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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445481 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/20/2014 |
| NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660 | |
| (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 000 | INITIAL COMMENTS | F 000 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: | December 22, 2014 |
| F 247 SS=D | <p>A Recertification survey and complaint investigation #34281 was completed November 17-20, 2014, at Asbury Place of Kingsport. Deficiencies were cited related to complaint investigation #34281 under CFR Part 483, Requirements for Long Term Care Facilities. 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify one (#63) of three residents prior to a roommate change.</p> <p>The findings included:</p> <p>Resident #63 was admitted to the facility on July 3, 2014, with diagnoses including Hypertension, Anxiety State, Depressive Disorder, Hearing Loss, Dementia without Behavior Disturbances, and Anemia.</p> <p>Medical record review of the admission Minimum Data Set (MDS) dated July 15, 2014, revealed the resident had no cognitive impairment and required assistance with activities of daily living.</p> <p>Interview with the resident on November 18, 2014, at 1:20 p.m., in the resident's room, revealed the resident had not been notified prior to a roommate change.</p> | F 247 | <p>Resident #63 has had no additional roommate changes. If a roommate change is necessary in the future, resident #63 will be notified prior to the change.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Prior to this survey (in early November), the Interim Administrator met with the Admissions staff and Social Services staff to discuss room changes and the admissions process. During this meeting, it was recognized that there was no established process by which to ensure residents were notified of roommate changes. The Admissions staff was assigned to notify current residents of new admission roommates. Social Services was assigned to notify current residents of room changes causing new roommates. Therefore, it was determined that all residents have the potential to be affected. All residents will be notified of room and roommate changes effective Dec.8, 2014.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carolyn P. Hill* TITLE *Administrator* (X6) DATE *12/14/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| <p>F 247</p> <p>F 278 SS=D</p> | <p>Continued From page 1</p> <p>Interview with the Admissions Coordinator and the Social Worker on November 19, 2014, at 12:50 p.m., in the Admissions office, confirmed, when a new resident is admitted or a roommate change is necessary, the Admissions Coordinator or the Social Worker was responsible for notifying the resident residing in the room, prior to placement of the new resident. Further interview confirmed resident #102 was moved into the room with resident #63 on August 12, 2014, and no one notified resident #63 prior to the move.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each</p> | <p>F 247</p> <p>F 278</p> | <p>Effective December 8, 2014, the admissions coordinator will notify current residents (or their responsible party when the resident is cognitively impaired) when a new resident is going to be admitted to their room prior to the new resident's arrival. The Social Worker, Director of Nursing, Nursing Supervisor, or Charge Nurse will notify current residents (or their responsible party when the resident is cognitively impaired) of the need to change their room or of a roommate change prior to the change being made.</p> <p>Effective December 8, 2014, a log will be maintained by the Admissions Coordinator and Social Worker of all notifications of room and roommate changes. If the Director of Nursing, Nursing Supervisor, or Charge Nurse makes the notification, that nurse will notify the Social Worker of the date, time, and person notified so that the log will be maintained accurately.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>Beginning the week of December 15, 2014, the Administrator, Director of Nursing, or Nursing Supervisor will monitor the Notification Logs maintained by the Admissions Coordinator and Social Worker 3x/week x 4 weeks; then weekly x 4 weeks to ensure the log is accurate. Accuracy will be determined by comparing a room change report to the logs to ensure all residents impacted by admissions and room changes have been notified.</p> | |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 278 | <p>Continued From page 2 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, the facility failed to accurately complete the Minimum Data Set (MDS) for one resident (#87) of forty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #87 was admitted to the facility on October 14, 2014, with diagnoses including Atrial Fibrillation, Osteoporosis, Congestive Heart Failure, Hyperlipidemia, Diabetes Mellitus II, Malaise and Fatigue, Chronic Anticoagulation, and Right Hip Fracture.