F 280 483.20(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.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the resident's current status for a diet change and a Hoyer lift for 1 of 19 (Resident #4) sampled residents. The facility failed to ensure residents were invited to participate in care planning for 8 of 8 alert residents attending the group interview.

The findings included:
1. Review of the facility's "COMPREHENSIVE

LABORATORY DIRECTORS OR PROVIDER/ SUPPLIER/ REPRESENTATIVE'S SIGNATURE

Title

Date

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 required to continued program participation.
F 280  Continued From page 1

CARE PLAN policy documented, "The care plan... Must be reviewed every 90 days and as needed... When there is a change in patient status... All progress notes pertaining to problems identified on the comprehensive care plan should be consistent and reflect the patient's current status... QUARTERLY REVIEWS... New problems should be added with date of review reflected on the care plan..."

Medical record review for Resident #4 documented an admission date of 2/20/05 with diagnoses of Respiratory Failure, Insulin Dependent Diabetes Mellitus, Alzheimer's, Depressive Disorder, Gastro-esophageal Reflux Disease, Acute Renal Failure and Chronic Obstructive Pulmonary Disease. Review of a physician's order dated 1/13/12 documented, "...change diet to Regular..." Review of the nurses' progress notes dated 1/13/12 documented, "...change diet to Regular..."

Review of the care plan dated 12/29/11 to present documented, "...Risk for choking and needs mechanically altered diet... INTERVENTIONS... Diet as ordered with monitoring for texture tolerance... Needs to be lifted due to: weakness, will not bear weight, fear of falling... Use: hoyer lift..."

During an interview at the 100 hall nurses' station on 3/7/12 at 8:30 AM, Certified Nursing Assistant (CNA) #1 was asked if they still use a Hoyer lift to get Resident #4 out of bed. CNA #1 stated, "No..." CNA #1 was asked how long it had been since they used the Hoyer lift. CNA #1 stated, "About a month..."
**F 280** Continued From page 2

During an interview in the Minimum Data Set (MDS) office on 3/7/12 at 9:00 AM, Nurse #1 was asked if the care plan had been revised or updated to reflect the change in the physician's order for a Regular diet. Nurse #1 stated, "I missed that one...” Nurse #1 was asked if she knew the staff were no longer using the Hoyer lift. Nurse #1 stated, "...I know... I just haven’t changed the care plan..."

2. Review of the facility’s "COMPREHENSIVE CARE PLAN" policy documented, "...An interdisciplinary team, in conjunction with the patient, patient's family, surrogate, or assessment... representative, as appropriate, should develop the care plan for the highest level of functioning the patient may be expected to attain, based on the comprehensive assessment..."

During the group interview in the 200 hall dining room on 3/5/10 at 1:00 PM, 8 of 8 alert and oriented residents attending the group interview stated they had not been invited to participate in meetings to plan their care and treatment.

During an interview in the Minimum Data Set office on 3/7/11 at 10:00 AM, the Minimum Data Set Coordinator stated, "Honestly we don't invite them [residents]...we do invite families..."

**F 323** 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

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<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F280</td>
<td>483.25(h) Free of Accident Hazards/ Supervision/ Devices</td>
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<tr>
<td>SS=E</td>
<td>Requirement:</td>
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<td>The facility will ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents.</td>
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This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow interventions put in place to prevent falls or failed to update the care plan with interventions for falls for 4 of 8 (Residents #8, 9, 10 and 11) sampled residents.

The findings included:

1. Review of the facility's "Fall Risk/Fall Prevention Guidelines" documented, "...B. Care Plans 1. A care plan will be developed by the interdisciplinary team specific to the patient assessment, interventions and goals..."

Review of the facility's comprehensive care plan policy documented, "...The care plan... Must be reviewed every 90 days and as needed. "As needed" may mean... c) When there is a change in patient status... All progress notes pertaining to problems identified on the comprehensive care plan should be consistent and reflect the patient's current status..."

2. Medical record review for Resident #8 documented an admission date of 12/26/07 with diagnoses of Alzheimer's, Hypertension, Depression and Dementia with Behavioral Disturbances. Review of Resident #8's nurse event notes documented falls with no injuries on the following dates: 3/11/11, 8/5/11, 10/12/11, 12/7/11, 1/21/12 (12:45 PM and 6:40 PM),

Corrective Action:
1. a) On 3-7-12, MDS Coordinators updated resident #8's care plan to reflect current status.
b) On 3-7-12, MDS Coordinators updated resident #9's care plan to reflect current status and bed alarm placed on resident's bed.
c) On 3-16-12, MDS Coordinators updated resident #10's care plan to reflect current status.
d) On 3-19-12, resident #11 was assessed for proper fall intervention, with a current intervention of a lap buddy when up in a wheelchair and a body alarm while in bed. Also, on 3-19-12, MDS Coordinators updated resident #11's care plan to reflect current status.

