

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7916	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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N 000	<p>Initial Comments</p> <p>Type A Penalty Suspension of Admissions</p> <p>On 9/10/12 through 9/20/12 an annual licensure survey was completed.</p> <p>The facility's administrative staff failed to assure the provision of resources was effective and efficient to meet the needs of each resident; provide a medical director whose role was to coordinate facility-wide medical care; and failure to maintain an effective Performance Improvement (Quality Assurance and Assessment) Committee. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. Refer to N401, N601, and N616.</p> <p>The facility failed to protect residents form verbal, physical, and mental abuse and failure to follow the facility policy of thoroughly investigating and reporting allegations of abuse. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of Residents #14, 23, 47, 68, 81, 82 and 116. Refer to N1207.</p> <p>The facility failed to ensure the environment was free of accident hazards related to side rails; falls and by allowing access to unattended, closed units in the facility. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of residents residing in the facility. Refer to N424.</p> <p>The facility failed to follow physician's orders; obtain laboratory testing as ordered; and promptly notify the physician of the abnormal laboratory results for Residents #23, 81 and 82. These</p>	N 000		

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TITLE

(X6) DATE

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

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N 000	Continued From page 1 findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of these residents. Refer to N669 and N689. The facility failed to ensure the social worker assured residents received the necessary care and services related to psychiatric services, dental or vision for Residents #43, 60, 63, 68, 104, 116 and 124. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the resident. Refer to N780. The facility failed to put preventive measures in place; assess skin conditions; and provide care treatments to prevent the development of pressure ulcers for Residents #54, 74 and 82. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of these residents. Refer to N691. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being, which resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The facility failed to ensure there was a Registered Nurse (RN) on duty to supervise and evaluate the nursing care for each resident. Refer to N658 and N681. An exit conference was conducted with the Administrator (Adm), Facility Consultant (FC), Vice President (VP) and the Nursing Supervisor (NS) on 9/20/12 at 6:15 PM. The Administrator, Vice President and Director of Nursing (DON)	N 000		

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N 000	Continued From page 2 were informed of the citations identified at N424 and N1207 on 9/13/12 at 10:30 AM. The Adm and DON were informed of the citations identified at N669 and N689 on 9/14/12 at 1:20 PM. The Adm and DON were informed of the citations at N691 on 9/14/12 at 4:55 PM. The Adm, FC, VP, and NS were informed of the citations at N401, N616, N627, N645, N658, N666, N681, N682, N751 and N780 on 9/20/12 at 6:00 PM. The Adm. was informed on 10/3/12 at 8:45 AM of the citation at N601 and N692. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility.	N 000		
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on review of the Federal Drug	N 401		

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N 401	Continued From page 3 Administration (FDA) guidance concerning side rails as entrapment hazards, review of incident reports, policy review, review of suspected abuse investigation form, review of nursing schedules, time clock forms, review of a payroll payout form, review of nursing agency invoices, contract review, review of a job description, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to assure the provision of resources effectively and efficiently met the needs of each resident. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The findings included: 1. Review of the "Payroll Payout Form" for August 25, 2012 through September 20, 2012 documented the total of 32.04 hours the Administrator was paid for the 4 week period. Thirty two hours would not total to be even a week of coverage. 2. During an interview in the conference room on 9/13/12 at 10:30 AM the Vice President (VP) and the Administrator were asked who is in charge at this facility. The VP stated the [named management entity] communicates with her, not with the Administrator. The Administrator stated, "I am the licensed Administrator of record." 3. During an interview in the conference room on 9/17/12 at 4:28 PM, the Administrator stated, "We have no Board of Directors or Governing Body... I have not spoken with the new owner, don't have a number or address, have not informed him of the jeopardies. I don't consider this a normal situation... that is how I feel..."	N 401		

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N 401	Continued From page 4 4. The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails. The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer N424. 5. The facility failed to identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents. Resident #54 and Resident #82 developed avoidable in-house acquired pressure ulcers and Resident #54 and 74's pressure ulcers deteriorated. Refer to N691. 6. The facility failed to identify abuse; ensure allegations of abuse an injuries of unknown origin were reported immediately to the Administrator; allegations of abuse and injuries of unknown origin were thoroughly investigated; protect residents during the investigation and report an injury of an unknown origin and allegations of abuse to the state survey office for Residents #14, 47, 68, 81, 82, and 116. Refer to N1207.	N 401		

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N 401	Continued From page 5 7. The facility failed to notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or of unplanned significant weight loss for 4 of 38 (Residents #81, 23, 101 and 124) sampled residents. Refer to N669. 8. The facility failed provide a partial bath each time the bed or bed clothing has been wet for 1 of 38 (Residents #82) sampled residents. The facility staff knowingly left the resident wet with urine during the evening and night shift, which resulted in the resident developing new avoidable stage II pressure ulcers (two). Refer to N692. 9. The facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents. Refer to N780. 10. The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician for 7 of 38 (Residents #81, 23, 28, 43, 84, 104, and 124) sampled residents. Refer to N689. 11. The facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), vision and/or falls for 12 of 38 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84,	N 401		

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N 401	Continued From page 6 104, 118 and 124) sampled residents. Refer N682. 12. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. Refer to N658 and N666. 13. The facility failed to ensure there was a Registered Nurse (RN) on duty to supervise and evaluate the nursing care for each resident. Refer to N681. 14. The facility failed to employ a Registered Dietitian (RD) and ensure an RD assessed and implemented interventions that addressed nutritionally compromised residents with unplanned significant weight loss for 2 of 38 (Residents #101 and 124) sampled residents. Refer to N751. 15. The facility failed to ensure the physician was promptly notified of toxic and critical laboratory tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents. Refer to N689 and N669. 16. The facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the 97 residents residing in the facility. Refer N616.	N 401		

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N 401	Continued From page 7 17. The facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units. Refer to N645. 18. The facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. Refer to N627.	N 401		
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on review of the Federal Drug Administration (FDA) guidance concerning side rails as entrapment hazards, review of incident reports, policy review, medical record review, observation and interview, it was determined the facility failed to ensure that safety measures were implemented to prevent entrapment hazards	N 424		

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N 424	Continued From page 8 associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails. The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The ability of residents to enter unoccupied areas of the building that are not staffed and have access to the outside, via elevators, stairs and doors could lead to elopement in a high crime area, with access to a major highway less than (<) 500 yards from the facility and a functioning railroad yard with multiple train tracks < than 200 yards from the facility; falls with no ability to call for help and the capability of anyone entering the building through non secured doors. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The findings included: A. SIDE RAILS 1. Review of the FDA Safety Alert: Entrapment Hazards with Side Rails alert notice dated August 23, 1995 documented, "...This Safety Alert concerns entrapment hazards associated with the	N 424		

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N 424	Continued From page 9 use of ...side rails ...All reported entrapments occurred in one of the following ways ...1. through the bars of an individual side rail; 2. through the space between split side rails; 3. between the side rail and mattress; or 4. between the headboard or footboard, side rail, and mattress... FDA recommends the following actions to prevent deaths and injuries from entrapment in... side rails: Inspect all ...bed frames, bed side rails, and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body... Be alert to replace mattresses and bed side rails with dimensions different than the original equipment supplied or specified by the bed frame manufacturer... Not all bed side rails, mattresses, and bed frames are interchangeable... Additional safety measures should be considered for patients identified as high risk for entrapment. Such patients include those with altered mental status (organic or medication related) or general restlessness..." Review of the "Guidance for Industry and FDA Staff" guidelines dated March 10, 2006 documented, "...Bed System Dimensional and Assessment Guidance to Reduce Entrapment... evaluating the dimensional limits of the gaps in ...beds is one component of an overall assessment and mitigation strategy... most vulnerable to entrapment are elderly patients... especially those who are frail, confused... incontinent, experience pain or who get out of bed and walk unsafely without assistance... one component of a bed safety program includes a comprehensive plan for patient assessment... FDA recommends... a risk benefit analysis to	N 424		

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N 424	<p>Continued From page 10</p> <p>reduce entrapment... FDA using a head breadth dimension 4 ¾ inches [""] as the basis for its dimensional recommendations... FDA recommends space enough to prevent dimensional neck entrapment... head entrapment under the rail less than 4 ¾ inches... in some positions the potential for entrapment exist when the deck is articulated... movement of the bed deck is known as articulation... we recommend that patient assessment procedures be used to assess the risk entrapment when clinical care is provided..."</p> <p>Review of the facility's side rails policy documented, "...Assess siderail fit on the bed prior to use to determine any potential risks associated with gaps between the rails and the mattress of the bed. Also assess size of resident in proportion to siderail openings..."</p> <p>a. Medical record review for Resident #6 documented an admission date of 5/15/2000 with diagnoses of Paralysis Agitans, Hypertension, Adult Failure to Thrive, Osteoarthritis, Osteoporosis, Percutaneous Endoscopy Gastrostomy, History of Cerebrovascular Accident, Depressive Disorder, Neurogenic Bladder, and Osteopenia.</p> <p>Observations in Resident #6's room on 9/11/12 at 3:24 PM, revealed Resident #6 lying in bed with full side rails up on both sides of the bed. The resident is very small and thin, eyes open, no speech, actively moving around in bed. The side rails measured 5 1/4 inches from top rail to middle and 5 1/2 inches from middle rail to the bed frame. The mattress does not fit the bed, leaving a 3 inch gap between mattress and siderail and a 6 inch space between the mattress and the footboard. This resident could freely</p>	N 424			

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N 424	<p>Continued From page 11</p> <p>move around in the bed and was at risk for entrapment between the top and middle rail and between the middle rail and the bottom rail.</p> <p>b. Medical record review for Resident #13 documented an admission date of 11/21/09 with diagnoses of Mental Retardation, Seizure Disorder, Depression, Anemia, Heart Failure, and Diabetes Mellitus. Review of the quarterly minimum data set (MDS) dated 7/5/12 documented in Section C for Cognitive Patterns, Resident #13's Brief Interview for Mental Status (BIMS) score was "7" indicating severe impairment in decision making. The MDS documented the resident's height was 62 inches and weight was 121 pounds.</p> <p>Observations of the side rails on Resident #13's bed revealed the space from the middle rail to bottom rail was 5 1/2". The space from the mattress to the rail on both sides of the bed measured 5 1/2". A wedge was placed between the mattress and the siderail in the middle section of the bed on the resident's right side. This resident could freely move around in the bed and was at risk for entrapment between the middle rail and the bottom rail.</p> <p>Observations in room 405 on 9/14/12 at 11:10 AM, revealed Resident #13 lying in the bed with side rails up on both sides of the bed.</p> <p>During an interview in the administrative hall on 9/20/12 at 10:10 AM, Nurse #4 was asked what was the facility's policy for assessing and reassessing the use of side rails. Nurse #4 stated, "On admission and then I believe it is supposed to be done quarterly. I'm not really sure. I'll see if we have a policy."</p>	N 424		

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N 424	<p>Continued From page 12</p> <p>c. Medical record record for Resident #84 documented an admission date of 2/13/12 with diagnoses of Dementia, Anxiety, Depression, Hypertension, and Anemia. Review of the quarterly MDS dated 7/12/12 documented in Section C for Cognitive Patterns, Resident #84 was coded a "2" indicating moderately impaired and poor decision making. The MDS documented the resident's height was 62 inches and weight was 79 pounds.</p> <p>Observations of the siderails on Resident #84's bed on 9/18/12 at 11:05 AM, revealed the space from the top rail to the middle rail was 5 1/4" and the middle rail to the bottom rail was 5 1/2". This resident could freely move around in the bed and was at risk for entrapment between the top rail and the middle rail and between the middle rail and the bottom rail.</p> <p>During an interview on 1st McRee hallway on 9/18/12 at 11:05 AM, certified nursing assistant (CNA) #13 was asked if Resident #84 attempts to get out of the bed on her own. CNA #13 stated, "Yes, she has before. She tries to get out of the bed at the end of the rail. I have to straighten her up in bed and move her from the rail. She will move over to the side of the bed."</p> <p>d. Medical record review for Resident #122 documented an admission date of 9/1/11 with diagnoses of Schizophrenia, Traumatic Brain Injury, Hypertension, and renal Insufficiency. Review of the annual MDS dated 8/9/12 documented in Section C for Cognitive Patterns, Resident #122's BIMS score was "3" indicating severe impairment in decision making. The MDS documented the resident's height was 62 inches and the weight was 121 pounds.</p>	N 424			

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N 424	<p>Continued From page 13</p> <p>Observations in Resident #122's room on 9/17/12 at 3:23 PM, revealed the resident lying in bed with the head of bed up and 3/4 side rails up on both sides of bed. The resident was confused and moving about in bed. The siderails on Resident #122's bed space from the middle rail to bottom rail was 5 1/2". This resident could freely move around in the bed and was at risk for entrapment between the middle rail and the bottom rail.</p> <p>During an interview in Resident #122's room on 9/17/12 at 3:23 PM, CNA #3 was asked if the resident moved around in the bed. CNA #3 stated, "Yes ma'am. He moves around a lot, all over the bed. Sometimes he gets his legs off the sides of the bed."</p> <p>B. FALLS</p> <p>1. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity.</p> <p>Review of an incident report revealed the following: a. 8/31/12 - "...resident noted to have fallen in hallway out of w/c [wheelchair] onto floor..." b. 9/3/12 - "...resident found on floor in room... resident stated he fell while getting out of w/c because he felt weak... Abrasion noted to R [right] side of lip..." c. 9/4/12 - "...resident found on floor in an upright position... in dayroom bathroom... he stated "I was getting off commode trying to sit in wheelchair and lost my balance... c/o [complained of] headache... swollen red area noted on R side of face... treatment: Emergency Dept. [Department]..." d. 9/5/12 - "...Resident was found outside of building... laying flat on back with</p>	N 424		

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N 424	<p>Continued From page 14</p> <p>a swollen lip and abrasions to R side of face, knee and shoulder... treatment: Emergency Dept..."</p> <p>Review of nurses notes documented the following: a. 9/10/12 at 11:30 AM - "...Received back to facility from [named hospital]..." 9/10/12 at 5:30 PM - "...Resident found on floor in activities bathroom..."</p> <p>Review of care plan dated 5/1/12 had no updates with new interventions documented following the falls that occurred on 8/31/12, 9/3/12, 9/4/12, 9/5/12, or 9/10/12 after the hospital return.</p> <p>The Director of Nursing and Minimum Data Set nurse were not available for interview during the last four days of the survey. There was no one at the facility to interview to provide confirmation of the falls.</p> <p>The facility's failure to adequately assess the resident and implement new interventions after each of the five falls. This fining resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of Resident #23.</p> <p>C. ENVIRONMENT ACCIDENT HAZARDS</p> <p>1. Building Layout The facility is divided into 3 buildings: Magoffin, McRee, and Cleveland.</p> <p>Magoffin has three floors:</p> <p>a. 1st Magoffin houses residents.</p> <p>b. 2nd Magoffin houses residents.</p> <p>c. 3rd Magoffin was closed with no residents residing on the unit. This area was dark with no lighting available; the walls had visible open areas to the outside; with the presence of trash, cigarette butts and roaches located in several</p>	N 424		

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N 424	<p>Continued From page 15</p> <p>areas of this unit. An open emergency cart (crash cart) was present that contained needles, syringes and intravenous fluids that was accessible to anyone that entered this floor.</p> <p>McRee had two floors: a. 1st McRee houses residents. b. 2nd McRee was closed with no residents residing in this area, however residents have to enter this area to access the residents' bank and the Social Worker's office located on the 2nd Cleveland unit. This unit was dark with electricity turned off in the fuse box. There was trash and insects located in this area.</p> <p>Cleveland has two floors: a. 1st is where the Administrative offices are with no residents housed in this area. b. 2nd Cleveland has no residents housed but contains the residents' bank and the Social Worker's office which the residents have access at all times. c. 2nd Magoffin and 2nd Cleveland are connected via the 2nd McRee unit that is closed with no residents or staff housed here.</p> <p>There is an elevator in the middle of the Magoffin building that has capability of going to the basement and 3rd Magoffin.</p> <p>During an interview in the conference room on 9/12/12 at 4:47 PM, the Financial Services Manager (FSM) was asked if the residents used the closed 2nd McRee floor. The FSM stated, "...They [residents] take the elevator [1st Magoffin to 2nd Magoffin through the fire doors to 2nd McRee] and follow the hall around [to 2nd Cleveland where the resident personal funds office/business office and the social worker's office are located]. It winds and turns to the</p>	N 424		

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N 424	Continued From page 16 business office... A lot come on their own if they are alert. The majority come on there own. Sometimes I have to help them open the door. Some do wander down [to the closed 2nd McRee living area and into 2nd Cleveland]. An extremely tall white man came down one day last week. He didn't know where he was... She [Resident #19] comes up to visit, to sing, to use the bathroom... The lights are off and the doors are closed. The FSM was asked if after staff left for the day if the 2nd floor through 2nd McRee and into 2nd Cleveland would be dark. The FSM stated, "Yes ma'am. After the social worker leaves the lights are out. It would be completely dark..." The FSM was asked, if it was after hours and a resident came up through 2nd McRee to 2nd Cleveland, would anyone know or be there. The FSM stated, "No ma'am. No one would be there." Observations and interview on 2nd McRee on 9/12/12 at 12:00 PM, revealed Resident #19 (who was coded as moderately impaired with poor decision making, required cues and supervision according to her most recent cognitive assessment) alone on the closed dark area of 2nd McRee. Resident #19 was asked how she came to be in room 508 on 2nd McRee. Resident #19 stated, "I came up here to pee. I not scared..." Resident #19 was asked by the surveyor how she got up there. Resident #19 stated, "I'll show you." Resident #19 proceeded to lead the surveyors through the dark hallway of 2nd McRee (a closed unit) that lead through the open fire doors to 2nd Magoffin, to the elevator and down to her room on 1st Magoffin. The Social Worker's office and the business office/bank are located on the dark closed unit of 2nd McRee where residents have to go to obtain their money.	N 424		

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N 424	<p>Continued From page 17</p> <p>Observations of 2nd McRee (closed unit) on 9/12/12 revealed the following:</p> <p>a. 5:35 PM, the light switches did not turn the lights on.</p> <p>b. 5:40 PM, in room 508 in the top drawer of the bedside table, 4 disposable razors, a smoking pipe with a tobacco like substance in it, and dead roaches too numerous to count were found.</p> <p>c. 5:45 PM, the exit door, at the end of the hall near room 507, opened to a metal set of stairs that led to the ground. The exit door could be pushed open. There was a key pad on the wall beside the door that was not functional. The surveyor was able to step down to the metal stairs, allow the door to close and re-enter the building without the door locking or an alarm sounding.</p> <p>d. 5:47 PM, the exit door near room 501 led to an emergency stairwell. There were 2 key pads on the wall beside the door that were not functional. The surveyor was able to go outside, but not able to re-enter the building, until another surveyor opened the door.</p> <p>e. 5:50 PM, the exit door near room 514 opened to the outside of the building and made a "chirp" sound.</p> <p>f. 5:54, PM the exit door near room 518 opened to the outside. The surveyor was able to go outside, allow the door to close, and re-enter the building without the door locking or an alarm sounding. There was a key pad on the wall that was not functional.</p> <p>g. 5:57 PM, survey team left 2nd McRee. The staff had not responded to the "chirp" sound.</p> <p>Observations of 3rd Magoffin (closed unit) on 9/12/12 revealed the following:</p> <p>a. 6:00 PM, room 317 the window was open and had no screen. A cigarette butt was laying on the floor.</p>	N 424		

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N 424	<p>Continued From page 18</p> <p>b. 6:01 PM, room 316 there was an open space on the exterior wall where the air unit had been removed that left the space open to the outside.</p> <p>c. 6:02 PM, room 320 a cigarette butt was in the sink.</p> <p>d. 6:03 PM, room 325 a cigarette butt was laying on the floor.</p> <p>e. 6:04 PM, the clean linen room had 2 cigarette butts on the floor.</p> <p>f. 6:05 PM, the nurses station had an open space in the exterior wall where the air unit had been removed that left the space open to the outside.</p> <p>g. 6:05 PM, near the nurses station there was an unlocked emergency crash cart that contained needles and syringes, 3 bags of intravenous fluids and 8 needles attached to syringes.</p> <p>h. 6:05 PM, the elevator came to 3rd Magoffin with a resident, the receptionist, a certified nursing assistant and the Vice President.</p> <p>i. 6:10 PM, the surveyor rode the elevator down to the 1st floor, back up to 3rd floor and down again. The 3rd floor was accessible to anyone who got on the elevator and pushed the 3rd floor elevator button.</p> <p>During an interview in the hall of 1st Magoffin on 9/12/12 at 3:40 PM, the Assistant Activity Director (AAD) was asked if Resident #19 goes to the other floor. The AAD stated, "I've never seen her go up to the other floor, unless she is going to the bank to get a quarter. She does that every day." The AAD was asked if the bank was located in the part of the building that is closed. The AAD stated, "Yes, through the double doors down the blue carpet and around."</p> <p>During an interview in the conference room on 9/13/12 at 10:30 AM, the Vice President (VP) was asked on what date the 2nd Floor of McRee had been closed to residents. The VP stated the 2nd</p>	N 424		

