

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

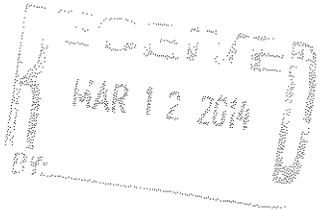
PRINTED: 02/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2014
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval: 03/11/1964</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One (1) Story with basement Type III (211) Unprotected</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete (Dry) Sprinkler System</p> <p>Generator: Type II (new system installed 11/09/12)</p> <p>A life safety code survey was initiated and concluded on 02/05/14. The findings revealed the facility meets the requirements for compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). No deficiencies cited.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathleen E. Miley</i>	TITLE Owner/CEO	(X6) DATE 2-27-2014
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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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PRINTED: 03/17/2014  
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NAME OF PROVIDER OR SUPPLIER  <b>ROSE MANOR HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3057 NORTH CLEVELAND ROAD</b> <b>LEXINGTON, KY 40516</b>
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{F 000}	INITIAL COMMENTS  An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 02/26/14.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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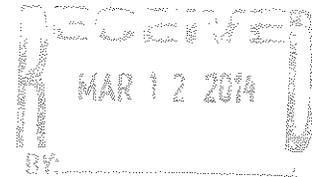
F 000 INITIAL COMMENTS

F 000

A Recertification Survey was initiated on 02/04/14 and concluded on 02/07/14 with deficiencies cited at the highest scope and severity of an "E".

F 278 483.20(g) - (j) ASSESSMENT  
SS=D ACCURACY/COORDINATION/CERTIFIED

F 278



The assessment must accurately reflect the resident's status.

F 278

Immediate Corrective Action:  
An MDS Assessment coded as "Significant change" was completed on 02/06/14 by the QA Coordinator, DON, SS/Act, and the Food Service Supervisor for Resident #1 to accurately reflect current status and all diagnoses.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

Other Residents Potentially Affected: A review of all MDS Assessments was completed by the DON and the Quality Assurance Coordinator from 02/07/14 thru 02/17/14. All Residents have the potential to be affected when the facility fails to accurately assess the resident's medical, functional, and psychosocial needs.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alfred J. [Signature]</i>	TITLE Owner/CEO	(X6) DATE 2-27-2014
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
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F 278 Continued From page 1  
by:  
Based on interview and record Review, it was determined the facility failed to perform an accurate assessment of the resident's medical, functional, and psychosocial problems and accurately code these problems on the Minimum Data Set (MDS) Assessment for one (1) out of nine (9) sampled residents (Resident #1).  
  
The findings include:  
  
Review of Resident #1's medical revealed the facility admitted the resident on 06/10/14, with diagnoses which included Hyperlipidemia, Cerebral Vascular Accident (CVA), Hypertension (HTN), Depression, Congestive Heart Failure (CHF), Alzheimer's Dementia, and Urge Incontinence. Continued record review revealed the facility transferred Resident #1 to a Behavior Health Facility (BHF) on 06/17/13, due to increased acting out behaviors at the facility. Record review revealed the resident was readmitted to the facility on 07/08/13. Review of the BHF, Record of Initial Discharge Summary dated 07/08/13, revealed it listed Resident #1's past medical history included the following diagnoses: CHF, Urinary Incontinence, Dyslipidemia, Cerebrovascular Disease status post CVA, HTN, Depression, and Alzheimer's Dementia.  
  
Review of Resident #1's Admission History and Physical, written by the Attending Physician on 08/20/13, revealed Resident #1's past medical history included CHF, Alzheimer's Dementia, Hyperlipidemia and Depression.  
  
Review of the Initial MDS Assessment, dated 07/28/13, revealed under Section I, Active

F 278  
Systemic Changes: Disciplinary team members (DON, QA, ACT/SS, FSS, AA) met on 02/17/14 to be re-educated on the MDS completion and to develop a plan to assure that a review of MDS diagnoses is maintained by all disciplines (see addendum). The review log "MDS ACCURACY REVIEW" will now become part of the MDS process for all disciplines.  
Monitoring: Compliance will be assured by the DON and QAC who will audit the entire MDS to ensure it accurately reflects the resident's medical, functional, and psychosocial status for all assessments that are completed. The "MDS ACCURACY REVIEW" will be maintained with every assessment and submitted for review at QA meetings monthly.  
  
