

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

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

45th 10/23/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2011
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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTHCARE-NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918
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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
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>F-225</p> <p>1. Resident #10 was assessed by licensed nurse on 7/17/2011 with no signs or symptoms of injury. Resident #19 was assessed by licensed nurse on 7/17/2011 with no signs or symptoms of injury. Resident #3 was placed in a private room on a different floor with a one-on-one sitter on 7/17/2011. Resident #3 was admitted to Mercy Medical Center's gero-psychiatric unit on 7/19/2011. A report was made to Knox County Police Department on 9/15/2011 and to the Tennessee Department of Health Unusual Incident Reporting System per direction of Tennessee Department of Health by the Director of Nursing. Residents #10, #19 and #3 continue with no adverse outcome.</p> <p>2. A 100% audit of incidents occurring 8/1/2011 through 9/15/2011 was completed by Director of Nursing and Team Leaders on 9/15/2011. No reportable events were noted. No residents were identified to be affected.</p> <p>3. The Regional Director of Clinical Services in-serviced the Director of Nursing and Administrator on facility's procedure for reporting of allegations on 9/8/2011.</p> <p>4. The Director of Nursing/Assistant Director of Nursing/Team Leader/Administrator will audit all incidents in the morning meetings x 3 months to ensure compliance. Audit results will be reported by the Director of Nursing once per month x 3 months and/or until 100% compliance</p>	9-23-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sherrill Williamson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-23-11</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.

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F 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, observation, review of facility policy, and interview, the facility failed to notify law enforcement and the State Survey and Certification Agency of an allegation of abuse for two (#10 and #19) of thirty residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on June 2, 2011, with diagnoses including Acute Kidney Failure, Congestive Heart Failure, Osteoarthritis, and Chronic Anemia.</p> <p>Medical record review of the Minimum Data Set (MDS) dated June 9, 2011, revealed the resident had severely impaired cognitive skills and did not walk.</p> <p>Medical record review of a nursing note dated July 17, 2011, revealed "Resident voices concern over inappropriate behavior from another resident...Full body assessed no s/s (signs/symptoms) of pain or distress."</p> <p>Medical record review revealed resident #19 was admitted to the facility on June 28, 2010, with diagnoses including Debility, Dysphagia, Chronic Kidney Disease, Chronic Obstructive Pulmonary</p>	F 225	<p>is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.</p>		

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F 225	<p>Continued From page 2 Disease, and Depressive Disorder.</p> <p>Medical record review of the MDS dated June 16, 2011, revealed resident #19 was independent with daily decision making and was independent with ambulation.</p> <p>Medical record review of a nursing note dated July 17, 2011, revealed "Resident voices concern over inappropriate behavior from another resident...Full body assessed no s/s of pain or distress."</p> <p>Resident #3 was admitted to the facility on January 7, 2008, with diagnoses including Dementia, Psychosis, Cerebrovascular Accident with Left Hemiparesis, Depression, Hypertension, Salivary Secretion Disorder, and Dysphagia.</p> <p>Medical record review of the MDS dated May 14, 2011, revealed the resident had moderately impaired cognitive skills and did not walk.</p> <p>Medical record review of a nursing note dated July 17, 2011, revealed "Resident transferred to room...this afternoon...Resident is up in w/c (wheelchair) in room, has 1:1 care at side, adjusting well to room. Zero inappropriate behaviors noted since transfer."</p> <p>Review of documentation provided by the facility dated July 17, 2011, revealed "Allegation of inappropriate touching made by 2...residents (#10 and #19) against resident (#3). MD (physician) & families notified. DON (Director of Nursing), Administrator & RDCS (Regional Director of Clinical Services) notified. Resident (#3) moved to 3rd floor in a private room & 1 on1 sitter placed</p>	F 225			