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N 424	Continued From page 19 McRee unit was closed and the last resident was moved out on the evening shift of 7/27/12. 2. Observations of non-functioning smoke detectors in rooms as followed: a. Resident #82's room on 9/10/12 at 11:15 AM, smoke detector beeping. b. Resident #14's room on 9/10/12 at 5:20 PM and 9/11/12 at 8:45 AM, smoke detector beeping. c. Resident #60's room on 9/10/12 at 10:40 AM and 6:00 PM, on 9/11/12 at 8:55 AM and on 9/12/12 at 3:20 PM, smoke detector beeping. d. Resident #70's room on 9/12/12 at 10:45 AM, smoke detector beeping.	N 424		
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, contract review, pharmacy review, review of incident reports, review of the Social Worker's job description, review of nursing schedules, review of the time clock forms, review of nursing agency invoices, review of a payroll payout form, medical record review, observation and interview, it was determined the facility's performance improvement program (quality assessment (QA) and assurance committee) failed to identify issues, develop and implement appropriate plans of action to correct identified deficiencies. These	N 601		

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N 601	<p>Continued From page 20</p> <p>findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility.</p> <p>The findings included:</p> <ol style="list-style-type: none"> During an interview in the Administrator's office on 9/20/12 at 1:40 PM the Administrator stated, "The QA committee meeting is conducted by the medical director and all department heads participate... the meetings are conducted monthly... issues recently addressed by the QA committee were falls, weights... and behaviors... once identified interventions are put in place, there is a monitoring process..." <p>The interventions put in place were not effective as evidenced by:</p> <ol style="list-style-type: none"> The facility failed to implement interventions after fall to prevent further falls. Refer to N424. The facility failed to ensure psychiatric services were provided to assess and provide the necessary care and services to address the behaviors of the resident displaying mental difficulty. Refer to N780. The facility failed to ensure nutritional status was assessed and develop approaches to prevent significant weight loss. Refer N751. <ol style="list-style-type: none"> The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 4 residents. The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) 	N 601		

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N 601	Continued From page 21 sampled residents reviewed with falls. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer N424. 3. The facility failed to identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents with pressure ulcers. Resident #54, 74, and #82 developed avoidable in-house acquired pressure ulcers and Resident #54 and 74's pressure ulcers deteriorated. Refer to N691. 4. The facility failed to identify abuse; ensure allegations of abuse an injuries of unknown origin were reported immediately to the Administrator; allegations of abuse and injuries of unknown origin were thoroughly investigated; protect residents during the investigation and report an injury of an unknown origin and allegations of abuse to the state survey office for Residents #14, 47, 68, 81, 82, and 116. Refer to N1207. 5. The facility failed to notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained or of unplanned significant weight loss for Residents #23, 81 and 101 and 124. Refer to N669. 6. The facility failed to provide a partial bath	N 601		

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N 601	Continued From page 22 each time the bed or bed clothing has been wet for 1 of 38 (Residents #82) sampled residents that staff knowingly left wet with urine during the evening and night shift, which resulted in the development of two new avoidable pressure ulcers. Refer to N692. 7. The facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents. Refer to N780. 8. The facility failed to ensure the building was kept in good repair, clean, sanitary and safe at all times as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink, odors, missing knob from water faucet, hole in wall, dirty baseboard, missing tile and a dirty, unkept shower room, and the presence of gnats, flies, spiders and roaches on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units resident living areas and on 2 of 3 (2nd McRee and Cleveland building) areas currently unoccupied by residents. Refer to N645. 9. The facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. Refer to N627. 10. The facility failed to provide the necessary	N 601		

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N 601	Continued From page 23 care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician for 7 of 31 (Residents #81, 23, 28, 43, 84, 104, and 124) sampled residents. Refer to N689. 11. The facility failed to ensure care plan interventions were followed for laboratory, dental care, pressure ulcer care, nutritional status, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), vision care and/or falls for 12 of 38 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents. Refer to N682. 12. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. Refer to N658. 13. The facility failed to ensure there was a Registered Nurse (RN) on duty to supervise and evaluate the nursing care for each resident. Refer to N681. 14. The facility failed to employ a Registered Dietitian (RD) and ensure an RD assessed and implemented interventions that addressed nutritionally compromised residents with unplanned significant weight loss for 2 of 38 (Residents #101 and 124) sampled residents. Refer to N751.	N 601		

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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N 601	Continued From page 24 15. The facility failed to ensure the physician was promptly notified of toxic and critical laboratory tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents. Refer to N689 and N669. 16. The facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice. Refer N616.	N 601		
N 616	1200-8-6-.06(2)(d)4. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 4. Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements; This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on contract review, policy review, review of a payroll payout form, review of the facility's working nursing schedule, review of nursing agency invoices, contract review, review of a job description for the Social Worker, time clock forms, pharmacy review, medical record review, observation, and interview, it was determined the	N 616		

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N 616	<p>Continued From page 25</p> <p>facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the 97 residents residing in the facility. The failure of the facility to ensure the Medical Director assisted with addressing clinical concerns, and provided guidance regarding resident care resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility.</p> <p>The findings included:</p> <p>Review of the Medical Director's contract dated 6/27/12 documented, "...6. Develop, recommend and implement appropriate clinical practices and medical care polices that help to ensure that each resident's medical regime is a [an] integral part of the interdisciplinary plan of care. 7. Review accident and/or incident reports to identify potential health and safety hazards at [name of facility] and recommend and/or consult with the Administrator and /or Director of Nursing in helping resolve those issues..."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Medical Director stated, "I am not aware of jeopardy's, was surprised you all are still here. I am the medical director here, started a couple of months ago, I talk with the Administrator every time I visit... I don't remember if I got a job description, I did get a contract with lots of papers, papers are papers, I don't remember a job description. I am part of the QA [quality assurance] committee here, other facilities I have they discuss wounds, incidents,</p>	N 616		

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N 616	Continued From page 26 falls, weight loss and other things. I am not interested in such as maintenance. I do not have an office, my office is my briefcase and car, my practice is several nursing homes, assisted livings, and I make some house calls." During an interview in the Administrator's Office on 9/20/12 at 1:40 PM the Administrator stated, "The QA committee meeting is conducted by the Medical Director and all department heads participate... the meetings are conducted monthly... issues recently addressed by the QA committee were falls, weights, infections, and behaviors... once identified interventions are put in place, there is a monitoring process..." The facility failed to ensure the Medical Director provided oversight in addressing clinical concerns, assisted with providing guidance for the medical care of the 97 residents residing in the facility. Refer to N424, N601, N658, N669, N689, N691, N692, N751, N780 and N1207.	N 616		
N 627	1200-8-6-.06(3)(b)6. Basic Services (3) Infection Control. 6. Individual wash cloths, towels and bed linens must be provided for each resident. Linen shall not be interchanged from resident to resident until it has been properly laundered. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on observations and interview, it was determined the facility failed to ensure wash	N 627		

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N 627	<p>Continued From page 27</p> <p>cloths, towels and bed linens were clean and in good condition for the residents residing in the facility on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations during the initial tour of 1st McRee on 9/10/12 beginning at 9:45 AM, revealed the following: <ol style="list-style-type: none"> a. Room 402, sheets thin. b. Room 403, torn sheet on bed. c. Room 406, pillowcase dingy. d. Room 407, pillow brown in color with cracks noted in pillow no pillowcase. e. Room 410, pillowcase dirty with stains. f. Room 411-2 bedspread with four yellowish-brownish stains. g. Room 102, pillowcase was dingy. h. Room 110, linens thin and dingy. i. Linen cart with a threadbare cover. j. Linen room with 10 dingy flat sheets, 3 dingy fitted sheets, 14 dingy towels and 7 thin gowns. <p>Observations of the linen room on 1st McRee on 9/11/12 at 8:30 AM, revealed the following:</p> <ol style="list-style-type: none"> a. 20 fitted sheets, thin and dingy. b. 4 hand towels. c. 5 flat sheets, thin and dingy. d. 7 dingy rough thin towels. e. 4 threadbare gowns. f. 17 blue pads. <p>There were no pillowcases in the linen room. There were 29 residents residing on 1st McRee.</p> <p>During an interview in the linen room on 1st McRee on 9/11/12 at 8:30 AM, certified nursing</p>	N 627		

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N 627	<p>Continued From page 28</p> <p>assistant (CNA) #9 was asked about linen supply. CNA #9 stated, "This is all [linens] I have for the day."</p> <p>During an interview on 1st McRee hall on 9/12/12 at 6:40 PM, CNA #12 was asked if there were any pillowcases on the cart. CNA #12 stated, "No Ma'am I don't." CNA #12 was then asked if she had trouble getting pillowcases. CNA #12 stated, "We get them sometimes."</p> <p>During an interview in the conference room on 9/13/12 at 11:15 AM, Nurse #10 was asked about linen supply. Nurse #10 stated, "On 11-7 shift there is no linen to make rounds, 3-11 shift using the 11-7 shift linen. Linens come in spurts and bits..."</p> <p>Observations on 1st McRee in room 401 on 9/14/12 at 10:24 AM, revealed CNA #3 washed the resident's face using a corner of a hand towel. CNA #3 stated, "We don't have wash cloths. We have these [towels]."</p> <p>During an interview in the hallway of 1st McRee on 9/17/12 at 10:00 AM, CNA #1 was asked if there were linens to restock the linen cart. CNA #1 stated, "I'm going to fill my cart with what we have." CNA #1 was asked if there were pillow cases. CNA #1 stated, "No, we don't have pillow cases."</p> <p>During an interview on 1st McRee outside room 404 on 9/17/12 at 10:00 AM, CNA #2 was asked if there were any pillowcases on the linen cart. CNA #2 stated, "No Ma'am."</p> <p>2. Observations during the initial tour of 1st Magoffin on 9/10/12 beginning at 9:45 AM, revealed three linen carts with no wash cloths or</p>	N 627		

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N 627	<p>Continued From page 29</p> <p>pillow cases.</p> <p>Observations of the clean linen cart on 1st Magoffin on 9/12/12 at 10:18 AM, revealed there were no pillowcases available for use.</p> <p>There were 37 residents residing on 1st Magoffin.</p> <p>3. Observations during the initial tour of 2nd Magoffin on 9/10/12 beginning at 10:00 AM, revealed the following:</p> <ul style="list-style-type: none"> a. Room 201, Resident #6's gown was threadbare and the bed linens were thin. Resident #6's skin could be seen through the threadbare gown. b. Room 204, numerous holes in the blanket. c. Room 206, fitted sheet thin, pillowcase dingy. d. Room 210, fitted sheet thin. e. Room 211, fitted sheet thin. f. Room 212, fitted sheet threadbare, no pillowcase on pillow. g. Room 215, fitted sheet thin. h. Room 221, thin fitted sheet, no pillowcase on pillow, top sheet thin with stains. i. Room 216, top sheet thin and blanket was wet with yellow stains. j. Room 217, no pillowcase on the pillow. <p>Observations in Resident #6's room (2nd Magoffin) on 9/10/12 at 11:15 AM, revealed Resident #6's gown was threadbare and the bed linens were thin. Resident #6's skin could be seen through the threadbare gown.</p> <p>Observations in Resident #6's room (2nd Magoffin) on 9/10/12 at 5:10 PM, Resident #6 had a very thin sheet over her.</p> <p>During a phone interview in the conference room on 9/12/12 at 8:50 AM, the family member of</p>	N 627		

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N 627	Continued From page 30 Resident #6 stated, "She [Resident #6]... had holes in her garments... sheets were threadbare..." Observations of the linen carts on 2nd Magoffin on 9/11/12 at 8:20 AM, revealed the following: Linen cart #1 had a. 9 blue pads. b. 6 hand towels. c. 4 bath towels, dingy and rough. d. 7 thin threadbare gowns. e. 4 thin flat sheets. f. 7 thin dingy fitted sheets. Linen cart #2 had a. 2 blue pads. b. 1 gown thin and threadbare. c. 5 towels, dingy and rough. d. 1 hand towel. e. 4 thin fitted sheets. f. 10 flat thin sheets and one sheet had a burnt hole. There were no pillowcases on Cart #1 or Cart #2. There were 31 residents residing on 2nd Magoffin.	N 627		
N 645	1200-8-6-.06(3)(k) Basic Services (3) Infection Control. (k) Space and facilities for housekeeping equipment and supply storage shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions	N 645		

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N 645	Continued From page 31 Based on policy review, observation and interview, it was determined the facility failed to the building was kept in good repair, clean, sanitary and safe at all times as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink, odors, missing knob from water faucet, hole in wall, dirty baseboard, missing tile and a dirty, unkept shower room, and the presence of gnats, flies, spiders and roaches on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units resident living areas and on 2 of 3 (2nd McRee and Cleveland building) areas currently unoccupied by residents. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The findings included: 1. Review of the facility's daily housekeeping policy documented, "...floors cleaned and mopped, basin cleaned, baseboards clean, vents cleaned and dust free, window sills clean and dust free, window/privacy curtains clean and in good repair, AC unit clean and dust free, all furniture dusted, paper products replenished, mirror cleaned, trash emptied and replace liners, bathroom cleaned, replenish soap. 2. Observations during the initial tour of 1st Magoffin on 9/10/12 beginning at 9:45 AM	N 645		

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N 645	Continued From page 32 revealed the following: a. Room 101 - Walls scuffed with black marks. b. Room 103 - Walls scuffed with paint off, bath pan in floor with dirty water. c. Room 104 - Soiled wheelchair with one missing arm. Trash on the floor in room. A wet hand towel hanging over the soap dispenser with multiple gnats crawling on it. d. Room 105 - Small metal bedside table with large amount of paint missing with rusty brownish areas showing. Walls scuffed with black marks with paint off, sheetrock corners scuffed with paint off. e. Room 107 - Lock on closet door with a screw in it with the lock hanging loosely. f. Room 108 - Heating unit in bathroom with exposed installation on pipe to floor under unit in front of commode and spider webs over the sink. g. Room 109 - Strong urine odors. h. Room 110 - Strong urine odors, AC leaking water on the floor, moldy appearance, two gnats flying around the bed, bedside commode with cracked plastic arms patched with tape and dirty tape hanging from broken arms. i. Room 111- No handle on the sink faucet. j. Room 112 - Broken floor tiles missing between the bed and window. k. Room 115 - Black scars on walls and outside corners of door frame. l. Room 117 - Walls with black scuffed marks. m. Room 118 - No bedside tables in the room. n. Room 119 - the light above the sink was not functioning and the light above the A bed was flickering on the bottom. The light above B bed was not working. o. Room 120 - Walls with peeling and chipped paint between the bed and window, missing call light reset button, broken commode with the top of the tank off sitting on the seat, handle for the commode missing, water to commode turned off,	N 645			

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N 645	<p>Continued From page 33</p> <p>toilet paper holder pulled out of the wall and hanging on grab bar, dust in vents and on the top of AC unit.</p> <p>p. Room 121 - Fan cover missing from in front of the fan, dresser drawer off the track and hanging down by the bed.</p> <p>q. Room 123 - Black scuff marks on walls.</p> <p>r. Strong urine odor on the hallway.</p> <p>s. Soiled utility room had a strong urine odor dirty gloves on the floor.</p> <p>t. Bathroom just past double doors with chipped paint on rear wall with moldy substance on wallboard, no toilet tissue dispenser, no handle on sink faucets and one handle in the sink.</p> <p>u. Dayroom had a dirty wet blanket on top of air conditioner unit, sticky brown substance noted on front of the unit, broken floor tiles, hanging wire to telephone jack dangling from the wall with exposed wires.</p> <p>v. Storage room with a dirty gerichair, bags of clothes on the floor and dirty gloves on the floor.</p> <p>w. Slanted dead end hall with broken floor tiles and damaged walls.</p> <p>Observations on 1st Magoffin on 9/10/12 beginning at 4:35 PM revealed the following:</p> <p>a. Gnats flying in the hallway.</p> <p>b. Room 119 - a roach crawling on the floor.</p> <p>Observations on 1st Magoffin on 9/12/12 beginning at 9:55 AM revealed the following:</p> <p>a. The elevator on 1st Magoffin to the basement on 9/12/12 at 9:55 AM, revealed a gnat flying in the elevator.</p> <p>b. In the hallway outside room 102 revealed a gnat flying.</p> <p>Observations in the hallway on 1st Magoffin on 9/14/12 at 10:40 AM, revealed the presence of gnats.</p>	N 645		

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N 645	Continued From page 34 Observations in room 116 on 1st Magoffin on 9/17/12 at 9:45 AM, revealed a roach crawling on the sink. Observations in the ice machine room on 1st Magoffin on 9/17/12 at 10:20 AM and 12:00 PM, revealed the sliding door on the ice machine was open. Ice was present in the bin and gnats were flying in the room. During an interview and observation in Resident #99's room on 9/10/12 at 4:40 PM, Resident #99 was asked if the facility was clean. Resident #99 stated, "There are cockroaches in my bed and everywhere. I'm bed bound." The surveyor looked down and saw a roach crawling on the floor next to Resident #99's bed. 3. Observations during initial tour 2nd Magoffin on 9/10/12 beginning at 10:00 AM revealed the following: a. Room 201 - Walls scuffed. b. Room 203 - Broken and missing tile under the bed. c. Room 204 - Feeding pump with light brown spillage noted on top of it and strong urine odors. d. Room 205 - Strong urine odors and a strong sour odor in the room and penetrating to the hallway. e. Room 206 - Privacy curtains off hooks, a roach in the room and scuffed walls. f. Room 207 - Privacy curtains with holes. g. Room 208 - Scuffed marks on the wall, faucet to sink will not turn on, missing privacy curtains from foot of bed #1, bed #2 with torn privacy curtain and personal fan with dust on the blades. h. Room 211 - Strong urine odor and sticky floor . i. Room 212 - Floor sticky. j. Room 214 - Strong urine odor in the bathroom,	N 645			

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N 645	Continued From page 35 toothbrush laying uncovered on the sink, a fly and gnat flying around in room. k. Room 215 - Strong urine odor in room and bathroom room, privacy curtains off the hooks, faucet to the sink will not turn on/off (knobs will turn all the way around), a blanket on the floor near the sink and personal fan with dust on the blades. l. Room 216 - Loose baseboards in bathroom, sink dripping and will not turn off and light over bed will not turn on or off. m. Room 217 - Brown dried stains on the privacy curtains. n. Room 219 - Strong urine odor in the room and bathroom, peeling baseboards in the bathroom, privacy curtains off the hooks, brown color stains on the curtains and scuffed walls. o. Room 220 - Seat of chair cracked with foam exposed, privacy curtains off the hook and urinal containing yellow liquid sitting on the floor. p. Room 221 - Strong urine odor in the bathroom with a sticky floor. q. In the hallway - the presence of flies. r. The supply room - the presence of a large dead roach. s. The bathroom of room 205 - a live roach on the floor. t. Room 212 - the presence of a fly. u. The nurses' station - revealed a flying insect. v. Strong urine odor on the hallway. w. Room labeled "Authorized personnel only" was unlocked, with a laundry rack with personal clothing on hangers and on the floor and a gerichair with a broken arm and torn seat. x. Soiled linen room with a hopper with water running continuously, unable to turn off and a foul smelling odor in the room. y. Hydro room #1 tub with rust in the drain and an oily substance on the floor at the base of the tub. z. Hydro room #2 had a brown oily substance at	N 645		

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N 645	<p>Continued From page 36</p> <p>the base of the lift.</p> <p>Observations in the hall on 2nd Magoffin, outside rooms 202 and 206 on 9/12/12 at 10:41 AM and 3:40 PM and on 9/17/12 at 10:41 AM, revealed a strong smell of urine and body odors.</p> <p>Observations at the 2nd Magoffin nurses station revealed the following:</p> <ul style="list-style-type: none"> a. on 9/11/12 at 8:00 AM and 10:30 AM, revealed a flying insect. b. 9/12/12 at 10:06 AM - a gnat landed on the surveyor's computer screen. c. 9/12/12 at 5:00 PM - revealed a roach crawling down the counter. d. 9/17/12 at 3:20 PM - revealed a fly buzzing around. e. 9/20/12 at 10:30 AM - revealed gnats flying around the surveyor's face. <p>Observations in the 2nd Magoffin shower room on 9/17/12 at 12:10 PM, revealed dirty buildup around the edge of the tile floor, the shower door sticking badly and very difficult to open, the inside surface of the wooden paneling on the door splitting leaving the bottom of the door with jagged edges and small pieces of chipped off wood on the shower room floor. Observations in 2nd Magoffin shower room on 9/20/12 at 8:25 AM, revealed a live roach on the floor.</p> <p>Observations in 2nd Magoffin hydrotherapy room on 9/20/12 at 8:26 AM, revealed a dead roach in the whirlpool tub chair.</p> <p>During an interview on 2nd Magoffin on 9/14/12 at 10:15 AM, the Vice-President and Maintenance Supervisor verified the presence of odors in room 205 and of urine odors on the 2nd Magoffin hallway.</p>	N 645		