2. On 3-7-12, the DON, ADON, and Risk Management nurse conducted care plan audits to ensure that care plans reflect the residents' current status and proper fall interventions.

3. On 3-19-12, all licensed staff was inserviced by the DON regarding appropriate care planning to include fall interventions and reflect current status.

4. The DON, ADON, Risk Management nurse and/or other designee will conduct routine monthly facility chart audits to ensure appropriate care planning to include fall interventions and reflect current status. The findings will be reported to the OAB Committee quarterly.

3-19-12
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2/15/12 (4:30 AM and 12:30 PM) and 3/4/12.
Review of the care plan dated 9/13/10 and
updated 5/11/11 documented the following:
   b. Fall 6/6/11 - Staff in service to have shoes at
      bedside.
The facility was unable to provide documentation
that interventions were put in place for the falls
Resident #8 sustained on 10/12/11, 12/7/11 and
1/21/12 (12:45 PM and 6:40 PM).

Review of the current care plan dated 1/14/12
documented the following:
   a. Fall 2/15/12 - Body alarm while in bed and
      under seat alarm.
   b. Fall 3/4/12 - Staff in service check patient
      whereabouts frequently.
The facility failed to put the interventions for
non-skid shoes and to have shoes at the bedside
on the current care plan.

During an interview in the Minimum Data Set
(MDS) office on 3/7/12 at 9:05 AM, Nurse #1 was
asked if any interventions were documented on
the care plan for the 10/12/11, 12/7/11 and
1/21/12 (12:45 PM and 6:40 PM) falls. Nurse #1
stated, "No..." Nurse #1 was asked if the
interventions for non-skid socks and shoes at the
bedside had been put on the current care plan.
Nurse #1 stated, "...No..."

3. Medical record review for Resident #9
documented an admission date of 1/14/08 with
diagnoses of Hypertension, Atrial Fibrillation,
Insomnia, Diverticulitis and Depression. Review
of Resident #9's nurse event notes documented
falls with no injuries on the following dates:
1/23/11, 2/21/11, 2/25/11, 2/28/11, 4/29/11,
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<th>F 323</th>
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<tr>
<td>5/1/11, 6/5/11, 11/2/11, 11/12/11, 12/8/11 and 2/26/12. The following interventions were documented in the &quot;...Immediate Steps Implemented to Prevent Recurrence...&quot;</td>
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<td>a. 1/23/11 - &quot;...Visual cues placed on residents wall to remind her &amp; [and] roommate to call staff for assistance...&quot;</td>
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<td>b. 4/29/11 - &quot;...Non-skid shapes placed in front of commode to prevent falls...&quot;</td>
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<td>c. 5/1/11 - &quot;...Pt. [patient] will also wear non-skid socks when she is in bed to prevent sliding...&quot;</td>
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<td>d. 12/9/11 - &quot;...Non-skid strips placed on floor at bedside...&quot;</td>
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<td>The facility failed to document these interventions on Resident #9's care plan.</td>
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Review of the care plan dated 10/15/10 and updated 6/23/11 documented the following: |
| a. Fall 1/23/11 - No interventions documented on the care plan. |
| b. Fall 2/21/11 - Self release belt. |
| c. Fall 2/25/11 - Bed Alarm. |
| d. Fall 2/28/11 - Staff in-services to help to bed after meals. |
| e. Fall 4/29/11 - Instruct patient and roommate to call for assist. |
| f. Fall 6/1/11 - Urinalysis (UA) due to frequent toileting. |
| g. Fall 6/5/11 Staff in-service to lock bed. |

Review of the care plan dated 9/22/11 and updated 12/20/11 documented the following: |
| a. Fall 11/2/11 - Floor Applications-monitor that patient has non-skid stockings. |
| b. Fall 11/12/11 - Patient instructed to use call light for assist/staff in-services to assist patient to bed after supper. |
| c. Fall 12/9/11 - Reinstreucted to use call light.
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d. Fall 2/26/12 - Body alarm when in bed and
non-skid socks.
The facility failed to put the interventions for visual
cues on the wall, non-skid shapes in front of the
commode and non-skid socks in bed that were
documented on the "...Immediate Steps
Implemented to Prevent Recurrence..." on the
current care plan.

