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 medical record review, observation, and interview, it was determined the facility failed to revise the care plan for falls 2 of 13 (Residents #44 and 109) sampled residents reviewed of the 27 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #44 documented an admission date of 1/27/10 and a readmission date of 12/27/13 with diagnoses of Pathological Fracture Distal Radius and Ulna.

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 60 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.

This case was from 4/11/14 to 4/11/14.

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F 280 Continued From page 1

Dementia with Behavior Disturbance, Muscle Weakness, Dysphagia, Osteoarthritis, Anxiety, Gastro Esophageal Reflux Disease, Diabetes, Hypertension, Hyperlipidemia, Difficulty Walking, Psychosis and Alzheimer's. Review of the falls investigation worksheet dated 12/14/13 documented Resident #44 had a fall without injury attempting to transfer self unassisted.

Review of the care plan dated 2/13/13 and revised 1/15/14 documented, "...Problem Onset... 12-14-13-fall... Approaches... 12-14-13... Stop sign to wall to help remind res [resident]..."

Review of the care plan dated 12/30/13 and revised 3/10/14 did document the intervention initiated on 12/14/13 to place a stop sign in the resident's room.

Observations in Resident #44's room on 3/24/14 at 11:20 AM, revealed Resident #44 seated in a wheelchair, and a stop sign above the bed documented, "STOP DON'T STAND BY MYSELF HELP."

Observations in Resident #44's room on 3/25/14 at 3:00 PM and on 3/26/14 at 8:45 AM, revealed Resident #44 lying in the bed, 1/2 sidereall up, and a stop sign above the bed documented, "STOP DON'T STAND BY MYSELF HELP."

During an interview in the north nurses' station on 3/26/14 at 2:45 PM, the Minimum Data Set (MDS) Coordinator was asked about the care plan dated 12/30/13 with the intervention of stop sign to wall to help remind this resident not being present on this care plan. The MDS Coordinator confirmed this intervention was not present on this care plan. The MDS Coordinator stated, "To be honest, the other care plan was actually missing."
F 280  Continued From page 2

I made another one based on her orders present and her chart, so did not have this one to follow when I made this new care plan. This care plan actually just turned back up today."

2. Medical record review for Resident #109 documented an admission date of 3/8/14 with diagnoses of Renal Failure, Hypertension, Diabetes, Congestive Heart Failure, Neuropathy, Oxygen Dependent Chronic Obstructive Pulmonary Disease, Anemia, Hyperlipidemia, Chronic Back Pain, Depression and Anxiety.

Review of the interim plan of care dated 3/8/14 documented, "...FALL RISK... [marked with an x] Encourage use of call light... [marked with an x] Assess for possible contributors..."

Review of nurses note documented the following:

a. 3/14/14 - "...Resident explained that she fell in her room last night around 8:30 PM..."

b. 3/18/14 - "...Res.[resident] states she fell last night going to bathroom and did not notify any one..."

Review of the falls investigation worksheets documented the following:

a. 3/13/14 - "...Going to BR [bathroom] [symbol for without] assistance ambulating... INTERVENTIONS... Pressure Pad Alarm to Bed..."

b. 3/17/14 - "...Loss of balance & [and] fell self transfer... INTERVENTIONS... Encourage use of call light; notify staff of fall..."

The interventions on the falls investigation worksheets were not documented on the care plan dated 3/8/14.

During an interview at the north nurses' station on

Comprehensive care plan will be revised to reflect resident status.

1. Resident #44 – care plan revised to reflect resident status.
   Resident #109 – care plan revised to include interventions for falls.

2. Care plans of each resident with falls have been revised to include interventions to prevent falls.

3. MDS Coordinator/DON/UM will Review care plans with falls weekly x 4 weeks then monthly x 2 months.

4. Results of all the above reviews will be presented to the QA committee monthly x 3 to assess effectiveness of the plan.
**F 280** Continued From page 3

3/25/14 at 4:40 PM, the MDS Coordinator was asked if she updates the care plan with fall interventions. The MDS coordinator stated, "When there is a fall, I don't update the care plans. The nurse that it is reported to usually does that, or the unit manager..."

