on resident's tray by RD or designee. Resident # 9 nails clipped by licensed nursing staff. Resident #83 - dietary staff was re educated on tray cards and assistive devices on trays by Dietary Manager. <u>Identification of Other Residents Potentially Affected:</u> Residents with assistive devices and impaired skin integrity. <u>Measures/Systemic Changes Implemented:</u> Education to CNAs to ensure assistive devices are on residents trays and reading tray cards. Nurse educator to re in service on ADL and nail care to all licensed nursing staff. Re educate licensed nursing staff on kardexes for accuracy by DON or designee. <u>Monitoring :</u> Nail care to be monitored by rooms rounds and reported in daily stand up by management. 10 tray and tray card audits for devices weekly X4 then monthly X3 by DON or Designee. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. | 10/21/13 |
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Shirley 9/24/13

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| F 282 | <p>Continued From page 17 not followed.</p> <p>Resident #9 was admitted to the facility on July 16, 2013, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety.</p> <p>Observation on September 10, 2013, at 11:17 a.m., in the resident's room revealed the resident scratched both arms, with one area bleeding, and several bruises and scratches were present on the resident's arms</p> <p>Medical record review of the resident's care plan up-dated September 6, 2013, revealed "...Resident has potential impairment to skin integrity r/t fragile skin..." with approaches for the skin care including "...keep fingernails short..."</p> <p>Interview and observation on September 11, 2013, at 4:45 p.m., in the resident's room with the A-B Unit Manager revealed dry flaky skin on the arms with multiple bruises and skin tears, and the resident stated that the skin was "itchy". Continued observation revealed all ten fingernails were approx 1/4 inch past the finger tips and were soiled. The A-B Unit Manager confirmed the fingernails were long and dirty and the care plan was not followed.</p> <p>Resident # 83 was admitted to the facility on March 25, 2013, with diagnoses including Dementia, Anxiety, Diabetes Mellitus Type II, Osteoarthritis, Epilepsy, Peripheral Neuropathy, and Hypertension.</p> <p>Medical record review of the physician's orders dated June 6, 2013, revealed a physician's order</p> | F 282 | | |
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| F 282 | Continued From page 18 for the resident to have a plate guard. Medical record review of the care plan dated June 6, 2013, revealed the resident was to have a plate guard at all meals. Observation on September 10, 2013, at 8:19 a.m., in the resident's room revealed the resident was eating breakfast and with the spoon, sliding food off of the plate, while attempting to scoop food onto the spoon. Interview with CNA #3 on September 10, 2013, at 8:23 a.m., in the resident's room confirmed the resident did not have a plate guard and the CNA was unaware the care plan indicated the use of a plate guard. | F 282 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide assistance to maintain oral hygiene and fingernail grooming for one (#9) of thirty-seven residents reviewed. The findings included: Resident #9 was admitted to the facility on July | F 312 | F312 SS=D 483.25 ADL care provided for dependent residents Facility strives to ensure that residents receive care and services when a resident who is unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident #9 care plans were updated to reflect current interventions Oral care and nail care by DON or designee. Oral and dietary assessment completed on resident #9 by licensed nursing staff and dietary manager. Nails clipped and cleaned on resident #9 by licensed nurse. <u>Identification of Other Residents Potentially Affected:</u> Residents with impaired skin and oral concerns have the potential to be affected. | 10/24/13 |

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| F 312 | <p>Continued From page 19</p> <p>16, 2013, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety.</p> <p>Medical record review of the August 12, 2013, Quarterly Minimum Data Set revealed the resident required minimal assistance for personal hygiene.</p> <p>Observation and interview with the resident on September 10, 2013, at 11:23 a.m., in the resident's room revealed the resident had six lower teeth, with heavy plaque, blackish in color, and the resident stated "...no one helps me brush them..."</p> <p>Observation and interview on September 11, 2013, at 12:15 p.m., in the resident's room with Certified Nursing Assistant (CNA) #1 confirmed no tooth brush or toothpaste identified as resident #9's was found in the room and the resident's teeth were not brushed.</p> <p>Observation on September 10, 2013, at 11:17 a.m., in the resident's room revealed the resident scratched both arms, with one area bleeding, and several bruises and scratches were present on the resident's arms.</p> <p>Interview and observation on September 11, 2013, at 4:45 p.m., in the resident's room with the A-B Unit Manager revealed all ten fingernails were approximately 1/4 inch past the finger tips and were soiled. The A-B Unit Manager confirmed the fingernails were long and dirty, and required trimming and cleaning.</p> | F 312 | <p><u>Measures/Systemic Changes Implemented:</u> An oral assessment of residents was conducted by Director of Nursing, and or designee for dental needs updates and revisions completed as needed. Nurse educator to re educate on ADL, oral and nail care all licensed nursing staff. 100% audit on nail care by DON or designee.</p> <p><u>Monitoring:</u> Nail care to be monitored by room rounds and discussed in morning stand up management. 10 Care plans and kardexes to be randomly audited X4 weeks for 1 month then monthly X3 by DON or Designee for accuracy. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/24/13 |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | |