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F 225	<p>Continued From page 3 with resident...Skin assessments completed on other 2 residents (#10 and #19) with no issues noted."</p> <p>Observation on September 7, 2011, at 9:37 a.m., revealed resident #10 seated in a wheelchair, in the resident's room eating breakfast.</p> <p>Observation on September 7, 2011, at 12:40 p.m., revealed resident #19 lying on the bed. Interview with resident #19, at the time of the observation revealed "(Resident #3) was not in...right mind...came into my room and touched my private area." Continued interview revealed no other incidents had occurred after the incident was reported to the staff.</p> <p>Observation on September 7, 2011, at 9:10 a.m., revealed resident #3 lying on the bed with a Certified Nursing Assistant in the room, providing one on one supervision.</p> <p>Review of the facility's policy Resident Abuse, Neglect and Misappropriation Prevention Program (policy) revealed "...Written notification to the State Health Department and other required regulatory agencies summarizing the incident, investigation results and facility actions taken to protect the resident(s) and prevent a similar, occurrence...The Administrator or designee shall call local police when assault, sexual abuse...is suspected and/or confirmed by investigation..."</p> <p>Interview on September 8, 2011, at 10:30 a.m., with the Administrator, in the Administrator's office, confirmed the allegation of sexual abuse was not reported to law enforcement or the State</p>	F 225			

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F 225	Continued From page 4 Department of Health.	F 225			
F 315 SS=D	c/o #28433 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete a bladder assessment for a bladder retraining program for one (#24) of thirty residents reviewed. The findings included: Resident #24 was admitted to the facility on August 20, 2007, with diagnoses including Senile Depressive Disorder, Osteoporosis, Anemia, and Hypertension. Medical record review of the Minimum Data Set dated March 16, 2011, revealed the resident was occasionally incontinent of bladder. Medical record review of the Minimum Data Set dated June 15, 2011, revealed the resident was	F 315	F-315 1. A bladder assessment was completed on resident #24 on 9/8/2011 by Team Leader. A voiding diary was completed on 9/10/2011 and results were placed on the care plan by the Team Leader. Resident #24 had no negative outcomes. 2. A 100% audit of resident's bladder assessments was completed on 9/14/2011 by Team Leaders and/or Director of Nursing and/or Assistant Directors of Nursing. No residents were identified to be affected. 3. The Director of Nursing and/or Staff Development Coordinator in-serviced licensed nurses on 9/9/2011 - 9/14/2011 on the proper completion of bladder assessments. 4. The Director of Nursing and/or Assistant Directors of Nursing and/or Team Leader(s) will audit 20 bladder assessments per week for 4 weeks and then 20 bladder assessments per month x 2 months to ensure compliance. Audit results will be reported once per month by Director of Nursing for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.	Q-23-11	

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F 315	Continued From page 5 frequently incontinent of bladder. Medical record review of the Urinary Continence Data Collection Form dated September 7, 2011, revealed, "...Resident is currently incontinent of bladder...Incontinence Symptoms Profile (not completed)...Summary and Program Placement Decision (not completed)..." Observation on September 8, 2011, at 9:15 a.m., revealed the resident lying in the bed. Interview on September 8, 2011, with Registered Nurse #1 at the nursing station, confirmed the bladder assessment was not completed to determine if the resident was a candidate for a bladder retraining program.	F 315			
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, and interview, the facility failed to obtain an assessment for a safety device for one (#25) of thirty residents reviewed. The findings included:	F 323	F-323 <u>1.</u> Resident #25 was screened by Therapy on 9/9/2011. On 7/21/2011 dycem was placed in the wheelchair and resident was supplied with an activities basket. <u>2.</u> A 100% audit of fall interventions since 8/1/2011 was completed on 9/16/2011 by Director of Nursing and/or Assistant Directors of Nursing and/or Team Leader(s). No residents were found to be affected. <u>3.</u> Director of Nursing and/or Staff Development Coordinator in-serviced licensed nurses and therapy staff on 9/9/2011 - 9/14/2011 on the procedure for completion of therapy interventions related to falls.	9-23-11	

