

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

PRINTED: 12/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED RECEIVED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p><i>acceptable POC 12/20/11</i></p>	F 272	<p>483.20(b)(1) Comprehensive Assessments Requirement:</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>George Munchow</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12-20-11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This same POC was faxed 12/20/11

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F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to completely assess residents for dentures for 1 of 10 (Resident #2) sampled residents reviewed of the 38 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #2 documented an admission date of 6/16/11 with diagnoses of Recurrent Falls, Urinary Tract Infections, Chronic Anxiety, Debility and Advanced Dementia. Review of the admission Minimum Data Set (MDS) dated 6/23/11 MDS documented, "...Section L- Oral / Dental Status- LO200. Dental ...z. None of the above present..." Review of the admission dietician assessment revealed "...U/L [upper/lower] Dentures ...7/26/11 weight 3.2% [percent] decrease 30 days..." Review of the admission nursing assessment dated 6/16/11 documented, "...Appetite good... Dentures Upper and Lower..." Review of the weight-record documented the following: admission weight 6/16/11 - 82.6; 6/27/11 - 81.8; 7/5/11 - 82.0; 7/11/11 - 81.4; 7/18/11 - 79; 7/25 - 79; 8/1/11 - 78; 8/8/11 - 77; 8/15/11 - 75.5; 8/22/11 - 74 and 8/29/11 - 75.6. Review of the care plan dated 6/29/11 and updated 9/20/11 documented, "...Risk for poor intake due to leaving 25%- [to] 50% diet left uneaten... Monitor weights and appetites..."</p> <p>During a telephone Interview with Resident #2's granddaughter on 11/29/11 around 4:00 PM, the</p>	F 272	<p>Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Resident #2 dentures assessed by DON on 11/29/2011 for proper fit with referral to dental services obtained and scheduled. 2. All residents oral cavities were observed from 11/29/11-12/09/11 by nursing staff with interventions in place. 3. the DON in-serviced the licensed nursing staff on 12/06/11 on complete body audits to include oral cavity related to dental care. 	12/09/2011
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F 272	Continued From page 2 granddaughter stated, "...she has difficulty chewing food due to dentures being too big... has lost weight and her dentures don't fit properly..." During an interview in the Director of Nursing's (DON) office on 11/30/11 at 4:05 PM, the DON was asked who is responsible for assessing residents mouth for issues with teeth or dentures. The DON stated, "...CNAs [Certified Nursing Assistants] and Nursing..." The DON was then asked should nurses inspect the dentures when a resident has weight loss. The DON stated, "I would before she had a 7% weight loss... They should have it [dentures] documented on monthly summary... It is not there..."	F 272	4. Nurse management will monitor for compliance through random oral cavity inspections and finding will be reported to the QA Committee monthly for one quarter.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		

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F 278	<p>Continued From page 3</p> <p>to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to accurately assess residents receiving hospice care for 1 of 10 (Resident #9) sampled residents reviewed of the 38 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #163 documented an admission date of 8/7/06 with diagnoses (dx) of Coronary Artery Disease (CAD), Hypertension, Depression, Insomnia and Gastroesophageal Reflux Disease. Review of the quarterly Minimum Data Set (MDS) dated 9/13/11 documented Resident #163 was receiving hospice while a resident. Review of the quarterly MDS dated 6/21/11 documented Resident #163 was not receiving hospice while a resident. The [Named Hospice] care plan dated 1/22/11 documented, "...Hospice care d/t [due to] terminal diagnosis listed above..." Review of the care plan dated 3/30/11 and updated 9/15/11 documented, "...Care and comfort measures only per MD [medical doctor] orders... Hospice care program of: [Named Hospice]..." Review of physician's orders dated 10/26/11 documented, "...Palliative Care... Admit to [Named Hospice] Care..."</p>	F 278	<p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in resident assessment is subject to a civil money penalty of not more than \$5000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement</p> <p>F278 Corrective Action:</p> <ol style="list-style-type: none"> 1. Resident #9 MDS was revised to reflect Hospice status on 12/02/11. 2. All residents MDS was audited by MDS staff for accuracy. 3. The DON in-serviced the MDS staff on 12/06/11 on accuracy of assessments. MDS staff will audit each other before transmittion of hospice assessments. 	12/09/11	