During an interview in the Director of Nursing's (DON) office on 3/25/14 beginning at 5:00 PM, the DON was asked what the expectation of staff is when a resident falls. The DON stated, "I expect them to assess [the resident] after the fall... put something [an intervention] in place... It gets put on the care plan the next day or that night... it would be either me or [named Nurse #1] or the MDS Coordinator..." The DON was asked if she expects the new interventions to be on the care plan. The DON stated, "Yes, you should expect to see it on the care plan." The DON stated if the interventions for the 2 falls [for Resident #109] were on the initial care plan. The DON stated, "No."

**F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN**

The services provided or arranged by the facility, must be provided by qualified persons in accordance with each resident's written plan of care.

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, review of residents' meal cards, medical record review, observation, and interview, it was determined the facility failed to ensure care plan interventions were followed for nutrition or a dialysis shunt site for 3 of 13...
F 282 Continued From page 4

(Residents #9, 16, and 95) sampled residents of the 27 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Resident Nutrition Services" policy documented, "...Policy Statement... Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident..."

2. Review of the facility's "Nutrition...Unplanned Weight Loss Clinical Protocol" documented, "...1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time..."

3. Medical record review for Resident #9 documented an admission date of 2/7/12 with diagnoses of Anemia, Dementia with Behaviors, Mental Disorder, Anxiety, Hypertension, Chronic Airway Obstruction, Esophageal Reflux, Urinary Tract Infection, Osteoarthritis, Difficulty in Walking, Muscle Weakness, Osteoporosis, Symbolic Dysfunction, Respiratory Abnormality and Dysphagia. Review of the Minimum Data Set (MDS) dated 2/26/14 documented a Brief Interview for Mental Status score of 02 which indicates severe cognitive impairment, and a weight loss of 5 percent (%) or more in 1 month or 10% or more in 6 months.

Review of Resident #9's monthly weight records documented the following weights:

a. 9/10/13 - 83 pounds (lbs).
   b. 10/21/13 - 85 lbs.
   c. 11/11/13 - 80 lbs.
F 282 Continued From page 5

d. 12/15/13 - 75 lbs.
  a. 1/9/14 - 79 lbs.
  f. 2/6/14 - 77 lbs.
  g. 3/11/14 - 79 lbs.

Review of a care plan dated 2/6/13 documented, "...Problem...: At risk for alteration in nutrition...Approaches...1/5/14...supplements as ordered..."

Review of the Registered Dietitian's note dated 2/11/14 documented, "...weight 77 lbs, a decrease of 2 lbs/ [per] month and 8 lbs/6 months... Recommend shakes [for] lunch and supper."

Observations in the dining room on 3/24/14 at 11:50 AM and on 3/26/14 at 12:15 PM, revealed there was no health shake on the meal trays for Resident #9.

Review of Resident #9's meal card in the dining room on 3/25/14 at 12:15 PM documented no health shake supplement. Review of the meal cards for Resident #9 on 3/28/14 documented no health shake supplements for lunch or supper.

During an interview in the dining room on 3/28/14 at 12:25 PM, the Dietary Manager (DM) was asked how the dietary staff know when to put supplements on a meal tray. The DM stated, "The supplement is listed on the tray cards and they put them on the tray from that." The DM was given Resident #9's tray card and asked about the supplement order not showing on the card. The DM stated, "I will have to look into why it did not print out on the card that I printed from the color printer."
F 282 Continued From page 6

documented an admission date of 9/22/10 with diagnoses of Renal Failure, Diabetes, Dialysis, Hypertension, Congestive Heart Failure, Symbolic Dysfunction, Dysphagia, Difficulty Walking, Disorder of Phosphorus Metabolism, Dementia, and Depression. Review of the care plan dated 1/15/14 documented, "...Problem... At risk for complications R/T [related to] dialysis... Interventions... Observe shunt site for bleeding q [every] shift... Check dressing to shunt site daily... Check for thrill q shift." Review of the nurses' notes and the medication administration records (MARS) did not document every shift or daily documentation of assessing the access site, or assessing for thrills and bruits.

Observations in the north hall on 3/24/14 at 11:45 AM, revealed Resident #16 seated in a wheelchair, with a dialysis shunt site to her left upper arm covered with a bandage.

