

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

PRINTED: 06/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050	
(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 Amended SOD 06/30/14 A Recertification Survey was initiated on 05/28/14 and concluded on 05/30/14. The Division of Health Care found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".	F 000	Submission of this plan of correction does not constitute admission of agreement with conclusions set forth in the statement of deficiencies. However, in an effort to enhance the care furnished to our residents, we have augmented some of our existing policies and protocols. We acknowledge that federal and state regulations require a plan of correction, and we are therefore submitting this plan. It is the intent of this facility to provide each resident with an area to conduct a private phone conversation. Some of the ways this has been achieved is as follows:	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	1. On 6/9/14, Residents #4 and #5, and Resident A were educated by the Social Services Director on the areas within the facility where private phone conversations can be held and reiterated that it was their right to have a private area to conduct a phone conversation (residents may use the phones at the desk, the dining room the conference room, or any private office.) 2. In the resident council meeting held 6/10/14, the Social Service Director reminded all residents in attendance of the areas in the facility where a resident may make and conduct a private phone call. 3. The maintenance department will install an extra phone at chair level in the Beauty Shop by 6/20/14 for use of residents. The Social Services Director in the resident council meetings will inform residents monthly of the locations in the facility where a private phone call can be made and conducted. The Admissions Coordinator will include a separate form in the admissions packet explaining to residents and their responsible parties the locations where private calls can be conducted. In July 2014 newsletter that is delivered to all residents and responsible parties, the Administrator will reiterate the right for the resident to have a private phone conversation and the areas within our facility	

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

Julie Faller

TITLE
Administrator

(X6) DATE
7/3/2014

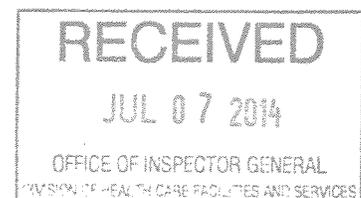
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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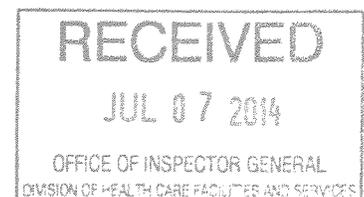
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F 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide telephone privacy for two (2) of fourteen (14) sampled residents (Residents #4 and #5), and one (1) of four (4) Unsampled Residents (Unsampled Resident A).</p> <p>The findings include: Interview with the Administrator, on 05/30/14 at 2:50 PM, revealed there was no policy related to privacy for residents during telephone usage. Interview during the resident group meeting, on 05/28/14 at 2:00 PM, revealed Residents #4 and #5 did not have adequate phone privacy during conversations, and revealed they were required to use the phone at the nurse's station or the phone on the wall behind the desk. Observation of the telephone system at the nurse's station, on 05/30/14 at 12:00 PM, revealed a desk phone with a long cord attached and a phone hanging on the wall behind the desk. Further observation, on 05/30/14 at 12:49 PM, revealed Unsampled Resident A talking on the desk telephone, sitting outside the nurse's station, with the phone cord pulled over the top of the counter Interview with Unsampled Resident A, on 05/30/14 at 1:25 PM, revealed she had only been a resident at the facility for a couple of weeks,</p>	F 164	<p>available for the resident to conduct such calls. On 6/27/14 the Staff Development Coordinator will inservice all staff on the residents right to a private location for phone calls and will inform staff of the areas to direct residents who wish to make phone calls and will inform staff of the areas to direct residents who wish to make a call or conduct a phone conversation in private.</p> <p>4. An audit was developed to interview residents on their knowledge of their right to a private location for phone calls and of the adequacy of the locations provided. The Social Services Director will interview all residents with a BIM score of 8 or more once weekly times 4 weeks, then once monthly times 3 months starting 6/23/14. Then, the Quality Assurance Performance Improvement committee will determine the need for continuation.</p> <p>5. The Administrator is responsible for compliance.</p>	July 11, 2014	



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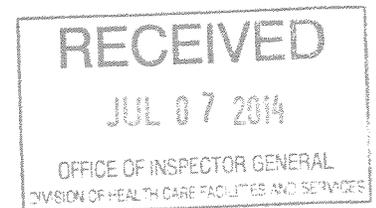
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F 164	Continued From page 2 and revealed he/she had just used the phone at the nurses's station. Unsamped Resident A was his/her own Power of Attorney and stated he/she had been told on admission that residents could use the phone at the desk, or the phone on the wall, but had not been told he/she could use any of the private offices. Interview with LPN #1, on 05/30/14 at 1:25 PM, revealed resident's always use the phone at the nurse's desk, either on the wall or the desk. The LPN stated sometimes resident's would go to the dining room and use the phone there. Interview with the Social Services Director, on 05/30/14 at 1:05 PM, revealed they allowed residents to use the phones in the private offices for phone calls; however, there was no evidence or documentation to show resident's had been informed of this process. Interview with the Administrator, on 05/30/14 at 2:50 PM, revealed there was no privacy policy, and residents were allowed to go to the conference room, if needed, to use the phone. However, interview with residents revealed they were not informed of this, and there was no documented evidence to support it.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241	It is the intent of this facility to treat each resident with dignity and respect. Some of the ways this has been achieved is as follows: 1. On 6/2/14 resident #8, B, and D were given apologies and assessed for signs and symptoms of emotional distress by the Director of Nursing Services and the Social Services Director. No signs and symptoms of distress noted of any of the identified residents. At that time the Director of Nursing and Social Services Director explained to residents #6, B, and D, that every resident has the right to be treated with dignity and respect. The paper sign located in the bathroom of resident D was removed	



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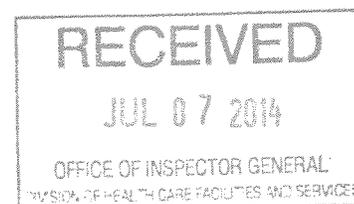
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F 241	Continued From page 3 by: Based on observation, interview, record review, and facility policy, it was determined the facility failed to ensure three (3) of twenty-one (21) residents in the dining room (Residents #8, B, and D) were treated with dignity by the facility staff at breakfast and lunch on 05/29/14. Nursing staff brought Resident B to their assigned table and let go of the wheelchair, without warning, leaving the resident to coast to the table. Nursing staff approached Resident #8's table, grab the wheelchair and moved the resident to a different table without speaking to the resident or providing a reason for the move. Nursing staff accidentally, hit Resident B's wheelchair with Resident D's wheelchair and failed to speak to either resident about the incident. In addition, the facility posted a paper sign taped to the shared bathroom wall with information about Unsamped Resident D's care plan. The findings include: Interview with the Administrator, on 05/30/14 at 10:00 AM, revealed the facility did not have a policy regarding treating residents with dignity. She stated the facility practice was to treat all residents with dignity and respect. Observation of Resident #8, on 05/29/14 at 7:10 AM, revealed Resident #8 sitting in a wheelchair at a table. Another resident entered the dining room and complained that Resident #8 was seated in his/her place. Certified Nurse Aide (CNA) #1 went to Resident #8 and quickly removed the resident and placed him at another table without explanation to Resident #8. A few minutes later CNA #1 moved Resident #8 to the back of the dining room without explanation. The	F 241	on 6/2/14. 2. On 6/10/14 the Social Services Director informed the resident council of the facility's obligation to provide dignity and respect to every resident. Residents were encouraged to report immediately any incident where a resident felt they have been disrespected or treated without dignity. No further residents reported having such incidences at that time. On 6/3/14 an audit was conducted by the Quality Assurance Performance Improvement nurse to identify any further resident with signage in non-private areas detailing their private health information. Any identified signage was removed at that time and placed inside the resident's closet door where their certified nursing assistant care plan is located. 3. On 6/27/14, the Staff Development Coordinator and Social Services Director will inservice all staff and therapy personnel on dignity and respect of residents focusing on the dining room and signage. The Staff Development Coordinator provided individualized inservicing and counseling on dignity and respect on 6/2/14 to all aides working during the breakfast and lunch meals on 5/29/14. On 6/18/14 the dining room was rearranged to allow wheelchairs and geriatric chairs ease of access to tables. 4. The Quality Assurance Performance Improvement nurse developed an audit to ensure residents are being observed for treatment with dignity and respect in the dining room during meal times. The nurse assigned to the dining room starting 6/23/14, will conduct this audit at alternating meals daily times 2 weeks, three times a week times 2 weeks, once weekly times 4 weeks, then monthly times 3 months. Then the Quality Assurance Performance Improvement Committee will determine the need for continuation. The Quality Assurance Performance Improvement nurse developed an audit to ensure residents did not have signage in non-private areas detailing their plans of care. The Quality Assurance Performance Improvement nurse starting 6/9/14 will conduct this audit weekly times 4 weeks, then monthly times 3		