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F 278	Continued From page 4 Review of a physician's telephone order dated 1/22/11 documented, "...Admit to [Named Hospice]... Dx: CAD..."	F 278	4. Nursing management will monitor for compliance through random chart audits and finding will be reported to the QA committee monthly.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure residents were invited to participate in	F 280	483.20(d)(3) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP REQUIREMENT The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed wqothin 7 days after the completion of the comprehensive assessment; prepared by an		

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F 280	<p>Continued From page 5</p> <p>care planning or to revise the care plan for a bed alarm for 2 of 10 (Residents #80 and 100) sampled residents reviewed of 38 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #80 documented an admission date of 2/24/11 with diagnoses of Dementia with Behavioral Disturbances, Hypertension, Gastroesophageal Reflux Disease, Dementia with Psychosis, Macular Degeneration and Anemia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/22/11 documented section C-Cognition coded the resident as 13 indicating capable of making own decisions. Review of the MDS with an ARD of 8/23/11 documented section C-Cognition coded the resident a 10 indicating modified independence in decision-making skills. Review of the "MDS/Care Plan Progress Notes" dated 8/25/11 documented, "...Quarterly Assessment done & [and] CP [care plan] updated..." Review of the "MDS/Care Plan Progress Notes" dated 11/16/11 documented, "...Quarterly assessment done & CP completed..."</p> <p>During an interview in Resident #80's room on 11/28/11 at 2:30 PM, Resident #80 was asked about being involved in decisions about her daily care. Resident #80 stated, "No, [involved with decision making] not sure about that."</p> <p>During an interview in the MDS office on 11/30/11 at 2:50 PM, the MDS Coordinator stated, "We mail a letter to the responsible party about the care plan meeting. I give the original to the Social</p>	F 280	<p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons agter each assessment.</p> <p>Corrective action:</p> <p>1. Resident #80 placed on list to be notified of care plan meeting on 11/30/11. Resident #100 MDS was corrected to reflect low bed; bed alarm D/C'd on 12/1/11.</p> <p>2. All resident will be notified of care paln meetings and documented on Care Plan team agenda. Care Olans were audited for accurate interventions 12/1/11-12/6/11.</p>	12/06/11	

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F 280	<p>Continued From page 6 Worker and she mails them out."</p> <p>The facility was unable to provide documentation of Resident #80 being invited to participate in the care plan meetings.</p> <p>2. Medical record review for Resident #100 documented an admission date of 6/16/11 with diagnoses of Dementia, Hematuria, Suspected Prostatitis and History of Falls, Benign Prostatic Hypertrophy, Hypertension, and Vitamin D Deficiency. Review of the admission MDS dated 9/8/11 documented section C- Cognition coded Resident #100 as 9 indicating the resident's decision making skills were moderately impaired,extensive assist for bed mobility, transfer, walk in room, yes to falls anytime in the last month prior to admission, and 1 fall with no injury since admission or prior assessment whichever is more recent. Review of the physician orders dated 11/29/11 documented "...BED ALARM TO BED..." Review of the care plan dated 9/7/11 documented, "...Actual fall... bed alarm to bed..."</p> <p>Observations on the 200 hall on 11/29/11 at 9:20 AM, revealed Resident #100 sitting in the hallway in a wheelchair (w/c), with no alarm on the w/c.</p> <p>Observations on the 200 hall on 11/30/11 at 9:15 AM, revealed Resident #100 propelling self in the hall with no pad or cushion in w/c seat, and no alarm on the chair</p> <p>Observations in the dining room on 12/1/11 at 2:50 PM, revealed Resident #100 sitting in a w/c with no alarm on the chair.</p>	F 280	<p>3.The DON in-serviced the MDS staff on 12/6/11 on notification of care plan meetings with patients and documentation of invitation; proper interventions and discontinuing of interventions on care plans.</p> <p>4. Nurse management will monitor for compliance through random chart audits and finding will be reported to the QA committee monthly.</p>		