G. Mabry 9/24/13

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F 315 Continued From page 20

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to evaluate the bladder status and failed to institute a bladder training program for one (#27) of thirty-seven residents reviewed.

The findings included:

Resident # 27 was readmitted to the facility on August 27, 2013, with diagnoses including Dehydration, Schizophrenia, Dementia, Coronary Artery Disease with Coronary Artery Bypass Graft, Pacemaker Insertion, Hypertension, and Degenerative Joint Disease.

Medical record review of the Nursing Admission Assessment dated August 27, 2013, revealed the resident was incontinent of urine both day and night time and voided large amounts (puddles/soaks, clothes, bed, floor).

Medical record review revealed no documentation of a bladder assessment; three day bladder tracking program; or interventions to improve bladder function.

F 315 F315 SS=D 483.25
NO CATHETER, PREVENT UTI, RESTORE BLADDER

10/21/13

The facility offers catheter care to promote prevention of UTIs.

Residents Affected/Potentially Affected by the Cited Deficient Practice:
Resident #27 was assessed for signs and symptoms of any ill effects such as infection or irritation related to cited practice by DON or designee.

Identification of Other Residents Potentially Affected:
Residents with incontinence have the potential to be effected.

Measures/Systemic Changes Implemented:
Assess bowel and bladder function on admission, quarterly and as needed by licensed nurses. Residents with incontinence reviewed monthly by DON or designee.
F315—Re In serviced licensed nursing staff on bowel and bladder documentation by Nurse educator.

Monitoring :
10 Bowel and bladder audit X4 weeks then monthly X3 by DON or Designee for accuracy. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.

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| F 315 | Continued From page 21 | F 315 | | |
| F 322 SS=D | <p>Interview with the Unit Manager on September 11, 2013, at 2:18 p.m., in A-B Hall nurses' station, confirmed a bladder evaluation should have been completed on admission but the medical record did not contain evidence an evaluation was completed or the resident had undergone a bladder tracking program.</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</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 complications from the use of a</p> | F 322 | <p>F322 SS=D 483.25 NG treatment/services restore eating skills</p> <p>Residents Affected/Potentially Affected by the Cited Deficient Practice: Resident #12 was assessed for peg tube placement by DON or designee.</p> <p>Identification of Other Residents Potentially Affected: Residents with G tube.</p> <p>Measures/Systemic Changes Implemented: Re Education to licensed nursing staff on peg tube placement care and treatment, policies and procedures by DON or designee. Assessment of residents with peg tubes for signs and symptoms of complications by licensed nurse.</p> <p>Monitoring : A Medication pass audit weekly X4 weeks then monthly X3 by DON or Designee for PEG tube placement and medication administration for accuracy. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/21/13 |

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| F 322 | <p>Continued From page 22</p> <p>percutaneous gastrostomy (PEG) tube were minimized by utilizing acceptable standards of practice for checking tube placement before administering medications through the PEG tube for one resident (#12) reviewed for PEG tubes.</p> <p>The findings included:</p> <p>Resident #12 was admitted to the facility on February 23, 2012, with diagnoses including Unspecified Cerebral Artery Occlusion with Infarct, Chronic Pain, Stricture and Stenosis of Esophagus, and Adult Failure to Thrive.</p> <p>Review of the Annual Minimum Data Set (MDS) dated February 7, 2013, revealed the resident had short/long term memory problems, and severe cognitive impairment.</p> <p>Review of the Quarterly MDS dated August 8, 2013, revealed the resident required extensive assist of two persons for bed mobility, was totally dependent on two persons for transfers, and totally dependent with assist of one person for eating including management of enteral nutrition. Review of the same MDS, Section K, Nutrition Approach, revealed the resident received nutritional support from tube feeding.</p> <p>Observation of medication administration on September 10, 2013, at 8:00 a.m., with Licensed Practical Nurse (LPN) #1, revealed LPN #1 prepared three medications for resident #12 at the medication cart by crushing the medications and mixing the crushed medications with water. Continued observation revealed LPN #1 took the medication cup into the resident's room and placed the medication cup on the resident's over-bed-table. Continued observation revealed</p> | F 322 | | |