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N 645	Continued From page 37 During an interview in the 2nd Magoffin shower room on 9/20/12 at 8:25 AM, Nurse #8 confirmed the presence of roaches in both the shower room and hydrotherapy room. 4. Observations during the initial tour of 1st McRee on 9/10/12 beginning at 9:45 AM, revealed the following: a. Room 401 - Wheelchair with dirty residue buildup on the wheels and torn seat. b. Room 403 - Mattress on the bed had a large brown stained covering the middle section of the mattress, three gnats were crawling on the mattress and swarming around an area of black/clumped dried substance in the fold of the mattress covering, foul smelling odor from the mattress and the mattress entire middle section was sunken in. c. Room 406 - Room was cluttered with a strong urine odor. d. Room 408 - Bed #1's pillow had stuffing hanging out, strong urine odor coming from the closet, bed #2 had a cracked pillow cover, dirty over-bed table, floor dirty, not swept or moped. e. Room 409 - Trash on the floor. f. Room 410 - Window open with dust on window seal, personal fan with dust on blades, sink with no hot water, armless chair with smell of urine and chipped tile under the sink. g. Room 411 - Bed #2's flat sheet with brown circle in the middle, strong urine odor in the room, a large yellowish wet area on the floor at the head of the bed, over-bed table sticky and dirty with dried food, an uncovered syringe laying on the table, urinal with yellow liquid sitting on the over-bed table, ceiling tile pushed up in the ceiling over Bed #3 and wall covering pulled from the wall between the window and Bed 3. h. Room 414 - Strong urine odor in room and the	N 645		

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N 645	Continued From page 38 cover was torn away from the ceiling light. i. Room 415 - Over-bed table dirty and sticky. j. Room 417 - Strong urine odors in the room. k. Room 419 - Chair with missing vinyl on arms with stuffing exposed, faucet running in sink and will not shut off l. Room 421 - Twelve to 14 winged insects crawling on a wet brown stained towel in the sink, no mirror over the sink with a piece of cardboard over the area. m. Room 424 - Sink faucet dripping and wall scuffed with back marks. n. Strong urine odors on the hall. o. Soiled utility room had several bags of clothes and loose clothing items in a gray rolling hamper with strong urine odors. p. Missing handrail between room 116 and 118. q. Hydro room #1 sink with yellow stains. r. Hydro room #2 (next to room 415) had trash, paper towels and clothes hanging in the whirlpool and no doors on the commode stalls. s. Water fountain missing knob to turn faucet on. t. Hole in floor beside pipe next to ice machine, vent above door not covered, floor dirty, baseboard missing on wall facing doorway. u. Tile missing from wall against dirty utility door frame. v. Soiled utility room with hangers in the sink and on the floor, several bags of clothing items in a gray rolling basket with urine odor, hopper stained and a black bag hanging down in the hopper close to the water. w. Whirlpool room with chipped plastic chair, no curtains, missing wall tile with exposed moldy concrete, dirty toilet, sink stained, floor tiles stained and urine odors in the bathroom. x. Dirty hoyer lift with a torn sheet. y. Closet near room 409 with a loose door knob, floor dirty, dirty rags on shelf, dirty walker and two trays on the floor.	N 645		

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N 645	Continued From page 39 z. Clean linen room with a bag of trash on the floor, pillow on floor and a pillow on top of a bag of trash. Observations in room 406 on 1st McRee on 9/10/12 at 5:50 PM, revealed a fly in the room during the supper meal. Observations on 1st McRee on 9/11/12 beginning at 8:15 AM revealed the following: a. Room 415 - a spider crawling on the floor under the bed. b. A roach crawling on the wall beside the soiled utility room. d. A gnat flying around 1st McRee nurses' station. Observations in the hall on 1st McRee at the entrance to the unit from 1st Cleveland on 9/11/12 at 8:14 AM and 9/13/12 at 4:45 PM, revealed a strong urine odor. Observations on 1st McRee on 9/12/12 beginning at 8:50 AM revealed the following: a. Clean linen room - a roach crawling across the floor. b. Room 410 - revealed several flies in the room and a gnat flying in room around the sink. c. Room 414 on 9/12/12 at 3:20 PM Observations on 1st McRee on 9/13/12 beginning at 8:34 AM revealed the following: a. Women's restroom - a roach crawling on the floor. b. The hall outside room 423 - a fly buzzing around and landing on a resident's head. Observations in room 410 on 1st McRee on 9/14/12 at 7:45 AM, on 9/17/12 at 9:55 AM and at 10:00 AM, and on 9/18/12 at 7:45 AM, revealed several flies in the room and a gnat	N 645		

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N 645	<p>Continued From page 40</p> <p>flying in room around the sink.</p> <p>Observations on 1st McRee on 9/17/12 beginning at 10:00 AM, revealed the following:</p> <p>a. Room 414 - a gnat flying around the sink. b. Nurses' station - a gnat flying around.</p> <p>Observations and interview in Resident #14's room on 1st McRee on 9/18/12 at 3:40 PM, revealed Resident #14 had her pillow over the top of her head an over the left side of her face. A fly was noted to be flying around in the room.</p> <p>Observations in room 406 on 1st McRee on 9/19/12 at 8:00 AM, revealed the resident eating her breakfast with a gnat flying around her food.</p> <p>During an interview on 1st McRee on 9/12/12 at 7:40 AM, certified nursing assistant (CNA) #12 stated, "11-7 shift is suppose to deep clean, but they don't..." CNA #12 was asked if the wheelchair was clean she looked at the wheelchair and stated, "No it's dirty. It should have been cleaned."</p> <p>During an interview on 1st McRee on 9/14/12 at 10:15 AM, the Director of Nursing (DON) was asked if she ws aware of problems with gnats or roaches. The DON stated, "I knew we had a problem with roaches but not with gnats."</p> <p>During an interview in room 403 on 9/14/12 at 12:50 PM, the Director of Nursing (DON) was asked what the brown discoloration and dried substance on the covering of the mattress was. The DON stated, "I don't know. The mattress is old." The DON verified the mattress need replacing.</p> <p>During an interview in room 414 on 9/17/12 at</p>	N 645		

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N 645	Continued From page 41 10:00 AM and 11:10 the maintenance supervisor stated, "The odor is better than it was and he would get them to clean the room." During an interview in Resident #14's room on 9/18/12 at 3:40 PM, Resident #14 was asked, "Why do you have your pillow over your head and face?" Resident #14 stated, "...it's to keep the flies off my face... when I have a bowel movement the flies get bad..." 5. During an interview on 3rd Magoffin on 9/14/12 at 10:00 AM, the maintenance supervisor was asked how cleaning is done in the resident rooms to control odors and if the resident rooms are terminally cleaned. The maintenance supervisor stated, "They [nursing staff] watch that every day and tell me when rooms need cleaning..." The maintenance supervisor confirmed they do pull furniture out of the rooms and clean but do not take the residents clothes out of the closets to clean. The maintenance supervisor did not answer how often terminal cleaning was done. 6. Observations on 2nd McRee were as follows: a. Room 508 on 9/12/12 at 5:40 PM, revealed dead roaches in the bedside table drawer too numerous to count. 7. During an interview in the Social Worker's office in the Cleveland building on 9/18/12 at 11:30 AM, revealed a roach crawling up the side of the refrigerator.	N 645		
N 658	1200-8-6-.06(4)(a) Basic Services (4) Nursing Services. (a) Each home shall have a licensed practical	N 658		

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N 658	<p>Continued From page 42</p> <p>nurse or registered nurse on duty at all times and at least two (2) nursing personnel on duty each shift.</p> <p>This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions</p> <p>Based on review of nursing schedules, review of a payroll payout form, review of a time slip, review of nursing agency invoices, observations, and interviews, it was determined the facility failed to ensure there was a licensed practical nurse (LPN) or registered nurse (RN) on duty at all times on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. The facility failed to ensure there was sufficient nursing staff which resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility.</p> <p>The findings included.</p> <p>Review of the August 2012 licensed nursing schedule documented, 1 full-time RN and 2 part-time RNs. There was no RN coverage on 8/5/12.</p> <p>Review of the August 2012 nurses schedule for PN documented the following:</p> <p>a. 1st McRee 7-3 shift had no nurse coverage for 8/6, 8/13, 8/14, 8/15, 8/16, 8/20, 8/21 and 8/30/12.</p> <p>b. 1st McRee 3-11 shift had no nurse coverage for 8/4, 8/5, 8/8, 8/13, 8/18, 8/19 and 8/22/12.</p>	N 658		

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N 658	<p>Continued From page 43</p> <p>c. 1st McRee 11-7 shift had no nurse coverage for 8/18/12.</p> <p>d. 1st Magoffin 7-3 shift had no nurse coverage for 8/5, 8/18, 8/19 and 8/27/12.</p> <p>e. 1st Magoffin 3-11 shift had no nurse coverage for 8/3, 8/6, 8/17, 8/20, 8/25, 8/26 and 8/31/12.</p> <p>f. 2nd Magoffin 7-3 shift had no nurse coverage for 8/13, 8/21, and 8/22/12.</p> <p>g. 2nd Magoffin 3-11 shift had no nurse coverage for 8/2, 8/7, 8/11, 8/12, 8/16, 8/18, and 8/27/12.</p> <p>h. 2nd Magoffin 11-7 shift had no nurse coverage for 8/20/12.</p> <p>Review of the September 2012 licensed nursing schedule documented the following:</p> <p>a. 1st McRee 7-3 shift had no nurse coverage for 9/8/12, 9/9/12, 9/22/12, and 9/23/12.</p> <p>b. 1st McRee 3-11 shift had no nurse coverage for 9/1/12, 9/2/12, 9/10/12, 9/15/12, 9/16/12, 9/29/12 and 9/30/12.</p> <p>c. 1st Magoffin 7-3 shift had no nurse coverage for 9/8/12 and 9/9/12.</p> <p>d. 1st Magoffin 11-7 shift had no nurse coverage for 9/8/12, 9/9/12, 9/22/12, 9/23/12 and 9/24/12.</p> <p>The September 2012 nursing schedule documented no RN coverage for the facility on 9/1/12, 9/2/12, 9/8/12, 9/9/12, 9/15/12, 9/16/12, 9/22/12 and 9/23/12.</p> <p>Review of the "Payroll Hours Paid Out" for August 25, 2012 through September 20, 2012 documented a total of 86.39 hours for the Registered Nurse coverage for the 4 week period. The required coverage hours was this period of time 240 hours.</p> <p>The facility could not produce invoices to show RN or LPN coverage on the dates noted above for August or September 2012.</p>	N 658		

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N 658	<p>Continued From page 44</p> <p>Review of the nursing agency time slips given to the survey team by the Vice President on 9/14/12 documenting agency presence in the facility in August 2012 could not be verified by correlating payment invoices. The payroll invoices presented have the appearance of being altered.</p> <p>During an interview in the Financial Services Manager's (FSM) office on 9/14/12 at 11:30 AM, the FSM provided copies of nursing agency invoices and confirmed the last payment for an agency nurse was 5/20/12.</p> <p>Observations in the administrative hall beside the Director of Nursing's (DON) office on 9/14/12 at 4:00 PM, Nurse #6 was standing in the hall beside the DON's office attempting to give the Vice President the narcotic keys from 1st Magoffin as she was trying to leave the facility.</p> <p>Observations on 1st Magoffin on 9/14/12 at 4:05 PM, revealed no licensed nursing staff available on the unit.</p> <p>Observations on 2nd Magoffin on 9/14/12 at 4:10 PM, revealed no licensed nursing staff available on the unit.</p> <p>During a phone interview in the conference room on 9/12/12 at 8:50 AM, a family member for Resident #6 stated, "She [Resident #6] was dirty, not cared for, had holes in her garments, was soiled, the sheets were threadbare. I could not find a nurse at first, she eventually came around but did not know anything about the patient... How can she [nurse] effectively care for patient's if she doesn't know their history?"</p> <p>During an interview in the conference room on</p>	N 658		

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N 658	<p>Continued From page 45</p> <p>9/12/12 at 11:35 AM, the Vice President was asked about the RN and LPN coverage not being documented on the September schedule. The Vice President stated, "I didn't write it down, it is all up here [pointing to her head.]"</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 stated, "...There is no RN on the weekends..."</p> <p>During an interview in the conference room on 9/13/12 at 5:30 PM, the Administrator was asked about RN coverage. The Administrator stated, "To be honest I thought we had weekend RN coverage but [Named Vice President] is over that."</p> <p>During an interview in the administrative hall on 9/14/12 at 4:00 PM, Nurse #6 (nurse for 1st Magoffin unit) was asked about nurse coverage for her unit. Nurse #6 stated, "...I am trying to give them [keys] to someone and they won't take them..." Nurse #6 was then asked if she had someone to relieve her. Nurse #6 stated, "No ma'am..." Nurse #6 was then asked if she had been working today and who was scheduled to relieve her on the unit. Nurse #6 stated, "Yes... I don't know..."</p> <p>During an interview on the 2nd Magoffin hallway on 9/14/12 at 4:10 PM, Nurse #2 and Nurse #6 were asked, "Who is here to work the 3 to 11 shift? Nurse #6 stated, "...Just one... [named Nurse #17] on 1st McRee... He won't take the keys either..." Nurse #2 stated, "He [Nurse #17] won't take the keys..." He is the only licensed nurse here to work the 3 to 11 shift for the entire building when Nurse #2 and Nurse #6 left.</p> <p>During an interview in the 1st Magoffin hall on</p>	N 658		

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N 658	Continued From page 46 9/14/12 at 4:20 PM, Nurse #4 was asked who was scheduled to work the 3-11 shift as relief for the day shift nurses. Nurse #4 confirmed she doesn't know who is working the 3-11 shift. Nurse #4 stated, "...I can't take all these sets of keys and be responsible for 3 different areas... you need to ask [named the Vice President]..." During an interview at the 1st Magoffin nurses' station on 9/14/12 at 4:25 PM, Nurse #6 was asked if she had seen a Registered Nurse working the weekends. Nurse #6 stated, "No RN on the weekends... I haven't seen an RN working on the weekends since the wound nurse left..." During an interview on 1st Magoffin on 9/17/12 at 12:00, Nurse #9 was asked about the medications being given late. Nurse #9 stated, "...Today is my first day to work here... I was hired this weekend to work 11-7, but this morning [named Vice-President] called me to come in on day shift because they had nobody to work... I will be faster tomorrow..." During an interview in the conference room on 9/17/12 at 4:28 PM, the Vice President stated, "I've been doing staffing over 30 years. I use to be a certified nursing assistant (CNA), I was taught to go by census for staffing. No, we do not have a staffing grid. The census is 96 in house, there may be another lay off."	N 658		
N 666	1200-8-6-.06(4)(c)1.(v) Basic Services (4) Nursing Services. (c) The Director of Nursing shall have the following responsibilities: 1. Develop, maintain and periodically update:	N 666		

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N 666	Continued From page 47 (v) Mechanisms for monitoring quality of nursing care, including the periodic review of medical records. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, contract review, review of a job description, pharmacy review, review of nursing schedules, observations, and interviews, it was determined the Director of Nursing failed to monitor nursing care on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units. The facility failed to ensure there was sufficient nursing staff which resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The findings included. 1. The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails. The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the	N 666		

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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) COMPLETE DATE
N 666	Continued From page 48 closed dark units of 2nd McRee and 3rd Magoffin. The ability of residents to enter unoccupied areas of the building that are not staffed and have access to the outside, via elevators, stairs and doors could lead to elopement in a high crime area, with access to a major highway less than (<) 500 yards from the facility and a functioning railroad yard with multiple train tracks < than 200 yards from the facility; falls with no ability to call for help and the capability of anyone entering the building through non secured doors. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer to N424. 2. Resident #82's was not treated with dignity and respect when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers. Refer to N692. 3. Nurses failed to assess/accurately assess or provide treatments for pressure ulcers as ordered by the physician resulted conditions that are, or are likely to be detrimental to the health, safety or welfare for Residents #54, 74, and 82 developed avoidable in-house acquired pressure ulcers or the pressure ulcers deteriorated. Refer to N691. 4. The facility failed to recognize abuse; protect residents from verbal, mental and physical harm; and failed to follow the facility's abuse policy for reporting and investigating abuse. Refer to N1207. 5. The facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities	N 666		

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N 666	Continued From page 49 of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), oxygen (O2), vision and/or falls for 12 of 31 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents of the 38 residents included in the stage 2 review. Refer to N682. 6. The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician per the facility policy for 8 of 38 (Residents #23, 28, 43, 81, 82, 84, 104, and 124) sampled residents. Refer to N689. 7. The facility's performance improvement program (quality assessment (QA) and assurance committee) failed to identify issues, develop and implement appropriate plans of action to correct identified quality deficiencies. Refer to N601. 8. The facility failed to notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or weight loss for 4 of 38 (Residents #81, 23, 101 and 124) sampled residents. Refer to N669.	N 666		
N 669	1200-8-6-.06(4)(c)4. Basic Services (4) Nursing Services. (c) The Director of Nursing shall have the following responsibilities: 4. Notify the resident ' s physician when	N 669		

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N 669	Continued From page 50 medically indicated. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, medical record review, observation, and interview, it was determined the facility failed to notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or unplanned significant weight loss for 4 of 38 (Residents #81, 23, 101 and 124) sampled residents. The failure to notify the physician of toxic, critical, and abnormal laboratory results and obtaining a swallowing study placed Resident #23 and Resident #81 in conditions that are, or are likely to be detrimental to their health, safety or welfare. The findings included: 1. Review of the facility "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebral	N 669		

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N 669	Continued From page 51 Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation, and Peripheral Vascular Disease. A physician's order dated 7/16/12 documented "Warfarin 3 mg [milligrams] QD [every day] and Warfarin 10mg QHS [every night]." A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time and normalized international ratio]." The annual Minimum Data Set (MDS) dated 3/1/12 documented a Brief Interview Mental Status (BIMS) score of 7 (indicating the resident was moderately impaired in decision making skills), extensive total care with activity of daily living (ADL), no swallowing issues and not on anticoagulants. The quarterly MDS dated 8/16/12 documented a BIMS score of 5 (severely impaired), no swallowing issues and on daily anticoagulants. The care plan dated 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... 3. Obtain lab work as ordered by MD..." The July 2012 Medication Administration Record (MAR) documented Resident #81 received a total of Warfarin 13 mg daily from 7/16/12 to (-) 7/31/12. The August 2012 MAR documented Resident #81 received a total of Warfarin 13 mg daily from 8/1/12-8/31/12. The September 2012 MAR documented Resident #81 received Warfarin 13 mg daily from 9/1/12-9/13/12. During an interview in the conference room on 9/12/12 at 5:30 PM, the DON stated, "unable to find any PT/INR's since his return from the hospital [7/16/12]." The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.	N 669		

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N 669	<p>Continued From page 52</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I</p>	N 669		

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N 669	<p>Continued From page 53</p> <p>called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient..."</p> <p>Further review of nurse's note dated 9/14/12 at 10:30 AM documented, "Attempted to drawn a PT/INR. Resident refused stating "no" and jerking his arm back, pt. [patient] is scheduled for MBS [modified barium swallow]."</p> <p>During an interview at the 1st McRee nurses' station on 9/15/12 at 8:05 AM, Nurse #4 stated, "No I did not document that I notified [named physician] that [named Resident #81] refused to let me draw the lab."</p> <p>Further review of physician's orders dated 8/17/12 documented, "MBS and speech eval [evaluation] due to coughing while eating." There was no documentation of the MBS being done until 9/14/12 with a MBS study that documented the following recommendations: 1 NPO [nothing by mouth], 2. Dysphagia tx [treatment] for focus on laryngeal elevation and closure... 3. Repeat MBS in 2-3 weeks."</p> <p>Observations in Resident #81's room on 9/18/12 at 7:45 AM, revealed Resident #81 coughing while eating a pureed meal.</p>	N 669		

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N 669	<p>Continued From page 54</p> <p>During an interview in Resident #81's room on 9/18/12 at 7:45 AM, certified nursing assistant (CNA) #3 stated, "He [Resident #81] feeds himself. I come back and check on him and help if he needs it. I have noticed since he came back from the hospital [7/16/12] that he is coughing more with eating. I did tell the charge nurse about it."</p> <p>During an interview in the conference room on 9/18/12 at 6:00 PM, the Physician stated, "No, I was not aware that they did not get the swallow study until today [9/18/12]. He is now NPO, currently has IV's [intravenous] going for hydration, family is being contacted for a possible PEG [Percutaneous Endoscopy Gastrostomy Tube]. If they [family] refuse the PEG then hospice will be contacted. I am not sure how speech therapy works here, will check, if it works we can reverse the PEG."</p> <p>The facility failed to notify the physician that the monthly PT/INR labs were not obtained as ordered and once obtained failed to timely notify the physician of the abnormal high results. The facility failed to notify the physician that Resident #81 refused the repeat lab draw and that the MBS was not obtained as ordered.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 8/12/12 documented, "...Add Dilantin 100 mg in A.M.; continue 400 mg HS [hour of sleep]; check Dilantin levels in 2 wks [weeks]..." Review of a physician's order dated 9/2/12 documented,</p>	N 669		

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N 669	<p>Continued From page 55</p> <p>"...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..." The facility was unable to provide documentation of lab results for the ordered Dilantin levels, CBC, CMP or Urine C&S.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval of head due to fall on concrete..."</p> <p>Review of the hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the medical director was asked if the facility had notified him of the 28.8 Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level. The DON stated, "...we have been</p>	N 669		