Completion Date: 02/24/14

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F 278	Continued From page 2  Diagnoses, only Alzheimer's Disease was selected as Resident #1's active medical problem.  Interview with the Director of Nursing (DON)/MDS Coordinator on 02/06/14 at 5:50 PM, revealed she was told by the "case mix" the facility could only use diagnoses which were signed during the assessment time frame. She stated when Resident #1 returned to the facility from the BHF, only Alzheimer's Disease was listed as the discharge diagnosis. She indicated the other diagnoses were listed as past medical history.  Interview with the Quality Assurance (QA) Coordinator on 02/06/14 at 5:55 PM, revealed the past medical history diagnoses should have been included on the MDS Assessment as the facility continued to list the additional diagnoses as medical diagnoses in the resident's record.	F 278	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	

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F 279	<p>Continued From page 3</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed ensure the Comprehensive Care Plan was developed to include necessary revisions in regards to the to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care for five (5) of ten (10) sampled residents. (Residents #1, 3, 5, 7, 9)</p> <p>The findings include:</p> <p>Review of the facility's Resident Care Plan policy, undated, revealed the results of the comprehensive assessment were to be used to develop, review and revise each resident's Comprehensive Care Plan. Further review the policy revealed residents' care plans were to be kept current at all times.</p> <p>Review of the facility's policy titled, "Care Plan Update Protocol", effective 02/23/09, revealed the facility was to assure responsible staff maintained consistent efforts to update residents' care plans as changes occurred.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident on 06/10/14, with diagnoses which included Hyperlipidemia, Cerebral Vascular Accident</p>	F 279	<p><u>Immediate Corrective Action:</u> A complete revision of care plan for Resident #1 was completed by the QAC (Quality Assurance Coordinator) on 02/06/14 per a "significant change" assessment. Care plan of Resident #3 was updated to reflect Pacemaker status and diagnosis of SSS by QAC on 02/07/14. Update was added to care plan for Resident #9 on 02/07/14 by QAC. The update included addition of diagnoses A-Fib, Valvular Heart Disease, and Advanced Aortic Stenosis. Intervention for use of ASA 81mg as anti-coagulant therapy was noted. Update of care plan for resident #5 was completed by the QAC on 02/24/14. Diagnosis for H/O Seizure Disorder with negative EEG was added. Problem to address behaviors was present per problem #5 and Anxiety and Depression were added as diagnoses. Care plan of Resident #7 was updated on 02/19/14 by the QAC to reflect diagnosis of A-Fib and intervention of anti-coagulant medication.</p>	F 279

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F 279	<p>Continued From page 4</p> <p>(CVA), Hypertension (HTN), Depression, Congestive Heart Failure (CHF), Alzheimer's Dementia, and Urge Incontinence. Record review revealed Resident #1 was transferred on 06/17/13 to a Behavior Health Facility (BHF) and readmitted to the facility on 07/08/13. Review of the BHF Discharge Summary revealed Resident #1's past medical history included CHF, Alzheimer's Dementia, HTN and Cerebrovascular Disease status post CVA.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/13/14, revealed the active diagnoses included Heart Failure, Hyperlipidemia, Alzheimer's Disease, Depression, Edema, Debility, Atrial Fibrillation, Loss of Weight and Dysphagia.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 01/13/14, revealed care plans no documented evidence of care plans developed related to the resident's active diagnoses of Heart Failure, Depression, Edema, or Atrial Fibrillation.</p> <p>Interview with the Quality Assurance (QA) Coordinator on 02/06/14 at 5:50 PM, revealed Resident #1's Comprehensive Care Plan should have included the development of care plans for the residents CHF and other active diagnoses listed on Quarterly MDS Assessment.</p> <p>2. Record review revealed the facility admitted Resident #3 on 05/01/13, with diagnoses which included Alzheimer's Disease, Atrial Fibrillation (A-fib), Hypothyroidism, and Pacemaker for Sick Sinus Syndrome (SSS).</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 11/07/13, revealed diagnoses which</p>	F 279	<p><u>Other Residents Potentially Affected:</u> All residents are affected when the facility does not assure that the plan of care reflects appropriate review and revisions per results of the comprehensive assessment. A review of all care plans was completed by the DON and QAC from 02/07/14 thru 02/24/14 to assure accuracy.</p> <p><u>Systemic Changes:</u> A mandatory meeting was held on 02/17/14 by the DON to address survey results. All RN/LPN charge staff was informed of need for accurate review and update of care plans as mandated weekly. Charge staff was informed of revisions to the form for care plan updates and protocol for weekly reviews at this meeting. Review process will become part of training and education for new hires and agency staff. Copies of these forms were posted for reference per the Nursing Communication book for review by staff, new hires and agency personnel (see addendum).</p>