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F 323	Continued From page 6 Resident #25 was admitted to the facility on May 26, 2011, with diagnoses including Cerebrovascular Disease, Dysphagia, Hypertension, and Diabetes. Medical record review of the Departmental Notes dated July 21, 2011, revealed, "...Resident up in wheelchair...housekeeper informed resident slid (out) of wheelchair, entered room resident leaning against wheelchair pointed to nightstand trying to reach make-up slowly slid to floor...noted large bruise to left elbow and two dime size skin tears to right elbow..." Medical record review of the care plan dated June 7, 2011, revealed, "...7/21/11 therapy to eval (evaluate) for pommel (cushion) (related to) sitting on edge of chair..." Medical record review of the Departmental Notes dated September 2, 2011, revealed, "...roommate came out voiced resident had slid to floor...slid from wheelchair...small skin tear to left elbow treatment in place..." Observation on September 8, 2011, at 8:30 a.m., revealed the resident in the resident's room, seated in a wheelchair with no safety device. Interview on September 8, 2011, at 1:00 p.m., in the conference room, with Occupational Therapist #1, confirmed an evaluation for the use of a pommel cushion had not been completed.	F 323	<u>4.</u> The Director of Nursing and/or Assistant Director of Nursing and/or Team Leader(s) will audit all fall interventions related to therapy in the morning meeting x 3 months to ensure compliance. Audit results will be reported by Director of Nursing once per month for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333			

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F 333	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure residents are free of any significant medication errors. Medical record review revealed significant medication errors occurred with one (Resident #20) of thirty residents reviewed. The findings included: Resident #20 was re-admitted to the facility on August 18, 2011, with diagnoses including convulsions and mood disorder. Medical record review of the facility signed physician order dated August 18, 2011, for Resident #20 revealed an order for, "...Dilantin 125 m [milligrams]/5ml Give 150mg [6ml] TID [three times daily]..." Medical record review of the September 2011, Medication Administration Record (MAR) for Resident #20 on the First Floor North Hall Medication Cart, revealed "...DILANTIN 125MG/5ML SUSP PHENYTOIN 125MG/5ML SUSPE [suspension] TAKE 5ML (125MG) PER TUBE THREE TIMES DAILY..." Further review of the September 2011, MAR for Resident #20 on September 6, 2011, at 4:10 p.m., with LPN #1 and the Assistant Director of Nursing (ADON) at the First Floor Nursing Station revealed sixteen, 5ml doses of Dilantin 125mg were administered between 8 a.m., on September 1, 2011, and 12 noon, on September 6, 2011, by LPN#1, #2, #3, and #4.	F 333	F-333 <u>1.</u> Resident #20 was assessed by Assistant Director of Nursing on 9/6/2011 with no negative outcome. The Nurse Practitioner was notified and the order was clarified on 9/6/2011. The Family was also notified on 9/6/2011. Licensed Practical Nurses #1, #2, #3 and #4 were in-serviced by Director of Nursing/Staff Development Coordinator on the procedure for ensuring accurate completion of physician orders to Medication Administration Records on 9/9/2011 - 9/14/2011. The Medication Administration Record was corrected on 9/6/2011 by Assistant Director of Nursing. <u>2.</u> A 100% audit of all Dilantin orders was completed by Assistant Directors of Nursing and/or Regional Director of Clinical Services on 9/7/2011. No residents were identified to be affected. A 100% audit of physician orders/Medication Administration Records for September was completed on 9/16/2011 by the Assistant Directors of Nursing and the Team Leaders. No residents were identified to be affected. <u>3.</u> Director of Nursing and/or Staff Development Coordinator in-serviced licensed staff on 9/9/2011 - 9/14/2011 on the procedure for ensuring accurate completion of physician orders to Medication Administration Records. <u>4.</u> Director of Nursing and/or Assistant Director of Nursing and/or Team Leader(s) will audit 10 Dilantin orders per week x 4 weeks, then 10 Dilantin orders per month x 2 months to ensure compliance. Audit results will be reported by	9-23-11	