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| F 322 | <p>Continued From page 23</p> <p>LPN #1 placed the bell of the stethoscope on the resident's abdomen near the PEG tube site, and commented, "Well you've got good bubbles today." Continued observation revealed LPN #1 attached a 60 ml (milliliter) syringe to the end of the resident's PEG tube, poured the liquefied medications (approximately 30 ml) into the barrel of the syringe, and added more water (approximately 30 ml). Continued observation revealed LPN #1 listened with the stethoscope to the resident's abdomen as the medications were administered by pushing the liquefied medication through the syringe into the PEG tube. Continued observation revealed LPN #1 followed the medication administration with a 60 ml flush of water.</p> <p>Review of the facility's policy, Section IIA9: Enteral Tube Medication Administration, revealed, "...Crushed medications are not mixed together. The powder from each medication is mixed with water...before administration. Each medication is administered separately to avoid interaction and clumping..." Continued review of the facility's policy at Section IIB13, revealed, "...Purpose, To safely and accurately administer oral medications through an enteral tube...Procedures...F. Verify tube placement. 1) Unclamp tube and use either of the following procedures: a. Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds; or b. Aspirate stomach contents with syringe..."</p> <p>Interview with LPN #1 at the A-hall medication cart on September 10, 2013, at 8:10 a.m., confirmed the resident's PEG tube had not been properly checked before administering the medications.</p> | F 322 | | |
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| F 322 | Continued From page 24 | F 322 | | |
| F 323 SS=E | <p>Interview with the Unit Manager at the A-B Nurses Station on September 10, 2013, at 8:15 a.m., confirmed the facility's policy for administering medications through a PEG tube had not been followed.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, facility policy review, and review of facility investigations, the facility failed to investigate falls for two residents (#135, #23); failed to protect a wandering resident (#95) and failed to ensure equipment was safe for one resident (#25) of thirty-seven residents reviewed.</p> <p>The findings included: Resident #135 was admitted to the facility on August 16, 2013, with diagnoses including Human Immunodeficiency Virus, (HIV), Chronic Kidney Disease (CKD), Prostatitis, Dysphagia, Hypertension, and Urinary Tract Infection.</p> <p>Medical record review of the Minimum Data Set dated August 23, 2013, revealed the resident</p> | F 323 | <p>F323 SS=E 483.25(h) Free of accidents hazards/supervision/devices</p> <p>The Facility ensures that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident # 135 was assessed and treatment was initiated to abrasion on back by wound care nurse. Resident #23 fall assessment completed and interventions care planned by DON or designee. Resident #95 assessed for any complications related to her wandering and interventions care planned by licensed nurse. Resident #25 was assessed for skin tears related to screws in tray. Tray was removed from wheelchair after assessment by Maintenance.</p> <p><u>Identification of Other Residents Potentially Affected:</u> Residents at risk for falls, wandering, and trays attached to wheelchairs have the potential to be affected.</p> | 10/21/13 |

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F 323 Continued From page 25 required limited assistance of one person physical assist with transfer between surfaces.

Medical record review of the Care Plan dated August 19, 2013, revealed "...TRANSFER: the resident requires supervision with transferring related to safety awareness issues...follow facility fall protocol...at risk for falls..."

Interview with Licensed Practical Nurse (LPN) #3, on September 11, 2013, at 8:30 a.m., in the C Hallway revealed resident #135 had been discovered on the floor in the resident's room at approximately 7:15 a.m. by night shift LPN # 4.

Interview with LPN #5, on September 11, 2013, at 8:35 a.m., in the C Hallway, revealed resident #135 sustained an abrasion to the back.

Interview with the Treatment Nurse on September 11, 2013, at 8:40 a.m., in the C Hallway, revealed "...fell...injuring right lower back...measured 1.5 centimeters (cm) by 0.5 cm...cleansed the wound...covered with a dressing, notifying the Nurse Practitioner and the resident's family..." Further interview revealed the Treatment Nurse was notified by LPN #5.

Medical record review revealed no nursing progress note detailing the events of the fall.

Review of the Fall Management Program policy dated 2010, "...the committee reviews all incident reports and findings from the investigations that involves falls/incidents..."

Interview on September 11, 2013, at 9:00 a.m., with the Assistant Director of Nursing (ADON), in the C Hallway nursing station confirmed there

F 323

Measures/Systemic Changes Implemented: Nurse was re educated on following fall policy and procedure. Said nurse completed fall assessment and progress note.