Observations in Resident #16's room on 3/24/14 at 2:30 PM, revealed Resident #16 lying in bed, with a dialysis shunt site to her left upper arm covered with a bandage.

Observations in Resident #16's room on 3/25/14 at 8:30 AM, revealed Resident #16 seated in a wheelchair, with a dialysis shunt site to her left upper arm covered with a bandage.

During an interview in the north hall nurses' station on 3/25/14 at 5:40 PM, Nurse #2 was asked about the documentation of assessment of the dialysis shunt site. Nurse #2 stated, "The access site, thrills and bruits are checked every day and documented in the nurses notes."

During an interview in the activity room on

Residents #9 and #96 are receiving supplements as per care plan interventions.

Current residents with care plan interventions for supplements are receiving supplements.

Dietary employees were educated on checking tray cards during tray line for correct supplement order.

Current residents tray cards will be audited by the Dietary Manager to ensure correct supplements are present on tray cards five times a week for four weeks then weekly for four weeks.

Results of the audit forms will be presented to the QA Committee monthly x 3 months to assess effectiveness of the plan.

F 282
F 282

Continued From page 7

3/26/14 at 8:15 AM, the Director of Nursing (DON) was asked about documentation of assessment of the dialysis site. The DON stated, "I expect nurses to check site every shift for signs and symptoms of infection, bleeding, check thrills and bruits and document on the MARS [medication administration records]..." The DON confirmed there was no documentation of assessment of the dialysis shunt site on the MARS.

5. Medical record review for Resident #96 documented an admission date of 10/9/13 with diagnoses of Acute Kidney Failure, Dehydration, Esophagitis, Chronic Gastric Ulcer, Weakness, Anorexia, Confusion, Hypertension, and Failure to Thrive. Review of the dietary progress notes dated 10/10/13 documented, "...Will add ice cream [and] sherbet on L [lunch] [and] S [supper] tray..." Review of Resident #96's care plan dated 1/16/14 documented, "...Provide and serve supplements as ordered... Provide, serve diet as ordered..."

Review of the physician's orders dated 2/19/14 documented, "...Ensure 1 can po [by mouth] TID [three times a day]..." Review of the physician's progress notes dated 2/19/14 documented, "...She is significantly cachectic and dehydrated with severe protein calorie malnutrition. We will add Ensure one can PO [by mouth] TID [three times a day]..." Review of the physician orders dated 3/8/14 documented, "...SHAKES THREE TIMES DAILY (SUPPLEMENT) FYI [For Your Information]..." with a start date of 10/22/13.

Review of Resident #98's tray card documented, "...LUNCH... ICE CREAM... SUPPER... SHERBET..."
Review of Resident #96's February and March 2014 Medication Administration Records (MARS) documented, "...SHAKES THREE TIMES DAILY..." There was no documentation these shakes were given. Review of the February 2014 MARS documented, "...Ensure [1] can po TID..." There was no documentation the Ensure was given TID. Review of the March 2014 MARS did not document Ensure as an order or as being given.

Observations in Resident #96's room on 3/25/14 at 6:20 PM, revealed there was no Ensure or sherbet on Resident #96's meal tray.

During an interview in the activity room on 3/25/14 at 5:40 PM, the DON was asked about the Ensure and the shakes for Resident #96. The DON stated, "Shakes or health shakes come out of the kitchen with the trays and not documented when given. The ensure should be on the MAR..."

During an interview in the activity room on 3/26/14 at 7:45 AM, the DM brought in copies of the tray cards which documented ice cream at lunch and sherbet at supper. The DM stated, "I expect staff to follow tray card for supplements, shakes and ice cream. We put health shakes on the trays. Ensure is usually discontinued if resident is on a health shake. If not we would put the ensure on the tray."

During an interview in the activity room on 3/26/14 at 8:50 AM, the Registered Dietician (RD) was asked about the shakes and Ensure for Resident #96. The RD stated, "Is common practice here, if a resident is on a health shake, the ensure is discontinued but I will look into..."
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OR CORRECTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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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, it was determined the facility failed to ensure a dialysis access site was assessed for 1 of 1 (Resident #16) sampled resident reviewed of the 1 resident receiving dialysis included in the stage 2 review.