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F 333	Continued From page 8 Review of the facility policy, "Clinical Nursing Skills", "...Administering Medication Protocol...", revealed, "...8. Administer medication according to route procedure and adhering to the "Six Rights" [the right client, the right drug, the right dose, the right route, the right time, the right documentation] of medication administration...10. Record administered medications in client's record; the time, medication given, dosage, route (including site of injection); and any relevant assessment findings..." Interview on September 6, 2011, at 4:15 p.m., with LPN #1 and the ADON confirmed 6ml doses of Dilantin 150mg Suspension were ordered by the physician beginning August 18, 2011, and sixteen, 5ml doses of Dilantin 125mg Suspension were documented on the September 2011, MAR for Resident #20 as administered in error. Further interview with the ADON confirmed no other documentation in the medical record of Resident #20 substantiated the administration of a 6ml dose of Dilantin 150mg Suspension at any time between 8 a.m., on September 1, 2011, and noon on September 6, 2011.	F 333	Director of Nursing once per month for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386	F-386 L The telephone order for Tramadol for resident #14 was signed by the Nurse Practitioner and the Medical Director and placed in the chart by the Director of Nursing on 9/9/2011.	9-23-11	

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F 386	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure the Nurse Practitioner timely signed and dated a Physician's Telephone Order, for one (#14) of thirty residents reviewed.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on January 20, 2007 with diagnoses including Anoxic Brain Injury, Seizure Disorder, Psychosis, and Pulmonary Embolism.</p> <p>Medical record review of a Physician's Order dated June 29, 2011, revealed an order to "discontinue Tramadol due to increased risk of seizure."</p> <p>Medical record review of the Medication Administration Record revealed Tramadol had been administered to resident #14 on July 4, 2011, at 5:30 a.m., and on July 8, 2011 at 6:30 a.m.</p> <p>Review of the facility policy regarding Medication Orders and review, revealed " ... 2. A current list of orders must be maintained in the clinical record of each resident ...and ...4. Physician orders/Progress Notes must be signed and dated ..."</p> <p>Interview with Licensed Practice Nurse (LPN) #7, third floor Team Leader on September 7, 2011, at 8:05 a.m., in the third floor nurses station</p>	F 386	<p><u>2.</u> A 100% audit of all physician orders for the past 3 months was completed and verified for physician signature/placement on 9/12/2011 by the Medical Records Coordinator and the Administrator-in-Training. No residents were identified to be affected.</p> <p><u>3.</u> Director of Nursing and/or Staff Development Coordinator in-serviced licensed nurses on the procedure for ensuring all physician orders are signed by a physician and properly placed in medical record between 9/9/2011-9/14/2011.</p> <p><u>4.</u> Director of Nursing and/or Assistant Directors of Nursing and/or Team Leader(s) and/or Medical Records Coordinator and/or Administrator-in-Training will audit 20 charts per week for 4 weeks, then 20 charts per month x 2 months to ensure compliance. Audit results will be reported by Director of Nursing once per month for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2011
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTHCARE-NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918		
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F 386	Continued From page 10 confirmed there was no physician's order to continue Tramadol in the medical record. Interview with the Administrator and Director of Nursing (DON) on September 8, 2011, at 11:05 a.m., in the Administrator's office revealed, that after contacting the pharmacy, a telephone order by the Nurse Practitioner to continue Tramadol had been sent to the pharmacy on June 30, 2011. The telephone order was undated and unsigned by the Nurse Practitioner. The pharmacy faxed the telephone order to the facility on September 8, 2011, at 8:58 a.m. Continued interview confirmed the order was not signed and dated as required.	F 386		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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	F 441	F-441 <u>1.</u> The wound on Resident #1 was assessed on 9/6/2011 by the Assistant Director of Nursing. No signs or symptoms of infection were observed. Licensed Practical Nurse #8 was in-serviced by the Assistant Director of Nursing on 9/7/2011 on proper hand hygiene procedures during dressing changes. <u>2.</u> A 100% audit of all residents that were treated by Licensed Practical Nurse #8 on 9/6/2011 was completed on 9/7/2011 by Assistant Director of Nursing. No signs or symptoms of infection were noted. No residents were identified to be effected. <u>3.</u> Assistant Directors of Nursing and/or Staff Development Coordinator in-serviced licensed nurses on proper hand hygiene procedures during dressing changes on 9/9/2011 - 9/14/2011.	9-23-11