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N 669	Continued From page 56 having problems with lab..." The facility failed to obtain, monitor and report Dilantin levels as ordered for Resident #23. 4. Medical Record review for Resident #101 documented an admission date of 4/1/10 with diagnoses of Diabetes Mellitus, Subarachnoid Hemorrhage, Hemiplegia Left-sided Weakness, Convulsions, Cerebrovascular Accident, Schizophrenia, Hypotension, Status Post Pneumonia and Dysphagia. Review of the weight tracking record dated 9/14/11 documented the resident's weight was 195 pounds (lbs). Six months later on 3/24/12 the resident's weight was documented as 175 lbs. The loss of 20 lbs in 6 months is an unplanned significant weight loss of 10.26 percent (%). The nurses notes, physician's orders and physician progress notes from 9/20/11 to 4/15/12 did not address the 10.26% weight loss. There is no documentation that the MD was notified of the unplanned significant weight loss. 5. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the weight tracking record dated 3/24/12 documented an admission weight of 200 lbs and a weight of 190 lbs on 4/20/12. The weight loss of 10 lbs in one month (5%) was an unplanned significant weight loss. The physician was not notified of the unplanned significant weight loss.	N 669			
N 681	1200-8-6-.06(4)(e) Basic Services (4) Nursing Services.	N 681			

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N 681	Continued From page 57 (e) A registered nurse must supervise and evaluate the nursing care for each resident. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on review of time slips, review nursing schedules and interview, it was determined the facility failed to ensure there was a Registered Nurse (RN) on duty to supervise and evaluate the nursing care for each resident. The failure to have an RN on duty resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of the 97 residents residing in the facility. The findings included: Review of the time slip for Nurse #15 (RN) documented the following: "DATE WORKED: 8/10/12 TIME STARTED 0700... TIME FINISHED: 1330... REGULAR HOURS: 6.50..." During an interview with in the conference room on 9/14/12 at 1:20 PM, the Director of Nursing (DON) was asked about RN coverage for the weekends. The DON stated, "I can't answer that for sure [Named Vice President] she handles that [referring to staffing and RN coverage]. During an interview in the conference room on 9/14/12 at 1:20 PM, the Vice-President was asked about RN coverage. The Vice-President stated, "We do have a weekend RN I will get the schedule..." The Vice-President was unable to provide documentation of weekend RN coverage for every weekend.	N 681		

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N 681	Continued From page 58 Review of the September 2012 nursing schedule revealed there was no RN scheduled to work on the following dates: 9/1/12, 9/2/12, 9/8/12, 9/9/12, 9/15/12, 9/16/12, 9/22/12 and 9/23/12. During an interview in the conference room on 9/12/12 at 11:35 AM, the Vice President was asked about the RN coverage not documented on the September schedule. The Vice President stated, "I didn't write it down, it is all up here [pointing to her head]."	N 681		
N 682	1200-8-6-.06(4)(f) Basic Services (4) Nursing Services. (f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or the resident ' s family or the resident ' s representative. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, review of incident reports, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to ensure care plan interventions were followed for obtaining laboratory test, dental care, pressure ulcer care, nutrition status, rehabilitation services, providing activities of daily living (ADL), accident prevention, restraint usage, unnecessary medications, range of motion (ROM), oxygen (O2) therapy, vision care and/or care for falls for 12 of 38 (Residents #21, 23, 28, 43, 63, 74, 81, 82, 84, 104, 118 and 124) sampled residents of the 38 residents included in	N 682		

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N 682	Continued From page 59 the stage 2 review. The facility failed to follow care plan interventions for fall preventive program; obtain, monitor and report abnormal laboratory levels as ordered, and perform wound care and ADL care as ordered placed residents in conditions that are, or are likely to be detrimental to the health, safety or welfare. The findings included: 1. Review of the facility's "Care Plan" policy documented, "Each resident will have an individualized Care Plan that is developed by the interdisciplinary team with input from the resident and family. All nursing personnel will refer to the Care Plan when providing care..." Review of the facility's "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab [laboratory] results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of the care plan dated 5/1/12 and reviewed 7/24/12 documented, "...FALL RISK R/T [related to] HISTORY AND UNSTEADY GAIT..."	N 682		

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N 682	<p>Continued From page 60</p> <p>Place resident on fall prevention program... Potential for Seizure Activity r/t Hx [history] of Seizure Disorder..."</p> <p>Review of incident reports documented the following:</p> <p>a. 8/31/12 - "...resident noted to have fallen in hallway out of w/c [wheelchair] onto floor..."</p> <p>b. 9/3/12 - "...resident found on floor in room... resident stated he fell while getting out of w/c because he felt weak... Abrasion noted to R [right] side of lip..."</p> <p>c. 9/4/12 - "...resident found on floor in an upright position... in dayroom bathroom... he stated "I was getting off commode trying to sit in wheelchair and lost my balance... c/o [complained of] headache... swollen red area noted on R side of face... treatment: Emergency Dept. [Department]..."</p> <p>d. 9/5/12 - "...Resident was found outside of building... laying flat on back with a swollen lip and abrasions to R side of face, knee and shoulder... treatment: Emergency Dept..."</p> <p>Review of nurses notes documented the following:</p> <p>a. 9/10/12 at 11:30 AM - "...Received back to facility from [named hospital]..."</p> <p>b. 9/10/12 at 5:30 PM - "...Resident found on floor in activities bathroom..."</p> <p>The facility was unable to provide documentation of Resident #23 being placed on a fall prevention program as care planned.</p> <p>Further review of the care plan dated 5/1/12 and reviewed 7/24/12 documented, "...Potential for Seizure Activity r/t Hx [history] of Seizure Disorder... Lab tests as ordered and notify MD of abnormal findings..."</p>	N 682		

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N 682	Continued From page 61 Review of a physician's order dated 9/2/12 documented, "...Dilantin level..." The facility was unable to provide documentation that the Dilantin level was done as ordered. Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval [evaluation] of head due to fall on concrete..." Review of a hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..." Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..." During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..." Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a high Dilantin level of 28.8. The therapeutic reference range was 10-20. During an interview in the administrative office on 9/14/12 at 11:00 AM, the attending physician / medical director was asked if the facility had notified him of the 28.8 Dilantin level done 8/30/12. The medical director stated, "...No, if I	N 682		

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N 682	<p>Continued From page 62</p> <p>had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level on 8/30/12. The DON stated, "...lab has been a big issue..."</p> <p>The facility failed to follow the care plan interventions to place the resident on the fall prevention program and obtain, monitor and report abnormal dilantin levels.</p> <p>3. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation, and Peripheral Vascular Disease. A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time/normalized international ratio]." The care plan dated on 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... Obtain lab work as ordered by MD... Notify physician of abnormal lab..."</p> <p>The facility was unable to provide documentation of PT/INR lab results as ordered.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the Director of Nursing (DON) stated, "Unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the</p>	N 682		

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N 682	<p>Continued From page 63</p> <p>results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened</p>	N 682		

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N 682	<p>Continued From page 64</p> <p>often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10 mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient...</p> <p>The facility failed to follow care plan interventions to obtain, monitor and report abnormal laboratory levels as ordered which resulted in Residents #23, 81, 82 and 74 in conditions that are, or are likely to be detrimental to the health, safety or welfare.</p> <p>Further review of the care plan dated on 3/30/11 and updated on 8/22/12 documented, "...Impaired skin integrity r/t left upper chest... Administer treatment as ordered by the physician..."</p> <p>A physician's order dated 9/9/12 documented, "Xenaderm to Left Clavicle and cover with a dry dressing every day." A review of the September 2012 Treatment Administration Record (TAR) revealed no documentation of a treatment being done on the left clavicle on 9/12/12 and from 9/14/12 through 9/17/12 as ordered.</p> <p>Observations in Resident #81's room on 9/12/12 at 10:00 AM, revealed Resident #81 with a dressing noted on the left upper chest area.</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area, revealing a wound approximately 3 inches long,</p>	N 682		

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N 682	<p>Continued From page 65</p> <p>1/2 inches wide with lower 1/2 of wound bed open red and raw, with the upper part of wound was pink.</p> <p>The facility failed to follow the care plan intervention to provide treatments as ordered.</p> <p>4. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact. Review of the care plan dated 6/20/12 documented, "...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Turn and reposition resident q [every] 2 hours and prn [as needed]... PERINEAL CARE EVERY 2 HOURS... SELF CARE DEFICIT IN ADL'S [activity of daily living] R/T [related to] IMPAIRED MOBILITY... BATH DAILY..."</p> <p>During an interview Resident #82's room 401 on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night [9/13/12]. I called [named Nurse #11] and I called the head nurse [Nurse</p>	N 682		

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N 682	<p>Continued From page 66</p> <p>#16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 AM] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>Resident #82 was left wet with urine during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and one on the right buttocks.</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh. There was nothing else. No other areas..."</p> <p>The facility failed to provide incontinent care for Resident #82 when staff knowingly left her wet with urine during the evening and night shift, which resulted in the resident developing two new avoidable in house acquired stage II pressure ulcers.</p> <p>Review of the nursing ADL's dated August 2012, had documentation that Resident #82 received a bed bath or shower on 8/2, 8/7, 8/11, 8/12, 8/17, and 8/21. Review of the nursing ADL's dated September 2012, had no documentation Resident</p>	N 682		

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N 682	<p>Continued From page 67</p> <p>#82 received a bed bath or shower on 9/8 or 9/12.</p> <p>Observations in Resident #82's room on 9/10/12 at 5:13 PM, revealed Resident #82's eyes had crust around them.</p> <p>The facility failed to follow the care plan interventions to bathe daily, turn and reposition q 2 hours and prn or provide perineal care every 2 hours which resulted in Resident #82 developing two new avoidable stage II pressure ulcers..</p> <p>5. Medical record review for Resident #74 documented an admission date of 2/18/10 with diagnoses of Alzheimer's Disease, Dysphagia, History of Cerebrovascular Accident, Lung Cancer with Metastasis, Hypertension, Gastro Esophageal Reflux Disease and Depression. Review of the Physician's orders dated 8/15/12 documented, "...clean Lt [left] hip area c [symbol for with] pat dry and cover c duoderm. [symbol for change] q [every] 3 days..." Review of the care plan dated 8/16/12 documented, "...Problem Impaired skin integrity... Approach Frequency... Weekly skin assessments per Charge Nurse... Administer treatment as ordered..."</p> <p>Review of the weekly pressure ulcer records documented the following:</p> <p>a. An onset date of 5/31/12 - Stage II left hip pressure sore 1 centimeter (c) cm by (x) 1 cm less than (<) 0.1 depth.</p> <p>b. 6/7/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>c. 6/13/12 - Stage II left hip pressure sore 1 cm x 0.8 cm <0.1 depth.</p> <p>The facility was unable to provide documentation of weekly skin assessments from 6/13/12 until 8/20/12.</p>	N 682		

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N 682	<p>Continued From page 68</p> <p>d. 8/20/12 - Stage II left hip pressure sore 2 cm x 2 cm <0.1 depth. This pressure ulcer had deteriorated since 6/13/12.</p> <p>e. 8/27/12 - Stage II left hip pressure sore 2 cm x 1.5 cm <0.1 depth.</p> <p>Review of the Treatment Administration Record (TAR) for 9/1/12 through 9/30/12 revealed treatment for pressure ulcers was not provided as ordered on 9/1/12, 9/7/12, 9/10/12, or 9/14/12 through 9/17/12.</p> <p>Observations in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 removed the duoderm dressing from Resident #74's left hip for assessment of the pressure ulcer. The pressure ulcer was assessed to be a Stage III with measurements of approximately 2 cm in diameter, full thickness of skin loss with reddish drainage noted on duoderm. The pressure ulcer had deteriorated to appear as a Stage III since the most recent skin assessment dated 8/27/12.</p> <p>During an interview in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 was asked what was the stage of the pressure sore. Nurse #5 stated, "...it's a Stage III..."</p> <p>During an interview in the MDS office on 9/18/12 at 10:43 AM, Nurse #4 was asked who is responsible to measure and stage pressure ulcers. Nurse #4 stated, "...the treatment nurse is suppose to measure the wounds weekly... The nurses on the floor are not supposed to measure or stage [pressure ulcers]..." Nurse #4 was asked who does the measurements and staging when the treatment nurse is working the floor instead of providing treatments. Nurse #4 stated, "...it has been three weeks to one month since the other treatment nurse has been here..."</p>	N 682		

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N 682	<p>Continued From page 69</p> <p>The facility failed to provide weekly pressure ulcer assessments and treatments as ordered which resulted in deterioration of an avoidable in-house acquired pressure ulcer for Resident #74.</p> <p>6. Medical record review for Resident #21 documented an admission date of 1/13/99 and a readmission date of 10/12/06 with diagnoses of Late Effects of Cerebrovascular Disease, Hemiplegia affecting Dominant Side Right, Aphasia, Dementia, Depression, Gastro Esophageal Reflux Disease, Hypertension and Adult Failure to Thrive. Review of nursing re-admission assessment dated 10/12/06 documented, "...Contractures-specify Rt [right] hand..." Review of the annual MDS dated 4/11/12 and the quarterly MDS dated 7/4/12 documented in section G0400 functional limitation in ROM with upper and lower extremity on one side.</p> <p>Review of the care plan dated 7/10/12 documented, "...Problem... Potential for increased contractures... Approach... Perform active and passive ROM during ADL's as indicated..."</p> <p>Review of the nursing care ADL sheets had no ROM documented on 7/4/12, 7/16/12, 7/18/12, 7/19/12, 7/20/12, 7/25/12 and 7/27/12. Review of the nursing care ADL sheets had no ROM documented on 8/2/12, 8/4/12, 8/5/12, 8/6/12, 8/9/12, 8/16/12, 8/17/12, 8/18/12, 8/19/12, 8/20/12, 8/24/12, 8/27/12, 8/28/12 and 8/31/12.</p> <p>Observations on 1st Magoffin dining room on 9/10/12 at 5:10 PM, on 9/11/12 at 7:58 AM and on 9/12/12 at 8:30 AM, revealed Resident #21 had a contracture of the right hand.</p> <p>During an interview at the nurses' station on 1st</p>	N 682		

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N 682	<p>Continued From page 70</p> <p>Magoffin on 9/11/12 at 8:21 AM, Nurse #6 was asked if Resident #21 had a contracture defined as a condition of fixed high resistance to passive stretch of a muscle. Nurse #6 stated, "Yes." Nurse #6 was then asked if Resident #21 received ROM services. Nurse #6 stated, "No."</p> <p>The facility failed to follow the care plan interventions for ROM exercises during ADL's.</p> <p>7. Medical record review for Resident #28 documented an admission date of 11/24/99 and a readmission date of 4/12/11 with diagnoses of Diabetes Mellitus, Gastroenteritis, Renal Insufficiency, Hypertension, Back Pain, Bipolar Disorder, Cerebrovascular Accident, Epilepsy, and Cognitive Dementia. Review of the physician orders dated 8/4/12 documented, "...BMP [Basic Metabolic Panel], HGBA1C [glycosylated hemoglobin A1C], DEPAKOTE LEVEL, EVERY... MONTHS... FEB [February], MAY, AUG [August], NOV [November]..."</p> <p>Review of the care plan dated 5/29/12 and updated 8/21/12 documented, "...Potential complications related to the use of psychotropic medication... monitor labs as ordered by physician..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...past due labs... BMP, Lipid Panel, HgbA1c, Depakote... ordered q [every] 3 months... was due May 2012..."</p> <p>The facility was unable to provide laboratory results for the BMP, HgbA1C and Depakote level for May 2012.</p> <p>During an interview in the conference room on</p>	N 682		

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N 682	<p>Continued From page 71</p> <p>9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason that lab would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>The facility failed to follow the care plan for monitoring labs as ordered.</p> <p>8. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual MDS dated 11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 has impaired vision but does not have corrective lenses, has functional limitation in ROM on one side for the upper and lower extremities and receives psychotropic medication. Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...2. IMPAIRED VISION... 3... FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..."</p> <p>During an interview in the activity room on 9/12/12 at 11:30 AM, Resident #43 was asked if there was any trouble reading. Resident #43 stated, "...when I read for a while my sight gets a little blurry..." Resident #43 was asked about glasses. Resident #43 stated, "...I could probably use some glasses..."</p> <p>During an interview in the Social Worker's (SW) office on 9/18/12 at 11:30 AM, the SW was asked how referrals are made for a vision consult. The SW stated, "...I get with nursing, residents and family's... then I get with [named staff] from Resident Trust to see if the resident is... eligible... or if the family is willing to pay for the glasses..."</p>	N 682		

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N 682	<p>Continued From page 72</p> <p>The SW was asked if Resident #43 had ever had a vision consult. The SW stated, "...I will have to check..."</p> <p>During an interview in the conference room on 9/18/12 at 1:55 PM, the SW confirmed that Resident #43 had not previously had a vision consult.</p> <p>Further review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...3. SELF CARE DEFICIT IN ADL'S R/T IMPAIRED MOBILITY... ROM TO ALL EXTREMITIES AS SCHEDULED..."</p> <p>Review of the restorative and rehabilitation nursing assessment dated 8/9/12, documented, "...Nursing Maintenance Program... YES [checked]... Restorative Program... YES [checked]..."</p> <p>Review of the Nursing Monthly Summary dated March through July 2012 documented that Resident #43 received rehabilitation/restorative services at least 15 minutes 3 times a week.</p> <p>Review of Nursing Monthly Summary dated August 2012 has ROM exercises crossed off.</p> <p>Review of the nursing care ADL's dated March - September 2012 had ROM crossed out.</p> <p>Observations in the activity room on 9/12/12 at 10:22 AM, revealed Resident #43 participating in exercises. Resident #43 performed the exercises with both legs and right arm, but not with his left arm.</p> <p>Observations in room 109 on 9/18/12 at 7:45 AM, revealed Resident #43 seated on the side of the bed eating breakfast using right hand.</p>	N 682		

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N 682	<p>Continued From page 73</p> <p>During an interview at the nurses station on 1st Magoffin on 9/11/12 at 8:10 AM, Nurse #6 was asked if Resident #43 had a contracture defined as a condition of fixed high resistance to passive stretch of a muscle. Nurse #6 stated, "Yes... left hand." Nurse #6 was then asked if resident #43 received ROM services or had a splint device in place. Nurse #6 stated, "No."</p> <p>During an interview at the nurses station on 1st Magoffin on 9/18/12 at 8:15 AM, certified nursing assistant (CNA) #14 was asked if Resident #43 received rehabilitation or restorative services. CNA #14 stated, "...I don't see [named resident #43] "</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if Resident #43 was receiving ROM exercising. Nurse #4 stated, "...it should be documented..." Nurse #4 reviewed the medical record and stated, "...I don't see an order to discontinue ROM... that's not good if it's not documented..."</p> <p>Further review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...9 POTENTIAL FOR COMPLICATIONS RELATED TO USE OF PSYCHOTROPIC MEDICATIONS... ASSESS/MONITOR ...ADVERSE SIDE EFFECTS..."</p> <p>Review of the "Summary of All Recommendations / Findings" from the Consulting pharmacist dated 6/13/12 documented, "...Please obtain an abnormal movement evaluation and place in the chart to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended every 6 mos [months]. Last assessment 11/14 [2011].</p>	N 682		

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N 682	Continued From page 74 The facility failed to follow the care plan interventions for an eye exam, ROM exercises, and assess and monitor adverse effect for psychotropic medication. 9. Medical record review for Resident #63 documented an admission date of 12/3/08 with diagnoses of Diabetes Mellitus, Schizophrenia, Dementia and Dyslipidemia. Review of the MDS with an assessment reference date (ARD) of 10/31/11 section L was coded for D and F indicating obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. Review of the care plan dated 10/19/11 documented, "Problem... DENTAL PROBLEMS WITH TOOTH PAIN REPORTED... Approach... Notify MD [Medical Doctor] of any dental/mouth problem noted... REFER TO DENTIST FOR EVALUATION AND TREATMENT..." Observation in the dayroom on 9/10/12 at 10:30 AM, Resident #63 was noted to have two top teeth visible with brownish stains, bottom teeth chipped and broken with brownish stains noted and need of cleaning. Observations in the dayroom on 9/10/12 at 3:00 PM and 4:45 PM and 9/12/12 at 8:00 AM, Resident #63's teeth needed cleaning. During an interview in the Social Worker's (SW) office on 9/12/12 at 3:38 PM, the SW was asked about dental assistance for Resident #63. The SW stated, "I call [named dental office] and they put them [residents] on a list. If they are... eligible then the state will cover it otherwise family responsible party have to pay for it. [Named dental office] will call family and let them know	N 682		

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N 682	<p>Continued From page 75</p> <p>cost of examination." The SW proceeded to place a call to the dental office to find out when Resident #63 was last seen by the dentist. Resident #63 was last seen by the dentist in 2007, which was prior to admission to the facility. The SW further stated, "She's [referring to Resident #63] is not... eligible so her daughter would have to pay for it and she don't like to spend money." The surveyor then asked the SW about other sources to assist with dental needs of the resident. The SW stated, "I don't have any other sources..."</p> <p>During an interview in the conference room on 9/12/12 at 4:00 PM, the Director of Nursing (DON) was asked who was responsible for dental appointments for residents. The DON stated, "Whoever did the CAA should have told nurse on unit so they could notify Social Services and she will in turn check with [named dental provider] to see if they can see her if not then we would check for our services to see who can see her."</p> <p>During an interview in the administration office on 9/12/12 at 4:20 PM, Nurse #3 was asked about a dental consult for Resident #63. Nurse #3 stated, "I put it [dental consult] on the CAA [care area assessment]. When we have the care plan meeting, I normally if SW in there will tell her then. If not in care plan meeting will call her [SW] and let her know."</p> <p>During an interview on the administration hall on 9/13/12 at 5:50 PM, the SW stated, "She doesn't have [financial resources] so her daughter will have to pay for any dental service and I know her, she doesn't like to spend any money."</p> <p>During an interview in the conference room on 9/14/12 at 1:15 PM, the DON was asked about</p>	N 682		