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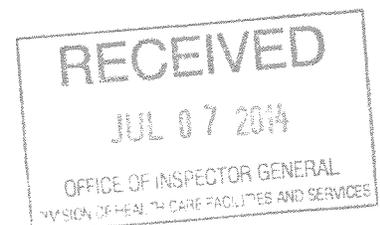
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F 241	<p>Continued From page 4</p> <p>resident was leaning over the left armrest and struggled several times to sit up to eat. Staff were present; however, no assistance was provided to the resident.</p> <p>CNA #2 was observed at 7:16 AM to wheel Resident B into the dining room. The resident had a specialty chair and she could not maneuver the resident to the right table as the walk way was too crowded. She walked up behind Resident #4, without speaking to the resident, and pushed the resident's wheelchair hard to move it out of the way. Resident #4 was already close to the table edge and the push caused the dining table to move and for the resident to look around to see what happened. The resident then grunted at the staff. The CNA then pushed Resident B towards the table, accidentally, hitting the wheelchair of Resident D. The CNA did not stop or inquire if both residents were all right. When CNA #2 reached Resident B's table, she let go of the wheelchair and Resident B coasted to the table. She was not observed to speak to any of the residents and left the dining room.</p> <p>Observation, on 05/29/14 at 7:25 AM, of Resident D's bathroom in the four (4) bed Room 127, revealed a paper sign taped to the wall in the bathroom. The sign revealed details regarding the resident's toileting.</p> <p>Interview with Unsampled Resident D, on 05/29/14 at 7:25 AM, revealed the hit to the wheelchair did shake the resident up; however, the resident was all right now. The resident stated he/she was not aware of a paper sign taped to the wall in his/her shared bathroom and did not want it there.</p>	F 241	<p>months. Then, the Quality Assurance Performance Improvement Committee will review trends from audits and assess to determine the need for continuation.</p> <p>5. The Social Services Director is responsible for compliance.</p>	July 11, 2014	



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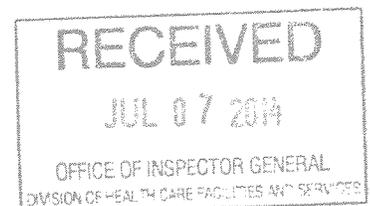
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F 241	Continued From page 5 Interview with CNA #1, on 05/29/14 at 7:30 AM, revealed she did not realize she did not give Resident #8 a reason for moving to another table. She stated she had been trained to explain procedures before doing them. She stated she should not have treated the resident that way. She indicated she did not show the resident respect. Interview with CNA #2, on 05/29/14 at 7:36 AM, revealed she was in a hurry and she did not intend to harm the residents dignity. She stated she should have made room for the wheelchair by telling the residents what she was doing. She revealed she should have checked with Unsampled Resident D to ensure she was not harmed when hit by Unsampled Resident B's wheelchair. She stated she was trained to treat residents with dignity and respect. Interview with the Director of Nursing, on 05/29/14 at 8:20 AM, revealed CNAs were trained to treat residents with respect and dignity. She stated she was not aware of the paper sign in Unsampled Resident D's bathroom and that the sign was not appropriate.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure resident	F 253	It is the intent of this facility to provide excellence in housekeeping and maintenance services. Some of the ways in which this has been achieved is as follows: 1. On 6/12/14, bathroom doors from rooms 115, 116, 118, and 122 were sanded and refinished by the maintenance assistant, removing the tape residue. On 6/9/14 the pillows used to prop up the residents feet in rooms 104-1, 105-1, 107-1, and 114 were cleansed by the environmental services department to remove any soiling. On 6/13/14, the wheelchair of resident in 123-1 was removed from use by the maintenance assistant and another wheel chair in good repair and approved by the therapy department was provided to the resident.	



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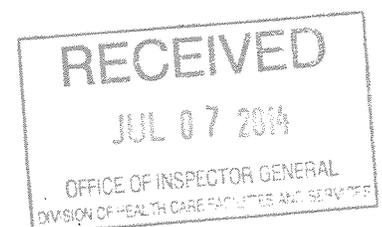
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F 253	<p>Continued From page 6</p> <p>rooms and equipment were in good repair. Four (4) of twenty-eight (28) bathroom doors (Rooms 115, 116, 118 and 122) were found with tape residue all over the doors. Blue pillows used to prop up residents' feet were found in three (3) of twelve (12) rooms to be soiled with brown and black marks (Rooms 104-1, 105-1, 107-1 and 114). In addition, a wheelchair in Room 123-1 had a metal bar behind the seat back which was broken and repaired with white medical tape.</p> <p>The findings include:</p> <p>Interview with the Maintenance Director, on 05/29/14 at 10:00 AM, revealed there was no policy for maintenance.</p> <p>Observation of the facility, on 05/29/14 at 9:00 AM, revealed the bathroom doors in Rooms 115, 116, 118, and 122 were heavily covered with tape residue. The doors were shiny and the residue easily seen. A wheelchair in Room 123-1 had a metal bar going horizontally across the back side of the seat back that was broken and had white medical looking tape wrapped around the bar where it attached to the wheelchair. Foot pillows in four (4) rooms (Room 104-1, 105-1, 107-1 and 114) were soiled with brown and black particles and marks.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 05/30/14 at 2:40 PM, revealed the foot pillow covers should have been removed and sent to the laundry.</p> <p>Interview with the Maintenance Director, on 05/29/14 at 2:30 PM, revealed he received no request from nursing regarding the broken wheelchair. He stated he had not noticed a</p>	F 253	<p>2. On 6/5/14, the Maintenance Director completed an audit of all bathroom doors throughout the facility. Any door identified in need of maintenance repair or refinishing will be completed by 7/11/14. On 6/9/14, the Environmental Services Director completed an audit on all cushions used to prop up residents' feet. All cushions were cleaned at that time. On 6/13/14, the Maintenance Assistant completed an audit of all resident mobility devices. No further wheelchairs, walkers, or geriatric chairs were found in need of repair.</p> <p>3. In the July 2014 newsletter that is delivered to all residents and responsible parties, the Administrator will explain that tape is not to be utilized in the facility and that poster putty is available and should be used. The Director of Nursing Developed a weekly cleaning schedule and procedure for cleaning all devices used to prop up a residents' feet on 6/16/14. The Staff Development Coordinator will conduct a mandatory inservice for all nursing staff on the revised cleaning schedule and procedure, and for all staff on not using tape, identifying broken mobility devices, and documenting the need for repairs in the maintenance repair log located at the nurses station on 6/27/14.</p> <p>4. The Quality Assurance and Performance Improvement nurse developed separate audits to identify tape residue and usage on facility doors, cleanliness of cushions used to prop up residents' feet, and to monitor condition and need for repair of residents mobility devices (wheelchairs, walkers, and geriatric chairs). The Maintenance Director will conduct the tape residue and usage audit weekly times 4 weeks and then monthly times 4 months starting 6/12/14. The Environmental Services Director will conduct the audit for cleanliness of cushions used to prop up residents' feet weekly times 4 weeks, then every other week times 4 weeks, then monthly times 4 months starting</p>	