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F 441	<p>Continued From page 11</p> <p>isolate the resident.</p> <p>(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.</p> <p>(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> <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 medical record review, review of the facility policy, observation, and interview, the facility failed to perform hand hygiene during a dressing change for one (#1) resident of thirty residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on March 25, 2009, with diagnoses including Chronic Kidney Disease, Diabetes, and Hypertension.</p> <p>Review of the facility policy, "Hand-hygiene technique", revealed, "...If hands are not visibly soiled, use an alcohol-based hand rub for all of the following situations...Before or after direct contact with residents...before handling clean or soiled dressings...after contact with inanimate objects (e.g., (example) medical equipment) in</p>	F 441	<p>4. Director of Nursing and/or Assistant Directors of Nursing and/or Team Leader(s) will observe 3 dressing changes per day x 1 week, then 3 per week x 3 weeks, then 3 per month x 2 months. Audit results will be reported by Director of Nursing once per month for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.</p>		

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F 441	Continued From page 12 the immediate vicinity of the resident..." Observation of the dressing change on September 7, 2011, at 8:40 a.m., with Licensed Practical Nurse (LPN) #8 (treatment nurse) revealed the following: LPN #8 opened the treatment cart in the hall to place a box of dressings; obtained a dressing from the box; closed the treatment cart; entered the resident's room; placed the dressing on the barrier; applied gloves without washing the hands and measured the wound on the coccyx. Interview on September 7, 2011, at 8:55 a.m., in the hall, with LPN #8 confirmed the wound on the coccyx was measured without washing the hands after obtaining supplies from the treatment cart in the hall and applying gloves.	F 441			
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:	F 514	F-514 1. On 9/9/2011 Director of Nursing placed the signed physician order for Tramadol on Resident #14 chart. 2. A 100% audit of physician orders/Medication Administration Records for September was completed on 9/16/2011 by the Assistant Directors of Nursing and/or Team Leaders. We verified all the physician orders were in the medical record for the last 3 months on 9/12/2011. No residents were identified to be affected. 3. Director of Nursing and/or Staff Development Coordinator in-serviced the licensed nurses on 9/14/2011 on the procedure for ensuring that physician orders remain on the chart for 3 months.	9-23-11	

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F 514	<p>Continued From page 13</p> <p>Based on medical record review, facility policy review, and interview, the facility failed to maintain a current clinical record for one (#14) of thirty residents reviewed.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on January 20, 2007 with diagnoses including Anoxic Brain Injury, Seizure Disorder, Psychosis, and Pulmonary Embolism.</p> <p>Medical record review of a Physician's Order dated June 29, 2011, revealed an order to "discontinue Tramadol due to increased risk of seizure."</p> <p>Medical record review of the Medication Administration Record revealed Tramadol had been administered to resident #14 on July 4, 2011, at 5:30 a.m. and on July 8, 2011 at 6:30 a.m.</p> <p>Review of the facility policy regarding Medication Orders and review, revealed " ... 2. A current list of orders must be maintained in the clinical record of each resident ...and ...4. Physician orders/Progress Notes must be signed and date ..."</p> <p>Interview with Licensed Practical Nurse (LPN) #7, third floor Team Leader on September 7, 2011, at 8:05 a.m., in the third floor nurses station confirmed there was no physician's order to continue Tramadol in the medical record.</p> <p>Interview with the Administrator and Director of Nursing (DON) on September 8, 2011, at 11:05</p>	F 514	<p>4. Director of Nursing and/or Assistant Director of Nursing and/or Team Leader(s) will audit 20 charts per week x 4 weeks, then 20 charts per month x 2 months to ensure compliance. Audit results will be reported once per month by Director of Nursing for 3 months and/or until 100% compliance is met at the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.</p>		

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F 514	Continued From page 14 a.m., in the Administrator's office revealed, that after contacting the pharmacy, a telephone order by the Nurse Practitioner to continue Tramadol had been sent to the pharmacy on June 30, 2011. The pharmacy faxed the telephone order to the facility on September 8, 2011, at 8:58 a.m. Continued interview confirmed the order was not in the medical record.	F 514			