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N 682	Continued From page 76 dental appointments for residents. The DON stated, "[Named Social Worker] makes the appointment she checks to see if they have [financial resources]. If not... eligible and family can't pay then the facility has to take care of it..." The facility had not followed the care plan intervention to refer to the dentist for dental caries. 10. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of the care plan dated 7/18/12 documented, "...Bath daily... hair groomed daily; nails checked daily for cleanliness and trimmed once a week... perineal (perineal) care every two hours..." Observations in Resident #84's room on 9/10/12 at 1:00 PM, revealed Resident #84 in bed wearing a thin hospital gown. Her nails were unkept, long and dirty, wig was unstyled and tipped forward down toward eyes. Observations in Resident #84's room on 9/11/12 at 8:00 AM, 12:00 PM and 2:00 PM, revealed Resident #84 wearing a thin, threadbare hospital gown. Her wig was unstyled and slipping forward down above eyes. Observations in Resident #84's room on 9/12/12 at 9:00 AM, 12:00 PM and 3:00 PM, revealed Resident #84's nails were long and unkept. Observations and interview in Resident #84's room on 9/13/12 at 9:20 AM, revealed in Resident #84 was lying in bed with wet linens. Her nails remained long and dirty her toenails were unkept.	N 682		

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N 682	<p>Continued From page 77</p> <p>Her wig was unstyled and slipping forward down above eyes. Resident #84 stated, "...I have not had a bath today..."</p> <p>During an interview in Resident #84's room on 9/13/12 at 9:30 AM, Resident #84 was asked if she was wet, Resident #84 answered, "Yes." Resident #84 was asked if she had had a bath this morning. Resident #84 stated, "...I haven't had anything done for me..." Resident #84 was asked if she ever removed her wig for hair care. Resident #84 stated, "...they never brush my hair... I wish they would..."</p> <p>During an interview on 1st McRee hall on 9/13/12 at 10:00 AM, CNA #2 was asked about Resident #84's morning (9/13/12) care. CNA #2 stated, "...no I haven't bathed her yet... she was last changed on the 11-7 shift at 5:30 AM..."</p> <p>The facility failed to follow the care plan interventions for bath daily; hair groomed daily; nails checked daily for cleanliness and trimmed once a week... pearineal (perineal) care every two hours..."</p> <p>11. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia and a readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube.</p> <p>Review of the care plan dated 6/4/12 documented, "...OT [Occupational Therapy]... perform therapy 5 x [times] wk [week] x 8 wks... ST [Speech Therapy] for oral dysphagia and oral therapy... provide therapy 5 x week x 60 days..." The facility was unable to provide documentation</p>	N 682		

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N 682	<p>Continued From page 78</p> <p>that the resident received OT and ST services.</p> <p>During an interview in the reception office on 9/20/12 at 8:30 AM, the receptionist was asked what the process for obtaining speech and occupational therapy was. The receptionist stated, "...the nurses notify [the Vice President] and she contacts the therapists... if there is a problem with insurance, then I make arrangements for the resident to go out for therapy..." The receptionist was asked if Resident #104 had gone out for therapy. The receptionist stated, "No."</p> <p>During an interview in the medical records office on 9/20/12 at 8:40 AM, the medical records director was asked if there were any records of OT or ST for Resident #104. The Medical Records director stated, "No."</p> <p>During an interview in the administration hallway on 9/20/12 at 8:45 AM, the Vice President was asked if there were any records of OT or ST being contacted. The Vice President stated, "No."</p> <p>During an interview in the conference room on 9/20/12 at 11:00 AM, the Vice President presented a faxed copy of an OT evaluation dated 6/4/12, which was unsigned by the physician, and a faxed copy of an OT Therapy Daily/Weekly Progress Report which covered the period of 6/4/12 to 6/10/12. The Vice President was asked about Speech Therapy notes. The Vice President shrugged. The Vice President was asked about the second week of OT notes. The Vice President stated, "...I don't know..."</p> <p>The facility failed to follow the care plan intervention for OT and ST services.</p>	N 682		

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N 682	<p>Continued From page 79</p> <p>12. Medical record review for Resident #118 documented an admission date of 6/29/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Lower Lobe Pneumonia, Anemia, Diabetes Mellitus, Hypotension, Depression, Dementia, Hypomagnesemia and Urinary Tract Infection. Review of care plan dated 9/5/12 documented, "...Administer oxygen [O2] at 2 L [liters] via BNC [binasal cannula]..."</p> <p>Observations in Resident #118's room on 9/10/12 at 10:45 AM, revealed Resident #118 lying in bed receiving O2 at 6 L/M [liters per minute] via concentrator.</p> <p>Observations in Resident #118's room on 9/14/12 at 3:00 PM, revealed Resident #118 lying in bed, receiving a breathing treatment via nebulizer and O2 at 6 L/M via concentrator.</p> <p>Observations in Resident #118's room on 9/17/12 at 9:00 AM and 11:00 AM and on 9/19/12 at 8:45 AM, revealed Resident #118 lying in bed receiving O2 at 4 L/M via concentrator.</p> <p>During an interview in Resident #118's room on 9/19/12 at 8:50 AM, Nurse #4 was asked what was the oxygen rate. Nurse #4 stated, "...It [O2] is set between 3 [L/M] and 4... it should be set on 2..."</p> <p>The facility failed to follow the care plan intervention for O2 to be administered at 2 L/M.</p> <p>13. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and</p>	N 682		

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N 682	<p>Continued From page 80</p> <p>Dysphagia Oropharyngeal Phase. Review of the care plan dated 4/5/12 and updated 6/27/12 documented, "...Alteration in visual function r/t impaired vision... will maintain optimal level of function... follow up with ophthalmology/optometry physicians..."</p> <p>Observations in Resident #124's room on 9/11/12 at 9:50 AM, revealed the resident was not wearing glasses.</p> <p>During an interview in Resident #124's room on 9/12/12 at 5:00 PM, Resident #124 was asked if he had ever had his eyes tested or if he had ever worn glasses. Resident #124 stated, "They [glasses] were stolen at the last place I was at. I probably need to be seen by an eye doctor for a new pair of glasses."</p> <p>During an interview in the MDS office on 9/14/12 at 9:00 AM, the SW was asked if Resident #124 had impaired vision at the time of admission, had no glasses then why was the needed care not addressed. The SW stated, "...I don't know. It's the resident or family member that will ask for vision consult, that's how I get notified that the resident needs glasses. Before [named school of optometry] comes out and sees them, they have to be ensured of payment. If... eligible, the state [Department of Human Services determines eligibility], will pay for the eye exam and glasses, if not, I will have to get in touch with the family..."</p> <p>During an interview in the MDS office on 9/14/12 at 10:30 AM, Nurse #3 was asked if Resident #124 had impaired vision. Nurse #3 confirmed that the resident had been assessed as having impaired vision on the comprehensive assessment at the time of admission.</p>	N 682		

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N 682	Continued From page 81 During an interview in business office on 9/14/12 at 10:43 AM, the Financial Services Manager (FSM) was asked if Resident #124 had been referred to her to determine... eligibility due to a request for a vision referral. The FSM stated, "...No, he has not. He is Medicaid and does receive a social security check, so that would make him... eligible..." Further review of a physician's order dated 5/10/12 and 5/30/12 documented, obtain a 3 day calorie count Review of the care plan dated 4/25/12 and updated 6/27/12 documented "...calorie count Nsg/Diet [nursing and dietician]..." Review of the nurses notes and dietary progress notes for May 2012 did not document a calorie count in progress. During an interview in the Director of Nursing (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract with one but she hasn't been here since March..." The facility failed to follow the care plan interventions for eye exam and 3 day calorie count.	N 682		
N 689	1200-8-6-.06(4)(m) Basic Services (4) Nursing Services. (m) Medications, treatments, and diet shall be carried out as prescribed to safeguard the resident, to minimize discomfort and to attain the physician ' s objective. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions	N 689		

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N 689	Continued From page 82 Based on policy review, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician per the facility policy for 8 of 38 (Residents #23, 28, 43, 81, 82, 84, 104, and 124) sampled residents. The failure of the facility to obtain laboratory tests and a swallowing study, provide treatments and notify the physician of abnormal lab results as per policy resulted in conditions that are, or are likely to be detrimental to their health, safety or welfare. The findings included: 1. Review of the facility "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebrovascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation,	N 689		

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N 689	Continued From page 83 and Peripheral Vascular Disease. A physician's order dated 7/16/12 documented "Warfarin 3 mg [milligrams] QD [every day] and Warfarin 10 mg QHS [every night]" A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time/normalized international ratio]." The annual Minimum Data Set (MDS) dated 3/1/12 documented a brief interview for mental status (BIMS) score of 7 (severe impairment); there were no behaviors, falls, wounds, swallowing issues, or use of anticoagulants documented. The resident was total care for activities of daily living (ADL). The quarterly MDS dated 8/16/12 documented a BIMS score of 5 (severe impairment), there were no behaviors, falls, wounds or swallowing issues documented. The resident was on daily anticoagulants. The care plan dated 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... 3. Obtain lab work as ordered by MD, and ...Impaired skin integrity r/t [related to] left upper chest... 1. Administer treatment as ordered by the physician..." The July 2012 Medication Administration Record (MAR) documented the resident received a total of Warfarin 13 mg daily from 7/16/12 to (-) 7/31/12. The August 2012 MAR documented the resident received a total of Warfarin 13 mg daily from 8/1/12-8/31/12. The September 2012 MAR documented the resident received Warfarin 13 mg daily 9/1/12-9/13/12. The facility was unable to provide documentation of PT/INR lab results as ordered. During an interview in the conference room on	N 689		

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N 689	<p>Continued From page 84</p> <p>9/12/12 at 5:30 PM, the Director of Nursing (DON) stated, "Unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p>	N 689		

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N 689	<p>Continued From page 85</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10 mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient... I don't remember who told me about his wound. I did look at it, it was a fresh wound, very unusual shape and area..."</p> <p>Review of nurse's note dated 9/14/12 at 10:30 AM, documented, "Attempted to drawn a PT/INR. Resident refused stating "no" and jerking his arm back, pt. [patient] is scheduled for MBS [modified barium swallow]."</p> <p>During an interview at the 1st McRee nursing station on 9/15/12 at 8:05 AM, Nurse #4 stated, "No I did not document that I notified [named physician] that [named Resident #81] refused to let me draw the lab."</p> <p>Further review of a physician's order dated 8/17/12 documented, "MBS and speech eval [evaluation] due to coughing while eating." There was no documentation of the MBS being done until 9/14/12 with a MBS Study that documented the following recommendations: 1 NPO [nothing</p>	N 689		

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N 689	Continued From page 86 by mouth], 2. Dysphagia tx [treatment] for focus on laryngeal elevation and closure... 3. Repeat MBS in 2-3 weeks." Observations in Resident #81's room on 9/12/12 at 10:00 AM, revealed Resident #81 with a dressing noted on the left upper chest area. Observations in Resident #81's room on 9/17/12 at 10:00 AM, Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area, revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw, the upper part of wound was pink. The dressing that was removed had brown drainage present. Observations in Resident #81's room on 9/18/12 at 7:45 AM, Resident #81 coughing while eating a pureed diet. During an interview in Resident #81's room on 9/18/12 at 7:45 AM, certified nursing assistant (CNA) #3 stated, "He [Resident #81] feeds himself. I come back and check on him and help if he needs it. I have noticed since he came back from the hospital [7/16/12] that he is coughing more with eating. I did tell the charge nurse about it." During an interview in the conference room on 9/18/12 at 6:00 PM, the Physician was asked if he knew the swallowing study was not obtained until 9/18/12. The Physician stated, "No I was not aware that they did not get the swallow study until today. He [Resident #81] is now NPO, currently has IV's [intravenous fluids] going for hydration, family is being contacted for a possible PEG [Percutaneous Endoscopy Gastrostomy tube], if they refuse the PEG then hospice will be	N 689		

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N 689	<p>Continued From page 87</p> <p>contacted. I am not sure how speech therapy works here, will check, if it works we can reverse the PEG."</p> <p>A physician's order dated 9/9/12 documented, "Xenaderm to Left Clavicle and cover with a dry dressing every day." A review of the September 2012 Treatment Administration Record (TAR) revealed no documentation of a treatment being done on the left clavicle on 9/12/12 and from 9/14/12 through 9/17/12 as ordered.</p> <p>The facility failed to obtain lab work and a MBS as ordered; keep the physician notified of the resident status; timely notify the physician of status and provide treatments as ordered placed Resident #81 in a condition that is or is likely to be detrimental to the resident's health, safety or welfare.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Diabetes, Hemiplegia, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 9/2/12 documented, "...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..."</p> <p>The facility was unable to provide documentation that the lab results for Dilantin level, CBC, CMP, Urine C&S had been done as ordered.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval [evaluation] of head due to fall on concrete..."</p>	N 689		

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N 689	<p>Continued From page 88</p> <p>Review of a hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a high Dilantin level of 28.8. The therapeutic reference range was 10-20.</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the attending physician / medical director was asked if the facility had notified him of the 28.8 Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level. The DON stated, "...lab has been a big issue..."</p> <p>The facility failed to obtain, monitor and report Dilantin levels as ordered placed Resident #23 in a condition that is, or is likely to be detrimental to the resident's health, safety or welfare.</p>	N 689		

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N 689	<p>Continued From page 89</p> <p>4. Medical record review for Resident #28 documented an admission date of 11/24/99 and a readmission date of 4/12/11 with diagnoses of Gastroenteritis, Renal Insufficiency, Back Pain, Diabetes Mellitus, Hypertension, Cerebrovascular Accident, Epilepsy, Bipolar Disorder, and Cognitive Dementia. Review of the physician orders dated 8/4/12 documented, obtain "...BMP [Basic Metabolic Panel], HGBA1C [glycosylated Hemoglobin A1c], DEPAKOTE LEVEL, EVERY... MONTHS... FEB [February], MAY, AUG [August], NOV [November]..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...past due labs... BMP, Lipid Panel, HgbA1c, Depakote... ordered q [every] 3 months... was due May 2012..."</p> <p>The facility was unable to provide documentation that the BMP, HgbA1C and Depakote level were obtained as ordered.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason the labs would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>5. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the physician's orders dated 6/6/12 documented, "...DILANTIN [Phenytoin] LEVEL EVERY 3 MONTHS (MAY/AUG/NOV/FEB)..."</p>	N 689		

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N 689	Continued From page 90 Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...following lab(s) past due... Phenytoin... ordered every 3 months... was due May 2012... " The facility was unable to provide documentation that the Dilantin level was done as ordered. During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason that the lab would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..." 6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the August 2012 physician's order documented the following, "...ALLOPURINOL 100 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... ASPRIN EC [enteric coated] 325 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... ATENOLOL 25 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... LASIX 29 MG qd [daily]... COLACE 100 MG... TAKE 1 CAPSULE BY MOUTH DAILY... DILTIAZEM 240 MG... TAKE 1 CAPSULE BY MOUTH... GLUCOPHAGE 500 MG TABLET... TAKE 1 TABLET BY MOUTH DAILY... RISPERDAL 2 MG TABLET... TAKE 1 TABLET BY MOUTH EVERY MORNING... DEPAKOTE 500 MG TABLET... PRILOSEC 20 MG CAPSULE... TAKE 1 CAPSULE BY MOUTH 2 TIMES DAILY BEFORE MEALS... ARTIFICIAL TEARS DROPS INSTILL 1 DROP INTO EACH EYE 4 TIMES DAILY... KLONOPIN 1 MG	N 689		

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N 689	Continued From page 91 TABLET... TAKE 1 TABLET BY MOUTH AT BEDTIME... RISPERDAL 4 MG TABLET...TAKE 1 TABLET BY MOUTH AT BEDTIME...MULTIVITAMIN TABLET TAKE 1 TABLET BY MOUTH DAILY..." Review of a physician's order dated 9/13/12 documented, "...Keflex 500mg tid [three times daily] x [times] 7 days..." Review of the medication administration record (MAR) dated 9/1/12 through 9/30/12 for Resident #82 revealed the resident did not receive the following medications as ordered on the dates listed: a. Artificial Tears 1 drop into each eye at 5 PM and 9 PM on 9/11/12 through 9/15/12 or on 9/17/12. b. Klonopin 1 milligram (mg) at hour of sleep (hs) from 9/12/12 through 9/14/12 and on 9/17/12. c. Risperdal 4 mg at hs from 9/12/12 through 9/14/12. d. Risperdal 2 mg at 9 AM on 9/3/12 or 9/14/12. e. Prilosec 20 mg at 7:30 AM on 9/4/12 or at 5 PM from 9/12/12 through 9/14/12. f. Allopurinol 100 mg at 9 AM on 9/3/12. g. Aspirin 325 mg at 9 AM on 9/3/12. h. Atenolol 25 mg at 9 AM on 9/3/12. i. Colace 100 mg at 9 AM on 9/3/12. j. Diltiazem 240 mg at 9 AM on 9/3/12. k. Glucophage 500 mg at 9 AM on 9/3/12. l. Lasix 20 mg at 9 AM on 9/3/12. m. Depakote 500 mg at 9 AM on 9/3/12 or at 5 PM from 9/12/12 through 9/14/12. n. Multivitamin at 9 AM on 9/3/12. o. Keflex 500mg at 5 PM on 9/17 or 9 AM on 9/18. During an interview at the 1st McRee nurses' station on 9/19/12 at 3:30 PM, Nurse #4 was asked if medications were administered to	N 689		

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N 689	<p>Continued From page 92</p> <p>Resident #82 as ordered. Nurse #4 reviewed the MAR for September 2012 and stated, "No, it's [medication administration] not documented."</p> <p>7. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of a physician's order dated 8/19/12 documented, "...GGT [Gamma glutamyl transferase] lab test..."</p> <p>Review of a history and physical dated 8/19/12 documented, "...Impression: R/O [rule out] liver disease... Plan: GGT to rule out liver disease as source of ^ [increased] alk [alkaline] phos [phosphatase]..."</p> <p>The facility was unable to provide lab results for a GGT as ordered in August 2012.</p> <p>During an interview in the medical records office on 9/19/12 at 3:30 PM, medical records director was asked about the GGT results. The medical records director stated, "...we cannot locate them [GGT lab results]..."</p> <p>8. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Tardive Dyskinesia and Seizure Disorder. A readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of a physician's order dated 10/8/11 documented, "...CBC c [with] DIFFERENTIAL q [every] 2 WEEKS..."</p> <p>Review of a physician's order dated 11/4/11 documented, "...Pt [patient] should be having a</p>	N 689		

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N 689	<p>Continued From page 93</p> <p>WBC [white blood count] with differential every 2 weeks. Has not been being done. WBC with diff [differential] q 2 weeks..."</p> <p>Review of a physician's order dated 11/15/11 documented, "...BE SURE AND DO A WBC c DIFFERENTIAL ON 11-17-11..."</p> <p>Review of a physician's order dated 11/30/11 documented, "...WE NEED CBC c DIFFERENTIAL REPORT FROM 11-17-11 ON THE CHART. CONTINUE CBC c DIFFERENTIAL EVERY 2 WEEKS. PT. [patient] IS ON CLOZARIL AND WE NEED TO CHECK FOR NEUTROPENIA PERIODICALLY. THAT'S WHY WE DO THE CBC's AND DIFFERENTIALS TO TRY TO AVOID INFECTIONS..."</p> <p>The facility was unable to provide documentation of lab results for the CBC and WBC with differentials as ordered.</p> <p>During an interview in the DON's office on 9/14/12 at 12:20 PM, the DON was asked about the lab reports which were unavailable. The DON stated, "...lab has been a big issue..."</p> <p>9. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of a physician's orders dated 5/10/12 documented, "Calorie Count x [times] 3 days..." Review of a physician's order dated 5/30/12 documented, "3 day calorie count to start today..."</p> <p>The facility was unable to provide documentation</p>	N 689		

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N 689	Continued From page 94 that the 3 day calorie count was done as ordered.	N 689		
N 691	1200-8-6-.06(4)(o) Basic Services (4) Nursing Services. (o) Body position of residents in bed or chair bound shall be changed at least every two (2) hours, day and night, while maintaining good body alignment. Proper skin care shall be provided for bony prominences and weight bearing parts to prevent discomfort and the development of pressure areas, unless contraindicated by physician ' s orders. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, medical record review, observation and interview, it was determined the facility failed to identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents at risk of developing pressure ulcers. Failure of the facility to identify, assess, accurately assess and/or provide care and treatments resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of Resident #54 and #82 who developed avoidable in-house acquired pressure ulcers and Resident #54 and 74 when their pressure ulcers deteriorated. The findings included: 1. Review of the facility's "Identifying Residents at Risk for Pressure Ulcers" policy documented, "...Re-assess all patients on re-admission to the facility and bi-monthly on skilled unit and monthly	N 691		