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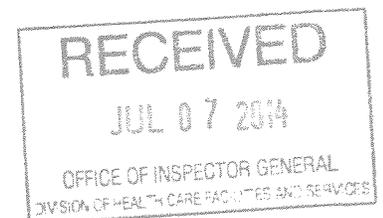
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F 253	Continued From page 7 problem with the bathroom doors. Interview with Licensed Practical Nurse #2, on 05/30/14 at 2:20 PM, revealed work orders for maintenance were sent to maintenance and the repairs were then completed. She stated she had no knowledge of the broken wheelchair or the bathroom doors with tape residue. She stated she did not remember requesting repair of the wheelchair or the doors covered with tape residue. She stated the covers on the blue pillows were to be removed by nursing and sent to the laundry when soiled. She indicated she had made rounds on residents; however, the soiled pillows were not noted.	F 253	6/16/14. The Maintenance Director will conduct the audit on condition and need for repair of the resident mobility devices weekly times 4 weeks, then monthly times 4 months starting 6/20/14. Audit results will be reviewed monthly in the Quality Assurance Performance Improvement meetings. Then, the Quality Assurance Performance Improvement committee will review trends from audits and assess to determine the need for continuation. 5. The Administrator is responsible for compliance.	July 11, 2014	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	It is the intent of this facility to provide each resident with an individualized care plan that is revised to meet the residents' individualized needs. Some of the ways this has been achieved is as follows: 1. On 6/13/14, the catheter comprehensive care plans for residents #2 and #4 were revised to include the use of a leg strap to secure the catheter tubing. The comprehensive care plan for resident #8 was revised on 6/9/14 to reflect his need for positioning devices when leaning while sitting in a wheel chair. Resident #6 comprehensive care plan was revised on 6/2/14 to reflect specific side effects and by who and when monitoring for the side effects for the medications Zolof and Abilify would occur. 2. On 6/16/14 the Quality Assurance and Performance Improvement nurse conducted an audit on the care plans of all residents with urinary catheters to ensure documentation of the use of a securing device. No further residents were affected. On 6/16/14 an audit was conducted by the Therapy Manager of all residents utilizing a wheelchair for wheelchair positioning. A resident leaning or with positioning concerns were referred for evaluation for therapy services for positioning.		



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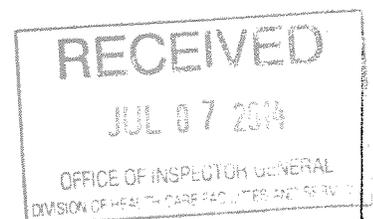
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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Catheter Care policy, it was determined the facility failed to revise the comprehensive care plan for four (4) of fourteen (14) sampled residents (Residents #2, #4, #6 and #8). The care plan failed to reflect Resident #2's preference for a leg strap to secure the tubing, and the care plan for Resident #4 failed to reflect the use of leg straps to secure the catheter tubing. The care plan for Resident #8 failed to reflect positioning for leaning while sitting in a wheelchair. The care plan for Resident #6 failed to direct staff in who and when monitoring would occur for potential side effects and failed to specify the specific side effects for Zoloft (antidepressant) and Abilify (antipsychotic). The findings include: Interview with Administrator, on 05/30/14 at 11:25 AM, revealed the facility did not have a care plan policy, but followed the Resident Assessment Instrument User Manual Version 3.0 for development of comprehensive and revisions of care plans for facility residents. She further stated resident care plans were to be individualized to the resident's needs. Review of the Resident Assessment Instrument User Manual Version 3.0 for development of comprehensive and revisions of care plans for facility residents indicated care plan goals should be measurable. Including a subject, verb, modifiers, time frames, and goals and chapter 4	F 280	The MDS Coordinator updated comprehensive physical functioning care plans with interventions at that time to reflect residents with positioning concerns. The Quality Assurance and Performance Improvement nurse on all comprehensive care plans of residents on antipsychotic and antidepressant medications conducted and audit on 6/16/14. Care plans requiring revisions to reflect specific side effects and by whom and when monitoring for the side effects for the medications would occur will be completed by 7/10/14. 3. On 6/27/14, the Staff Development Coordinator will educate all nurses on following comprehensive plan of care in relation to securing of catheter devices, identifying and care planning interventions for residents that do not have optimal positioning in a wheelchair, and on monitoring for side effects of medications as noted in the comprehensive plans of care and on the medications Administration Record. Side effects for specific medications will be pulled off the website Medline Plus, a service of the US National Library of Medicine and the National Institute of Health, thus ensuring the most accurate and up to date monitoring of side effects. A copy of all antipsychotic or antidepressant orders will be given to the MDS Coordinator in the morning meetings Monday through Friday for comprehensive care plans revisions. The MDS Coordinator was inserviced on 6/23/14 by the Director of Nursing related to documenting specific side effects for medications on the comprehensive care plans for antipsychotic and antidepressant medications. The Wound Nurse responsible for the urinary catheter comprehensive care plans were inserviced on 6/16/14 by the Director of Nursing on documenting the specific securing device ordered and how to secure the catheter with the device on the comprehensive plan of care for each resident with a urinary catheter to reflect the Individualized preference of the resident.		



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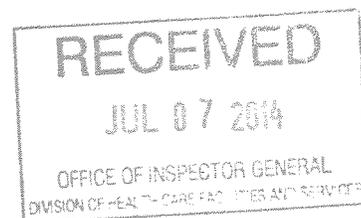
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F 280	Continued From page 9 stated re-evaluate the resident's status quarterly, annually or if a significant change occurs and following the decision to address a triggered condition on the care plan, key staff or the Interdisciplinary Team should subsequently review and revise the current care plan as needed. Interview with Quality and Assurance Registered Nurse, on 05/30/14 at 3:05 PM, revealed the latest care plan information was written by the staff nurses when physician orders are transcribed and then the nurse revised the care plan based on the new order. She stated the physician's verbal orders are written on a multiple part form and the form contained the physician order portion and a care plan portion. She stated the nurse was required to write a care plan, with problem, goal and intervention based on the order received from the physician. The nurse stated the care plan updates were not added to the comprehensive care plan if they were for acute medical concerns. She further stated the facility practice was to update the comprehensive care plan quarterly using the care plan update slips within 14 days. Review of the facility's policy regarding Catheter Care, Indwelling Catheter for the Licensed Nurse's basic responsibility, not dated, revealed under general resident care plan documentation guidelines the nursing staff was to identify the underlying problem and develop an individualized care plan.	F 280	4. The Quality Assurance and Performance Improvement nurse has developed individual audits to ensure comprehensive care plans for urinary catheters are updated to reflect the usage of a securing device, that any resident with positioning concern has been care planed on the comprehensive plan of care to reflect their positioning needs, and that all resident's on antipsychotic and antidepressant medications have separate care plans identifying their need of specific side effects monitoring and by who and when the monitoring for the side effects for the medications will occur. The Quality Assurance and Performance Improvement nurse will conduct the audit on the comprehensive care plans for securing devices for urinary catheters monthly times 4 months starting 6/23/14. Results will be reviewed at the monthly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement nurse will conduct an audit on all residents in the building with referrals to therapy for positioning Monday through Friday in the morning standards of care meetings. Comprehensive care plans will be checked to ensure residents' need for positioning has been addressed starting 6/23/14. All residents receiving antipsychotics or antidepressants will have their care plans revised to reflect side effect monitoring, who will conduct the monitoring and when by 7/10/14. The Quality Assurance and Performance Improvement nurse will check all comprehensive care plans of residents with new orders for antipsychotics and antidepressants for specific side effects monitoring and by who and when the monitoring for the side effects of the medications will occur. This audit will be conducted weekly times 8 weeks, then monthly times 3 months starting 6/30/14. The Quality Assurance and Performance Improvement Committee will determine the need for continuation of all audits upon completion. 5. The Director of Nursing will be responsible for compliance.	July 11, 2014
	1. Observation of Resident #2, on 05/28/14 at 9:45 AM, revealed an indwelling catheter tubing in a dignity bag connected to his/her wheelchair. Resident #2 declined skin assessment requests			