Education to licensed nurses by nurse educator on fall policy and procedure. Fall policy and procedures to be reviewed and revised by QA&A team to include: Medical director, DON, administrator, activity director and social services for updates to Golden star program. Fall assessments completed on residents by licensed nurses for accuracy. Key pads placed on therapy doors to ensure safety by maintenance. Therapy staff educated on not leaving therapy rooms unattended. Maintenance to do 100% audit of all wheelchairs with trays attached.

Monitoring:
Room Rounds completed and discussed in morning stand up to monitor safety by management team. Falls to be reported in monthly QA&A. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.

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| F 323 | <p>Continued From page 26</p> <p>was no nursing progress note or written report of the fall.</p> <p>Interview with LPN #5, on September 11, 2013, at 10:40 a.m., in the C Hallway nursing station, confirmed "...no nursing progress note was written..." to document the resident's fall.</p> <p>Review of the facility policy, "Accidents/Incidents/Unusual Circumstances" and the "Fall Management Program" revised 2010, revealed, "...residents experiencing repeated falls... will be identified in some ways...e.g. Gold Star..."</p> <p>Observation on September 11, 2013, at 12:40 p.m., of the resident's room revealed no Gold Star or falls identifier.</p> <p>Interview on September 11, 2013, at 12:55 p.m., in C Hallway, with the ADON confirmed there was no gold star positioned on the doorframe or anywhere in the resident's room. Further interview with the ADON confirmed the staff did not follow the policy to recognize the resident identified as a fall risk.</p> <p>Resident #23 was admitted to the facility on July 9, 2013, and after a fall resulting in fractures and hospitalization, was readmitted to the facility on July 22, 2013, with diagnoses including Fractured Right Elbow, Distal Right Radial Fracture, Fractured Right Hip, Peptic Ulcer Disease, Renal Insufficiency, Peripheral Neuropathy Affecting Hands and Feet, and Anxiety/Depression.</p> <p>Review of a facility document of an incident report</p> | F 323 | | |
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| F 323 | <p>Continued From page 27</p> <p>with an incident date of July 14, 2013, revealed the resident was "...this nurse heard cries of distress coming from room...upon entering room, pt (patient) was found on floor in front of closet laying on right side. Pt wearing t-shirt, underwear, no pants, no shoes, without walker. Pt ambulating from bed to closet to obtain Sprite and reports feeling "dizzy" and fell on floor. Pt stated hitting head, arm and hip.</p> <p>Immediate action taken: VS (vital signs)...pain response appropriate. Attempted to move pt, but pt reported pain in right shoulder, wrist, and hip. Pt remains on floor with pillow under head and blanket covering body with 2 CNAs (Certified Nurse Aides) and 1 nurse present while this nurse telephoned 911 for pt transport to (named hospital) via stretcher. Skin tear present on right elbow, and severe edema present on right wrist. Right sided facial swelling present. Voicemail message left with son, currently waiting callback. MD (physician) notified of transfer..."</p> <p>Review of the hospital history and physical with the admission date of July 14, 2013, revealed the resident "...reports that (resident) set (sit) up quickly and became lightheaded...fell and landed on...right side injuring...right arm and hip. (Resident) was taken to the emergency room for evaluation. (Resident) complained of right arm and hip pain. X-rays confirmed a right hip fracture as well as fractures of the right elbow and distal right radial fracture..."</p> <p>Review of the facility policy Accidents/Incidents/Unusual Circumstances, dated 2010, revealed, "...1. Fall management program...Policy: It is the policy of the facility to provide residents with adequate supervision to minimize the risk of</p> | F 323 | | |
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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 323 | <p>Continued From page 28</p> <p>accidents. The facility will identify residents at risk for falls and implement interventions to minimize the occurrence of falls for those at risk...Procedure:...9. Any resident who falls (or is involved in any accident) is discussed at the daily morning meeting in an effort to determine why the resident fell or a involved in an incident, interventions already in place and interventions to implement in an effort to minimize the risk of the fall or incident from reoccurring...the committee reviews all incident reports and findings from the investigation that involves falls/incident..."</p> <p>Interview on September 11, 2013, at 11:00 a.m., with the administrator, in the conference room, confirmed the facility failed to investigate the fall. Observation on September 9, 2013 at 7:40 p.m., revealed Resident # 95 was in a wheelchair, wandering throughout the hallways and in and out of any unlocked rooms. Further observation revealed the resident went into the unlocked therapy department. Further observation revealed the therapy department door was closed, the lights turned down and no staff were present. Observation revealed a staff member removed the resident from the therapy department, closed the door, and did not lock the door.</p> <p>Observation of the unlocked therapy department on September 9, 2013, at 8:00 p.m., revealed the department was filled with equipment for therapy, wires, cords, office supplies/equipment, Biofreeze (a topical pain reliever), and ultrasound gels.</p> <p>Interview on September 9, 2013 at 8:09 p.m., with the restorative nursing supervisor confirmed the therapy department was to be locked after staff completed their shift and exited the building.</p> | F 323 | | |
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| F 323 | Continued From page 29 Observation on September 10, 2013, at 9:44 a.m., and September 11, 2013, at 10:30 a.m., revealed resident #25 was seated in a high-back wheelchair with a half-tray table affixed to the left side of the wheelchair. Continued observation revealed the half-tray table was secured to the arm of the wheelchair with two screws, one of which protruded approximately 1/2 to 3/4 inch out from the frame of the chair. Interview and observation with the Maintenance Director on September 11, 2013, at 10:30 a.m., in the dining room where the resident was seated in the wheelchair confirmed the half-tray table was not affixed appropriately to the wheelchair. Continued interview confirmed the screw posed a hazard to the resident and to others passing the wheelchair because the screw protruded outward beyond the frame and the wheel of the chair. | F 323 | | |
| F 364 SS=E | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility dietary department failed to serve food at the proper temperature. The findings included: Resident #47 was admitted to the facility on July | F 364 | F364 SS=E 483.35 Nutritive value/appear palatable/prefer temp Facility provides food by methods that conserve nutritive value, flavor, and appearance at proper temperature. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident #47, #15, #71 will receive food at proper temperatures. Resident #71 was assessed for independence with meal consumption and assistance as needed by licensed nursing staff. <u>Identification of Other Residents Potentially Affected:</u> All residents have the potential to be affected by this practice. | 10/21/13 |

