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

RECEIVED
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445485		01/11/2012

NAME OF PROVIDER OR SUPPLIER: ALLENBROOKE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3933 ALLENBROOKE COVE, MEMPHIS, TN 38118

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) was accurate for range of motion (ROM), catheters, and/or pneumonia vaccine for 4 of 26 (Residents	F 278	Please consider this Plan of Correction as Allenbrooke Nursing and Rehabilitation Center, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. 1. Residents 3, 5, 9, 22 MDS's were immediately corrected 2. All residents have the potential to be affected. 3. All MDS Staff were re-inserviced on ensuring accuracy of the MDS. 4. The MDS Coordinator will complete 10 random MDS audits weekly for 1 month, then 10 random MDS audits monthly for 2 months for accuracy. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.	1/29/12

accept the POC 1/24/12 SPP Hrc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 1/23/12

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 1/24/12 SPP

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F 278	Continued From page 1 #3, 5, 9, and 22) sampled residents. The findings included: 1. Medical record review for Resident #3 documented an admission date of 11/19/07 with diagnoses of Hypertension, Congestive Heart Failure, Diabetes Mellitus Type II, Cerebral Vascular Accident, Progressive Dementia, Right Mastectomy 2nd to Cancer, Urinary Tract Infection, Urinary Obstruction, Urinary Retention, Constipation, Psychosis, Glaucoma, Low Iron and Gastroesphogeal Reflux Disease. Review of Resident #3's annual MDS dated 9/15/11 documented, "...ROM Limits 1 Impairment on one side... A. Upper extremity (shoulder, elbow, wrist, hand)... Urinary Continence... 3 Always Incontinent..." Review of the care plan initiated 6/18/09 and updated 12/15/11 documented "...hand contractors..." The care plan initiated 9/22/10 and updated 12/15/11 documented..."Resident has indwelling foley catheter..." The MDS did not reflect that Resident #3 had bilateral impairments and that the resident was continent with the use of a foley catheter. Observations in Resident #3's room on 1/10/12 at 10:30 AM, Resident #3 had hand splints to left and right hand and a Foley catheter. 2. Medical record review for Resident #5 documented an admission date of 6/15/11 with diagnoses of Congestive Heart Failure, Chronic Kidney Disease, Hypertension, Diabetes and Edema. Review of the MDS dated 12/01/11 documented, "...Section H ...H0100 A. Indwelling catheter..." The MDS was coded incorrectly for the use of a catheter.	F 278		

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Observations in Resident #5's room on 1/9/12 at 9:31 AM, revealed Resident #5 did not have a catheter.

During an interview at the west nurses' station on 1/10/12 at 9:30 AM, Nurse #7 verified that Resident #5 did not have a catheter and has not had a catheter while in the facility.

3. Medical record review for Resident #9 documented an admission date of 10/3/07 and a readmission date of 7/15/11 with diagnoses of Paranoid Schizophrenia, Sacral Decubitus, Hypomagnesemia, Dehydration, Altered Mental Status, Neurogenic Bladder and Hypokalemia. Review of a physician's order dated 1/6/12 documented, "...Foley catheter... neurogenic bladder..." Review of the MDS dated 12/13/11 documented, "...H0100 Appliances... None of the above [Indwelling catheter, External catheter, Ostomy, Intermittent catheterization]..." and H0300 Urinary Continence "...Always incontinent..." the MDS was not coded correctly for the use of a foley catheter.

Observations in Resident #9's room on 1/9/12 at 11:00 AM, 2:30 PM and 4:00 PM, and on 1/10/12 at 7:15 AM and 9:30 AM, revealed Resident #9 with Foley catheter in place.

During an interview in the conference room on 1/11/12 at 10:05 AM, Nurse #10 stated, "...I couldn't find the Foley listed on the MDS. It was my mistake [not coding the foley catheter on the MDS]."

