SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 280
483.20(d)(3), 483.10%(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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and
interview, it was determined the facility failed to
ensure the comprehensive care plans were
revised to reflect the resident's current status for
emergency bleeding, cognitive status and/or fluid
restrictions for 4 of 24 (Residents #6, 16, 18 and
20) sampled residents.

The findings included:

1. Medical record review for Resident #6
documented an admission date of 11/3/09 and a
readmission date of 5/2/10 with diagnoses of

1. Resident #6 and #16's care plan has been
addressed and revised regarding emergency
bleeding procedures. The MDS Coordinators
have been instructed regarding proper steps in
documenting emergency bleeding to ensure this
deficient practice does not recur.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

8/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excuses 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 required to continued
program participation.
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Aspiration Pneumonia and Coumadin Toxicity. Review of the physician's order dated 6/22/10 documented, "...WARFARIN SOD [SODIUM] 4 MG [milligram] 1 TABLET TUES [Tuesday], -THURS [Thursday], SAT [Saturday], - SUN [Sunday]. WARFARIN SOD 3 MG 1 TABLET ONCE DAILY ON Monday, Wednesday, AND Friday." Review of the care plan dated 11/24/09 documented, "MONITOR FOR SIDE EFFECTS INCLUDING BLEEDING EXTREME BRUISING, EDEMA, ANEMIA, IRRITATION, PAIN, THROMBOCYTOPENIA, HEMATOMAS... ASSESS RESIDENT FOR S/SX [signs and symptoms] OF BLEEDING AND HEMORRHAGE (BLEEDING GUMS, NOSE BLEEDS, UNUSUAL BRUISING, BLACK TARRY STOOLS, HEMATURIA, FALL IN HEMATOCLIT OR BP [blood pressure], GUIAIC-POSITIVE STOOLS) NOTIFY MD [Medical Doctor] OF POSITIVE FINDINGS..." The care plan had no documentation to address procedures for emergency bleeding.

2. Medical record review for Resident #16 documented an admission date of 11/19/08 with the diagnoses of Cerebrovascular Accident, Diabetes Insulin Dependent, Falls, Hypertension, Cellulitis Right Leg, Chronic Deep Venous Thrombophlebitis. Review of the physician's orders dated 6/1/10 to 6/30/10 documented, "Warfarin Sod 3 mg 1 tablet once daily changed 6/1/10". Review of the care plan dated 11/30/09 documented "Anticoagulant Therapy... Monitor for side effects including bleeding, extreme bruising, edema, hematomas... hemorrhage (bleeding gums, nose bleeds)..." The care plan had no documentation to address procedures for emergency bleeding.
### Summary Statement of Deficiencies

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#### F 280


During an interview at the 300-400 Nurses’ station on 7/21/10 at 2:30 PM, the Dietary Manager and Nurse #4 confirmed that the care plan did not address the fluid restrictions.

4. Medical record review for Resident #20 documented an admission date of 7/16/08 with current diagnoses of Diabetes, Grand Mal Seizures, Organic Psychosis, Senile Dementia with Organic Depressive Syndrome. Review of the care plan dated 9/16/08 documented, "...MONITOR WHEREABOUTS AND REDIRECT PRN [as needed] ...ENCOURAGE RESIDENT TO AVOID UNASSISTED AMBULATION AND TO CALL FOR ASSISTANCE AS NEEDED... G1. Total dependence for locomotion." Review of the MDS dated for 6/3/10 documented, "...B2. MEMORY... a. Short-term memory... 1. Memory problem. b. Long-term memory... 1. Memory problem... B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING 3. SEVERELY IMPAIRED..." The approach to redirect is not an appropriate approach for a confused and severely impaired resident.

During an interview in the MDS office on 7/21/10 at 2:40 PM, Nurse #2 and Nurse #3 confirmed that everyone up dates their part on the care plan.
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<td>3. To ensure this deficient practice does not recur, the facility has implemented several changes.</td>
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<td>Hiring a new MDS Coordinator, Inservicing Social Services, Dietary, MDS regarding resident specific goals/interventions.</td>
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<td>In particular, the cognition of the resident in relationship to the goals/interventions.</td>
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<td>4. To ensure that the above mentioned measures are implemented and the deficient practice does not recur, random audits of care plans will be audited by the Nursing office and reviewed weekly during the Interdisciplinary Team's care plan meeting.</td>
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The finding included:

Medical record review for Resident #10 documented an admission date of 12/6/04 with diagnoses of Acute Compression Fracture, Diabetes Mellitus, Depression, Hypertension, Arthritis, Cataract, and Hyperlipidemia. Review of the physician's orders dated 5/1/10 documented, "...AMIODARONE LEVEL MONTHLY..." The facility was unable to provide documentation that the Amiodarone level was done for April and June 2010 as ordered.

During an interview in the activity department room on 7/21/10 at 10:05 AM, Nurse #3 was asked to provide any laboratory results for April and June 2010 that were not in the medical record. Nurse #3 stated, "It [Amiodarone level] was not done [for April and June 2010]."
CHESTER COUNTY NURSING HOME

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records as evidence by failure to obtain a physician's order for hospice care for 1 of 24 (Resident #15) sampled residents.

The findings included:

Medical record review for Resident #15 documented an admission date of 6/24/06 with diagnoses of Protein Calorie Malnutrition, Cardiovascular Accident, Hypertension, Dementia, Palliative Care and Schizophrenia. A physician's recertification order dated 6/22/10 failed to document an order for hospice care.

During an interview in the social service office on 7/21/10 at 8:25 AM, the Director of Nursing verified that Resident #15 was indeed receiving

1. Resident #25's chart was reviewed for an order for hospice services. Order was noted in thinned chart. Order sent to MD for review and was signed and added to current medical record.
2. Currently, this is the only resident in the facility under hospice services but all residents have the potential to be affected by this deficient practice.
3. Recent changes have been implemented in the facility to ensure this deficient practice does not recur. Implementation of the electronic MAR has enabled each chart to be audited to ensure accuracy of orders, etc.
4. To ensure this deficient practice does not recur, random audits of medical records will be conducted by the nursing office and during the Interdisciplinary Team weekly. Results of findings will be reported to the DON.
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