Observations in Resident #9's room on 3/6/12 at
3:00 PM and 4:30 PM, revealed Resident #9 lying
in bed with no bed or body alarm on the bed or on
Resident #9.

Observations in Resident #9's room on 3/7/12 at
7:40 AM, revealed no bed alarm or body alarm in
the room.

During an interview in the MDS office on 3/7/12 at
9:10 AM, Nurse #1 was asked if the 1/23/11
intervention was on the care plan. Nurse #1
stated, "No..." Nurse #1 was asked if the
interventions for visual cues on the wall, non-skid
shapes in front of the commode and non-skid
socks in bed were on the current care plan.
Nurse #1 stated, "No..." and confirmed the
interventions should have been on the current
care plan.

During an interview in the 100 hall on 3/7/12 at
9:50 AM, the Assistant Director of Nursing
confirmed the bed alarm was not on the bed in
Resident #9's room.

4. Medical record review for Resident #10
documented an admission date of 3/9/11 with
diagnoses of Dementia with Behavioral
Disturbance, Arthritis, Anemia, Hypothyroidism
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<td>F 323</td>
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<td>F 441</td>
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<td>483.65 Infection Control, Prevent Spread, Linens</td>
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**F 323 Continued From page 7**

and Depression. Review of the care plan dated 7/6/11 documented, "...Fall... Intervention... 7/05 to ER [Emergency Room] for Eval [Evaluation]..." The facility was unable to provide documentation of an intervention being put in place after the fall that Resident #10 sustained on 7/5/11.

During an interview in the medical record room on 3/7/12 at 8:50 AM, the Director of Nursing (DON) was asked what was the intervention put in place after the fall on 7/5/11. The DON stated, "...it was a body alarm but I guess they failed to put it on the care plan..."

5. Medical record review for Resident #11 documented an admission date of 10/13/00 with diagnoses of Osteoarthritis, Dementia, Alzheimer's Disease, Diabetes Mellitus and Osteopenia. Review of the care plan dated August 2011 and updated 3/4/12 documented a fall on 10/7/11. The facility was unable to provide documentation of an intervention put in place after the fall that Resident #11 sustained on 10/7/11.

During an interview in the Administrator's office on 3/7/11 at 10:20 AM, the DON confirmed an intervention should have been documented for the fall on 10/7/11.

**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
F 441  Continued From page 8
(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 policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained when 6 of 7 Certified Nursing Assistants (CNAs #2, 3, 4, 5, 6 and 7)
F 441  Continued From page 9

failed to practice sanitary hand hygiene by
touching the residents' environment then
prepared meal trays and fed residents or placed
contaminated trays back on the cart with
unserved meal trays.

The findings included:

1. Review of the facility's "Hand Hygiene" policy
documented, "...Hand hygiene must be
performed at a minimum... Before and after each
patient contact."  

2. Observations in the main dining room on
3/6/12 at 11:33 AM, CNA #2 positioned a
resident's chair and then proceeded to set up the
resident's meal without using hand sanitizer or
washing her hands.

3. Observations in the main dining room on
3/6/12 at 11:34 AM, CNA #3 positioned a
resident's chair, moved a stool over to the table
and then began feeding the resident without using
hand sanitizer or washing her hands.

4. Observations in the main dining room on
3/6/12 at 11:35 AM, CNA #4 moved a stool, put a
clothing protector on a resident, set up the tray
and then began feeding the resident without using
hand sanitizer or washing her hands.

5. Observations in the main dining room on
3/6/12 at 11:25 AM, CNA #5 moved a chair, sat
down and then started feeding a resident without
performing hand hygiene.

6. Observations in the main dining room on
3/5/12 at 11:40 AM, CNA #6 moved a rolling
F 441 Continued From page 10

7. Observations on the 100 hall on 3/5/12 at 12:12 PM, CNA #7 walked out of Room 114 with a dirty tray, placed the tray on the cart which still contained a clean tray, washed her hands, then removed the clean tray from the cart and entered Room 112 to feed the resident.

Observations on the 100 hall on 3/6/12 at 12:25 PM, CNA #7 walked out of Room 112 with a dirty tray, placed it on the tray cart which still contained a clean tray, washed her hands, then removed the clean tray from the cart and entered Room 114 to feed the resident.

8. During an interview in the 100 hall nurses' station on 3/7/12 at 9:40 AM, the Assistant Director of Nursing (ADON) was asked if staff would be expected to wash their hands after touching chairs and prior to feeding the residents. The DON stated, "Yes."