4. Medical record review for Resident #22

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F 278	Continued From page 3 documented an admission date of 12/14/11 with diagnoses of Cerebrovascular Accident, Hypertension and Atrial Fibrillation. Review of the "Resident Initial Influenza & [and] Pneumococcal Vaccine Administration Acceptance & Declination" dated 12/14/11 documented that the resident declined both the influenza and the pneumococcal vaccines. Review of the MDS dated 12/20/11 documented, "...Section O Special Treatments, Procedures, and Programs... Influenza Vaccine... If Influenza vaccine not received, state reason ...5. Not offered... Pneumococcal Vaccine... If Pneumococcal vaccine not received, state reason ...3. Not offered..." The MDS did not accurately document the vaccines were offered and declined by the resident.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow physician's orders for splints or elevating arms on pillows for 2 of 23 (Residents #3 and 5) sampled residents and failed to document interventions for lack of bowel movements for 1 of 23 (Resident #6) sampled	F 309	1. RI#3 Splints were applied. RI#5 Arms were elevated and RI #6 had results. 2. All residents have the potential to be affected 3. All Restorative staff will be re-inserviced on applying splints. All licensed staff will be re-inserviced on following policy on BM's after 72 hours . All Licensed Staff will be re-inserviced on accuracy, completeness and following of physician orders. 4. The Director of Nursing or Designee will complete 10 random Splint, Physician Orders and Bowel Movement audits weekly for 1 month, then 10 random audits monthly for 2 months for	1/29/12

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F 309	Continued From page 4 residents. The findings included: 1. Medical record review for Resident #3 documented an admission date of 11/19/07 with diagnoses of Hypertension, Congestive Heart Failure, Diabetes Mellitus Type II, Cerebral Vascular Accident, Progressive Dementia, Right Mastectomy 2nd to Cancer, Urinary Retention, Gastroesphogeal Reflux Disease and Low Iron. Review of physicians orders dated 1/6/11 documented, "...BILATERAL HAND SPLINTS APPLY 4- [to] 6 DAILY HRS [hours] with PROME [passive range of motion extremity] X [time] 15 MIN [minutes] BELIEVE [before], DURING, AND AFTER SPLINT WEAR..." Observations in Resident #3's room on 1/9/11 at 9:35 AM, 2:15 PM, and 5:55 PM, revealed Resident #3 was not wearing hand splints as ordered. During an interview in the conference room on 1/11/12 at 1:00 PM, the Director of Nursing (DON) was asked how often and when splints should be applied. The DON stated, "...everyday or as ordered..." 2. Medical record review for Resident #5 documented an admission date of 6/15/11 with diagnoses of Congestive Heart Failure, Chronic Kidney Disease, Edema, Diabetes and Hypertension. Review of physician's orders dated 1/6/12 documented, "...Elevate both arms on pillows above heart level Dx [diagnosis] edema..." Observations in Resident #5's room on 1/9/12 at	F 309	accuracy. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.	1/29/12

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F 309	Continued From page 5 9:31 AM, 2:15 PM and 4:30 PM, and on 1/10/12 at 7:25 AM, revealed Resident #5's arms were not elevated on pillows as ordered. During an interview at the west nurses' station on 1/10/12 at 9:30 AM, Nurse #7 verified that Resident #5's arms were supposed to be elevated above the level of the heart due to edema. 3. Review of the facility's "BOWEL ELIMINATION PROTOCOL" policy documented, "...2. Licensed nurses are alerted via the "Dashboard" ...of residents who have not eliminated in 72 hours or 9 shifts... 3. The resident Bowel Regimen will be found on the MD [medical doctor] orders or as per care plan..." Medical record review for Resident #6 documented an admission date of 11/21/08 and a readmission date of 1/24/09 with diagnoses of Peripheral Vascular Disease, Diabetes Mellitus, Cerebral Vascular Accident, Hypertension and Presenile Dementia. Review of the physician's recertification orders dated 1/6/12 documented, "...DUCOLAX 5 MG [milligram] TABLET EC [enteric coated] TWO (2) TABLETS (10 MG) BY MOUTH ONCE DAILY AS NEEDED..." Review of the "Elimination Report" from 10/1/11 to 1/9/12 had no bowel movements (BM) documented on 10/1/11, 10/2/11, 10/3/11, 10/4/11, 11/27/11, 11/28/11, 11/29/11, 12/26/11, 12/27/11 and 12/28/11. The facility was unable to provide documentation that a laxative was given for no BM in 72 hours as ordered or per policy. During an interview at the east nurses' station on 1/11/12 at 1:05 PM, Nurse #9 confirmed no	F 309		