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N 691	Continued From page 95 on ICF [Intermediate Care facility] residents utilizing the Resident Skin Evaluation... Include skin assessment in daily charting on SNF [Skilled Nursing Facility] residents and in weekly charting on ICF residents... Wound Assessments and Documentation: Accurate assessment and documentation of wounds and wound status is important in management of wounds. The following factors should be documented on a weekly basis as directed... Weekly documentation should be done on the Treatment Flow Record. In addition a skin evaluation will be noted in the monthly and bi-monthly Skin Assessments completed by the staff nurse... Wound Classification... Stage I - Areas of skin redness (without a break in the skin) that does not disappear within 30 minutes after pressure is relieved. Stage II - Partial thickness loss of skin layers, may present clinically as an abrasion, blister, or shallow crater. Stage III - Full thickness of skin lost, exposing subcutaneous tissues... Appropriate Intervention should be implemented for all wounds. Pressure reduction mattress... Turn/Reposition every 2 hours... Keep clean, dry and well lubricated..." Review of the facility's "SKIN CARE AND EARLY TREATMENT" policy documented, "...Skin to be inspected every shift by direct caregivers paying close attention to bony prominence. Observe and report any unusual skin conditions to the charge nurse on the unit and to the treatment nurse utilizing the skin/body alert sheet... Minimize resident's skin to moisture... Residents must be checked at least every 2 hours, changed and given perineal/incontinent skin care..." 2. Medical record review for Resident #54 documented an admission date of 11/8/11 with diagnoses of Renal Insufficiency, Coronary Artery	N 691		

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N 691	<p>Continued From page 96</p> <p>Disease, Hypertension, Congestive Heart Failure and Obesity. Review of the nursing admission assessment dated 11/8/11 documented, "...No open areas... abrasion/bruising old... SKIN RISK ASSESSMENT... Score-11, Scores above 8 = [indicate] HIGH RISK..." Resident #54 was assessed as a high risk for developing skin breakdown, yet no preventative measure were put in place to prevent the development of pressure ulcers.</p> <p>Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/14/11 documented in Section G for activities of daily living (ADL) assistance, Resident #54 was independent in bed mobility, supervision with transfers, extensive assist with dressing, independent in eating and one person assist with toileting. The MDS documented in Section M Skin Condition, Resident #54 had no pressure ulcers..." Review of the MDS with an ARD of 2/2/12 Section M Skin Conditions documented Resident #54 had no pressure ulcers. Review of the MDS with an ARD of 3/9/12 Section M Skin Conditions, Resident #54 had three Stage 2 pressure ulcers.</p> <p>Review of skin assessments for Resident #54 documented the following:</p> <ul style="list-style-type: none"> a. 11/23/11 - "...Skin on limbs mottled and bruised easily... Score: 12..." b. 12/16/11 - "...thin paper like skin c [with] mottling [symbol for and] bruising... Score: 12..." c. 12/21/11 - "...Paper thin like skin mottling Bruising noted... Score: 12..." d. 2/1/12 - "...bruised easily, skin on limbs mottled. No skin breakdown noted...Score: 12..." e. 2/26/12 - "...Resident c deep tissue injury to buttocks (see wound documentation) Multiple old bruises to upper & [and] lower exts [extremities]. 	N 691		

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N 691	Continued From page 97 Old scar to face..." The facility was unable to provide documentation of weekly skin assessments for 2/8/12, 2/15/12 and 2/22/12. Review of the care plan dated 3/15/12 documented, "...Impaired skin integrity r/t [related/to] Stage II to the sacral area and Rt. [right] and Left buttocks... Weekly skin assessments per Charge Nurse..." Review of the weekly pressure ulcer records for Resident #54 documented the following: a. 3/1/12, 3/5/12 and 3/15/12 - "...DATE OF ONSET: 3/1/12... SITE LOCATION: Sacral... STAGE 2 was checked... Size IN CM [centimeters] 10cm x [by] 5 cm... DEPTH < [less than] 0.1cm..." b. 3/19/12 - "DATE OF ONSET 3/1/12... SITE LOCATION: Sacral... STAGE 4 was checked... SIZE IN CM 12cm x 8cm... DEPTH 0.5cm..." The sacral pressure ulcer had deteriorated to a Stage 4. c. 3/30/12 - "STAGE 4 was checked... DEPTH <0.1cm..." d. 4/5/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION (R) [right] hip... STAGE 2 was checked... SIZE IN CM 4cm x 3cm <0.1cm..." e. 4/9/12 - "...DATE OF ONSET: 4/9/12... SITE/LOCATION: (L) [left] hip... STAGE 3 was checked... SIZE IN CM 3cm x 4cm < 0.2cm..." Resident #54 developed an avoidable pressure ulcer that was a stage III before the facility had identified it's presence. 4/9/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: (L) trochanter... STAGE 2 was checked... SIZE IN CM 1/2cm x 2cm DEPTH <0.1cm... WOUND BED-Dk [dark] Red/Purple..." f. 4/11/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION (R) hip... STAGE 2 was checked..."	N 691		

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N 691	Continued From page 98 SIZE IN CM 4cm x 3cm <0.1cm..." g. 5/3/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION (R) hip... STAGE 2 was checked... SIZE IN CM 4cm x 3cm <0.1cm..." 5/3/12 - "...DATE OF ONSET: 4/9/12... SITE/LOCATION: (L) hip... STAGE 3 was checked... SIZE IN CM 3cm x 4cm... DEPTH <0.2... WOUND BED BROWN..." 5/3/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: (L) trochanter... STAGE 2 was checked... SIZE IN CM 1/2cm x 2cm DEPTH <0.1cm... WOUND BED-Dk Red/Purple..." h. 5/30/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked... SIZE IN CM 5cm x 4 cm... DEPTH 0.5cm..." This pressure ulcer had deteriorated to a stage III since 4/5/12. 5/30/12 " ...DATE OF ONSET: 4/9/12... SITE/LOCATION: Left hip... STAGE unstageable was checked... SIZE IN CM 8cm x 7.5 cm... DEPTH 2cm... WOUND BED-Black... SURROUNDING TISSUE-Black..." This pressure ulcer had deteriorated since the development on 4/9/12. 5/30/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: Left trochanter... STAGE unstageable was checked... SIZE IN CM 3cm x 13cm DEPTH 1cm... WOUND BED Black... SURROUNDING SKIN COLOR Black..." This pressure ulcer had deteriorated since the development on 4/9/12. i. 6/7/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked... SIZE IN CM 5cm x 4 cm... DEPTH 0.5cm..." This pressure ulcer had deteriorated since the development on 4/5/12. 6/7/12 - " ...DATE OF ONSET: 4/9/12... SITE/LOCATION: Left hip... STAGE unstageable was checked... SIZE IN CM 8cm x 7.5 cm... DEPTH 2cm... WOUND BED-Black... SURROUNDING TISSUE-Black..." This pressure ulcer had deteriorated since the development on 4/9/12.	N 691		

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N 691	<p>Continued From page 99</p> <p>j. 6/14/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked..." This pressure ulcer had deteriorated since the development on 4/9/12. All of Resident #54's pressure ulcers were avoidable and in house acquired.</p> <p>Review of treatment nurse in-house skin assessments documented the following: a. 2/26/12 - "...DATE NOTICE-2/26/12... DESCRIPTION OF WOUNDS - Resident c deep tissue injury to sacral right buttocks and left buttocks. Sacral size 11 cm x 8 cm c opening & center of wound bed deep dark red c bright red surrounding tissue. Right buttocks size 6 cm x 5.5 cm [symbol for zero] opening center of wound bed c dark red tissue and surrounding tissue bright red tissue. Left buttocks size 6cm x 5cm c center of ulcer dark red tissue & surrounding tissue bright red no drainage or odor noted to either ulcer... TREATMENT-Apply Xenaderm to entire buttocks BID [twice daily]..."</p> <p>b. 4/9/12 - "...description of wounds: Resident has several wounds located on (L) hip, (L) trochanter and (L) mid back. (L) hip is 3cm x 4cm x 0.1cm no odor or drainage (L) mid back is ½ x 1cm < 1.0 cm c black eschar. (L) trochanter is ½ cm x 2cm c slough area in center... TREATMENT: (L) hip clean c N/S [Normal Saline] pat dry & apply duoderm [symbol for change] q [every] 3 days (L) mid back clean c NS pat dry & apply silver nitrate q day until healed. (L) trochanter clean c N/S apply Xenaderm oint [ointment] & change q day. Clinitron bed to promote healing of all ulcers..."</p> <p>During an interview at the 2nd Magoffin nurses' station on 9/19/12 at 7:30 AM, Nurse #8 was asked about skin assessments for residents. Nurse #8 stated, "Skin assessments were done weekly in February and March [2012]. In April</p>	N 691		

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N 691	<p>Continued From page 100</p> <p>[2012] they were done twice a month." Nurse #8 was then asked about Resident #54's pressure ulcers. Nurse #8 stated, "He developed them [pressure ulcers] after he came here..."</p> <p>The facility failed to put preventative measures in place to prevent the development of pressure ulcers; assess/accurately assess skin conditions, and failed to identify a pressure ulcer until it was a stage 3 pressure ulcer placed Resident #54 in conditions that are, or are likely to be detrimental to the resident's health, safety or welfare. This stage 3 pressure ulcer was an avoidable in-house acquired pressure ulcer which deteriorated during his stay at the facility.</p> <p>3. Medical record review for Resident #74 documented an admission date of 2/18/10 with diagnoses of Alzheimer's Disease, Dysphagia, History of Cerebrovascular Accident, Gastro Esophageal Reflux Disease, Hypertension, Depression, and Lung Cancer with Metastasis.</p> <p>Review of the weekly pressure ulcer records documented the following:</p> <p>a. An onset date of 5/31/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>b. 6/7/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>c. 6/13/12 - Stage II left hip pressure sore 1 cm x 0.8 cm <0.1 depth.</p> <p>The facility was unable to provide documentation of weekly skin assessments from 6/13/12 until 8/20/12.</p> <p>d. 8/20/12 - Stage II left hip pressure sore 2 cm x 2 cm <0.1 depth. This pressure ulcer had deteriorated since 6/13/12.</p> <p>e. 8/27/12 - Stage II left hip pressure sore 2 cm x 1.5 cm <0.1 depth.</p> <p>The facility is unable to provide documentation of</p>	N 691		

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N 691	<p>Continued From page 101</p> <p>skin assessment since 8/27/12.</p> <p>Review of the quarterly MDS dated 7/11/12 documented Resident #74 required extensive assistance and was total dependent for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. This same MDS in Section M for skin conditions documented Resident #74 had two Stage II pressure ulcers.</p> <p>Review of the physician's orders dated 8/15/12 documented, "...clean Lt [left] hip area [symbol for with] pat dry and cover [symbol for with] duoderm. [symbol for change] q [every] 3 days..."</p> <p>Review of the care plan dated 8/16/12 documented, "...Problem Impaired skin integrity... Approach Frequency... Weekly skin assessments per Charge Nurse... Administer treatment as ordered.."</p> <p>Review of the Treatment Administration Record (TAR) for 9/1/12 through 9/30/12 revealed treatment for pressure ulcers was not provided as ordered on 9/1/12, 9/7/12, 9/10/12, or 9/14/12 through 9/17/12.</p> <p>Observations in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 removed the duoderm dressing from Resident #74's left hip for assessment of the pressure ulcer. The pressure ulcer was assessed to be a Stage III with measurements of approximately 2 cm in diameter, full thickness of skin loss with reddish drainage noted on duoderm. The pressure ulcer has deteriorated to a Stage III since the development as a Stage II.</p> <p>During an interview in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 was asked what</p>	N 691		

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N 691	<p>Continued From page 102</p> <p>was the stage of the pressure sore. Nurse #5 stated, "...it's a Stage III..."</p> <p>During an interview in the MDS office on 9/18/12 at 10:43 AM, Nurse #4 was asked who is responsible to measure and stage pressure ulcers. Nurse #4 stated, "...the treatment nurse is suppose to measure the wounds weekly... The nurses on the floor are not supposed to measure or stage [pressure ulcers]..." Nurse #4 was asked who does the measurements and staging when the treatment nurse is working the floor instead of providing treatments. Nurse #4 stated, "...it has been three weeks to one month since the other treatment nurse has been here..."</p> <p>The facility was unable to provide documentation the pressure ulcer treatments had been provided as ordered or that weekly pressure ulcer assessments had been done as defined in the facility's policy. The facility staff failed to assess/accurately assess or provide care and treatments which resulted in an avoidable in-house acquired pressure ulcer that deteriorated. This placed Resident #74 in conditions that are, or are likely to be detrimental to the health, safety or welfare.</p> <p>4. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact.</p>	N 691		

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N 691	<p>Continued From page 103</p> <p>Review of the care plan dated 6/20/12 documented, "...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Assess record and report any blisters redness soft/mushy areas to charge nurse/MD [Medical Doctor]... Assess resident skin condition weekly... Use pressure reduction devices and position devices as needed... Turn and reposition resident q [every] 2 hours and prn [as needed]... Notify physician as soon as possible of redness, blisters or breakdown for proper initiation of treatment... 9/4/12 Right upper Inner thigh... Administer treatment as ordered by the physician. Ointments/Creams... Weekly skin assessments per Charge Nurse... Treatment Nurse to evaluate effectiveness of treatment and notify physician of changes..."</p> <p>Review of a physician's order dated 8/12/12 and timed 2p [PM] documented, "...Clean area to (R) upper inner thigh [symbol for with] NS pat dry and apply xenaderm oint [ointment] and cover [symbol for with] dry dressing every day..."</p> <p>Review of the TAR dated 9/1/12 through 9/30/12 documented, "...Clean area to (R) upper inner thigh [symbol for with] NS [normal saline], pat dry and apply xenaderm oint and cover [symbol for with] dry dressing qd [every day]..." Documentation on the TAR revealed the treatment was started on 9/4/12. There was no documentation the treatment was provided as ordered on 9/6/12, 9/7/12, 9/8/12 or 9/12/12.</p> <p>During an interview in Resident #82's room on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have</p>	N 691		

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N 691	<p>Continued From page 104</p> <p>sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night. I called [named Nurse #11] and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 am] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>Resident #82 was left wet with urine during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and one on the right buttocks.</p> <p>Review of the weekly pressure ulcer record dated 9/14/12 documented, "...DATE OF ONSET: 9-14-12 SITE/LOCATION: R buttock... Stage 2 SIZE IN CM [centimeters] (LENGTH X WIDTH) 2.0 X 2.0 DEPTH 0..." The new pressure ulcer on the L upper thigh was not described on the pressure ulcer record.</p> <p>Review of a nurse's note dated 9/14/12 at 6:00 PM documented, "Stage II area on Rt buttock and small open areas on R and L inner thigh c [with]</p>	N 691		

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N 691	<p>Continued From page 105</p> <p>appearance of Stage II... New orders noted at this time for R & L inner thigh & R buttock..."</p> <p>Review of a physician's order dated 9/14/12 and timed 6:05 PM documented, "Clean Rt buttock c NS pat dry and apply duoderm Change q Monday & Thursday & PRN [as needed] as needed... Clean right & left inner thigh areas c NS and apply xenaderm q shift..."</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh. There was nothing else. No other areas. If there is an area found it would be put on the log sheet and in the physician's communication book." There was no documentation of any report in the physician's communication book or the treatment log sheet.</p> <p>Review of the Medication Administration Record (MAR) dated 9/1/12 through 9/30/12 documented, "...Clean R & L inner thigh c NS & apply xenaderm q shift..." There was no documentation the xenaderm was applied as ordered from 9/14/12 through 9/17/12.</p> <p>Observations in Resident #82's room on 9/17/12 at 11:20 AM, revealed Resident #82 lying in bed. Nurse #1 and Certified Nursing Assistant (CNA #1) repositioned the resident to her left side. Resident #82 was wet with urine. There was no dressing covering the Stage II pressure ulcer on the resident's right buttock.</p> <p>During an interview in room 420 on 9/17/12 at 11:22 AM, Nurse #1 was asked if the Stage II ulcer on the Resident #82's right buttock had a dressing applied as ordered. Nurse #1 stated,</p>	N 691		

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N 691	<p>Continued From page 106</p> <p>"It's not on. This is it." The duoderm dressing was rolled up and laying on the incontinent pad under Resident #82's right thigh.</p> <p>During an interview in the conference room on 9/17/12 at 4:18 PM, Nurse #3 stated, "The Skin Evaluation sheet is supposed to be done monthly." Nurse #3 was asked if the weekly charting of the skin evaluation was completed for Resident #82. Nurse #3 reviewed the medical record and stated, "They're [nurses] not doing it [skin evaluation]. In this nurse's notes I don't see it."</p> <p>During an interview on 9/18/12 at 8:32 AM, Resident #82 was asked if the dressing was applied to the wound on her right buttock and ointment applied to the wounds on 9/17/12. Resident #82 stated, "No ma'am. Nobody came to put a dressing on me yesterday and not yet today."</p> <p>During an interview in the hallway outside the conference room on 9/18/12 at 8:45 AM, the Vice President (VP) was asked if the treatment nurse was here on 9/17/12 and performed the treatments. The VP stated, "No, she didn't come. The agency nurse did some treatments. The ones she got around to doing. I don't know how many or which ones."</p> <p>The facility was unable to provide documentation that pressure ulcer treatments had been provided as ordered or that the pressure ulcers were assessed weekly as defined in the facility's policy. The resident was left unattended and wet with urine during the night shift of 9/13/12 resulting in the development of two new avoidable in house acquired stage II pressure ulcers on the left inner thigh and on the right buttocks. The facility's staff</p>	N 691		

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N 691	<p>Continued From page 107</p> <p>failed to assess/accurately assess or provide care and treatments placed Resident #82 in conditions that are, or are likely to be detrimental to the resident's health, safety or welfare.</p> <p>5. Medical record review for Resident #60 documented an admission date of 3/5/10 with a readmission date of 1/18/11 with diagnoses of Diabetes Mellitus, Essential Hypertension, Senile Dementia, Paraplegia, Seizure Disorder, Gastroesophageal Reflux Disease, Thyroid Disease, Gastrointestinal Bleed and Peripheral Vascular Disease.</p> <p>Review of a physician's order dated 12/3/11 documented, "...CLEAN RT HEEL W [with] / NS, PAT DRY & WIPE W/ ALCOHOL WIPE & COVER W/ 4X4'S, ABD [abdominal] PAD & KERLIX WRAP DAILY..." Review of a physician's order dated 10/26/11 documented, "...CLEAN LT HEEL WOUND W/ NS, APPLY ALCOHOL WIPE DRESS W/PAD & KERLIX WRAP CHANGE EVERY OTHER DAY..." Review of a physicians order dated 6/18/12 documented, "...D/C [discontinue] all previous wound care orders. Clean right lat. [lateral] thigh [symbol for with] NS, pat dry & apply opsite & change Q [every] 3 days until resolved.</p> <p>Review of the "WEEKLY PRESSURE ULCER HEALING RECORD" documented, "...DATE OF ONSET 10/26/11 SITE/LOCATION (L) heel... DATE 5/3/12 STAGE... [check mark in box] Unstageable size in cm (length x width) 1/2 cm X 1/2 cm DEPTH < 0.1 cm..."</p> <p>Review of the treatment record dated 12/1/11 through 12/31/11 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on</p>	N 691		

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N 691	<p>Continued From page 108</p> <p>12/5,12/7, 12/9, 12/11, 12/13, 12/15, 12/17, 12/22, 12/24, 12/26, and 12/28/11. There were no treatments documented as being provided as ordered for the right heel pressure ulcer on 12/5, 12/7, 12/9, 12/11, 12/13, 12/15, 12/17, 12/23, 12/25, 12/27, and 12/29/11.</p> <p>Review of the treatment records dated 1/1/12 through 1/31/12 revealed there were no treatments documented as being provided as ordered for the left heel and the right heel pressure ulcers on 1/30 and 1/31/12.</p> <p>Review of the treatment record dated 2/1/12 through 2/29/12 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on 2/13, 2/15, 2/22, 2/24, 2/26, and 2/28/12. There were no treatments documented as being provided as ordered for the right heel pressure ulcer on 2/21, 2/22, 2/23, 2/24, 2/26, 2/27, and 2/28/12.</p> <p>Review of the treatment record dated 3/1/12 through 3/31/12 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on 3/1, 3/7, 3/9, 3/12, 3/14, 3/16, and 3/20/12. The treatment record dated 3/1/12 through 3/31/12 documented the pressure ulcer on the right heel had "Resolved..."</p> <p>Observations in Resident #60's room on 9/17/12 at 10:05 AM, revealed Resident #60's left inner heel had a small area of purplish skin that appears to be blistered or wrinkled. There was a blue maxi float mattress on the bed.</p> <p>Observations in Resident #60's room on 9/17/12 at 11:30 AM, revealed a beige regular mattress was placed on the bed. The replacement</p>	N 691			