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F 279 Continued From page 5

included Pacemaker for SSS. Continued review of the Comprehensive Care Plan revealed no documented evidence a care plan was developed to address Resident #3's Pacemaker and diagnosis of SSS.

Interview with the QA Coordinator on 02/06/14 at 7:00 PM, revealed upon Resident #3's admission to the facility, the family stated the resident's Pacemaker was inactive. Continued interview revealed she should have care planned the Pacemaker as being inactive.

3. Review of Resident #9's medical record revealed the facility admitted the resident on 11/22/13, with diagnoses which included CHF, Chronic Anemia, A-fib, Valvular Heart Disease, Advanced Aortic Stenosis and HTN.

Review of the monthly Physician's Orders dated January 2014, revealed Resident #9 was to receive Aspirin (ASA) 81 milligram (mg) daily (ASA acts as a blood thinner for persons with heart disease).

Review of Resident #9's Comprehensive Care Plan, dated 12/05/13, revealed no documented evidence a care plan had been developed related to the resident's diagnoses of A-fib, Valvular Heart Disease and Advanced Aortic Stenosis to include the intervention of the use of the anti-coagulant therapy.

4. Review of the medical record for Resident #5 revealed the facility admitted the resident on 06/22/12, with diagnoses which included Coronary Artery Disease (CAD), HTN, Non-Alzheimer's Dementia, Seizure Disorder, Anxiety and Depression.

F 279

Monitoring: Compliance of update requirements will be assured by weekly review of residents care plans per DON and QAC. The weekly review will assure that each resident care plan reflects care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Failure to comply with stated requirement will result in disciplinary action as deemed appropriate by Asst. Administrator. An update compliance report will be presented by DON at QA meetings monthly (see addendum).

Completion Date: 02/26/14

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F 279 Continued From page 6

F 279

Review of Resident #5's Annual Minimum Data Set (MDS) Assessment dated 06/19/13, revealed the facility assessed the resident to have disruptive mood/behaviors; and active diagnoses which included Seizures, Depression and Anxiety. Review of the Care Area Assessment (CAA), dated 06/19/13, revealed Resident #5 triggered for behaviors. Review of the January 2014 Behavior Observation Profile revealed Resident #5 with documented behaviors. Review of the Interdisciplinary Care Plan meeting notes dated 06/19/13 revealed the Comprehensive Plan of Care, dated 06/19/13, was "completely revised" per annual review with all interventions updated to reflect the resident's current needs. However, review of Residents #5's Comprehensive Care Plan revealed no documented evidence the resident's behaviors were addresses. Continued review of the Comprehensive Care Plan revealed no documented evidence care plans addressing Resident #5's diagnoses of Seizures, Anxiety and Depression had been developed with interventions in place.

Interview with the QA Coordinator on 02/06/14 at 5:50 PM, revealed Resident #5's care plans should have been developed for his/her Behaviors, and diagnoses of Seizures, Anxiety and Depression.

5. Review of the medical record revealed the facility admitted Resident #7 on 04/14/11, with diagnoses which included A-fib and Peripheral Vascular Disease (PVD).

Review of the Physician Order dated 01/20/14, revealed Resident #7 had an order for a chewable ASA 81 mg by mouth daily.