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F 280	Continued From page 7 Observations in Resident #100's room on 12/1/11 at 3:30 PM, revealed no bed alarm on the bed. During an interview in Resident #100's room on 12/1/11 at 3:30 PM, Certified Nursing Assistant (CNA) #1 was asked if Resident #100 had a bed alarm on his bed. CNA #1 stated, "It [alarm] should be on his chair with him... no not here [alarm] in his bed... it must be in his w/c with him..." CNA #1 assisted Resident #100 to stand to look in the seat of his w/c. CNA #1 stated, "It's [alarm] not here..." During an interview with the Assistant Director of Nursing (ADON) in the sun room on 12/1/11 at 4:00 PM, the ADON was asked if Resident #100 had a bed alarm. The ADON stated, "No, we don't use them because we have the low beds..." The ADON was then asked should the bed alarm be used if there is a physician's order for a bed alarm. The ADON stated, "yes..." The ADON was asked if the bed alarm and the chair alarm were the same thing. The ADON stated, "yes..."	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation	F 323	REQUIREMENT 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervieion and assistance devices to prevent accidents.		

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F 323	<p>Continued From page 8</p> <p>and interview, it was determined the facility failed to follow a physician's order for a bed alarm for 1 of 2 (Resident #100) sampled residents reviewed of the 2 residents included in the Stage 2 review with falls.</p> <p>The findings included:</p> <p>Medical record review for Resident #100 documented an admission date of 8/26/11 with diagnoses of Dementia, Hematuria, Suspected Prostatitis, History of Falls, Benign Prostate Hypertrophy, Hypertension, and Vitamin D Deficiency. Review of a physician's certification order dated 11/29/11 documented, "...BED ALARM TO BED..." Review of the care plan dated 11/23/11 documented, "...Risk for falls due to unsteady gait and Hx [history] of falls... INTERVENTIONS... Encourage out of bed daily, Call light available and answered promptly. Staff to assure resident receive assistance when needed. Staff to instruct resident to use handrails. Staff to encourage resident to ask for assistance. Keep in view of staff when OOB [out of bed]. Bed alarm to bed, Instructed Res [resident] to call staff before getting up, Low bed to be put in place..." Resident #100's care plan had documentation that Resident #100 had a fall on 9/1/11, 9/7/11, 9/8/11 and 11/8/11 actual fall.</p> <p>Observations in Resident #100's room on 12/1/11 at 2:50 PM, revealed Resident #100 lying in bed with no bed alarm on the bed.</p> <p>During an interview in Resident #100's room on 12/1/11 at 3:30 PM, Certified Nursing Assistant (CNA) #1 was asked, if Resident #100 had a bed alarm on his bed. CNA #1 stated, 'It should be on</p>	F 323	<p>Corrective Action</p> <ol style="list-style-type: none"> 1. Resident #100 bed alarm was discontinued. Order obtained for low bed 12/1/11. 2. All charts were audited for bed alarms with no further order found. 3. The DON in-serviced the nursing staff on low beds and not using bed alarms on 12/7/11. 4. Nurse management will monitor for compliance through recertification audits and finding will be reported to the QA committee monthly. 	

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F 323	Continued From page 9 his chair with him." CNA #1 proceeded to look on the bed and stated, "No [alarm] not here on his bed." During an interview outside the dining room on 12/1/11 at 3:35 PM, CNA #1 was asked if Resident #100 had a bed alarm. CNA #1 stated, "No." During an interview in the sun room on 12/1/11 at 4:00 PM, the Assistant Director of Nursing (ADON) was asked if Resident #100 had a bed alarm. The ADON stated, "No, we don't use them because we have the low beds..." The ADON was then asked should the bed alarm be used if it is on the care plan and have physician's orders for a bed alarm. The ADON stated, "yes..." The ADON was asked if the bed alarm and the chair alarm were the same thing. The ADON stated "yes..."	F 323			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to	F 412	REQUIREMENT 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with 483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making		

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F 323	<p>Continued From page 9</p> <p>his chair with him." CNA #1 proceeded to look on the bed and stated, "No [alarm] not here on his bed."</p> <p>During an interview outside the dining room on 12/1/11 at 3:35 PM, CNA #1 was asked if Resident #100 had a bed alarm. CNA #1 stated, "No."</p> <p>During an interview in the sun room on 12/1/11 at 4:00 PM, the Assistant Director of Nursing (ADON) was asked if Resident #100 had a bed alarm. The ADON stated, "No, we don't use them because we have the low beds..." The ADON was then asked should the bed alarm be used if it is on the care plan and have physician's orders for a bed alarm. The ADON stated, "yes..." The ADON was asked if the bed alarm and the chair alarm were the same thing. The ADON stated "yes..."</p>	F 323		
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to</p>	F 412	<p>REQUIREMENT</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p>	