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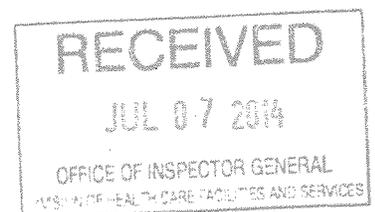
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F 280	<p>Continued From page 10</p> <p>on 05/29/14 and 05/30/14 as the resident was up in wheelchair and did not want to go back to bed or had family visitors.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 08/18/12 with diagnoses of Cerebral Palsy and Chronic Urinary Retention. Review of the Minimum Data Set (MDS) Quarterly assessment, dated 02/07/14, revealed the facility assessed Resident #2 with an indwelling catheter and was always incontinent of bowel. The resident had a Brief Interview Mental Status (BIMS) score of five (5). Review of the comprehensive care plan, dated 08/31/12, revealed interventions were a Foley Catheter per order, care and change of the catheter was per facility policy and a handwritten intervention #9 was to anchor the indwelling catheter to the thigh to prevent pulling and trauma to the bladder.</p> <p>Interview with the Director of Nursing, on 05/30/14 at 3:36 PM, revealed Resident #2 did not care for the tape fasteners, the resident preferred the velcro band that went around the leg to secure the tubing. In addition, she stated the care plan was individualized for this resident to reflect the resident's preference.</p> <p>2. Observation of Resident #4, on 05/29/14 at 9:30 AM, revealed during the skin assessment the resident was lying on the bed with an indwelling catheter connected to a bedside drainage bag that was observed to be anchored to the bed frame. Resident #4 was observed with a suprapubic catheter without a securing device to prevent movement and possible trauma.</p> <p>Review of the clinical record for Resident #4</p>	F 280			



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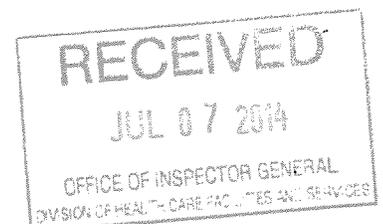
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F 280	<p>Continued From page 11</p> <p>revealed the facility admitted the resident on 09/23/13 with diagnoses of Chronic Kidney Disease, Hypospadias, and Neurogenic Bladder. Review of the MDS Admission assessment, dated 09/30/13, revealed the facility admitted the resident with a suprapubic catheter and was frequently incontinent of bowel and had a BIMS score of fifteen (15) with no cognitive impairment. Review of the comprehensive care plan, dated 10/26/13, revealed Resident #4 had an intervention for a Foley Catheter (indwelling catheter) per physician orders, the care and changing of the catheter ordered per facility policy. There were no interventions to address how to secure the indwelling catheter for the resident.</p> <p>Interview with License Practical Nurse (LPN) #1, on 05/30/14 at 2:45 PM, revealed the comprehensive care plans for Resident #2 and Resident #4 were not individualized. She further stated the care plan did not reflect the special placement of Resident #4's suprapubic catheter nor did the care plan for Resident #2 reflect the use of a strap or a tape device.</p> <p>Interview with the Wound Care LPN, on 05/30/14 at 2:25 PM, revealed after reviewing the comprehensive care plans for Residents #2 and #4 she indicated she was responsible for resident assessments and then the development of the wounds, and bowel and bladder function comprehensive care plans. She further stated the care plans were not individualized to either Resident #2 or #4 and should have been.</p> <p>Interview, on 05/30/14 at 10:00 AM, with the Director of Nursing (DON) revealed the care plan update slips used in the facility did not have to be</p>	F 280			



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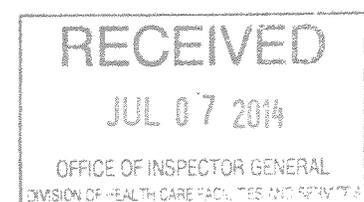
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F 280	Continued From page 12 on the comprehensive nursing care plan. 3. Observation of Resident #8, on 05/29/14 at 11:40 AM, revealed the resident was sitting in a wheelchair in the main dining room. The resident was leaning to the left over the arm of his/her wheelchair. Resident #8 attempted to reposition his/herself and sit upright on multiple occasions without success. Staff members were passing lunch trays and did not intervene to assist the resident with repositioning. Further observation, on 05/29/14 at 12:00 PM, revealed Resident #8 was sitting in his wheelchair in the main dining room. The resident continued leaning to the left over the arm of his/her wheelchair. There were no positioning devices on the resident's wheelchair. Staff members in the dining room did not intervene to assist the resident with repositioning. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 06/20/08 with diagnoses of Diabetes, Glaucoma, Left above the Knee Amputation, Hypertension, Congestive Heart Failure, Atrial Fibrillation, Hearing loss, Aphasia, and Mental Retardation. The facility completed an Annual MDS assessment on 05/30/13 which revealed the resident was cognitively impaired and required extensive assistance with Activities of Daily Living. Review of Resident #8's Comprehensive Care Plan (reviewed by the facility on 5/15/14) for preventative skin impairment revealed the resident required the total assist of staff for bed mobility and transfers. In addition, the care plan	F 280			



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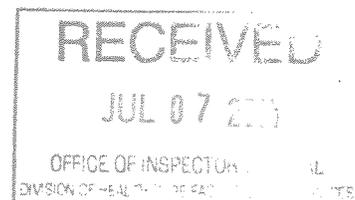
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F 280	<p>Continued From page 13</p> <p>indicated staff could use positional devices as needed to offload pressure. According to the care plan, Resident #8 was also at risk for falls. The fall risk interventions included screening of the resident as needed by Physical Therapy (PT) and Occupational Therapy (OT).</p> <p>Review of the clinical record for Resident #8 revealed the Licensed Practical Nurse (LPN) had documented a Condition Change Form, on 05/07/14 at 2:00 PM, in the nurse's notes. The condition change indicated the resident was leaning to the left while sitting in the wheelchair. Further review of the clinical record revealed a physician's order, dated 05/07/14 at 2:00 PM, to send the resident to the Emergency room to be evaluated for leaning to the left side and decreased grasp of left hand. Review of the nurse's notes, dated 05/07/14 at 9:30 PM, revealed Resident #8 returned to the facility from the hospital emergency room with no new physician orders. Review of the comprehensive care plan for Resident #8, revealed the care plan had not been updated to reflect interventions for the change of condition.</p> <p>Interview with the LPN #2, on 05/30/14 at 4:35 PM, revealed all new physician orders and resident condition changes were reviewed during the daily nurses meeting. She stated the MDS Coordinator was responsible for updating and revising the resident care plans. LPN #2 stated all new orders and condition change forms were given to the Minimum Data Set (MDS) Coordinator at the daily nurses meeting. The LPN further stated Resident #8's care plan had not been revised to reflect the change of condition to include the appropriate clinical interventions for wheelchair positioning.</p>	F 280			