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| F 364 | <p>Continued From page 30</p> <p>3, 2011, with diagnoses including Dementia, Hypertension, Depression, Congestive Heart Failure, Atrial Fibrillation, and Parkinson's Disease.</p> <p>Interview with the resident on September 10, 2013, at 8:30 a.m., in the resident's room, revealed the food on the trays was usually cold when delivered to the room.</p> <p>Resident #15 was admitted to the facility on March 22, 2013, with diagnoses including Coronary Artery Disease, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.</p> <p>Interview with the resident on September 10, 2013, at 9:03 a.m., revealed the food was usually cold when delivered to the room. Continued interview with the patient revealed "...the cart sits in the hall too long..."</p> <p>Resident #71 was admitted to the facility on March 8, 2012, with diagnoses including Diabetes, Chronic Obstructive Pulmonary Disease, Oxygen Dependence, Esophageal Reflux, and Benign Neoplasm of the Brain.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated April 20, 2013, revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status indicating the resident was cognitively intact. Review of the Quarterly MDS dated July 19, 2013, revealed the resident was independent with eating and required set-up help only.</p> <p>Interview with the resident in the resident's room on September 10, 2013, at 10:00 a.m., confirmed meals were not served at the proper temperature.</p> | F 364 | <p><u>Measures/Systemic Changes Implemented:</u> Re Educate dietary staff on proper food temps by RD or designee. Audit 100% of care plans and kardexes for meal assistance by DON or designee for accuracy.</p> <p><u>Monitoring :</u> 10 Care plans and kardexes to be audited X4 weeks for 1 month then monthly X3 by DON or Designee for accuracy. Food temps to be audited weekly X4 then monthly X3 by Dietary Manager or designee. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/21/13 | |

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| F 364 | <p>Continued From page 31</p> <p>Continued interview revealed, "The food is always cold; even the coffee is lukewarm."</p> <p>Observation in the dietary department on September 10, 2013, at 1:05 p.m., revealed the following food temperatures on the resident's mid-day meal tray line in operation: Sweet Potatoes - 141 degrees Fahrenheit (F.), Spinach - 141 degrees F., Pureed Sweet Potatoes - 142 degrees F., Pureed Spinach - 147 degrees F., Pureed Ham - 138 degrees F., and Ground Meat - 144 degrees F.</p> <p>Observation in the dietary department on September 10, 2013, at 1:18 p.m., revealed the tray cart was completed for the B hall. Continued observation revealed, the tray cart was delivered to the B hall at 1:20 p.m. Further observation revealed the last tray was removed and all residents were eating by 1:32 p.m. and the food temperatures were as follows: Sweet Potatoes - 112 degrees F. (decrease of 29 degrees F.), Spinach - 110 degrees F. (decrease of 31 degrees F.), Pureed Sweet Potatoes - 109 degrees F. (decrease of 33 degrees F.), Pureed Spinach - 110 degrees F. (decrease of 37 degrees F.), Pureed Ham - 102 degrees F. (decrease of 36 degrees), Ground Meat - 110 degrees F. (decrease of 34 degrees).</p> <p>Interview with the Dietary Manager on September 10, 2013, at 1:45 p.m., on the B hall, confirmed the resident lunch trays had an approximate drop in temperature of 30 degrees F. and the food was served cold.</p> | F 364 | | |
| F 369 SS=D | 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS | F 369 | | |