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F 412	<p>Continued From page 10 accommodate routine dental services for 1 of 1 sampled resident of the 3 residents who had family interviews conducted.</p> <p>The findings included:</p> <p>Medical record review for Resident #2 documented an admission date of 6/16/11 with diagnoses of Recurrent Falls, Urinary Tract Infections, Chronic Anxiety, Debility and Advanced Dementia. Review of the admission Minimum Data Set (MDS) dated 6/23/11 MDS documented, "...Section L- Oral / Dental Status- LO200. Dental ...z. None of the above present..." Review of the admission dietician assessment revealed "...U/L [upper/lower] Dentures ...7/26/11 weight 3.2% [percent] decrease 30 days..." Review of the admission nursing assessment dated 6/16/11 documented, "...Appetite good... Dentures Upper and Lower..." Review of the weight-record documented the following: admission weight 6/16/11 - 82.6; 6/27/11 - 81.8; 7/5/11 - 82.0; 7/11/11 - 81.4; 7/18/11 - 79; 7/25 - 79; 8/1/11 - 78; 8/8/11 - 77; 8/15/11 - 75.5; 8/22/11 - 74 and 8/29/11 - 75.6. Review of the care plan dated 6/29/11 and updated 9/20/11 documented, "...Risk for poor intake due to leaving 25%- [to] 50% diet left uneaten... Monitor weights and appetites..."</p> <p>During a telephone interview with Resident #2's granddaughter on 11/29/11 around 4:00 PM, the granddaughter stated, "...she [Resident #2] has difficulty chewing food because her dentures are too big because she has lost weight and her dentures don't fit properly now..."</p> <p>During an interview in the 200 hall on 11/30/11 at</p>	F 412	<p>appointments;and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Resident #2 had a dental consult scheduled on 11/30/11 by Social Worker. 2.All charts were audited for dental consults and referrals with no further order found. 3.The DON in-serviced the nursing staff and social worker on correct procedure for dental consults on 12/6/11 and on timely scheduling on 12/7/11. 4.Nurse management and social services will monitor for compliance through new order audits weekly x4, then quarterly. Findngs will be reported to QA committee monthly. 	12/9/11

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F 412	Continued From page 11 2:50 PM, Nurse #4 was asked if Resident #2 feeds herself and who would do the dental referrals. Nurse #4 stated, "No, she doesn't feed herself and the nurses usually make the referrals..." The surveyor asked Nurse #4 what do you consult a dentist for. Nurse #4 stated, "broken, loose, missing teeth or pain or swelling..." Nurse #4 was asked, what about residents with dentures, do they ever get referred to the dentist and if so for what kinds of things? Nurse #4 stated, "No, well yes we do, if they are out of alignment like for weight loss or gain or if they have difficulty chewing." During an interview in the Director of Nursing's (DON) office on 11/30/11 at 4:05 PM, the DON was asked who is responsible for assessing residents mouth for issues with teeth or dentures. The DON stated, "...CNAs [Certified Nursing Assistants] and Nursing..." The DON was asked, should nurses inspect the dentures when a resident has weight loss. The DON stated, "I would..." During an interview in the MDS office on 11/30/11 at 4:55 PM, the MDS nurse was asked how would you know that someone's dentures do not fit and they have trouble chewing because they don't fit. The MDS nurse stated, "someone would tell us, they [the nurses] would have to look in their mouth... the Social Worker (SW) would make a referral for the dentist..." The SW was also in the room and left to make a referral stating, "...they [MDS nurse and SW] had not been told [about the loose dentures]..."	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	REQUIREMENT 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	12/6/11

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F 431	<p>Continued From page 12</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure</p>	F 431	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> Expired medication removed and destroyed. Pharmacy notified for replacement. All carts were audited for expired medications with none found. The DON in-serviced the nursing staff on 12/6/11 on checking expiration dates. Nurse management will monitor for compliance weekly 4x week, then monthly with medication pass audits. Findings will be reported to QA committee monthly. 		