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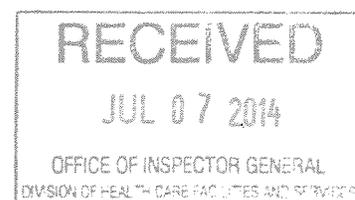
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F 280	Continued From page 14 4. Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Diabetes and Cerebral Vascular Accident. The facility completed a quarterly Minimum Data Set (MDS) assessment on 01/22/14 which indicated the resident was moderately impaired in cognition and required extensive assistance with bathing, grooming and dressing. The resident received antidepressants, Zoloft and Abilify. Review of the comprehensive care plan for Resident #6, revealed the facility identified that the resident received Zoloft and Abilify. The facility interventions included monitoring for side effects of the medications, however, there were no documented interventions for who would monitor and when monitoring would occur. In addition, the side effects were in one intervention and there were no side effects listed separately for each medication. The facility was monitoring for side effects of nausea, restlessness, agitation, dizziness for both medications. revealed the side effects for Abilify included: anticholinergic The side effects for Zoloft included: sore throat, excessive sweating, burning in hands and feet, uncontrolled shaking, gas, decreased appetite, nausea, vomiting, excessive tiredness, weight changes, dry mouth, dizziness. Interview with Licensed Practical Nurse (LPN) #1, on 05/30/14 at 2:25 PM, revealed there was no certain time to monitor residents for medication side effects and monitoring should be done all the	F 280			



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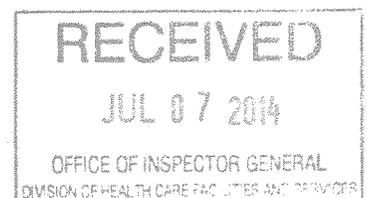
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F 280	Continued From page 15 time. She stated the care plan should have been revised to show each antidepressant and the side effects for each medication. She stated she would need to know the side effects for each medication in order to effectively monitor the resident and did not feel the care plan was adequately revised. Interview with LPN #2, on 05/30/14 at 2:15 PM, revealed she did not think the care plan was revised to contain the information needed to explain what the side effects were for each medication. Attempted interview with the MDS Coordinator regarding care plans were unsuccessful as she was out of the building for personal reasons.	F 280		
F 315 SS=D	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.	F 315	It is the policy of this facility to ensure residents with an indwelling urinary catheter are provided a device to secure the catheter tubing in place to prevent trauma. Some of the ways this has been achieved is as follows: 1. On 6/4/14, residents #2 and #4 had securing devices applied to their catheter tubing to prevent catheter movement and traction on the urethra. 2. On 6/5/14 an audit was conducted by the Wound Nurse to ensure all residents with urinary catheters had devices applied per their preference to secure their urinary catheter tubing. The device preference was noted on the residents catheter care plan in the comprehensive plan of care and on the certified nursing assistant plan of care on 6/5/14. No further residents were affected. 3. The Staff Development Coordinator will educate all nursing staff by 7/10/14 on the proper procedure and need for utilizing the catheter securing devices as defined in the Lippincott Manual of Nursing Practice 10th Edition which was purchased by the	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Catheter Care policy, it was determined the facility failed to ensure			



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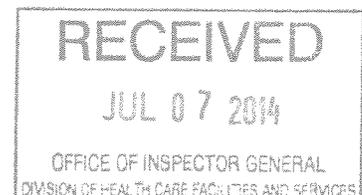
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F 315	Continued From page 16 residents with an indwelling catheter were provided a devise to secure the catheter tubing in place to prevent trauma for two (2) of fourteen (14) sampled residents, (Residents #2 and #4). The findings include: Review of the facility's policy regarding Catheter Care, Indwelling Catheter, basic responsibility for the licensed nurse, not dated, revealed catheter care procedures were to prevent catheter associated Urinary Tract Infections (UTI) and to reduce irritation. The policy detailed how to provide catheter care which included a handwritten statement regarding securing the tubing and to document in the medical record the date and time catheter care was completed with signature and title of the person recording the data. Interview with the Administrator, on 05/30/14 at 11:25 AM, revealed the facility utilized the Lippincott Manual 6th edition, for nursing procedures as a standard of practice. Review of the Lippincott Manual of Nursing Practice 6th Edition, copyright date 1996, revealed in Chapter 19: Renal and Urinary Disorders, page 596, revealed management of the patient's indwelling catheter should be secured with the rational to prevent catheter movement and traction on the urethra. 1. Observation of Resident #4, on 05/29/14 at 9:30 AM, revealed during the skin assessment the resident was lying on the bed with an indwelling catheter to a bedside drainage bag that was observed to be anchored to the bed frame. Resident #4 was observed with a suprapubic	F 315	facility and written into policy on 6/9/14. 4. The Quality Assurance and Performance Improvement nurse developed an audit to ensure all residents with urinary catheters have a device utilized to secure tubing. This audit will be conducted by the Wound Nurse daily times 5 days, 3 times a week times 2 weeks, once weekly times 4 weeks, then monthly times 3 months starting 6/9/14. Then, the Quality Assurance and Performance Improvement Committee will review trends from the audits to determine the need for continuation. 5. The Director of Nursing is responsible for compliance.	July 11, 2014	



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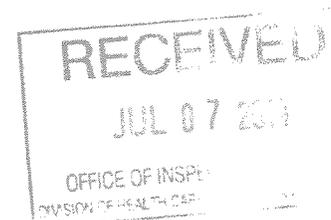
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F 315	<p>Continued From page 17</p> <p>catheter without a securing device to prevent movement and possible trauma.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 09/23/13 with diagnoses of Chronic Kidney Disease, Hypospadias, and Neurogenic bladder. Review of the admission nursing assessment and the initial Minimum Data Set (MDS) Admission assessment, dated 09/30/13, revealed the facility assessed the resident with a catheter and as frequently incontinent of bowel. Review of the comprehensive care plan, dated 12/26/13, revealed interventions of a Foley Catheter per order, care and change of the catheter were per facility policy.</p> <p>Interview with License Practical Nurse #1 (LPN), on 05/29/14 at 9:30 AM, during Resident #4's skin assessment revealed the suprapubic catheter was not secured to the resident's leg. The nurse stated the resident did not have a strap on today, and needed one. Further interview on 05/30/14 at 2:45 PM with LPN #1 revealed the facility had two devices to secure catheter tubing, one was an adhesive tape and the other was a strap that went around the resident's leg to secure the tubing.</p> <p>2. Observation of Resident #2, on 05/28/14 at 9:45 AM, revealed an indwelling catheter tubing in a dignity bag connected to his/her wheelchair. Resident #2 declined skin assessment requests on 05/29/14 and 05/30/14 due to the resident being up in a wheelchair and did not want to go back to bed and the resident had family visitors.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on</p>	F 315			



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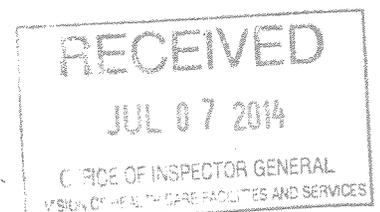
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F 315	Continued From page 18 08/18/12 with diagnoses of Cerebral palsy and Chronic Urinary Retention. Review of the Minimum Data Set (MDS) Quarterly assessment, dated 02/07/14, revealed the facility assessed Resident #2 with an indwelling catheter and as always incontinent of bowel. Review of the comprehensive care plan, dated 08/31/12, revealed interventions of a Foley Catheter per order, care and change of the catheter per facility policy and a handwritten intervention #9 was to anchor the indwelling catheter to the thigh to prevent pulling and trauma to the bladder. Interview with the DON, on 05/30/14 at 6:36 PM, revealed Resident #2 preferred the use of the strap device, but the device was on back order and the facility currently did not have any devices available. Interview with the Wound Care LPN, on 05/30/14 at 3:35 PM, revealed the purpose of securing the catheter tubing was to prevent trauma, if the tubing was pulled. Continued interview with the Director of Nursing (DON), on 05/30/14 at 3:36 PM, revealed the facility's nursing practice was to secure catheter tubing to prevent residents from pulling or causing irritation and the catheter tubing could be removed or dislodged if pulled on too hard causing trauma that might prevent re-insertion of another catheter. The DON further stated the facility had two devices to secure catheters with, one was a tape device and the other was a strap device.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	It is the intent of this facility to ensure every resident is appropriately monitored for medication side effects. Some of the ways this has been achieved is as follows: 1. The MDS nurse to reflect the individualized side effects for the resident's antidepressant and	