</p> <p>Medical record review of an Admission MDS dated October 27, 2014, revealed the resident was not receiving antipsychotic medication.</p> <p>Medical record review of the physician's orders dated November 1, 2014 through November 30, 2014, revealed an order for Mellaril (an antipsychotic medication) 25 mg (milligrams) daily and 50 mg at bedtime, with a start date of October 14, 2014.</p> <p>Interview with the MDS Coordinator on November 19, 2014, at 12:50 p.m., in the MDS office, confirmed the facility had failed to accurately assess the use of antipsychotic medication for resident #87.</p> | F 278 | <p>F 278</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The MDS assessment for Resident #87 has been updated to reflect the Antipsychotic medication.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents on Antipsychotic medications have the potential to be affected.</p> <p>By December 5, 2014, the MDS coordinator will obtain a report of all residents on Antipsychotic medications and review each of those resident's current MDS assessments to ensure each Antipsychotic medication is included in the Assessment.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>By December 5, 2014, the MDS coordinator will maintain a list of Antipsychotic medications for reference when completed MDS assessments.</p> | December 22, 2014 |
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| <p>F 278</p> <p>F 280 SS=D</p> | <p>Continued From page 3</p> <p>Interview with the Interim Director of Nurses on November 20, 2014, at 1:00 p.m., in the Administrator office, confirmed the facility had failed to accurately complete the MDS. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure a care plan was current related to a pressure ulcer for one resident (#86) of forty-one residents reviewed.</p> <p>The findings included:</p> | <p>F 278</p> <p>F 280</p> | <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>Beginning in December 2014, the Director of Nursing or Nursing Supervisor will obtain a report of all residents taking Antipsychotic medications monthly for 4 months and check the MDS assessment to ensure the medication(s) have been included on the Assessment.</p> <p>F 280 _____ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #86 was discharged on June 4, 2014.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the potential to be affected. The wound specialist nurse will have reviewed the care plans of all residents' with pressure ulcers by December 5, 2014. The care plans will have been updated as indicated to ensure the pressure ulcer is reflected by December 5, 2014.</p> | <p>December 22, 2014</p> |
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| F 280 | <p>Continued From page 4</p> <p>Resident #86 was admitted to the facility on May 3, 2014, with diagnoses including Diabetes Mellitus, Left Knee Replacement, and Thrombosis (blood clot). Further review revealed the resident was discharged from the facility on June 4, 2014.</p> <p>Medical record review of a Skin Assessment dated May 3, 2014, revealed "...no open ulcers...abrasion to left knee...bruises..."</p> <p>Medical record review of the Care Plan dated May 3, 2014, revealed "...resident at risk for impaired skin integrity due to impaired mobility...see interventions for skin breakdown and treatment status..." Further review of the Care Plan revealed no documentation the resident developed any open areas or pressure ulcers requiring interventions to be updated on the Care Plan.</p> <p>Medical record review of a Skin Assessment dated May 8, 2014, revealed "...bruises bilateral lower extremities...skin tear left foot...no open ulcers..."</p> <p>Medical record review of a Nurse's Note dated May 11, 2014, revealed "...at 7:30 p.m. while in pt's [patient's] room...asked if I would look at...bottom because...he was having discomfort...a wound 0.9 x [by] 1.0 < [less than] 0.1 cm [centimeters] was noted to right buttock...new wound care orders written to clean wd [wound] with NS [normal saline], apply skin prep to peri (perineal) wd...cover with [named dressing] and change every 3 days and pm [as needed]..."</p> | F 280 | <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>The Wound Specialist Nurse will update the care plan of each resident when she is consulted for any type of wound or skin problem.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>Beginning the week of December 7, 2014, using the weekly wound report, the Director of Nursing or Nursing Supervisor will check each resident's care plan to ensure it is updated properly to include the wound/skin problem. This will be done weekly x 4 weeks, then twice monthly x 2 months, then monthly x 2 months.</p> | |
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NAME OF PROVIDER OR SUPPLIER