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F 309	Continued From page 6 intervention was documented for no BM in 72 hours as per policy.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to administer oxygen at the physician's prescribed rate for 3 of 7 (Residents #8, 11, and 22) sampled residents receiving oxygen. The findings included: 1. Review of the facility's "OXYGEN THERAPY" policy documented,"...RESPONSIBILITY: All licensed Nursing Personnel... 4. Adjust delivery rate as ordered..." 2. Medical record review for Resident #8 documented an admission date of 11/12/09 and a readmission date of 8/17/10 with diagnoses of Alzheimer's, Urinary Tract Infection, Pneumonia,	F 328	1. RI#8, 11, and 22, Oxygen was corrected immediately. All residents were thoroughly assessed and free of negative outcome 2. All residents on Oxygen have the potential to be affected 3. All Licensed Staff will be re-inserviced on following Physician Orders properly 4. The Director of Nursing or Designee will complete 5 random audits on Residents receiving Oxygen weekly for 1 month, then 5 random audits on Residents receiving Oxygen monthly for 3 months. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.	1/29/12

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Hyperkalemia, Dehydration, Acute Renal Failure, Diabetes Mellitus Type II, Pressure Sores, and Gastroesophageal Reflux Disorder. Review of a physician's order dated 1/6/12 documented, "...Oxygen Therapy O2 [oxygen] @ [at] 4 L [liters] / [per] BNC [binasal cannula]..."

Observations in Resident #8's room on 1/9/12 at 10:35 AM, revealed Resident #8 receiving O2 at 1.5 L/BNC.

Observations in Resident #8's room on 1/9/12 at 2:00 PM, revealed Resident #8's O2 cannula was laying on the beside.

Observations in Resident #8's on 1/9/12 at 6:15 PM and on 1/10/12 at 7:15 AM, 9:30 AM, 11:30 PM, and 2:30 PM, revealed Resident #8 was receiving O2 at 2 L/BNC.

During an interview in Resident #8's room on 1/11/12 at 9:15 AM, Nurse #9 was asked to confirm the O2 setting on Resident #8's O2 concentrator. Nurse #9 stated, "...2 [L/BNC]..." Nurse #9 was asked to confirm the physician's order for Resident #8's O2 rate. Nurse #9 stated, "...4 [L/BNC]..."

3. Medical record review for Resident #11 documented an admission date of 10/20/11 with diagnoses of Pulmonary Edema, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Cardiomyopathy. Review of a physician's order dated 12/1/11 documented, "...O2 @ 2L BNC continuous Dx [diagnosis] SOB [shortness of breath]..."