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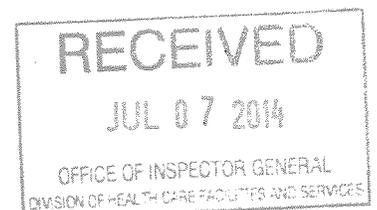
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F 329	Continued From page 19 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the side effects that should be monitored for Abilify (antipsychotic) and Zoloft (antidepressant), were monitored for one (1) of fourteen (14) sampled residents, (Resident #6). The facility administered Abilify and Zoloft, to Resident #6 on a routine basis; however, failed to accurately identify and monitor the correct side effects of these medications.	F 329	antipsychotic medications revised the comprehensive care plan for resident #6 on 6/2/14. A nurse assessed the resident for the side effects at that time and documented the assessment in the resident's chart. The resident's physician and psychiatrist were notified of any possible side effects the resident was experiencing. Both physicians chose not to change the medication order at that time. 2. On 6/16/14 the Quality Assurance and Performance Improvement nurse on all comprehensive care plans of residents on antipsychotic and antidepressant medications conducted an audit. Comprehensive care plans will be revised by 7/10/14 to reflect specific side effects and by whom and when monitoring for the side effects for the medications will occur for residents on antipsychotic and antidepressant medications. 3. On 6/27/14 the Staff Development Coordinator will educate all nurses on where to find the side effects for antidepressant and antipsychotic medications in the resident's comprehensive plan of care and on the Medication Administration Record. Side effects for specific medications will be pulled off the website Medline Plus, a service of the US National Library of Medicine and the National Institute of Health, thus ensuring the most accurate and up to date monitoring of side effects. All new antipsychotic or antidepressant orders will be given to the MDS Coordinator in the morning meetings Monday through Friday for comprehensive care plan revisions. The MDS Coordinator will be inserviced on 6/23/14 by the Director of Nursing related to documenting specific side effects for medications on the comprehensive care plan for antipsychotic and antidepressant medications. 4. All residents receiving antipsychotics or antidepressants will have their care plans revised to	



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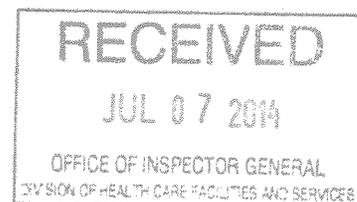
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F 329	<p>Continued From page 20 The findings include:</p> <p>Interview with the Administrator, on 05/30/14 at 4:00 PM, revealed the facility had no policy regarding the monitoring of psychotropic medications.</p> <p>Observation of Resident #6, on 05/28/14 at 10:20 AM, 10:52 AM, 2:10 PM, 2:46 PM, 3:09 PM and on 05/29/14 at 7:02 AM, 7:22 AM and 11:55 AM, revealed the resident was either in bed or in the wheelchair. Severe behaviors were not noted.</p> <p>Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Diabetes, Depression, and Peripheral Vascular Disease. The facility completed a Quarterly Minimum Data Set (MDS) assessment, on 01/22/14, which revealed the resident had a moderate cognitive impairment and required extensive assistance with bathing, dressing and walking. The resident could eat independently after tray set-up. Review of the comprehensive care plan for Resident #6, dated 04/24/14, revealed the resident received Abilify and Zoloft. The side effects of Abilify and Zoloft were listed as nausea, tiredness, weight changes, dizziness and fatigue. The same side effects were listed for both medications.</p> <p>Review of Table 1 in the State Operations Manual revealed Zoloft's side effects included: diarrhea, constipation, vomiting, dry mouth, gas, loss of appetite, drowsiness, headache, excessive sweating, uncontrollable shaking, and pain/burning in hands or feet. There was no evidence provided to validate the facility monitored Resident #6 for the common side effects of Zoloft.</p>	F 329	<p>reflect side effect monitoring, who will conduct the monitoring and when by 7/10/14. The Quality Assurance and Performance Improvement nurse will check all comprehensive care plans of residents with new orders for antipsychotics and antidepressants for specific side effects monitoring and by who and when the monitoring for the side effects of the medications will occur. This audit will be conducted weekly times 8 weeks, then monthly times 3 months starting 6/30/14. The Quality Assurance and Performance Improvement Committee will determine the need for continuation.</p> <p>5.The Director of Nursing is responsible for compliance. July 11, 2014</p>	



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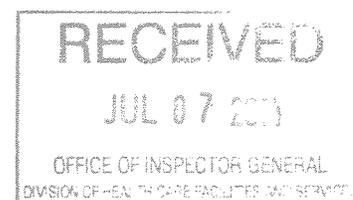
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F 329	Continued From page 21 Review of Table 1 in the State Operations Manual revealed Abilify's side effects included: anticholinergic effects; cardiac arrhythmias; orthostatic hypotension Tardive Dyskenesia; Parkinsonism; elevated blood glucose levels; lethergy; and falls. There was no evidence provided to validate the facility monitored Resident #6 for the common side effects of Abilify. Interview with Licensed Practical Nurse (LPN) #2, on 05/30/14 at 2:15 PM, revealed she would have to research the side effects for Abilify and Zoloft in order to monitor for the side effects of these medications. She stated she usually monitored for nausea, dizziness, and restlessness; however, she was not sure what other side effects each medication could cause. A request for evidence of monitoring was made; however, no evidence of monitoring for side effects was received. The Minimum Data Set (MDS) Coordinator was not available in the facility for interview.	F 329		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	It is the policy of this facility to prepare foods by methods that conserve nutritive value, appearance, and food that is palatable, attractive, and at the proper temperature. Some of the ways this has been achieved is as follows: 1. On 6/9/14 the Food Service manager interviewed residents #4 and #5 separately concerning their complaints of cold foods and tough meats. At that time individual resident food preferences were updated on their dietary care plan. Both resident sit in the dining room for the majority of their meals and will be served immediately upon entering the dining room directly from the steam table. If they choose to eat in their rooms, these individuals will be served first when floor trays are passed to ensure their food is served as hot	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Serving Meals policy, it was			