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| F 369 | <p>Continued From page 32</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide the needed assistive device to enhance a resident's eating ability for two residents (#83, #19) of thirty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident # 83 was admitted to the facility on March 25, 2013, with diagnoses including Dementia, Anxiety, Diabetes Mellitus Type II, Osteoarthritis, Epilepsy, Peripheral Neuropathy, and Hypertension.</p> <p>Review of the resident's Care Plan dated April 4, 2013, and updated June 6, 2013, revealed, "...The resident has unplanned/unexpected weight loss related to (r/t) Poor food intake..." The intervention for the focus of the care plan was "...plate guard for meals..."</p> <p>Observation on September 10, 2013 at 8:19 a.m., in the resident's room revealed the resident was eating breakfast with the spoon, sliding food off of the plate, attempting to scoop food onto the spoon.</p> <p>Interview with Certified Nursing Aide #3 (CNA) on September 10, 2013, at 8:23 a.m., in the resident's room confirmed the resident was having difficulty feeding self and "needs a plate guard."</p> | F 369 | <p>F369 SS=D 483.35</p> <p>NG treatment/services restore eating skills</p> <p>Residents Affected/Potentially Affected by the Cited Deficient Practice: Resident #83 and #19 was assessed for weight loss due to poor food intake and difficulty swallowing by DON or designee.</p> <p>Identification of Other Residents Potentially Affected: Residents with assistive devices have the potential to be affected.</p> <p>Measures/Systemic Changes Implemented: Re Education to CNAs, licensed nurses and therapy staff to ensure assistive devices are on residents trays and reading tray cards and care plan is updated and accurate by DON or designee.</p> <p>Monitoring : 10 audits weekly X4 then Monthly X3 of trays checking for assist Dietary Manager or designee for devices. 10 Care plans to be audited X4 weeks for 1 month then monthly X3 by DON or Designee for accuracy of devices. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/2/13 |
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| F 369 | <p>Continued From page 33</p> <p>Interview on September 10, 2013 at 8:38 a.m., with the Occupational Therapist (OT) in the therapy department revealed the OT had recommended the use of a plate guard and on June 6, 2013, a physician's order was obtained to use the plate guard.</p> <p>Resident #19 was admitted to the facility September 25, 2012, with diagnoses including Vascular Dementia with Delusions, Dysphagia Oral Stage (difficulty swallowing), Diabetes, and Anemia.</p> <p>Observation with the Dietary Manager (DM) on September 10, 2013, at 1:25 p.m., in resident #19's room revealed Certified Nurse Assistant (CNA) #1 served the resident's lunch tray. Continued observation revealed the tray card showed a picture of a plate guard to be used with meals. Observation with the DM revealed the plate guard was not on the resident's lunch tray. The DM went to the kitchen and obtained one. When the DM returned the resident had put the dome on the plate and was "done". Continued observation revealed the resident had a large portion of the pureed ham, potatoes, and greens on the shirt.</p> <p>Medical record review of the Certified Nursing Assistant (CNA) kardex careplan for the resident revealed no indication of the resident's need for a plate guard.</p> <p>Medical record review of the resident's care plan dated October 5, 2012, revealed "...The resident has a potential for nutritional problem r/t (related to) Dementia, Therapeutic Diet, Diabetes...Provide plate guard with meals..."</p> | F 369 | | |