The findings included:
Medical record review for Resident #16 documented an admission date of 9/22/10 with diagnoses of Renal Failure, Diabetes, Dialysis, Hypertension, Congestive Heart Failure, Symbolic Dysfunction, Dysphagia, Difficulty Walking, Dementia, Disorder of Phosphorus Metabolism, and Depression. Review of the care plan dated 1/15/16 documented, ". . . Problem... At risk for complications R/T [related to] dialysis...
Interventions... Observe shunt site for bleeding q [every] shift... Check dressing to shunt site daily...
Check for thrill q shift..." Review of the nurses' notes and the medication administration records (MARS) did not document every shift or daily
F 309 Continued From page 10

documentation of assessing the access site, or assessing for thrills and bruits.

Observations in the north hall on 3/24/14 at 11:45 AM, revealed Resident #16 seated in a wheelchair, with a dialysis shunt site to her left upper arm covered with a bandage.

Observations in Resident #16’s room on 3/24/14 at 2:30 PM, revealed Resident #16 lying in bed, with a dialysis shunt site to her left upper arm covered with a bandage.

Observations in Resident #16’s room on 3/25/14 at 8:30 AM, revealed Resident #16 seated in a wheelchair, with a dialysis shunt site to her left upper arm covered with a bandage.

During an interview in the north hall nurses’ station on 3/25/14 at 5:40 PM, Nurse #2 was asked about the documentation of assessment of the dialysis shunt site. Nurse #2 stated, “The access site, thrills and bruits are checked every day and documented in the nurses notes.”

During an interview in the activity room on 3/26/14 at 8:15 AM, the Director of Nursing (DON) was asked about documentation of assessment of the dialysis site. The DON stated, “I expect nurses to check site every shift for signs and symptoms of infection, bleeding, check thrills and bruits and document on the MARS…” The DON confirmed that was no documentation of assessment of the dialysis shunt site on the MARS.

F 325: 483.25(j) MAINTAIN NUTRITION STATUS SS-D UNLESS UNAVOIDABLE

F 309

The facility will provide necessary assessment of resident dialysis shunt sites.

1. Resident #16 dialysis shunt has been assessed with no negative findings. Careplan has been updated to reflect dialysis shunt and care.
2. Residents with dialysis shunt will have careplan updated to reflect current dialysis shunt and care.
3. Current licensed nursing staff have been educated by DON on observation of shunt site.
4. Audits will be done 5 x week x 4, then weekly x 4 weeks, to assess documentation of current resident dialysis shunt sites.
5. Results of audits will be presented to QA meetings monthly x 3 to assess effectiveness of system.
F 325 Continued From page 11

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

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 ensure supplements were given as ordered or documented for 2 of 5 (Residents #9 and #8) sampled residents reviewed of the 6 residents with nutritional issues included in the stage 2 review.

The findings included:

1. Review of the facility's "Nutrition... Unplanned Weight Loss Clinical Protocol" documented, "...1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time..."

Review of the facility's "Resident Nutrition Services" policy documented, "...Policy Statement... Prior to serving the food tray, the Nurse Aide / Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident..."
F 325  Continued From page 12

2. Medical record review for Resident #9 documented an admission date of 2/7/12 with diagnoses of Anemia, Dementia with Behaviors, Mental Disorder, Anxiety, Hypertension, Chronic Airway Obstruction, Esophageal Reflux, Urinary Tract Infection, Osteoarthritis, Difficulty In Walking, Muscle Weakness, Osteoporosis, Symbolic Dysfunction, Respiratory Abnormality and Dysphagia. Review of the Minimum Data Set dated 2/26/14 documented a Brief Interview for Mental Status score of 02 which indicates severe cognitive impairment, and a weight loss of 5 percent (%) or more in 1 month or 10% or more in 6 months.

Review of Resident #9's monthly weight records documented the following weights:

a. 9/10/13 - 83 pounds (lbs).
b. 10/21/13 - 85 lbs.
c. 11/11/13 - 80 lbs.
d. 12/15/13 - 75 lbs.
e. 1/9/14 - 79 lbs.
f. 2/6/14 - 77 lbs.
g. 3/11/14 - 79 lbs.

Review of a care plan dated 2/6/13 documented, "...Problem... At risk for alteration in nutrition... Approaches...1/5/14...supplements as ordered..."