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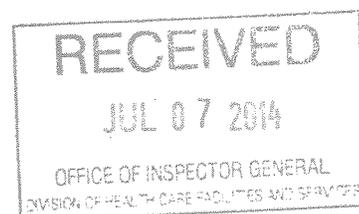
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F 364	<p>Continued From page 22</p> <p>determined that the facility failed to ensure residents were served food that was at the proper temperature and was palatable for the lunch served on 05/29/14.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Serving of Meals (Dining and Resident Room), not dated or approved, was identified as Policy A:5.22 revealed the facility would serve hot food hot and cold food cold when it reached the resident.</p> <p>Interview during the group meeting, on 05/28/14 at 2:00 PM, revealed two (2) of five (5) residents (Resident #4 and Resident #5) voiced concerns of food being cold and the meat sometimes was not tender enough to cut or chew. Resident #4 stated sometimes the meat was very tough and he/she was unable to chew it, and stated many times the bacon was cold. Resident #5 stated the food was cold most of the time, especially in the morning.</p> <p>Interview with Resident #4, and Unsampled Resident A and D, on 05/29/14 at 11:50 AM, revealed the pork chop served at lunch was tough and dry. They stated they could not cut the meat.</p> <p>Interview with CNAs #4 and #5, on 05/29/14 at 12:15 PM, revealed the pork chop at lunch was tough and difficult to cut.</p> <p>Observation of a test tray, on 5/29/14 at 12:20 PM, revealed a test tray was placed on the last cart in the kitchen at 12:11 PM. The cart arrived on the last unit to be served, Oak Street hallway, at 12:15 PM. At 12:20 PM, all residents trays were served, and the test tray was removed from</p>	F 364	<p>as possible. Both residents were reminded that a staff member could heat up their food whether they are in the their room or the dining room, and to let a staff member know if their meat is not tender to their preference.</p> <p>2. On 6/10/14 the Food Service Manager spoke to the resident council regarding the food temperatures at point of service, taste of the food, seasoning, and tenderness of the meats. No further complaints were voiced.</p> <p>3. On 6/27/14 the Staff Development Coordinator will be educating all staff on seasoning of foods at point of service, reheating food trays to resident food temperature preference, and letting dietary know immediately if meats are too tough or a resident dislikes a particular item so that a substitute can be provided. Gordon Food Services' Healthcare Customer Development Specialist and former Chef will provide all dietary employees with an inservice on 6/25/14 regarding food appearance, palatability, seasoning and methods of cooking meats to provide a more tender presentation.</p> <p>4.A food survey was developed by the Food Service Manager to question the resident and/or responsible party, during their care plan conferences quarterly, regarding resident food preferences, quality, and temperature of the food starting 7/3/14. The residents plan of care will be updated to reflect specific interventions to meet their individualized preferences. Test trays will be audited for palatability and temperature at point of service by the Food Service Manager, Assistant Food Service manager, or Supervisor at alternating meals daily times 4 weeks, then 3 times a week times 4 weeks, then weekly times 2 months starting 6/30/14. Results will be reviewed monthly in the Quality Assurance and Performance Improvement Meeting.</p> <p>5.The Food Service manager is responsible for compliance.</p>	July 11, 2014	



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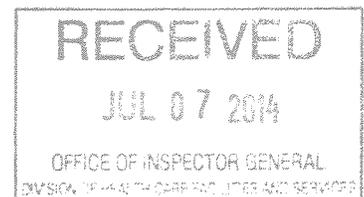
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F 364	Continued From page 23 the cart. Temperatures were obtained at 12:21 PM with readings of Au Gratin potatoes were 100 degrees Farenheit (F); carrots were 110 degrees (F); pork chops were 80 degrees (F), and the roll was 80 degrees (F). The food tasted cold, and bland. There was no seasoning tasted. The potatoes tasted of processed potatoes from a box that were grainy and were undercooked. The carrots had a metallic taste of tin. Interview with the Food Service Manager (FSM), on 5/29/14 at 12:30 PM, revealed the food tasted good to her and the food was warm, but could be a little hotter. The FSM stated the Registered Dietician (RD), completed a point of service check each month, and stated the RD had not had any issues with taste and temperature of the food. Review of the RD's reports from the last six (6) months revealed that four (4) out of six (6) months RD reports relating to temperatures revealed there were no temperatures above 135 degrees (F) at point of service. In addition, review revealed two (2) out of six (6) months food temperature reports indicated the food had to be reheated at point of service. Two (2) out of the six (6) months food reports stated the food was reported to be undercooked. All six (6) months reports were given a score of "acceptable" by the RD.	F 364			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	It is the policy of the facility to provide and maintain a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Some of the ways this has been achieved is as follows: 1. On 5/30/14, the Housekeeping Director cleaned room 101 using a 1:10 bleach solution effective for cleaning c-diff spores.		
	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				



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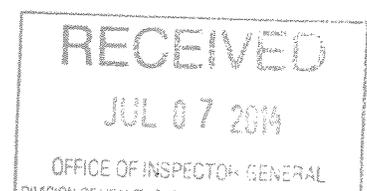
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F 441	Continued From page 24 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, 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 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Infection Control policy, it was determined the facility failed to provide housekeeping staff with training on cleaning of	F 441	2. Housekeeper #1 was immediately taken off the floor until inserviced and checked-off for competency of cleaning an isolation room by the Housekeeping Director on 6/2/14. On 5/30/14 the Housekeeping Director completed a competency check-off on all housekeeping staff on duty, and then all resident rooms were cleansed using a 1:10 bleach solution by the housekeeping department to kill any c-diff spores due to the risk for cross contamination. By 6/9/14, all housekeeping personnel were educated on cleaning of isolation rooms, personal protection equipment, and handling of garbage and linens in isolation rooms by the Staff Development Coordinator. 3. On 6/2/14, the Housekeeping Director implemented a new policy and procedure regarding cleaning of isolation rooms. By 6/30/14 all housekeeping and laundry staff will be inserviced on the policy and procedure, and a competency check-off completed on the cleaning of an isolation room. 4. The Quality Assurance and Performance Improvement nurse has developed an audit to be done by the Housekeeping Director or Supervisor to check-off each isolation room after it has been cleaned. The Housekeeping Director will also observe each cleaning of an isolation room daily times 5 days, 3 times a week for 2 weeks, then once weekly times 4 weeks starting 6/30/14. The Quality Assurance and Performance Improvement team, including the Director of Nursing who is responsible for infection control surveillance, will review the results of the audits monthly. 5. The Housekeeping Director is responsible for compliance.	July 11, 2014	



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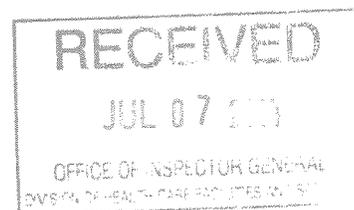
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F 441	<p>Continued From page 25</p> <p>isolation rooms to ensure isolation rooms were cleaned in a manner to prevent the spread of infection for one (1) of three (3) rooms with contact isolation for Clostridium Difficile (C-diff). Housekeeper #1 took a cleaning cloth and mop into an isolation room, and when finished, took the items back outside the room and placed them back on the housekeeping cart. During that time, she touched the cart numerous times with soiled gloves. The housekeeper removed the personal protective equipment (PPE) and placed it in the trash on the cart. In addition, Housekeeper #1 used a disinfectant to clean the room that was not effective against C-Diff spores.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control Policies, revealed it did not address how or when to clean isolation rooms and did not address the appropriate disinfectant to use.</p> <p>Review of the in-service training for employees, dated July 2013, revealed employees were trained to clean using Standard Precautions; however, no in-service training for isolation could be provided by the facility.</p> <p>Observation of Housekeeper (Hskg) #1, on 05/30/14 at 2:45 PM, revealed Hskg #1 gowning and gloving in the hall outside Room 101. The signage on the door revealed the resident was in isolation. Hskg #1 removed a rag from the pail of water on the cart and entered the room and wiped down the contact surfaces. She then returned to the cart and placed the rag back in to the bucket of water on the cart. She took a mop from the mop bucket and squeezed the water from the mop head touching the bucket wringer</p>	F 441			