Observations in Resident #11's room on 1/9/12 at

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F 328	Continued From page 8 10:00 AM, revealed Resident #11 was receiving O2 at a rate of 1/2 liter. During an interview at the west nurses' station on 1/11/12 at 9:45 AM, Nurse #7 was asked if anyone would change the flow rate of O2 besides licensed personnel. Nurse #7 confirmed only nurses adjust O2 rates. Nurse #7 stated, "...He [Resident #11] probably did it himself. He fidgets a lot..." During an interview in Resident #11's room on 1/11/12 at 9:55 AM, Resident #11 was asked if he could turn the knob on the O2 concentrator. Resident #11 stated, "...I don't know. I've never tried..." 4. Medical record review for Resident #22 documented an admission date of 12/14/11 with diagnoses of Cerebrovascular Accident, Hypertension and Atrial Fibrillation. Review of a physician's order dated 12/15/11 documented, "...O2 @ 2L BNC continuous..." Review of the care plan dated 12/20/11 and updated 1/3/12 documented, "...Administer O2 as ordered..." Review of the nurses' notes dated 12/16/11 documented, "...O2 sat [saturation] 98% [percent] on 3L BNC..." Review of the nurses' notes dated 12/17/11 documented, "...Sat 95% on 3L BNC O2..." Resident #22 had not received O2 as the physician's prescribed rate according to the documentation in the nurses notes.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	1 All residents were thoroughly assessed and were free of or negative outcome. Nurse 1, 3, and 5 were re-inserviced 2. All residents have the potential to be affected.	1/29/12

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F 332	Continued From page 9	F 332	3. All licensed staff will be re-inserviced on proper medication administration.	1/29/12

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to ensure the medication error rate was less than five percent (%) when 3 of 10 medication nurses (Nurses #1, 3, and 5) were observed to make medication errors. Three (3) errors were made out of 41 opportunities for error, which resulted in a medication error rate of 7.31%.

The findings included:

1. Medical record review for Random Resident (RR) #1 documented an admission date of 10/11/10 with diagnoses of Alzheimer's Disease, Hypertension, Peripheral Vascular Disease, Esophageal Reflux, Anemia, and Cardiovascular Disease. Review of the physician's order dated 1/6/12 documented "...FERROUS SULF [Sulfate] 300 mg [milligrams] / [per] 5 ml [milliliters] 5 cc [cubic centimeters] (300 mg) PER TUBE [Percutaneous Gastrostomy Tube] TWICE DAILY Bid..."

Observations in RR #1's room on 1/9/12 at 5:00 PM, Nurse #1 did not administer 300 mg of Ferrous Sulfate to RR #1 as ordered.

During an interview at the west nurses' station on 1/9/12 at 6:27 PM, Nurse #1 was asked if RR #1 received the Ferrous Sulfate as ordered. Nurse #1 stated, "No."

The failure to administer the Ferrous Sulfate as ordered resulted in medication error #1.

4. Director of Nursing or designee will conduct 5 random Medication Pass Audits weekly for 1 Month then 5 Random Medication Passes Monthly for 2 Months, to ensure compliance. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.

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2. Medical record review for RR #6 documented an admission date of 8/5/10 with diagnoses of Diabetes Mellitus Type II, Hypertension, Sinusitis, and Coronary Artery Disease. Review of the physician's order dated 1/6/12 documented, "...FLONASE 0.05 % NASAL SPRAY TWO (2) SPRAYS IN EACH NOSTRIL DAILY AS NEEDED..."

Observations in RR #6's room on 1/10/12 at 9:50 AM, Nurse #3 administered Fluticasone (Flonase) 50 micrograms 1 spray in each of RR #6's nostrils.

During an interview at the east nurses' station on 1/11/12 at 7:40 AM, Nurse #3 was asked about the administration of the nasal spray to RR #6. Nurse #3 stated, "I did 2 sprays to the left nostril and 1 spray to the right..."

The failure to administer 2 sprays of Flonase Nasal Spay in each of RR #6's nostrils as ordered resulted in medication error #2.

3. Medical record review for RR #5 documented an admission date of 3/24/10 with diagnoses of Conjunctivitis, Coronary Artery Disease, Hypertension, Chronic Kidney Disease, Arthritis, Anemia, and Alzheimer's Disease. Review of a physician's telephone order dated 1/4/12 documented, "Cipro [Ciprofloxacin] eye gtts [drops], 3 gtts left eye TID [three times each day] X [times] 7 days."