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N 691	Continued From page 109 mattress was not a pressure relieving mattress. During an interview in the conference room on 9/17/12 at 2:50 PM, Nurse #3 verified the empty spaces on the treatment record indicated the treatments were not provided as ordered for the months of December 2011 and January, February, and March 2012. During an interview in the hallway on 2nd Magoffin across from the nurses' station on 9/18/12 at 8:30 AM, Nurse #2 was asked if Resident #60 was on any preventative measures when he was admitted on 3/5/10. Nurse #2 stated, "...He had wounds to his heels that resolved. Then he developed unstageable wounds to his heels on 10/11..." During an interview in the medical records office on 9/19/12 at 8:30 AM, the medical records personnel stated, "...They're not there [referring to documented weekly skin assessments]..." During an interview at the 1st McRee nurses' station on 9/19/12 at 8:35 AM, Nurse #4 stated, "...Yes, they should have weekly documentation about skin assessments whether it is 7-3, 3-11 or 11-7 shift... It [skin assessments] should be done weekly..." Nurse #4 verified there were no weekly assessments completed for Resident #60 from January 2012 to September 2012. The facility's failure to provide pressure ulcer treatments as ordered placed Resident #60 in conditions that are, or are likely to be detrimental to the resident's health, safety or welfare.	N 691		
N 692	1200-8-6-.06(4)(p) Basic Services (4) Nursing Services.	N 692		

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N 692	<p>Continued From page 110</p> <p>(p) Residents who are incontinent shall have partial baths each time the bed or bed clothing has been wet or soiled. The soiled or wet bed linen and the bed clothing shall be replaced with clean, dry linen and clothing immediately after being soiled.</p> <p>This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions</p> <p>Based on medical record review, observation, and interview, it was determined the facility failed to provide a partial bath each time the bed or bed clothing has been wet for 1 of 38 (Residents #82) sampled residents. The facility staff knowingly left the resident wet with urine during the evening and night shift, which resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of Resident #82.</p> <p>The findings included:</p> <p>Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact. Review of the facility's nurses notes for Resident #82 dated 9/4/12 documented, "...Staff encouraged to keep resident dry by changing briefs as much as possible... Resident requires... extensive /total ADL [Activities of Daily Living] care..." Review of the care plan dated 6/20/12 documented,</p>	N 692		

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N 692	<p>Continued From page 111</p> <p>"...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Turn and reposition resident q [every] 2 hours and prn [as needed]... PERINEAL CARE EVERY 2 HOURS..."</p> <p>During an interview in Resident #82's room on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night [9/13/12]. I called [named Nurse #11] and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 AM] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>An alert and oriented Resident #82, who is dependent on staff for ADL care, was left wet with urine in the bed during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and</p>	N 692		

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N 692	Continued From page 112 one on the right buttocks. During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh. There was nothing else. No other areas..." The facility failed to provide a partial bath each time the bed or bed clothing has been wet when staff knowingly left Resident #82 wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers.	N 692		
N 751	1200-8-6-.06(9)(c) Basic Services (9) Food and Dietetic Services. (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis, who is responsible for the development and implementation of a nutrition care process to meet the needs of residents for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the resident and treatment through diet therapy, counseling and/or use of specialized nutrition supplements. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, contract review, medical record review and interview, it was determined	N 751		

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N 751	<p>Continued From page 113</p> <p>the facility failed to employ a Registered Dietitian (RD) and ensure an RD assessed and implemented interventions that addressed nutritionally compromised residents with unplanned significant weight loss for 2 of 38 (Residents #101 and 124) sampled residents. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of these residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's resident rights policy documented, "...Resident... rights to adequate and proper treatment and care established by any applicable statute, rule, regulation, or contract..." <p>During an interview in the conference room on 9/13/12 at 10:26 AM, the Vice President (VP) stated, "She [certified dietary manager (CDM)] is on FMLA [family medical leave of absence] since 9/9/12." The VP was asked, "Is there a Registered Dietitian (RD) to over see while the CDM is gone. The VP stated, "No."</p> <p>During an interview in the conference room on 9/17/12 at 3:30 PM, the VP was asked, "When is the last time you actually had an RD?" The VP stated, "April 30th [2012]." The VP was asked "Is there a reason you have not hired another [RD] to take her place?" The VP stated, "No reason in particular." The VP was asked, "If you have resident's with dietary needs, what do you do?" The VP stated, "That you will have to ask [named CDM]." The CDM was unavailable for interview due to being out on family medical leave as of 9/9/12.</p> <ol style="list-style-type: none"> Review of the "Professional Services Contract" dated 12/1/11 for Contractor (named 	N 751		

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N 751	<p>Continued From page 114</p> <p>dietitian) documented, "...TERMS OF CONTRACT - The term of this Contact [Contract] shall be from December 1, 2011 through June 30, 2012..."</p> <p>During an interview in the Director of Nursing's (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract one but she hasn't been here since March [2012]..."</p> <p>3. Medical Record review for Resident #101 documented an admission date of 4/1/10 with diagnoses of Diabetes Mellitus, Subarachnoid Hemorrhage, Hemiplegia Left-sided Weakness, Convulsions, Cerebrovascular Accident, Schizophrenia, Hypotension, Status Post Pneumonia and Dysphagia. Review of the weight tracking record dated 9/14/11 documented the resident's weight was 195 lbs. Six months later on 3/24/12 the resident's weight was documented as 175 lbs. The loss of 20 lbs in 6 months is an unplanned significant weight loss of 10.26 percent (%). Review of the dietary notes did not document a dietary assessment or progress note from 9/20/11 until 4/15/12. A Nutritional Risk Assessment was completed on 4/15/12 by the registered dietician (RD). The nurses notes, physician's orders and physician progress notes from 9/20/11 to 4/15/12 did not address the unplanned 10.26% weight loss. There is no documentation that the physician was notified of the unplanned significant (10.26%) weight loss. There were no interventions put in place to prevent further unplanned weight loss until 4/15/2, when the RD had assessed the resident.</p> <p>4. Medical record review for Resident #124 documented an admission date of 3/23/12 with</p>	N 751		

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N 751	<p>Continued From page 115</p> <p>diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the weight tracking record dated 3/24/12 documented an admission weight of 200 lbs and 4/20/12 documented a weight of 190 lbs. The unplanned weight loss of 10 lbs in one month (5%) was a significant weight loss. Review of the Nutrition Risk Assessment dated 4/1/12 documented that Resident #124 was moderate risk for weight loss. Resident #124's weight was documented as 182 lbs on 5/9/12, by this time the weight loss had reached 9% before his weight was addressed by the physician. The registered dietician nor the certified dietary manager (CDM) had addressed the resident's unplanned weight loss as of 9/20/12 when the survey was completed. The nurses notes do not address the unplanned significant weight loss.</p> <p>5. During an interview in the Director of Nursing's (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract one but she hasn't been here since March [2012]..."</p> <p>During an interview in the conference room on 9/18/12 at 8:42 AM, Nurse #4 was asked who addresses the dietary concerns when the CDM is not available. Nurse #4 stated, "We reply on the Doctor, since there is no RD."</p> <p>There was no one at the facility to interview to provide confirmation of the unplanned significant weight loss.</p> <p>The facility failed to provide nutritional</p>	N 751		

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N 751	Continued From page 116 intervention for residents with unplanned significant weight loss which placed Residents #101 and 124 in conditions that are, or are likely to be detrimental to the health, safety or welfare of these residents.	N 751		
N 780	1200-8-6-.06(10)(b) Basic Services (10) Social Work Services. (b) Social work services shall include psychosocial assessment, counseling, coordination of discharge planning, community liaison services, financial assistance and consultation. This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions Based on policy review, review of the Social Worker's (SW) job description, medical record review, observation and interview, it was determined the facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents. The facility failed to provide the necessary psychiatric services related to behaviors resulting in conditions that are, or are likely to be detrimental to the health, safety or welfare of these residents. The findings included: 1. Review of the facility's "DENTAL / OPHTHALMOLOGY / OPTOMETRY SERVICES" policy documented, "...OBJECTIVE: In an effort	N 780		

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N 780	Continued From page 117 to provide optimal quality of care to each resident. Diagnostic testing will be provided to maintain optimal function and timely treatment. PROCEDURE: 1. Obtain written order from MD [medical doctor] for needed services. 2. Send referral to assigned staff to set up appointment. (a) Dental referral to Social Services... 3. Notify Social Services for financial approval... If the resident has no payment source to cover treatment, Social Worker to call family and see if payment for services can be arranged. If no payment source found, the facility will pay for services..." 2. Review of the facility's "Social Worker" job description documented, "Provides... targeted intervention for social, emotional and environmental issues that impact client/family ability to optimally benefit from care. Actively collaborates with team to meet client care, outcome management and system improvement goals... 4. Maintains timely documentation. 4a. Consistently meets facility and regularly mandated documentation standards..." 3. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of	N 780		

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N 780	Continued From page 118 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days. Review of nurses notes documented the following: a. 10/28/11 - "...refused dinner... refuses skin assessment by staff... stays in room with door shut and privacy curtains pulled..." b. 11/22/11 - "...refused skin assessment... stays in the room with door closed and privacy curtain pulled..." c. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..." d. 3/20/12 - "...Aggressive towards other resident and staff..." e. 4/9/12 - "...confusion noted @ times with agitation..." f. 4/11/12 - "...resident refused this nurse's request to perform a head to toe skin assessment today..." g. 4/20/12 - "...Resident stays in the room with door closed often. Resident encouraged to socialize with other residents. Agitated @ times..." h. 7/18/12 - "...Attempted to notify RP [responsible party]... not to give resident large sum of money in order not to buy stuff from other residents. Resident has been purchasing stuff from another residents..." i. 8/9/12 - "...Refused blood draw x 2..." j. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c.	N 780		

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N 780	<p>Continued From page 119</p> <p>[wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."</p> <p>Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive or reclusive behaviors, refusals of care, social service referrals or mental health referrals.</p> <p>Review of the social service progress (SSP) notes from January 2012 to September 2012 there were no documented aggressive or reclusive behaviors, refusals of care or mental health referrals.</p> <p>The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11.</p> <p>Mental health documented visits on 11/15/11 and 12/6/11 with no documented problems. An abnormal involuntary movement scale (AIMS) assessment was done 12/6/11 with no problems noted. There has been no AIMS completed since 12/6/11.</p> <p>The facility failed to provide the necessary social services including mental health referrals for Resident #116.</p> <p>4. Medical record review for Resident #43 documented an admission date of 12/22/09 with diagnoses of Vascular Dementia with Delusions, Diabetes Mellitus, Alcohol Abuse, Hypertension, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual MDS dated</p>	N 780		

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N 780	<p>Continued From page 120</p> <p>11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 had impaired vision but did not have corrective lenses. Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...IMPAIRED VISION... 3... FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..." The facility was unable to provide documentation of a consult for vision services.</p> <p>During an interview in the activity room on 9/12/12 at 11:30 AM, the surveyor asked Resident #43 if he had any trouble reading. Resident #43 stated, "...when I read for a while my sight gets a little blurry..." Resident #43 was asked about glasses. Resident #43 stated, "...I could probably use some glasses..."</p> <p>During an interview in the SW's office on 9/18/12 at 11:30 AM, the SW was asked how referrals are made for a vision consult. The SW stated, "...I get with nursing, residents and family's... then I get with [named the financial service manager] from Resident Trust to see if the resident is... eligible... or if the family is willing to pay for the glasses..." The SW was asked if Resident #43 had ever had a vision consult. The SW stated, "...I will have to check..."</p> <p>During an interview in the conference room on 9/18/12 at 1:55 PM, the SW confirmed that Resident #43 had not previously had a vision consult.</p> <p>5. Medical record review for Resident #60 documented an admission date of 3/5/10 with diagnoses of Right and Left Heel Wounds, Diabetes Mellitus, Gastro Esophageal Reflux Disease, Multiple Sclerosis, Hypertension and</p>	N 780		

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N 780	<p>Continued From page 121</p> <p>Hypothyroidism. Review of the MDS with an ARD of 7/18/12 section B for vision was coded zero indicating no corrective lens. Review of the care area assessment (CAA) with an ARD of 7/18/12 documented, "...visual function summary notes Resident triggered D/T [due/to] impaired vision..."</p> <p>Review of a form from the "[Named eye clinic] dated 9/4/11 documented an eye exam with a prescription for glasses. Review of a form in Resident #60's medical record dated 1/11/12 documented, "...Glasses Dispensing Form..." dated 1/11/12.</p> <p>Review of the care plan dated 2/9/12 documented, "...IMPAIRED VISION... Approach... 3 FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..."</p> <p>Review of the social service progress (SSP) notes dated 9/2/10, 12/2/10 documented, "...Resident is seen as needed by...dental, eye care..."</p> <p>Observations in Resident #60's room on 9/12/12 at 3:30 PM, revealed Resident #60 wearing glasses.</p> <p>During an interview in Resident #60's room on 9/12/12 at 6:15 PM, Resident #60 was asked how long he had glasses. Resident #60 stated, "...6 or 7 months... my brother bought them for me..."</p> <p>During an interview in the conference room on 9/14/12 at 12:30 PM, the SW was asked for clarification of Resident #60's obtaining glasses. The SW validated Resident #60 came to her and told her he needed glasses and dentures at the same time. The SW stated this was sometime in October 2011. This surveyor asked the SW what</p>	N 780		

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N 780	Continued From page 122 the process was that was followed when a resident needed glasses or dentures. The SW stated that she checks to see if the Resident has [financial resources] and if the resident does not I notify the family they need glasses or dentures. This surveyor asked if she told this surveyor on 9/13/12 that this family did not have any money to buy the resident's glasses or dentures. The SW verified "Yes..." The SW was asked if she had resources for residents that don't have money that have needs for dental or visual exams. The SW stated, "Yes." The SW was then asked what the resources were. The SW stated she checks with local church groups and sometimes the facility will cover the expense. The surveyor asked if the facility covered these expenses [glasses/dentures]?" The SW stated, "No.." The SW was asked, "Are you aware that Resident #60 received glasses that his brother purchased in January 2011?" The SW stated, "No, the resident told me that his brother bought his glasses in April..." The SW was asked, "Did you attempt any resources to obtain glasses or dentures for Resident #60 from September 2011 through January 2012?" The SW stated "No, I did not..." The SW verified Resident #60 was not... eligible. The SW was asked if she had documented that this resident needed glasses or dentures, notified the RP or any attempts to help this resident get the items he needed. The SW stated, "No." The SW was asked, "For clarification, Resident #60 waited until May 2012 to have his teeth extracted because he was not approved through the state for [financial resources]?" The SW stated "Yes." The SW was asked, "...did you do anything to help him through your resources? The SW stated, "No.." 6. Medical record review for Resident #63 documented an admission date of 12/3/08 with	N 780		

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N 780	Continued From page 123 diagnoses of Diabetes Mellitus, Schizophrenia, Dementia and Dyslipidemia. Review of the MDS with an ARD of 10/31/11 section L was coded for D and F indicating obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. Review of the CAA Review Report dated 10/19/11 section Dental Care Summary Notes documented, "RESIDENT WITH CARIES AND DECAYED TEETH SOME WITH BLACK SEGMENTS AT GUM LINE. RESIDENT WITH COMPLAINTS OF TOOTHACHE DURING ASSESSMENT PERIOD AND WAS PLACED ON ANTIBIOTIC THERAPY. WILL PROCEED WITH WITH CARE PLANNING TO REFER TO DENTIST FOR EVALUATION AND TREATMENT AS INDICATED GIVE ANTIBIOTIC AS ORDERED AND TO MEDICATE FOR PAIN AS NEEDED FOR TOOTHACHE..." Observations in the dayroom on 9/10/12 at 10:30 AM, Resident #63 was was noted to have two top teeth visible with brownish stains, bottom teeth chipped and broken with brownish stains noted and need of cleaning. Observations in the dayroom on 9/10/12 at 3:00 PM and 4:45 PM and 9/12/12 at 8:00 AM, Resident #63's teeth needed cleaning. During an interview in the SW's office on 9/12/12 at 3:38 PM, the SW was asked about dental assistance for Resident #63. The SW stated, "I call [named dental office] and they put them [residents] on a list. If they are... eligible then the state will cover it otherwise family responsible party have to pay for it. [Named dental office] will call family and let them know cost of examination." The SW proceeded to place a call to the dental office to find out when Resident #63 was last seen by the dentist. Resident #63 was	N 780		

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N 780	Continued From page 124 last seen by the dentist in 2007, which was prior to admission to the facility. The SW further stated, "She's [referring to Resident #63] is not... eligible so her daughter would have to pay for it and she don't like to spend money." The surveyor then asked the SW about other sources to assist with dental needs of the resident. The SW stated, "I don't have any other sources..." During an interview in the conference room on 9/12/12 at 4:00 PM, the Director of Nursing (DON) was asked who was responsible for dental appointments for residents. The DON stated, "Whoever did the CAA should have told nurse on unit so they could notify Social Services and she will in turn check with [named dental provider] to see if they can see her if not then we would check for our services to see who can see her." During an interview in the Administration office on 9/12/12 at 4:20 PM, Nurse #3 was asked about a dental consult for Resident #63. Nurse #3 stated, "I put it [dental consult] on the CAA. When we have the care plan meeting, I normally if SW in there will tell her then. If not in care plan meeting will call her [SW] and let her know." During an interview on the administration hall on 9/13/12 at 5:50 PM, the SW stated, "She doesn't have [financial resources] so her daughter will have to pay for any dental service and I know her she doesn't like to spend any money." During an interview in the conference room on 9/14/12 at 1:15 PM, the DON was asked about dental appointments for residents. The DON stated, "[Named Social Worker] makes the appointment she checks to see if they have [financial resources]. If not... eligible and family can't pay then the facility has to take care of it..."	N 780		

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N 780	Continued From page 125 7. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Osteoarthritis, Diabetes Mellitus, Gastroenteritis, Renal Insufficiency, Degenerative Joint Disease, Callosities, Frequent Urination, Hypocholesterolemia, and Epilepsy. Nurses notes documented the following: a. 5/11/12 at 11:00 AM - "...found on second floor pulling down linen... staff said that he urinated on linen... Pt [patient] states "I was looking for a diaper, I didn't do that. I just pee on myself... told him to ask staff on his floor... understands and won't do it again..." b. 5/17/12 at 11:00 AM - "...Activity reported that resident had been informed multiple times to stop going in smoke... and going out doors and coming down handicap ramp... he just rode away from me in his wheelchair..." c. 7/11/12 at 11:00 AM - "...taking liners out of garbage cans..." d. 8/14/12 at 5:00 AM - "Resident continually taking other residents belongings personal items and clothing... going to other units taking or stealing items... going through personal things..." Review of the SSP for 2012 do not address the behaviors as noted in the nurses notes. 8. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia and a readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of the nurses notes throughout the	N 780		

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N 780	<p>Continued From page 126</p> <p>resident's stay documented multiple episodes of throwing and smearing bodily wastes and resisting care. There is no documentation in the SSP of behaviors.</p> <p>9. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the MDS with an ARD of 3/29/12, 4/2/12, 4/10/12 and 6/21/12 documented in Section B1000 assessed the resident's vision is "...Impaired - sees large print, but not regular print in newspapers / books..."</p> <p>Review of the CAA review report dated 3/29/12 documented, "Vision... Impaired... Resident triggered because he has impaired vision. His ability to see only in adequate light. Resident stated during interview that he does not have his glasses that were missing before admission to the facility. We will care plan to anticipate the resident's needs. We will also notify the ophthalmology department for new glasses, if possible."</p> <p>Review of the care plan dated 4/5/12 and updated 6/27/12 documented, "...Alteration in visual function r/t [related to] impaired vision... will maintain optimal level of function... follow up with ophthalmology/optometry physicians..."</p> <p>The facility was unable to provide documentation that a vision referral had been made.</p> <p>Observations in Resident #124's room on 9/11/12 at 9:50 AM, revealed Resident #124 was</p>	N 780		

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N 780	Continued From page 127 not wearing glasses. During an interview in Resident #124's room on 9/12/12 at 5:00 PM, Resident #124 was asked if he had ever had his eyes tested or if he had ever worn glasses. Resident #124 stated, "They [glasses] were stolen at the last place he was at and that he probably needed to be seen by an eye doctor for a new pair of glasses." During an interview in the MDS office on 9/14/12 at 9:00 AM, the SW was asked about Resident #124 having impaired vision at the time of admission, having no glasses and why this needed care was not addressed. The SW stated, "...I don't know. It's the resident or family member that will ask for vision consult, that's how I get notified that the resident needs glasses. Before [named school of optometry] comes out and sees them, they have to be ensured of payment... Department of Human Services determines eligibility, the state will pay for the eye exam and glasses, if not, I will have to get in touch with the family..." During an interview in the MDS office on 9/14/12 at 10:30 AM, Nurse #3 was asked if Resident #124 had impaired vision. Nurse #3 confirmed that the resident had been assessed as having impaired vision on the comprehensive assessment at the time of admission. During an interview in business office on 9/14/12 at 10:43 AM, the Financial Services Manager (FSM) was asked if Resident #124 had been referred to her to determine... eligibility due to a request for a vision referral. The FSM stated, "...No, he has not. He is Medicaid and does receive a social security check, so that would make him... eligible..."	N 780		

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N1207	<p>1200-8-6-.12(1)(g) Resident Rights</p> <p>(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:</p> <p>(g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103;</p> <p>This Rule is not met as evidenced by: Type A Penalty Suspension of Admissions</p> <p>Based on policy review, review of suspected abuse investigation form, review of nursing schedules, time clock forms, medical record review, observation, and interview, it was determined the facility failed to ensure 6 of 38 (Residents #47, 81, 14, 68, 82 and 116) sampled residents were free from physical, verbal, or resident to resident abuse. These findings resulted in conditions that are, or are likely to be detrimental to the health, safety or welfare of Residents #47, 81, 14, 68, 82 and 116 as evidenced by staff failing to report allegations to management and failing to protect residents from abuse. The facility failed to ensure that allegations of abuse were reported immediately to the Administrator; failed to report allegations of abuse and an injury of an unknown origin to the state survey agency; failed to investigate</p>	N1207		