ASBURY PLACE AT KINGSPORT

STREET ADDRESS, CITY, STATE, ZIP CODE

**100 NETHERLAND LANE
KINGSPORT, TN 37660**

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F 280 Continued From page 5
 Medical record review of a Physicians Order Sheet dated May 11, 2014, revealed "...Clean wound with Normal Saline...apply skin prep to peri wound...cover with [named dressing] and change every 3 days and pm..."
 Medical record review of a Skin Assessment dated May 15, 2014, revealed "...open area to coccyx..." Further review of the skin assessments revealed the resident had an open area to the coccyx on May 22, 2014, and May 29, 2014.
 Review of facility policy, Care Planning-Comprehensive, dated July 13, 2012, revealed "... (8) assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change... (9) the care planning/interdisciplinary Team is responsible for the review and updating care plans...when there has been a significant change in the resident's condition..."
 Interview with Registered Nurse (RN) #1 on November 20, 2014, at 9:50 a.m., in the Dogwood Nurse's Station, confirmed the resident developed a pressure ulcer to the coccyx on May 11, 2014, and the resident's care plan was not updated to reflect the pressure ulcer.

F 280

F 314 **F 314**
 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
 Resident #171 was discharged from the facility on June 12, 2014.

~~December 22, 2014~~
 Jan. I, 2015
 CAPAL, KATHA

F 314 SS=D **483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**
 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and

F 314

F 314
 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
 Resident #171 was discharged from the facility on June 12, 2014.

~~December 22, 2014~~
 Jan. I, 2015
 CAPAL, KATHA

12/30/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 314 | <p>Continued From page 6</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a weekly skin assessment was completed for one resident (#171) of four residents reviewed for skin breakdown.</p> <p>The findings included:</p> <p>Resident #171 was admitted to the facility on May 20, 2014, with diagnoses including Laceration to the Right Elbow, History of Stroke, History of Myocardial Infarction, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of a Hospital History dated May 20, 2014, revealed the resident was admitted to the hospital after a fall. Continued review revealed the resident received a laceration to the right elbow with sutures required, and a hit on the head.</p> <p>Medical record review of the facility admission note dated May 20, 2014, revealed "...abrasion noted to right elbow and scab to left foot...Skin condition reddened and pale dry and warm..."</p> <p>Medical record review of a Physician Progress note dated May 26, 2014, revealed "...resident with Expressive Aphasia after Cerebral Vascular Accident...Goal is palliative but may not meet hospice criteria...treatment with coumadin because of risk for painful thrombus of lower extremities with severe Peripheral Vascular</p> | F 314 | <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the potential to be affected. Current residents will have received a full skin assessment by 12/13/14 and will receive weekly skin assessments until discharged from the facility.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>By December 5, 2014, the Wound Specialist Nurse will ensure skin assessments are assigned to be completed by charge nurses or supervisors weekly for every resident. In the absence of the Wound Specialist, a second nurse will be responsible to make the assignments for skin assessments. The second nurse will be educated to the new process by the Wound Specialist by December 22, 2014.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>The Wound Specialist Nurse and her back up Nurse will review weekly skin assessments throughout the week to ensure they are being completed as assigned. The Interim Administrator will have educated the Wound</p> | |

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| F 314 | <p>Continued From page 7 Disease..."</p> <p>Medical record review of a Physician's order dated May 30, 2014, revealed "...eschar [dark scab] to top of left foot cover with...[named wound dressing]...change q [every] 3 [three] days and prn [as needed] till resolved..."</p> <p>Medical record review of a Nurse's Note dated June 4, 2014, at 9:57 p.m., revealed "...eschar has fallen off and the wound is erythematous [redness of the skin]...with minimal tan colored drainage..."</p> <p>Medical record review of a Physician's progress note dated June 7, 2014, revealed "...wound over dorsal foot examined...may not heal due to poor circulation...trial of antibiotic systemically..."</p> <p>Medical record review of a Physician order dated June 7, 2014, revealed "...top left foot cleanse with normal saline pat dry apply ointment cover with telfa [type of wound dressing] and wrap with kling change every day til healed...Bactrim [type of antibiotic] twice a day for 5 days..."</p> <p>Interview and medical record review with the Interim Director of Nursing (DON) and the facility wound treatment nurse on November 20, 2014, at 9:28 a.m., in the conference room, revealed the resident's scab opened and required treatment. Continued interview and medical record review of the facility Weekly Skin Assessment form confirmed there was no documentation of the wound or any wound staging after May 20, 2014.</p> <p>Interview and medical record review with the Interim Administrator and the Nurse Consultant on November 20, 2014, at 2:20 p.m., in the</p> | F 314 | <p>Specialist and the second nurse to this new process by December 22, 2014. This is an ongoing process. The results of the audits will be reviewed at the QAPI Committee [DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, and Dining Services] meeting at least quarterly.</p> | |