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F 371	<p>Continued From page 8</p> <p>avoid re-contaminating sanitized dishes.</p> <p>Observation of Dietary Aide (DA) #1 on 02/05/14 at 12:05 PM, revealed the employee placed a dish rack from the dirty side of the dishwasher onto the clean side. Continued observation revealed the DA #1 to carry a clean stack of plates and plate covers against his chest to the storage area. An additional observation on 02/06/14 at 11:00 AM, revealed DA #1 prepared drinks for the tray line, picked up four (4) sippie cups in one (1) hand with a finger inside each cup, and carried the cups to the tray line area.</p> <p>Interview with DA #1 on 02/05/14 at 1:00 PM, revealed he had been nervous and had carried too many dishes at one (1) time. He stated he just had not thought when he sat the dirty dish rack on the clean side of the dish machine. DA #1 stated he had received training on the correct procedures to prevent cross contamination in the kitchen area. An additional interview with DA #1 on 02/06/14 at 11:05 AM, revealed he didn't know why he had carried the sippie cups the way he had as he knew it caused cross contamination.</p> <p>Interview with the Dietary Manager on 02/06/14 at 1:00 PM, revealed DA #1 had received training on preventing cross contamination and she had re-inserviced him since the Surveyor's observations. She further stated expected him to realize when cross contamination had occurred and correct it before continuing his tasks.</p>	F 371	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	
The facility must establish and maintain an			

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F 441	<p>Continued From page 9</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review</p>	F 441	<p>F 441</p> <p><u>Immediate Corrective Action:</u> Disciplinary counseling was given by the Asst. Adm. to LPN #1 who was observed to touch resident food with bare hands as well as the SRNA #4 who contaminated utensils by laying them on the table.</p> <p><u>Other Residents Potentially Affected:</u> All residents have the potential for negative outcomes when facility staff fail to maintain infection control efforts to prevent the development and transmission of disease and infection.</p>

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and review of facility policies, it was determined the facility failed to 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, for one (1) of ten (10) sampled residents (Resident #6) and one (1) unsampled resident (Resident A).

Observation of the lunch meal revealed a Licensed Practical Nurse (LPN) used improper hand hygiene while assisting residents with their meal at the assist table, and a State Registered Nurse Aide (SRNA) contaminated Unsampled Resident A's silverware while preparing to assist the resident with his/her meal.

The findings include:

- Review of the facility "Hand Washing" Policy, undated, revealed handwashing was necessary to reduce the transmission of organisms from nursing staff to resident, resident to resident, and resident to staff.
- Review of the facility "Meal/Tray Service" Policy, undated, revealed meal service procedures were to be performed in a manner that maintained all infection control guidelines.
- 1. Review of the medical record revealed Resident #6 was admitted by the facility on 07/22/11 with diagnoses which included Alzheimer's Disease, Hypertension, and Osteoarthritis.

Observation, on 02/05/14 at 11:40 AM, revealed resident #6 and three (3) unsampled residents were seated at the assist table. All resident trays

F 441 Systemic Changes: Mandatory in-service training was held on 02/17/14 by the DON regarding deficient practice as identified by survey team. Instruction was given by the DON to all facility staff (see mandatory in-service per addendum) maintaining sanitary practices during meal service as well as review of the facilities Infection Control Program and policies. Sanitary food handling practices hand out will be added to infection control education as part of training for new hires and agency staff.

Monitoring: The facility will monitor and assure compliance per the infection control program. Infection control efforts include: Surveillance of staff (SRNA) who provide resident care per the charge nurse (RN/LPN) every shift with required rounds. Facility staff (all depts.) will receive infection control training per mandatory in-service given by DON monthly. The infection control nurse (RN) will maintain records of infection incidents and corrective actions to prevent and control outbreaks monthly

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F 441 Continued From page 11  
had been served and LPN #1 was assisting the residents to eat. Resident #6 spilled a glass of juice while reaching for the tray. LPN #1 turned to Resident #6, cleaned the spill, sanitized her hands and proceeded to cut the resident's steak sandwich in half using the fork and knife. LPN #1 picked up a sandwich half and placed it in resident #6's right hand with her ungloved hand. LPN #1 turned and began assisting the other residents to eat without sanitizing or washing her hands. Continued observation revealed Resident #6 was bringing his/her left hand to his/her mouth as if eating. LPN #1 turned to resident #6, removed the half sandwich from his/her right hand and placed it in the resident's left hand, with her ungloved hand and without sanitizing her hands after assisting other residents.

Interview with LPN #1, on 02/06/14 at 10:40 AM, revealed she worked the assist table when she was on duty. LPN #1 stated, "i guess I should sanitize my hands before I move to another resident". Continued interview revealed she thought it was okay to touch the resident's food with ungloved hands, as she hadn't worked with any other resident since sanitizing her hands. She further stated she did not see a problem with it.