Review of the Registered Dietitian's note dated 2/11/14 documented, "...weight 77 lbs, a decrease of 2 lbs [per] month and 6 lbs/6 months... Recommend shakes [for] lunch and supper."

Observations of Resident #9 in the dining room on 3/24/14 at 11:50 AM revealed no health shake on Resident #9's meal tray.
F 325 Continued From page 13

Observations of Resident #9 in the dining room on 3/26/14 at 12:15 PM revealed no health shake on Resident #9's meal tray.

Review of Resident #9's meal card in the dining room on 3/25/14 at 12:15 PM documented no healthshake supplement. Review of Resident #9's meal card on 3/26/14 documented no healthshake supplements for lunch or supper.

During an interview in the dining room on 3/26/14 at 12:25 PM, the Dietary Manager (DM) was asked how the dietary staff know when to put supplements on a meal tray. The DM stated, "The supplement is listed on the tray cards and they put them on the tray from that." The DM was given Resident #8's tray card and asked about the supplement order not showing on the card. The DM stated, "I will have to look into why it did not print out on the card that I printed from the color printer."

3. Medical record review for Resident #86 documented an admission date of 10/9/13 with diagnoses of Acute Kidney Failure, Dehydration, Esophagitis, Chronic Gastric Ulcer, Weakness, Anorexia, Confusion, Hypertension, and Failure to Thrive. Review of the dietary progress notes dated 10/10/13 documented, "...Will add ice cream [and] sherbet on L [lunch] [and] S [supper] tray..." Review of the care plan dated 1/16/14 documented, "...Provide and serve supplements as ordered... Provide, serve diet as ordered..."

Review of the physician's orders dated 2/19/14 documented, "...Ensure 1 can po [by mouth] TID [three times a day]." Review of the physician orders dated 3/8/14 documented, "...SHAKES THREE TIMES DAILY (SUPPLEMENT)..." with a
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<td>Review of Resident #96's February and March 2014 Medication Administration Records (MARS) documented, &quot;...SHAKES THREE TIMES DAILY...&quot; There was no documentation these shakes were given. Review of the February 2014 MARS documented, &quot;...Ensure [1] can po TID...&quot; There was no documentation the Ensure was given TID. Review of the March 2014 MARS did not document Ensure as an order or as being given.</td>
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F 325  Continued From page 15
the trays. Ensure is usually discontinued if resident is on a healthshake. If not we would put the ensure on the tray."

During an interview in the activity room on 3/26/14 at 8:50 AM, the Registered Dietician (RD) was asked about the shakes and Ensure for Resident #86. The RD stated, "Is common practice here, if a resident is on a health shake, the ensure is discontinued but I will look into this..."

F 356  483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
- Facility name;
- The current date;
- The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses;
  - Licensed practical nurses or licensed vocational nurses (as defined under State law);
  - Certified nurse aides;
- Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
- Clear and readable format;
- In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community...
F 356: Continued From page 16

standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to post nurse staffing information on a daily basis at the beginning of each shift on 3 of 3 (3/24/14, 3/25/14, and 3/26/14) days of the survey.

The findings included:

- Observations in the front lobby and throughout the facility on 3/24/14 at 9:50 AM, on 3/25/14 at 10:30 AM, and on 3/26/14 at 11:25 AM, revealed no nurse staffing information was posted.

- During an interview in front of the east hall nurses' station on 3/25/14 at 11:30 AM, Nurse #1 was asked where they posted the nurse staffing information for each shift. Nurse #1 turned and pointed to the wall across from the east hall nurses' station and stated, "It used to be right here."

- During an interview in the activity room on 3/26/14 at 3:30 PM, the Human Resources Director was asked where they posted the nurse staffing information for each shift. The Human Resources Director stated, "They took it down when they started painting about 3 months ago. I guess they haven't posted it since."

The facility will maintain nursing staffing data posted in common area.