Observations in RR #5's room on 1/10/12 at 9:10 AM, Nurse #5 instilled Ciprofloxacin Ophthalmic Solution 0.3% 1 gtt in RR #5's left eye.

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F 332	Continued From page 11	F 332		
	During an interview at the west nurses' station on 1/11/12 at 7:30 AM, Nurse #5 was asked about the order for the Cipro eye gtts. Nurse #5 stated, "I gave 1 drop in the left eye..." The failure to administer 3 gtts of Ciprofloxacin Ophthalmic solution in RR #5's left eye as ordered resulted in medication error #3.			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was stored under sanitary conditions as evidenced by expired nutritional supplements in 2 of 2 (East hall and Central hall storage rooms) supplement storage rooms. The findings included: 1. Observations in the supplement storage room located on the east hall on 1/9/12 at 3:00 PM revealed the following: a. 17 cans of Glucerna 1.0 cal with a use by date	F 371	1. All expired formula was immediately discarded 2. All residents receiving enteral nutrition have the potential to be affected 3. All licensed staff and the Central Supply Clerk will be re-inserviced on discarding enteral nutrition on or prior to expiration date. 4. Director of Nursing or designee will conduct weekly Enteral Nutrition audits for 1 Month then Monthly for 2 Months, to ensure compliance. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.	1/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445485	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER: ALLENBROOKE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3933 ALLENBROOKE COVE MEMPHIS, TN 38118	

(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 371	Continued From page 12 of 9/1/11. b. 12 cans of Jevity 1.2 cal with a use by date of 7/1/11. c. One 1000 milliliter (ml) bottle of Osmolite 1 cal with a use by date of 8/1/11. 2. Observations in the supplement storage room located on the central hall on 1/9/12 at 3:15 PM revealed the following: a. 16 cans of Two Cal HN with a use by date of 9/1/11. b. One 1000 ml bottle of Osmolite 1.2 cal with a use by date of 9/1/11. 3. During an interview on the central hall on 1/9/12 at 3:30 PM, the Director of Nursing was asked about the expired nutritional supplements. The DON confirmed the use by date of the supplements had been exceeded. The DON stated, "...She [central supply clerk] should get those [expired supplement feedings] out of here..."	F 371		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, it was determined the facility failed to obtain laboratory tests as ordered by the physician for 2 of 26 (Residents #2 and 19) sampled residents.	F 502	1. RI #2 and 19 orders were corrected. All residents were thoroughly assessed with no negative outcomes 2. All residents have the potential to be affected 3. All licensed staff will be re-inserviced on properly following physician orders 4. Director of Nursing or designee will conduct weekly Physician Order/Lab audits for 1 Month then Monthly for 2 Months, to ensure compliance. Findings will be reported to the Quality Assurance Committee for review and	1/29/12

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F 502	Continued From page 13 The findings included: 1. Review of the facility's "LABORATORY TESTS" policy documented, "...Lab tests are completed as ordered by the physician..." 2. Medical record review for Resident #2 documented an admission date of 1/15/11 and a readmission date of 10/21/11 with diagnoses of Alzheimer's Dementia, Parkinson's Disease, Anemia, Hypertension, Gastroesophageal Reflux Disorder, Right Hip Fracture, and Failure to Thrive. Review of a physician's order dated 11/25/11 documented, "...pre-albumin (wt. [weight] loss) 11/28/11..." There was no documentation that the pre-albumin was completed as ordered on 11/28/11. During an interview in the conference room on 1/11/12 at 10:45 AM, Nurse #11 stated, "...the pre-albumin was not done..." 3. Medical record review for Resident #19 documented an admission date of 11/10/99 with diagnoses Congestive Heart Failure, Diabetes Mellitus II, Urinary Tract Infection, Benign Prostatic Hypertrophy, Scleritis, Anemia and Exposure Keratoconjunctivitis. Review of the physician's orders dated 1/6/12 documented, "...UA [urinalysis] FOR MICROALBUMIN YEARLY (APR) [April]..." Review of the laboratory report dated 4/21/11 documented, "...MICROALBUMIN SPECIMEN QUANTITY NOT SUFFICIENT FOR TEST..." The facility was unable to provide documentation that the urinalysis specimen was recollected. During an interview in the conference room on	F 502	corrective action measures will be implemented as deemed necessary.	