2. Review of the medical record revealed the facility admitted Unsampled Resident A on 02/27/11 with diagnoses which included Dementia with Agitation and Anxiety, Depression, Hypertension, Parkinsonism and Psychosis.

Observation, on 02/06/14 at 11:35 AM, revealed SRNA #4 prepared Unsampled Resident A's meal tray to assist the resident to eat. SRNA #4 removed the silverware from the napkin and laid it

F 441 (see addendum). The disciplinary team (DON,QA,AA,SS/ACT,FSS)and charge staff (RN/LPN) will assure that employees who may have a communicable disease or infected skin lesions are prohibited from direct contact with residents and their food. All disciplinary team members and charge staff (RN/LPN) will monitor direct resident contact per rounds every shift and assure hand washing as indicated by accepted professional practice. Environmental observation will also include linen storage, processing, and transport per the housekeeping supervisor and charge staff (RN/LPN) qs. Audit for sanitary food handling practices will be maintained weekly as assigned per the QA Director to staff (DON,QA,FSS,SS/ACT,SRNA) by the "Infection Control Meal Service Review". Written reports per The Nosocomial Infection Summary, Line Listing of Patient Infections ,and all

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on the table, then picked it up and placed it on the resident's tray. She picked the spoon up and touched the resident's clothing protector with the spoon. SRNA #4 proceeded to assist the resident to eat, without obtaining new silverware.

Interview with SRNA #4, on 02/06/14 at 12:00 PM, revealed she laid Unsampld Resident A's silverware on the table and acknowledged she shouldn't have picked it up and placed it on the tray. She stated she did not realize the spoon had touched the clothing protector, but she should have obtained a new set of silverware after she placed it on the table, to prevent cross contamination. Continued Interview revealed SRNA #4 had received training on infection control.

Interview with the Director of Nursing/Infection Control Nurse, on 02/06/14 at 7:00 PM, revealed staff should wash their hands prior to serving meal trays, especially after touching anything which could contaminate the hands, and staff should never touch resident food items with ungloved hands. She stated staff should get new silverware anytime the silverware touched anything that could contaminate it.

F 514 SS-F 483.75(1)(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

F 441 meal service reviews will be submitted for review by the QA Team at meetings monthly as collected by the QA Director.

Completion Date : 02/26/14

F 514  
Immediate Corrective Action:  
A memo was posted in the nursing office by the DON on 02/10/14 with direction for all RN/LPN staff to assure that all physician phone orders reflect the time the order is received.

F 514  
Other Residents Potentially Affected: All residents have the potential to be affected when facility staff fail to maintain and assure accurate documentation practices.

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information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:  
Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure each resident's clinical record was accurately documented for ten (10) of ten (10) sampled residents. A review of Physician Telephone Orders for Resident #1 - #10 revealed all did not include the time they were received or written.

The findings include:  
Review of the facility policy titled "Medication Orders", undated, revealed each medication order was to be documented in the resident's medical record with the date, time, and signature of the person receiving the order.  
Review of the policy titled "Phone Orders/Pharmacy Notification", undated, revealed it did not specify what elements were required documentation when taking a telephone order, e.g. date and time of the order.

1. Review of the clinical record revealed Resident #1 was admitted by the facility on 06/10/14 with diagnoses which included Congestive Heart Failure, Alzheimer's Disease, Depression and Hyperlipidemia.  
Review of the Telephone Order dated 12/18/13, regarding a diet change, revealed no documented time the order was obtained.
2. Clinical record review revealed Resident #2 was admitted by the facility on 05/03/11 with diagnoses which included Hypertension, Chronic

F 514 Systemic Changes: A mandatory meeting for all facility staff was held on 02/17/14 by the DON who gave instruction and review of policy for "Medication Orders". All charge staff (RN/LPN) was informed to assure that all medication orders were documented as specified by policy with emphasis on timing all orders (see addendum). All facility staff who document in the residents medical record were educated by the DON on assuring accurate documentation.

Monitoring: A chart review to audit and assure accurate documentation for all residents' records will be completed weekly by the 11-7 charge nurse. The form to assure phone order compliance will be submitted to the DON for compliance review when completed and turned in at QA meetings monthly (see addendum).

Completion Date: 02/26/14

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Obstructive Pulmonary Disease and Depression. Review of the Telephone Order dated 11/03/13, regarding a blood test, revealed the time the order was received was not documented. Further review revealed a Telephone Order, dated 12/16/13, related to a weight loss prevention program and nutritional supplements, was not timed when order was obtained.

