Initial Comments:

Complaint investigation #29642 and #29669 were completed on April 26, 2012, at Imperial Gardens Health and Rehabilitation. No deficiencies were cited related to Complaint #29669 under 42 CFR PART 482, Requirements for Long Term Care. Deficiencies were cited related to Complaint #29642.

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to ensure three outside appointments were not missed for one resident (R3) of five residents reviewed.

The findings included:

Resident #3 was admitted to the facility on April 5, 2012, with diagnoses including Peripheral Vascular Disease (PVD), Congestive Heart Failure (CHF), and Hypertension.

Medical record review of a 30-Day Scheduled Minimum Data Set (MDS) Assessment dated March 2, 2012, revealed a Brief Interview for Mental Status (BIMS) assessment, with a score

This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations.

On April 17, 2012 Resident #3’s appointment with the podiatrist was rescheduled and transportation arranged. The appointment was placed on the calendar for April 19th, 2012 along with the transporting company. No new orders or follow up appointment were needed after April 19th 2012.

An audit was conducted on 5/1/12 of 15 new admission charts for any missed appointments. No new appointments have been missed as a result of the audit.
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of five out of fifteen. A score of three revealed the Resident's cognition was severely impaired.

Medical record review of a Physician's Telephone Order (TO) dated December 12, 2011, revealed orders for a follow-up appointment with the Nurse Practitioner (NP) at a local cardiology center scheduled for December 27, 2011. Continued review revealed no documentation of the resident attending the appointment on December 27, 2011.

Medical record review of a Physician's TO dated March 8, 2012, revealed orders for a follow-up appointment with a local vascular surgery clinic scheduled in three and one-half weeks.

Review of the West Hall Calendar revealed the follow-up appointment with the vascular surgery clinic, scheduled for April 9, 2012, was on the calendar. Continued review revealed no documentation of the resident attending the appointment on April 9, 2012.

Medical record review of the Nurse's Notes revealed an ulcer to the right second toe, measured as 0.5 centimeters (cms) in length, by 0.5 cms in width, dated April 5, 2012; continued review revealed the wound progressed weekly and was documented as "closed" on April 19, 2012.

Interview with the Director of Nursing (DON), on April 24, 2012, at 1:00 p.m., in the DON's Office, confirmed the facility did not have a "written or formal" protocol or policy and procedure for scheduling resident appointments, for following-up on outside appointments or consults.

F 309 On 5/1/12 an in-service to the licensed nursing staff was conducted by the DON with a focus on scheduling of resident appointments. When orders are received for appointments, the licensed nurse will enter the appointment in the electronic charting system. The nurse will then place the appointment time and place on the calendar kept at the nursing stations. Transportation arrangements will also be made at that time and placed on the calendar as well.

The Unit Manager or designee will check the calendar prior to the clinical meeting and the information will be discussed in that clinical meeting.

Monitoring will be completed in the clinical meeting per the DON or designee for 4 weeks. The Unit Manager or designee will do random audits of at least 10 resident charts for one week, five resident charts for 3 weeks, then random audits of at least 5 charts every month until compliance is determined by the Quality Assurance committee.
6/10/12

Improvements
Continuous monitoring and
Quality Assurance meeting for
any issues and problems in the
and information discussed in the
Results of the monitoring will be

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