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F 502	Continued From page 14 1/11/12 at 1:00 PM, the Director of Nursing (DON) was asked what should be done when a yearly lab is not done due to insufficient amounts. The DON stated, "...do it next lab day..."	F 502		
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 policy review, medical record review and interview, it was determined the facility failed to ensure physician's orders were accurate for 2 of 15 (Residents #1 and 12) sampled residents. The findings included: 1. Review of the facility's "PRINTED PHYSICIAN ORDERS" policy documented, "...1. Each month new Physician's Orders and MARs [medication administration records] / TARs [treatment administration record] will be printed, checked, and corrections made as necessary by licensed nurses prior to the implementation..."	F 514	1. RI#1 and 12 labs were corrected 2. All residents have the potential to be affected 3. All licensed staff will be re-inserviced on properly following physician orders 4. Director of Nursing or designee will conduct weekly Physician Order/Lab audits for 1 Month then Monthly for 2 Months, to ensure compliance. Findings will be reported to the Quality Assurance Committee for review and corrective action measures will be implemented as deemed necessary.	1/29/12

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F 514	Continued From page 15	F 514		

2. Medical record review for Resident #1 documented an admission date of 5/23/02 and a readmission date of 10/20/11 with diagnoses of Cerebral Vascular Accident, Congestive Heart Failure Diabetes Mellitus and Hypertension.

Review of a physician's order dated 10/20/11 documented, "...CBC [complete blood count], CMP [comprehensive metabolic panel], Albumin q [every] 6 [months] May Nov [November] TSH [thyroid stimulating hormone] q yr [year] Nov..."

Review of the physician's recertification orders dated 11/6/11 documented, "...CBC Q [every] 6 MONTH (OCT [October],APR [APRIL]) CHEM [chemistry] PROFILE Q 6 MONTH (OCT,APR) THYROID PROFILE Q YEARLY (OCT)..."

Review of the physician's recertification orders dated 12/8/11 documented, "...CBC Q 6 MONTH ... [symbol for change] to May,Nov CHEM PROFILE Q 6 MONTH...May/Nov THYROID PROFILE Q YEARLY... NOV Albumin Q 6 [symbol for degree] May,Nov..."

Review of the physician's recertification orders dated 1/6/12 documented, "...CBC Q 6 MONTH (MAY,NOV) CHEM PROFILE Q 6 MONTH (MAY,NOV) THYROID PROFILE Q YEARLY (NOV) ALBUMIN Q 6 MONTHS (MAY,NOV)."

During an interview at the central nurses' station on 1/11/12 at 8:55 AM, the Director of Nursing (DON) confirmed the 11/6/11, 12/8/11 and 1/6/12 recertification orders were not accurate for lab orders.

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F 514	Continued From page 16 3. Medical record review for Resident #12 documented an admission date of 7/18/11 with diagnoses of Dementia, History of Left Hip Fracture, Diabetes Mellitus and Degenerative Joint Disease. Review of the December 2011 physician's recertification orders documented that a complete blood count and comprehensive metabolic panel were to be drawn every 6 months. Review of the physician's recertification orders dated 1/6/12 documented, "...LAB [laboratory] ORDERS..." with no listed labs. During an interview at the east nurses' station on 1/11/12 at 2:00 PM, Nurse #9 was asked about the lab orders. Nurse #9 confirmed that the orders were not carried over from the previous month's recertification orders and stated, "...it was an oversight..."	F 514		

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