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| F 369 | Continued From page 34 | F 369 | | |
| F 371 SS=F | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the dish machine manufacturer's recommendation, review of the dish machine log, review of the sanitizer provider's service report, and interview, the facility failed to ensure the dish machine was sanitizing the dishes.</p> <p>The findings included: Observation in the dietary department, on September 9, 2013, at 7:30 p.m., of the dish machine in operation, revealed the sanitizer chemical test strips did not change in three separate attempts.</p> <p>Review of the manufacturer's recommendation,</p> | F 371 | <p>F371 SS=F 483.35 Food procure, store/prepare/serve - sanitary</p> <p>Facility procures food from sources approved and stores, prepares, distribute, and services food under sanitary conditions.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> No specific residents were identified.</p> <p><u>Identification of Other Residents Potentially Affected:</u> All residents have the potential to be affected.</p> <p><u>Measures/Systemic Changes Implemented:</u> RE Education to dietary staff to check sanitizer in sink with test strips before washing 3 times per day and document to log by RD or designee. EcoLab to place longer tube into sanitizer.</p> <p><u>Monitoring :</u> Audit of sanitizer log and sanitizer weekly X4 weeks then monthly X3 by Dietary Manager or designee. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/21/13 |

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| F 371 | Continued From page 35 posted on the dish machine, revealed the recommended minimum level for a chlorine sanitizer was 50 parts per million (ppm). Review of the most current chemical provider service report dated August 7, 2013, revealed the sanitizer level was 75 ppm. Review of the dish machine log for September 2013, revealed daily documentation sections for wash and rinse temperatures for "breakfast, lunch and evening." Further review revealed no documentation of the sanitizer chemical strip test results. Interview on September 9, 2013, at 7:30 p.m., in the dish room, with the dietary staff member operating the dish machine revealed this dietary staff member also washed the dishes at lunch. Further interview revealed the dietary staff member "did not check sanitizer at lunch." Interview in the dish room, on September 9, 2013, at 7:30 p.m., with the Dietary Manager, present during the observation, confirmed the sanitizer chemical test strips failed to register the level of sanitizer in three separate attempts. Further interview confirmed the facility failed to check and document the sanitizer level on each operation of the dish machine to ensure the dishes were sanitized according to the manufacturer's recommendation. | F 371 | | |
| F 412 SS=D | 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent | F 412 | | |

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| F 412 | Continued From page 36 covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dental care for one (#9) of thirty-seven residents reviewed. The findings included: Resident #9 was admitted to the facility on July 16, 2013, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety. Observation and interview with the resident on September 10, 2013, at 11:23 a.m., in the resident's room, revealed the resident had six lower teeth, with heavy plaque, blackish in color, and the resident stated "...I have asked them for a long time to get someone to pull them but nobody does anything..." Interview on September 11, 2013, at 12:25 p.m., with the Social Worker, in the Social Worker's office, confirmed the resident did not appear on previous lists for residents to be seen by the dentist. | F 412 | F412 SS=D 483.55 Routine/Emergency dental services NFS Facility provides dental services to meet the needs of the residents. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident #9 had oral assessment completed by licensed nurse and was placed on list to see dentist by social services. <u>Identification of Other Residents Potentially Affected:</u> All residents with oral concerns have the potential to be affected. <u>Measures/Systemic Changes Implemented:</u> Nurse Educator to re educate licensed nursing staff on oral assessments. 100% audit of oral assessments completed are care plan updated by DON or designee. <u>Monitoring:</u> 10 residents to be audited for oral care by DON or designee monthly for accuracy to assessments. The Quality Assurance and Assessment Committee will evaluate the effectiveness of this plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. | 10/20/13 | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON | F 428 | | | |

W. Murphy 9/24/13

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

PRINTED: 09/13/2013
FORM APPROVED
OMB NO. 0938-0391

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| 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 09/11/2013 |
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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 428 | <p>Continued From page 37</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respond to the Pharmacist's Medication Regimen Review for one resident (#38) of five residents reviewed.</p> <p>The findings included:</p> <p>Resident #38 was admitted to the facility on March 8, 2013, with diagnoses including Hypoglycemia, Muscular Wasting and Disuse Atrophy, Gastric Ulcer, Alcohol Induced Dementia, Diabetes II, Anemia, and Depression.</p> <p>Medical record review and review of the recapulation orders dated September 2013, revealed, the resident received Ativan, Levemir, Novolog, Effexor, Multivitamins, Megace, Coumadin, Namenda, Tramadol and Percocet.</p> <p>Review of the Note To Attending Physician/Prescriber dated April 22, 2013, and May 28, 2013, from the consultant Pharmacist revealed, "...evaluate the effectiveness of Megace...agent should be discontinued if there is no improvement..." Further review revealed no</p> | F 428 | <p>F428 SS=D 483.60</p> <p>Drug regimen review, report irregular, act on</p> <p>Facility provides pharmacist services that review drug regimens of each resident monthly to meet the needs of the residents.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u></p> <p>Resident #38 had pharmacy and physician medication review completed by Amy wright and Dr. Johnson.</p> <p><u>Identification of Other Residents Potentially Affected:</u></p> <p>Residents with pharmacy recommendations have the potential to be affected by this practice</p> <p><u>Measures/Systemic Changes Implemented:</u></p> <p>DON or designee to re educate licensed nurses on pharmacy recommendations policy and procedure and following up in a timely manner. Pharmacy recommendations to be discussed monthly in QA&A by Don or designee for timely follow up.</p> <p><u>Monitoring :</u></p> <p>Pharmacy recommendations to be audited and reported on monthly in QA&A by DON or designee. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/21/13 |
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J. Jones 9/24/13