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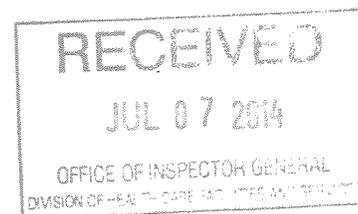
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F 441	<p>Continued From page 26</p> <p>with her soiled gloves. She mopped the room then returned the mop to the mop bucket again touching the bucket wringer with her soiled gloves.</p> <p>Continued observation of Hskg #1, on 5/30/14 at 2:52 PM, revealed she removed her PPE in the hallway next to the cart and placed the items in the trash bag on the cart. She removed the PPE items from the trash and deposited them in a small uncovered trash can in the resident's room. She then pushed the cart down the hall towards the back of the facility.</p> <p>Interview with Hskg #1, on 05/30/14 at 2:58 PM, revealed she was returning the cart to the housekeeping room. She stated she had been trained on cleaning an isolation room; however, she could not remember when the training occurred. She stated she used a disinfectant that the facility always used for cleaning and stated she thought the cleaner killed all germs. Observation of the bottle's label revealed it was not marked as to the solution inside the bottle. She stated she did not mix the cleaner herself, but was not sure who prepared the cleaning solution, as it was already on the cart. She stated the facility practice was to take the cart to the housekeeping room and wipe down all the surfaces. She stated she was not trained to bag the cleaning rag or the mop head and remove them from the room. She denied that she removed her PPE in the hallway next to the housekeeping cart. She stated she did place the PPE in the cart trash then removed them and placed them back in the resident room. She indicated she did not know why she did that. She stated she had cleaned the other two resident rooms who had C-diff that day; however, she was</p>	F 441			



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F 441	<p>Continued From page 27</p> <p>not sure which chemical she used or if she had used the same cart all day. She stated germs could be spread to others if the wrong chemical was used.</p> <p>Interview with the Housekeeping Director (HD), on 05/30/14 at 3:08 PM, revealed he trained the Housekeeping employees on cleaning isolation rooms; however, he was not able to provide any evidence of when the training was provided. He stated the cleaner on the cart was a solution mixed with chemical and water and was effective for killing C-diff spores. He brought the bottle of chemical to review and stated he had under lined C-diff; however, when the label was read, it stated it was effective against Methicillin Resistant Organisms. Documentation was not located on the bottle to indicate it was effective against C-diff. He stated he did not realize the chemical was not effective against C-diff and they might have used the wrong chemical to clean all the rooms of the residents with C-diff that day. He stated germs could spread and cause other residents to be sick.</p> <p>No other housekeepers were available to interview.</p> <p>Interview with the Administrator, on 05/30/14 at 3:14 PM, revealed she was not aware Housekeepers were cleaning with the wrong chemicals needed to eliminate the C-diff spores in isolation rooms.</p>	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete, automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 85KW generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code Survey was conducted on 05/28/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has sixty (60) certified beds and the census was forty-eight (48) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

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

Genevieve A. Hayes

TITLE

Administrative

(X6) DATE

6/20/2014

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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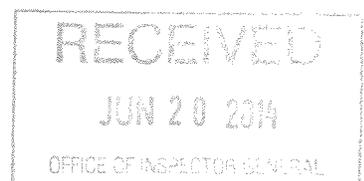
JUN 20 2014

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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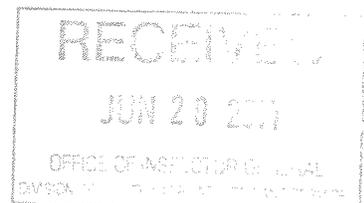
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K 000	Continued From page 1	K 000			
K 046 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide proper functioning emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds and the census was forty-eight (48) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/28/14 at 9:52 AM, with the Maintenance Director revealed one (1) of the two (2) emergency light fixtures located in the Laundry Room, did not function when tested.</p> <p>Interview, on 05/28/14 at 9:54 AM, with the Maintenance Director revealed the emergency light fixture located in the Laundry Room had functioned properly when he conducted the monthly ninety (90) second test the previous week. Review of the facility's records confirmed the required monthly testing had been conducted the previous week.</p> <p>The census of forty-eight (48) was verified by the</p>	K 046	<p>It is the intention of this facility to provide proper functioning emergency lighting. Some of the ways this has been achieved is as follows:</p> <ol style="list-style-type: none"> On 6/2/14 the Maintenance Director ordered a new emergency light for the laundry room replace the non-functioning emergency light fixture. This device was installed on 6/5/14. On 6/2/14 the Maintenance Director completed an audit that tested for proper functioning of all emergency light fixtures. No other emergency lights were affected. On 6/5/14, the Maintenance Director replaced the nonfunctioning emergency light in the Laundry Room with a new emergency light fixture. Any emergency light not functioning when tested will be replaced with a new operating fixture. The Quality Assurance and Performance Improvement nurse to test all emergency lights for proper functioning has developed an audit form. Starting 6/16/14, the Maintenance Director will complete this audit weekly times 4 weeks, then the audit will continue monthly. These results will be reported monthly to the Quality Assurance and Performance Improvement Meetings. The Maintenance Director is responsible for compliance. 	July 7, 2014	



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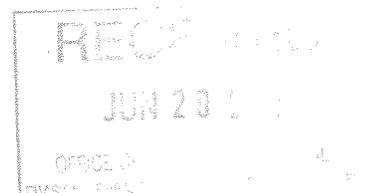
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K 046	Continued From page 2 Administrator on 05/28/14. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 05/28/14. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less	K 046			



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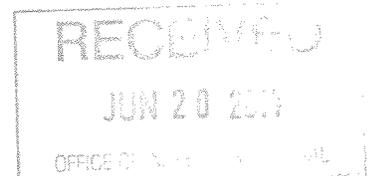
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K 046	Continued From page 3 than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD	K 046		
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, approximately thirty-five (35) residents, staff, and visitors. The facility has sixty (60) certified beds and the census was forty-eight (48) on the day of the survey. The findings include: 1. Observation, on 05/28/14 at 10:45 AM, with the Maintenance Director revealed a cooking appliance (crock pot) was plugged into a power strip located in the Director of Nursing's (DON) office. Interview, on 05/28/14 at 10:47 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with cooking appliances, but was not aware of the misuse of a	K 147	It is the intent of this facility to ensure electrical wiring is maintained in accordance with the National Fire Protection Association (NFPA) standards. Some of the ways this has been achieved is as follows: 1. On 5/28/14, the crock pot in the Director of Nurses office, motorized fan in room 117, and motorized reclining chair in room 121 were all unplugged from the power strip and plugged into a wall receptacle. 2. On 6/2/14, the Maintenance Director completed an audit throughout the building to ensure no motorized devices were plugged into power strips. No other power strips were noted with any plugged in motorized devices. 3. All staff will be inserviced on 6/27/14 by the Staff Development Coordinator on the proper usage of power strips emphasizing that no motorized device can be plugged into a power strip. The Maintenance Director will speak to the Resident Council on 7/8/14 regarding proper usage of power strips. The Administrator will reiterate the proper usage of power strips in the July newsletter that goes out to all residents and responsible parties. 4. The Maintenance Director starting 6/16/14 will conduct an audit to ensure power strips do not have plugged in motorized devices and are being used appropriately. This audit will be conducted weekly times 4 weeks, then monthly times 3 months. The results will be reported to the monthly Quality Assurance and Performance Improvement Committee, and then the committee will determine the need for continuation. 5. The Maintenance Director is responsible for	



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K 147	<p>Continued From page 4 power strip within the DON's Office.</p> <p>2. Observation, on 05/28/14 at 10:51 AM, with the Maintenance Director revealed a motorized fan was plugged into a power strip located within Resident Room 117.</p> <p>Interview, on 05/28/14 at 10:53 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with motorized fans, but was not aware of the misuse of a power strip within Resident Room 117.</p> <p>3. Observation, on 05/28/14 at 11:07 AM, with the Maintenance Director revealed a motorized reclining chair was plugged into a power strip located within Resident Room 121.</p> <p>Interview, on 05/28/14 at 11:07 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with motorized reclining chair, but was not aware of the misuse of a power strip within Resident Room 121.</p> <p>The census of forty-eight (48) was verified by the Administrator on 05/28/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 05/28/14.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the</p>	K 147	compliance.	July 7, 2014



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K 147	Continued From page 5 need for extension cords or multiple outlet adapters.	K 147			