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N1207	Continued From page 129 allegations of abuse and injury of unknown origin and failed to protect residents during investigations. The findings included: 1. Review of the facility's "ABUSE" policy documented..." It shall be the policy of Americare Health and Rehabilitation Center to ensure that all of its residents receive professional, humane, and compassionate medical and nursing care that is free from verbal, sexual and/or involuntary seclusion... 1. Verbal Abuse: Any use of oral, written or gestured language that includes derogatory terms to the resident, their families or is stated within hearing distances to describe a resident(s) regardless of their age, ability to comprehend or disability... 3. Physical Abuse: Behavior that includes, hitting slapping... Physical abuse may also included controlling behavior through corporal punishment... 6. Resident to Resident: Behavior between one resident to another that results in injury, pain, mental anguish or the deprivation of needed services... REPORTING THE INCIDENT: 1. Initially notify the Social Services personnel to intervene, and interview the resident(s) involved. 2. Notify the Director of Nursing [DON] and the Administrator of all reported alleged incidents of abuse... Management personnel shall assess, investigate and report all signs of suspect abuse... In the event that a possible incident of abuse has been reported, management personnel will conduct an investigation as follows: 1. Identify all parties involved... 2. Identify any witnesses's... 3. Conduct an immediate interview(s) of the persons involved in the alleged abuse and document... 4. Immediately provide a safe environment for the resident involved in the alleged incident... 5. If an employee is involved in the suspected abuse, the	N1207		

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N1207	<p>Continued From page 130</p> <p>employee will be suspended with pay, pending completed investigation of the alleged incident... 6. If another resident is involved, after the investigation has been completed, the resident will be returned to their assigned room or nursing unit and a room change will be made, if needed..."</p> <p>2. Medical record review for Resident #47 documented the resident admitted on 7/27/09 with diagnoses of Spina Bifida, Paraplegia, Anemia, Gastro Intestinal Hemorrhage, Major Depressive Disorder with Psychosis, Deep Vein Thrombosis and Hypertension. The annual Minimum Data Set (MDS) dated 5/31/12 and the quarterly MDS dated 3/8/12 documented the resident with a cognitive score of 15 which indicated that she was cognitively intact with no psychosis or behavioral symptoms.</p> <p>A nurses note dated 6/3/12 documented, "Resident came to this nurse while I was passing meds [medications], stated she was outside sitting in mobile chair next to her friend... stated, CNA [certified nursing assistant #14] started arguing with her, they both got into an argument, the quarrel escalated to 1st Magoffin hall, she said CNA [#14] put her hand on resident forehead and the other [hand] on her throat, started choking her and slap her face. tiny scratch noted to lt. [left] side of face... will continue to monitor..."</p> <p>During an interview in Resident #47's room on 9/19/12 at 8:00 AM, Resident #47 stated, "Been here 3 years... Yes, a CNA she tried to choke me, her name is [named CNA #14], yes, she has continued to take care of me [since that incident], I told the nurse."</p> <p>During an interview in the conference room on</p>	N1207		

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N1207	<p>Continued From page 131</p> <p>9/18/12 at 5:00 PM, the Administrator stated, "No, was not aware of this [allegation of abuse to Resident #47] until today. I have talked with the CNA involved [CNA #14] and she has been suspended [9/18/12] until the investigation completed. The facility was unable to provide documentation that the nurse protected the resident from further potential abuse by the staff member accused of abusing the resident.</p> <p>The facility was unable to provide documentation that an incident report was completed, the staff failed to immediately report an alleged allegation of abuse to management, failed to ensure an allegation of abuse was thoroughly investigated, failed to report an allegation of abuse to the state survey agency.</p> <p>3. Medical record review for Resident #81 documented the resident admitted on 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. The annual MDS dated 3/1/12 documented a cognitive score of 7 indicating he was severely impairment, no behavioral symptoms, no falls, no wounds, required extensive care with activities of daily living, had no swallowing issues and was not on anticoagulants. The quarterly MDS dated 8/16/12 documented a cognitive score of 5 indicating he was severely impairment, no behavioral symptoms, no falls, no wounds, no swallowing issues, and on daily anticoagulants.</p> <p>During an interview in the conference room on 9/11/12 at 10:30 AM, a family member of Resident #81 stated, "Nurse [named #10] on Saturday 9/8/12 ripped cover off of wound, wound bled and he [Nurse #10] wiped it, showing no</p>	N1207		

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N1207	<p>Continued From page 132</p> <p>compassion, [Nurse #10] got very loud and rude when asked to see his supervisor. [Nurse #10] said, "I'm black, that's why I'm loud." [Nurse #10] said he had 36 patients and was over this entire building, you are not the RP [responsible party] we cannot speak to ya'll..."</p> <p>During an interview in the conference room on 9/11/12 at 11:00 AM, the Administrator was informed of the wound of unknown origin noted on 8/25/12 and of the incident voiced by the family member that occurred on 9/8/12. The Administrator stated, "Will contact RP and get the process [investigation] started..."</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 was asked if he had ever been accused or involved in a abuse investigation. Nurse #10 stated, "Yes, about a year ago was accused of an inappropriate statement to a resident, was suspended and after investigation, it was found okay and they brought me back. Then about 4 to 6 months ago a resident accused me of pulling a plug of her hair out. They [management] found she [Resident #81] had told a CNA she planned to get my job and had requested hair from the brush." Nurse #10 was asked about Resident #81's wound care. Nurse #10 stated, "The CNA [#2] told me about the area [8/25/12]. I assessed it, cleaned and dressed it. I notified the physician and put a note in book for wound nurse to evaluate it. I did not notify family of the wound. The wound was open and bleeding... I was the supervisor that day and the next day and reported it to [named Vice President] on Sunday [8/26/12]... as an injury of unknown origin..."</p> <p>During an interview in the conference room on 9/13/12 at 4:50 PM, the Vice President (VP) was</p>	N1207		

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N1207	<p>Continued From page 133</p> <p>asked if Resident #81's injury of the unknown origin had been reported to her. The VP stated, "No, do not recall any report of an injury."</p> <p>During an interview in 1st McRee nurses station on 9/14/12 at 7:15 AM, CNA #2 was asked about Resident #81's wound. CNA #2 stated, "Yes, I found [named Resident #81's] wound, I was giving him his bath on Saturday 8/25/12, I called for [named Nurse #10], he came and took care of it. I worked on 8/24/12 and it [wound] was not there. I told [named VP] about it on Sunday 8/26/12 and she told me she was going to let the doctor know about it."</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Resident #81 looked at the surveyor, nodded his head but was non verbal. A dressing was noted on his left upper chest area. Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw and upper part of wound was pink.</p> <p>Review of the August 2012 and September 2012 nursing schedules which are completed by the VP and review of the time clock correction forms signed by the supervisor documented Nurse #10 worked the date of the incident 8/25/12, and on 8/26/12 the date that the incident was reported to the VP. The schedule and time clock forms revealed Nurse #10 worked 8/27/12, 8/28/12, 8/31/12, 9/1/12, 9/2/12, 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 continued to work and care for the resident after this alleged incident had been reported to the VP on 8/26/12.</p> <p>The facility staff failed to protect Resident #81</p>	N1207		

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N1207	<p>Continued From page 134</p> <p>from potential abuse after the VP was notified of the injury of unknown origin on 8/26/12. On 9/11/12 the Administrator was informed of the 8/25/12 injury of unknown origin and the allegation of alleged abuse that occurred on 9/8/12.</p> <p>The facility failed to protect Resident #81 from potential abuse when Nurse #10 continued to work and care for Resident #81 after being accused of an alleged abuse incident on 9/8/12. Nurse #10 was not suspended from work until 9/14/12. The facility was unable to provide documentation that an incident report was completed for an injury of an unknown origin and an allegation of abuse; the staff failed to immediately report an injury of an unknown origin and an allegation of abuse to management; failed to ensure an injury of an unknown origin and an allegation of abuse were thoroughly investigated, failed to report an injury of an unknown origin and an allegation of abuse to the state survey agency and failed to protect the resident from further potential abuse.</p> <p>4. Medical record review for Resident #14 documented an admission date 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident (CVA), Obesity, Bipolar Disorder, Constipation and Schizoaffective Disorder - Bipolar Type. Review of the annual MDS dated 12/8/11 documented, Resident #14 cognitive status scored "15" indicating being very cognitively aware and totally dependent on staff for bathing and toileting and that resident is always incontinent. The quarterly MDS dated 8/15/12 documented, cognitive status scored "11" indicating being cognitively aware and totally dependent on staff for bathing and always incontinent.</p>	N1207		

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N1207	<p>Continued From page 135</p> <p>During an interview in Resident #14's room on 9/10/12 beginning at 5:30 PM, Resident #14 was asked do you ever feel afraid because of the way you or some other residents are treated. Resident #14 stated, "Yes." Resident #14 was asked have you ever been treated roughly by staff. Resident #14 stated, "Yes." Resident #14 was asked if it was reported to anyone. Resident #14 stated, "No, I did not report them because I don't know who is the head nurse..." Resident #14 was asked has staff yelled or been rude to you. Resident #14 stated, "Yes... I ask them [CNAs] to wash my feet and legs and they say turn over here... I will beat your butt... they pull my bed away from the wall [so can't reach call light] they tell me don't push that call light... no nurses have said this, only CNAs..."</p> <p>During an interview in Resident #14's room on 9/12/12 at 4:00 PM, Resident #14 was asked again if she had ever been treated roughly by staff. Resident #14 stated, "Yes... that girl said turn over here and act right, she held my feet to the bed and squeezed my toes together... this is the only rough treatment that I've had... they never wash your legs or feet... they only want to wash the upper part..." Resident #14 was asked do you want to report this to the Director of Nursing (DON). Resident #14 stated, "Yes, I'll talk to her..."</p> <p>During an interview in the Director of Nursing's (DON) office on 9/12/12 at 4:20 PM, the DON was notified of Resident #14's request to talk to her. The DON was asked if she was aware that Resident #14 was having some problems with a CNA. The DON stated, "...I didn't know... I will talk to her..."</p>	N1207			

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N1207	<p>Continued From page 136</p> <p>During an interview in Resident #14's room on 9/13/12 at 8:18 AM, Resident #14 was asked if the DON talked with her yesterday. Resident #14 stated, "Yes, she did..." Resident #14 was asked if she was comfortable with the DON's response. Resident #14 stated, "Yes."</p> <p>During an interview in the DON's office on 9/14/12 at 12:15 PM, the DON was asked if she had talked to Resident #14, when the investigation was started and the progress on Resident #14's allegation. The DON stated, "Yes, I talked to her yesterday [9/13/12]... the investigation was started on 9/13/12 at 1:50 PM, the employees who work over there all the time were taken into her room... she was unable to identify the employee... the investigation continues..."</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked where the facility had gotten with the investigation of the allegation. Nurse #4 stated, "...I was in on that, she [Resident #14] didn't identify anybody, I even took a couple of people from 1st Magoffin and she didn't identify anyone... the DON is not here and I don't know how far she had gotten with it [investigation]..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 6:00 PM, the Administrator was asked about the status of the investigation for Resident #14's allegation of abuse by a CNA. The Administrator stated, "...I don't really know, but I will check on it and get back with you..."</p> <p>During an interview in the front office on 9/19/12 at 7:30 AM, the Administrator confirmed the facility knew of Resident #14's allegation of abuse prior to the beginning of the survey [9/10/12]. The</p>	N1207		

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N1207	<p>Continued From page 137</p> <p>Administrator stated, "...I knew about the allegation about [named Resident #14] from her son, he called me on 9/7 and I told [named DON] about it on 9/8... Yes, I knew about it..."</p> <p>The facility was unable to provide documentation of an investigation or an incident report for Resident #14's allegation of abuse.</p> <p>The facility failed to protect Resident #14 from verbal, mental and physical harm after being informed of the allegations of abuse on 9/7/12 and the failure to follow the facility's policy of reporting and/or investigating allegations of abuse resulted in Resident #14 being fearful. The facility failed to ensure staff knew who to report abuse to. The facility was unable to provide documentation that an incident report was completed after receiving an allegation of abuse; failed to conduct an investigation of the allegation of abuse that occurred on 9/7/12; failed to report the allegation of abuse to the state survey agency and failed to protect Resident #14 from abuse which resulted in Resident #14 being fearful.</p> <p>5. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Renal Insufficiency, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Diabetes Mellitus, Osteoarthritis, Gastroenteritis, Callosities, Degenerative Joint Disease, Hypocholesterolemia, Frequent Urination, and Epilepsy.</p> <p>Review of the complaint made by Resident #68 taken by the Director of Nursing (DON) and the Administrator dated 9/6/12 at approximately 2:00 PM documented, "[Resident #68] reported that on Monday, September 3, 2012, after breakfast and</p>	N1207		

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N1207	<p>Continued From page 138</p> <p>smoke break, he went to the office to check on his monthly check. [Nurse #10] was standing in the hallway pointing "Go back to 1st floor." Resident #68 stated he replied "I'm going to check on some business." [Nurse #10] replied, "No, you go back now." Resident #68 states that "[Nurse #10] grabbed the back of his chair, swung him around hastily and pushed him toward the elevator." Resident #68 stated that he felt light-headed. Since then he has been having severe pain in his neck but has not reported this [pain in his neck at time of incident] to anyone. He stated he has reported the incident to the Social Worker. After reporting the pain to his nurse, [Resident #68] was examined by the Medical Director on 9/7/12, regarding his complaint of pain. Noted "Getting better-cervical disc several years ago." No changes were made in his plan of care."</p> <p>Review of the nurses notes dated 9/5/12 at 2:55 PM documented, "...Resident [#68] c/o [complained of] neck pain... Placed name in physician's book..."</p> <p>Review of a physician's note dated 9/7/12 documented, "...neck pain sev [several] days... Has H/O [history of] cervical disc surgery year ago..."</p> <p>Review of the facility's review of suspected abuse investigation form documented, "...EMPLOYEE [circled on the form] /WITNESS STATEMENT... Resident's Name (alleged victim): [Resident #68]... Employee [circled on the form] ...Name: [Nurse #10]..." All other information on the form was blank. Review of the "INVESTIGATION OF ALLEDGED [alleged]... Abuse... Pending..."</p> <p>Review of the September 2012 nursing schedules</p>	N1207		

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N1207	<p>Continued From page 139</p> <p>which are completed by the Vice President revealed Nurse #10 worked and continued to care for Resident #68 on 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 was not suspended from work until 9/14/12.</p> <p>Observations at the 1st Magoffin nurses station on 9/11/12 at 7:45 AM, revealed Nurse #10 standing at the medication cart.</p> <p>During an interview in Resident #68's room on 9/11/12 beginning at 9:30 AM, Resident #68 was asked a series of screening questions to determine if he was of a cognitive level so that he could be interviewed regarding the care and treatment he received at the facility. Resident #68 was determined to be interviewable. Resident #68 was asked, "Have you ever been treated roughly by staff?" Resident #68 replied, "...[Named nurse #10] handles residents roughly... about a month ago I went upstairs to check on my funds... it was the first of the month... and [Nurse #10] immediately told me to go back to my room and [Nurse #10] began shoving me around... turned me around in my wheelchair and my neck hurt... told the Director of Nursing... she said she would talk to him [Nurse #10]..."</p> <p>During an interview in the Administrator's office on 9/12/12 at 5:26 PM, the Administrator was asked what usually happens when an allegation of abuse occurs. The Administrator stated, "...I try to get the investigation done in 5 days but I am not always faithful in this... if it is a caregiver they are reassigned even if it is to another area... then I get all the statements... and make a decision..." The Administrator was asked if staff members are suspended according to the facility policy. The Administrator stated, "Yes." The Administrator was asked why Nurse #10 was not</p>	N1207		

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N1207	<p>Continued From page 140</p> <p>suspended after the allegation made by Resident #68. The Administrator stated, "I don't think this is abuse..."</p> <p>During an interview in the conference room on 9/14/12 at 8:50 AM, the Administrator stated, "...We suspended [Nurse #10] this morning. We told the Vice president he is not to be scheduled to work until the investigation is complete. We are investigating and getting statements at present..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 11:00 AM, the Administrator confirmed that the investigation was still on-going.</p> <p>The facility failed to recognize abuse; protect residents from verbal, mental and physical harm; and failed to follow the facility's abuse policy for reporting and investigating abuse.</p> <p>6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual MDS dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident was cognitively intact.</p> <p>Resident #82 reported the following allegations of abuse to the surveyor:</p> <p>a. During an interview in Resident #82's room 401 on 9/12/12 at 8:20 AM, Resident #82 was asked if she was treated with respect and dignity by the staff. Resident #82 stated, "Some days [named CNA #2] is in one of her moods. She [CNA #2]</p>	N1207		

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N1207	<p>Continued From page 141</p> <p>talks to me like a little child, like she is my parent. One day she came in here and said if I blow that horn again I'm going to send you out. She [CNA #2] tried to say I had a horn and was blowing it and acting out... She [CNA #2] said I was going to go back to [named hospital]... She [CNA #2] threatens me with that all the time and makes me afraid. I told the supervisor."</p> <p>During an interview at the McRee nurses station on 9/13/12 at 9:15 AM, Nurse #4 was asked if she received a report of an allegation of abuse involving CNA #2 talking to Resident #82 in a demeaning way and threatening to have her sent out." Nurse #4 stated, "I remember her [Resident #82] telling me that... said it was something about a horn that was blowing... said the aide told her she would be sent back to [named hospital]. Nurse #4 was asked if the incident was investigated. Nurse #4 stated, "I didn't investigate. I reported it to the Social Worker (SW). I never heard anything else about it."</p> <p>During an interview in the SW's office on 9/13/12 at 3:40 PM, the SW was asked if Resident #82's allegation of abuse was investigated. The SW stated, "I talked to [named Resident #82] about the incident... I didn't officially investigate. I guess that would [responsible for investigating] be [named Administrator]... She [Resident #82] told me she was upset..."</p> <p>b. During an interview in room 401 on 9/13/12 at 4:35 PM, Resident #82 stated, "[Named CNA #16] called me names... called me "devil" and said "you are no good." I reported to the head nurse [DON]. [Named CNA #16] was taken off my assignment."</p> <p>During an interview in the DON's office on</p>	N1207		

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N1207	<p>Continued From page 142</p> <p>9/14/12 at 10:12 AM, the DON was asked if an allegation of abuse involving Resident #82 had been investigated. The DON stated, "I kind of remember her talking about [named CNA #16]... She may have said something about how he talked to her, but it would be because he is a male. He was moved from her assignment... She did not tell me anything that seemed abusive."</p> <p>During an interview in the Administrator's office on 9/14/12 at 12:25 PM, the Adm stated, "I do remember being told she [Resident #82] had a problem with [named CNA #16] and Resident #82 had expressed this to the DON. I don't know where it went from that. If she felt this was an allegation of abuse I would expect her tell me right away." The Adm was asked if the DON reported the allegation. The Adm stated, "No. She [DON] told me she was looking into something that happened, but she did not tell me of an abusive situation."</p> <p>During an interview in the Administrator's (Adm) office on 9/17/12 at 9:30 AM, the Adm was asked if he considered being called "devil" and telling a resident "you are no good" abusive. The Adm stated, "By all means, I would consider that verbal abuse." The Adm was asked if the allegation had been investigated and reported. The Adm stated, "I'll have to ask..."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked what was the process for handling an allegation of abuse. The DON stated, "...It's usually their [employees] word against the resident and I cannot prove anything. If they told me directly the employee was verbally abusive or physically rough I would report that. It just depends on what the resident tells me... If they say they cursed me,</p>	N1207		

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N1207	<p>Continued From page 143</p> <p>said ugly names, handled rough I know that is abuse. I report it immediately to Adm so he can start his investigation. The Adm reports it to the state because he is the abuse coordinator."</p> <p>During an interview in the Administrator's office on 9/18/12 at 4:01 PM, the Adm was asked where he was in the investigation process related to the reported allegation of abuse by Resident #82 on 9/14/12. The Adm stated, "Not very far. I'll get on that in the morning unless you want it today."</p> <p>The facility was unable to provide documentation of an incident report or an investigation of the allegations of abuse reported by Resident #82. The facility failed to recognize abuse; protect Resident #82 from verbal, physical and mental abuse; failed to investigate an allegation of abuse and failed to report an allegation of abuse to the state survey agency.</p> <p>7. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the MDS with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days.</p>	N1207			

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N1207	<p>Continued From page 144</p> <p>Review of nurses notes documented the following: a. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..." b. 3/20/12 - "...Aggressive towards other resident and staff..." c. 4/9/12 - "...confusion noted @ times with agitation..." d. 4/20/12 - "...Agitated @ times..." e. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."</p> <p>Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive behaviors, social service referrals or mental health referrals.</p> <p>Review of the social service notes from January 2012 to September 2012 documented no aggressive behaviors or mental health referrals.</p> <p>The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11.</p>	N1207		

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N1207	Continued From page 145 The facility failed to monitor and address Resident #116's aggressive behaviors, failed to investigate the incident and report the incident of resident to resident abuse to the state agency.	N1207			