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| F 428 | Continued From page 38 action by the physician. | F 428 | | |
| F 441 SS=D | <p>Interview on September 11, 2013, at 5:15 p.m., in the conference room, with the Director of Nursing, confirmed there was no response to the Pharmacist's monthly regimen review for the month of April or May, 2013.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</p> | F 441 | <p>F441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility has an established Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p><u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident # 15 has been evaluated by DON or designee and has been provided with sanitary eating utensils.</p> <p><u>Identification of Other Residents Potentially Affected:</u> Residents residing in the facility with assistive devices have the potential to be affected</p> <p><u>Measures/Systemic Changes Implemented:</u> Licensed nurses and CNA's have been re-educated on removing the silverware/assistive devices and sending to kitchen for proper cleaning by Nurse</p> | 10/24/13 |

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| F 441 | <p>Continued From page 39 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 observation and interview, the facility failed to provide sanitary eating utensils for one (#15) of thirty-seven residents reviewed.</p> <p>The findings included: Resident #15 was admitted the facility on March 22, 2013, with diagnoses including Obstructive Chronic Bronchitis with Exacerbation, Congestive Heart Failure, Generalized Anxiety Disorder, Pneumonia, Chronic Airway Obstruction, and Asthma.</p> <p>Observation and interview on September 10, 2013, at 1:30 p.m., in resident #15's room revealed the resident was served the lunch tray by a Certified Nurse Assistant. Continued observation revealed a picture of a built-up spoon on the tray card, indicating the resident required built-up silver ware to eat. Continued observation revealed the resident reached over to the bedside table and had a built-up spoon and fork in a large Styrofoam cup with water. The resident stated the built-up silverware doesn't come back on the meal trays and the resident cannot hold the regular silverware to eat. Continued interview with the resident revealed after meals the resident stirs the soiled silverware in coffee to cleanse</p> | F 441 | <p>educator. Dietary staff re educated on places proper assistive devices on trays by Dietary Manager.</p> <p><u>Monitoring :</u> Room Rounds completed to monitor for dirty silverware or devices and discussed in morning stand up meeting by management. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</p> | 10/21/13 |
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Sherry 9/24/13

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| F 441 | Continued From page 40 them, wipes them off on a napkin and puts them in the cup of water. Continued observation revealed the resident wiped the built-up silverware off with a napkin after removing them from the cup of water and stated "...that's so I don't get the runs..." Continued interview with the resident confirmed the cleaning and storage of the built-up silverware was not sanitary. | F 441 | | |
| F 461 SS=D | 483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. | F 461 | F461 SS=D 483.70 Bedrooms-windows/floor/bed/furniture/closet Facility provides proper living space for the residents. <u>Residents Affected/Potentially Affected by the Cited Deficient Practice:</u> Resident #45 had family to come in and clean out closet and provide extra covered closet due to resident prefers extra clothing. <u>Identification of Other Residents Potentially Affected:</u> All Residents have the potential to be affected. <u>Measures/Systemic Changes Implemented:</u> 100% audit conducted by laundry supervisor for adequate closet space. During admission families and residents are given information about how many belongings are suggested in their space. | 10/21/13 |

Sheffy 9/24/13

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| F 461 | Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide private closet space for one resident (#45) of thirty seven residents reviewed. The findings included: Observation on September 10, 2013, at 8:54 a.m., in resident # 45's room revealed the resident's clothes were hanging beside the bed on an open clothes rack. Interview with the resident on September 10, 2013, at 8:54 a.m., in the resident's room revealed, "my roommate uses the closet and there is not enough room." Interview with the facility administrator on September 10, 2013, at 1:20 p.m., near the A hall nurse's station confirmed the resident did not have private closet space. | F 461 | <u>Monitoring :</u> Room Rounds to be completed to monitor closets and discussed in morning stand up meeting. These findings will be presented in the monthly Quality Assurance Committee monthly x3 months. The Quality Assurance and Assessment Committee include the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. | 10/24/13 | |

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9/24/13