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| F 314 | Continued From page 8 Administrator's office, confirmed the facility had failed to complete weekly skin assessments of a wound. | F 314 | | |
| F 329 SS=D | <p>C/O #34281 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, and review of facility policy, the facility failed to</p> | F 329 | <p>F 329</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #87 Diagnosis of Psychosis has been added to the medical record. Resident # 171 was discharged from the facility on June 12, 2014.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents who are prescribed Antipsychotics have the potential to be affected. All current residents who are prescribed Antipsychotics have been reviewed for a Medical Diagnosis to support the use of the medication. All current residents who are prescribed Antipsychotics will be assessed for current effectiveness of the medication and associated behaviors.</p> | <p>December 22, 2014</p> <p>JAN 1 2015</p> <p>CAPUL LNHA 12/30/14</p> |

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

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| NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660 | |

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| F 329 | <p>Continued From page 9</p> <p>provide a medical diagnosis for the use of an antipsychotic medication for one resident (#87) and failed to monitor for the use of an antipsychotic medication for one resident (#171) of six residents reviewed for unnecessary medication use of forty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #87 was admitted to the facility on October 14, 2014, with diagnoses including Atrial Fibrillation, Osteoporosis, Congestive Heart Failure, Hyperlipidemia, Diabetes Mellitus II, Malaise and Fatigue, Chronic Anticoagulation, and Right Hip Fracture.</p> <p>Medical record review of an Admission Minimum Data Set dated October 27, 2014, revealed the resident had scored fifteen on the Brief Interview for Mental Status, indicating the resident was cognitively intact.</p> <p>Medical record review of the physician's orders dated November 1 through 30, 2014, revealed an order for Mellaril (an antipsychotic medication) 25 mg (milligrams) daily and 50 mg at bedtime, with a start date of October 14, 2104.</p> <p>Medical record review of the resident's diagnoses did not reveal a diagnosis supporting the use of an antipsychotic medication.</p> <p>Interview with the resident on November 19, 2014, at 12:00 p.m., in the resident's room, revealed "I had an episode of Schizophrenia in 1973 and I was put on Mellaril then." Continued interview revealed the resident had continued to take Mellaril from the time of the initial schizophrenic episode.</p> | F 329 | <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>Upon admission, the charge nurse, nursing supervisor or Director of Nursing will obtain a medical diagnosis for any resident who is prescribed an Antipsychotic. If a diagnosis cannot be determined by consultation with the resident's physician(s), the nursing supervisor or Director of Nursing will obtain a Pharmacy consult for recommendations to the Medical Director. The Interim Administrator will have educated the nursing supervisors and Director of Nursing by December 22, 2014 to this new and ongoing process.</p> <p>A behavior assessment tool will be in place for each resident who are currently taking Antipsychotics by December 22, 2014. Nursing staff will be educated as to the use of the behavior assessment tool by December 22, 2014.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> | |
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| F 329 | <p>Continued From page 10</p> <p>Interview with the Interim Director of Nursing on November 20, 2014, at 1:00 p.m., in the Administrator office, confirmed the facility had failed to provide a medical diagnosis for the use of the antipsychotic drug.</p> <p>Resident #171 was admitted to the facility on May 20, 2014, with diagnoses including Laceration to the Right Elbow, History of Stroke, History of Myocardial Infarction, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of the Physician's recapitulation orders dated May 20, 2014, revealed "...Lorazepam [antianxiety medication]...0.5 mg [milligram]...1 [one] tablet...twice daily...Haloperidol [antipsychotic medication]...2 mg...at bedtime as needed..."</p> <p>Medical record review of the Medication Administration Records for May and June 2014, revealed the resident received Lorazepam 0.5 mg twice daily from May 20 through June 7, 2014, and it was decreased to 0.25 mg twice a day. Further review revealed the resident received the Haloperidol six times between May 23 and June 8, 2014.</p> <p>Medical record review revealed no monitoring of resident behaviors or side effects of the medications.</p> <p>Review of the facility policy, Behavioral Management, dated October 2, 2004, revealed "...It is the policy...that resident behaviors are monitored on an ongoing basis..."</p> <p>Interview and medical record review with the facility Interim Administrator on November 19,</p> | F 329 | <p>The Director of Nursing and/or Nursing Supervisor will review the medications of each new admission within 72 hours of admission to ensure that all medications have a supporting diagnosis.</p> <p>The Director of Nursing and Nursing Supervisors will monitor the behavior assessments weekly x 4 weeks and then monthly x 4 months.</p> | |
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| F 329 | Continued From page 11 2014, at 10:05 a.m., in the Administrator's office, confirmed the facility had failed to follow it's policy for monitoring of behaviors and possible medication side effects. | F 329 | | |
| F 441 SS=D | <p>C/O #34281 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> | F 441 | <p>F 441</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Employee #1, LPN's #1&2 have been re-educated to the hand washing policy. Employees caring for residents #154, #162, and #26 will comply with the hand washing policy.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the potential to be affected. Staff members will wash or sanitize their hands in compliance with the hand washing policy.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>The Interim Administrator, Director of Nursing, or Nursing Supervisor(s) will educate all therapy and nursing employees to the hand washing policy by December 22, 2014.</p> | <p>December 22, 2014</p> <p>JAN. 1, 2015</p> <p>CP Neil LNH</p> <p>12/30/14</p> |