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F 431	Continued From page 13 medications were not stored past their expiration date in 1 of 4 (300 hall medication cart) medication storage areas. The findings included: Observations in the medication room on 12/1/11 at 5:45 PM, revealed the 300 hall medication cart contained Ondansetran 4 milligrams/2 milliliters with an expiration date of 7/11. During an interview in the medication room on 12/1/11 at 5:45 PM, Nurse #1 confirmed the Ondansetran 4 milligrams/2 milliliters medication was expired.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure medical records were maintained	F 514	REQUIREMENT 483.75(l) (1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.		

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F 514	<p>Continued From page 14 accurately and completely for a resident's diet, Philadelphia collar or decubitus precautions for 2 of 14 (Residents #2 and 17) sampled residents reviewed of 38 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #2 documented an admission date of 6/16/11 with diagnoses of Advanced Dementia, Debility, Anxiety, Hypothyroidism, Hypertension and Psychosis. Review of a physician's telephone order dated 6/30/11 documented, "...[symbol for change] diet to mechanical soft..." Review of a physician's order dated 10/13/11 documented, "...Regular..." for diet.</p> <p>Observations in the dining room on 11/30/11 at 12:20 PM, revealed Resident #2 was served a mechanical soft diet. The diet card for Resident #2 was marked to indicate mechanical soft diet.</p> <p>During an interview in the Director of Nursing's (DON) office on 11/30/11 at 4:00 PM, the DON stated, "...The order was for a regular diet since this was the most current diet order..."</p> <p>2. Medical record review for Resident #17 documented an admission date of 4/13/06 with diagnoses of Coronary Artery Disease, Dementia, Hypothyroidism, Osteoporosis, History of Compression Fracture, Severe Degenerative Joint Disease and Kyphoplasty. Review of a physician's order dated 10/11/11 documented, "...PHILADELPHIA COLLAR ON EXCEPT FOR BATHING (BED BATH ONLY) TURN SIDE BACK TO SIDE REGULARLY W [with] / DECUB</p>	F 514	<p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes.</p> <p>Corrective Action:</p> <p>1. Physician order obtained for Resident #2 for correct diet. Physician order obtained on 12/1/11 to discontinue neck collar and decubitus care.</p> <p>2. Current resident recertification orders were reviewed on 11/30/11-12/07/11 to ensure orders were current.</p> <p>3. The DON in-serviced the nursing staff on 12/6/11 on completion of recertifications with current orders.</p> <p>4. Nurse management will monitor for compliance during random chart audits. Results will be reported to the QA committee monthly.</p>	12/7/11	

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F 514	<p>Continued From page 15</p> <p>[decubitus] PRECAUTIONS..." Review of the nurses notes dated 11/5/10 documented, "...ret'd [returned] from appt [appointment] c [with] no neck brace..."</p> <p>Observations in Resident #17's room on 11/28/11 at 11:00 AM, revealed Resident #17 was lying in bed on her back watching television and at 4:45 PM sitting on side of bed watching television. Resident #17 did not have a Philadelphia collar on.</p> <p>Observations in Resident #17's room on 11/29/11 at 9:30 AM, revealed Resident #17 lying on top of her cover on her bed. Resident #17 did not have a Philadelphia Collar on.</p> <p>Observations on the 200 Hall on 11/29/11 at 12:30 PM, revealed Resident #17 walking in the hall pushing the wheelchair. Resident #17 did not have a Philadelphia collar on.</p> <p>Observations in Resident #17's room on 11/30/11 at 9:15 AM, revealed Resident #17 in bed on her back. Resident #17 did not have a Philadelphia collar on.</p> <p>During an interview in the Assistant Director of Nursing's (ADON) office on 12/1/11 at 11:15 AM, the ADON was asked if Resident #17 had a decubitus. The ADON stated, "No." The ADON was then asked to explain the physician order "turn side back to side regularly w/decub precautions". The ADON stated, "I don't know what that [order] means. She [Resident #17] does not have a decubitus and we do not have decubitus precautions..."</p>	F 514			

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F 514	Continued From page 16 During an interview in the sun room on 12/1/11 at 4:30 PM, the DON was asked if the Philadelphia collar had been discontinued for Resident #17. The DON stated "...No..."	F 514	<p>RECEIVED DEC 27 2011</p>	
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