3. Review of the clinical record revealed Resident #8 was admitted by the facility on 04/07/11 with diagnoses which included Dementia with Psychosis, Hypertension and Congestive Heart Failure. Review of a Telephone Order dated 12/09/13, regarding a blood test, revealed no documented time to indicate when the order was obtained. Further review revealed Telephone Orders, dated 12/19/13 and 12/23/13, both regarding care of the gastric tube, were not dated. Continued review revealed Telephone Orders dated 12/25/13, 12/26/13, 01/02/13, 01/06/13, and 01/13/14, regarding the resident's tube feedings and gastric tube site care, were not timed when they were obtained.

4. Review of the clinical record revealed the facility admitted Resident #9 on 11/22/13 with diagnoses which included Congestive Heart Failure, Chronic Anemia, and Hypertension. Review of the Physician Telephone Orders for Resident #9 revealed the following: an order dated 11/22/13 regarding a clarification on the dosage of Iron to be administered to the resident, contained no time the order was received; an order dated 11/29/13, for Prednisolone Acetate, did not include the time the order was received; an order for Tylenol, dated 12/22/13, contained no time as to when the order was received; and an order dated 12/18/13, regarding the time the resident's Polyethylene Glycol was to be

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administered, also contained no time as to when it was received.

5. Clinical record review revealed Resident #3 was admitted by the facility on 05/01/13 with diagnoses which included Alzheimer's Disease, Atrial Fibrillation, and Hypothyroidism. Review of the Physician Telephone Orders for Resident #3 revealed the following: an order for Levaquin, dated 12/04/13, contained no time as to when the order was received; an order dated 12/9/13, for a nutritional supplement was not timed; and two (2) orders dated 02/03/14 and 02/06/14, related to the resident's wound treatment instructions, contained no time as to when they were received.

6. Review of the clinical record revealed the facility admitted Resident #4 on 09/04/12 with Diagnoses which included Hypertension, Diabetes, Alzheimer's and Dementia. Review of the Physician Telephone Order for post-operative eye drops, dated 05/30/13, revealed no time the order was taken by the receiving nurse. Continued review of the Telephone Order for a medication dosage change, dated 09/25/13, revealed it did not include the time the order was taken by the receiving nurse. Further review revealed an order taken on 11/14/13, related to a medication change, was not timed when it was received.

7. Review of the clinical record revealed the facility admitted Resident #5 on 06/22/12 with Diagnoses which included Coronary Artery Disease, Seizure Disorder, Non Alzheimer's Dementia, Anxiety and Depression.

Review of Physicians Telephone Orders for changes in medications, dated 11/25/13, 12/04/13 and 12/06/13, revealed documentation did not

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include the time the orders were received.

8. Review of the clinical record revealed the facility admitted Resident #7 on 04/14/11 with diagnoses which included Depression, Atrial Fibrillation and Chronic Obstructive Pulmonary Disease. Review of the Physician Telephone Order for a medication change, dated 11/22/13, revealed the order was not timed when it was received. Continued review revealed Physician Telephone Orders written on 01/09/13, 01/10/14, 01/15/14, 01/10/14, 01/19/14 and 01/20/14, 01/09/13 were not timed when they were written.

9. Review of the medical record revealed the facility admitted Resident #6 on 07/22/11 with diagnosis which included Alzheimer's Disease, Hypertension, and Osteoarthritis. Continued review of the record revealed physician orders written on 09/04/13, 09/05/13, 10/07/13, 11/01/13, 11/13/13, 11/28/13, 01/14/14, and 02/05/14 were not timed when the orders were received.

10. Review of the medical record revealed the facility admitted Resident #10 on 02/22/08 with diagnoses which included Anemia, Alzheimer's Disease, Hypertension and Anxiety. Continued review revealed physician orders written on 12/03/13 and 12/04/13 were not documented with the time the orders were received.

Interview with the Director of Nursing (DON) on 02/06/14 at 7:00 PM, revealed it was her expectation for written physician orders to include the date and time, and the signature of the nurse receiving the order. She acknowledged she had failed to time orders she had written. She stated she did not recall if facility policy specified the time was to be documented when telephone orders were taken.

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