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| F 441 | <p>Continued From page 12</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to follow hand hygiene for three residents (#154, #162, and #26) of forty-one residents sampled on one of three hallways observed.</p> <p>The findings included:</p> <p>Observation on November 19, 2014, at 9:15 a.m., on the Dogwood Hallway, revealed employee #1 entered resident #154's room, placed gloves on the hands, and assisted the resident back into the bed. Further observation revealed the employee placed the resident's bed sheets over the patient, exited the room while removing the soiled gloves, placed the soiled gloves in the trash can, and failed to wash or sanitize the hands. Further observation revealed the employee entered resident #162's room and provided care to the resident, exited the room, and failed to wash or sanitize the hands.</p> <p>Interview with employee #1 on November 19, 2014, at 9:30 a.m., in the Dogwood Hallway, confirmed the employee failed to wash or sanitize the hands after providing care for two residents and removing soiled gloves.</p> <p>Review of the facility policy, Handwashing, dated</p> | F 441 | <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>The Director of Nursing and Nursing Supervisors will perform impromptu hand washing audits throughout all shifts with a minimum of 10 per week x 4 weeks, then 5 per week x 4 weeks. The Director of Nursing and/or Nursing Supervisors will council employees as indicated.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, and Dining Services) meeting at least quarterly.</p> | |
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| F 441 | <p>Continued From page 13</p> <p>March 2005, revealed "...times to wash hands...before and after each resident contact...after removing gloves..."</p> <p>Observation on November 20, 2014, at 9:30 a.m., on the Dogwood Hallway, revealed Licensed Practical Nurse (LPN) #1 entered resident #26's room, administered the resident's medication, and picked up the resident's dirty water pitcher in the resident's room. Further observation revealed the nurse exited the resident's room, without washing or sanitizing the hands, and then obtained another resident's medication from the medication cart.</p> <p>Interview with LPN #2 on November 20, 2014, at 9:40 a.m., in the Dogwood Hallway, confirmed the nurse failed to wash or sanitize the hands after administering the medications to the resident and picking up the resident's dirty water pitcher.</p> | F 441 | | |