1. Staffing data is currently maintained and posted daily.
2. DON/UM/RN manager will ensure current staffing data is posted daily.
3. Audits will be done 5 x week x 4 weeks then q week x 4 to ensure current staffing data is posted.
4. Results of audit will be presented to QA committee monthly x 3 to assess effectiveness.
F 371 Continued From page 17
STORE/PREPARE/SERVE - SANITARY

The facility must:
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

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 by 4 of 16 (Certified Nursing Assistants (CNA) #1, 2, 3, and 4) staff members observed during 2 of 2 (3/24/14 and 3/25/14) dining observations.

The findings included:
1. Review of the facility’s “Handwashing/Hand Hygiene” policy documented, "...Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections... Policy Interpretation and Implementation... Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions... Before and after direct resident contact... After removing gloves... Procedure... Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel..."
### Statement of Deficiencies and Plan of Correction

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</tbody>
</table>

2. Observations on the west hall on 3/25/14 beginning at 6:35 PM, CNA #1 served a meal tray, assisted a resident to a chair, moved the overbed table and then brushed the resident's hair. CNA #1 then washed her hands and turned the faucet off with her bare hand.

3. Observations in the dining room on 3/25/14 beginning at 5:40 PM, CNA #2 washed his hands and turned the faucet off with his bare hand. CNA #2 proceeded to move a chair, touched a resident, pulled his pants up, and then served the next meal tray and set the tray up for the resident without washing his hands. CNA #2 proceeded to assist another resident to be seated, touching the resident on the back and then washed his hands turning the faucet off with his bare hand.

4. Observations in the dining room on 3/24/14 at 11:37 AM, CNA #3 washed her hands, served a tray, set up the food, repositioned a resident, served and set up another tray, repositioned a second resident and failed to wash her hands in between each resident. CNA #4 washed her hands, began serving and setting up meal trays for several residents touching their shoulders and hands, and failed to wash her hands before serving to another resident.

5. Observations on the west hall on 3/24/14 beginning at 12:00 PM, CNA #4 entered room 16A with a meal tray, washed her hands, applied gloves, assisted a resident up to a wheelchair, removed her gloves, and continued to set up the meal tray without washing her hands. CNA #4 entered room 23A with a meal tray, adjusted the bed with a crank, and continued to set up the meal tray without washing her hands. CNA #4 entered room 17A with a meal tray, adjusted the...
F 371 Continued From page 19
bed with the control touching the bed, and
continued to set up the meal tray without washing
her hands.

6. During an interview in the north nurses’ station
on 3/26/14 at 2:20 PM, the Director of Nursing
(DON) was asked what her expectations were
when staff washed their hands. The DON stated,
"After washing their hands they are supposed to
dry them with a paper towel and then use another
paper towel to turn the water off. They are not to
turn the water off with their bare hand."

F 441 483.85 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.

(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.
F 441. Continued from page 20

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 by 4 of 16 (Certified Nursing Nursing Assistants (CNA) #1, 2, 3, and 4) staff members observed during 2 of 2 (3/24/14 and 3/25/14) dining observations and by 2 of 5 (Nurses #2 and #3) nurses during medication administration.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections... Policy Interpretation and Implementation... Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions... Before and after direct resident contact... After removing gloves... Procedure... Dry hands thoroughly with paper
### Statement of Deficiencies and Plan of Correction

**Provider/SupPLIER/Clinical Identification Number:** 445477

**Name of Provider or Supplier:** Dickson Health and Rehab

**Address:** 901 N Charlotte, Dickson, TN 37055

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Each deficiency must be preceded by full regulatory or LTC identifying information)</td>
<td></td>
<td></td>
<td></td>
<td>(Each corrective action should be cross-referenced to the appropriate deficiency)</td>
<td></td>
</tr>
</tbody>
</table>

**F 441 Continued From page 21**

2. Observations on the west hall on 3/25/14 beginning at 6:35 PM, CNA #1 served a meal tray, assisted a resident to a chair, moved the overbed table and then brushed the resident's hair. CNA #1 then washed her hands and turned the faucet off with her bare hand.

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5. Observations on the west hall on 3/24/14 beginning at 12:00 PM, CNA #4 entered room 18A with a meal tray, washed her hands, applied gloves, assisted a resident up to a wheelchair, removed her gloves, and continued to set up the meal tray without washing her hands. CNA #4 entered room 23A with a meal tray, adjusted the...
Continued From page 22

bed with a crank, and continued to set up the meal tray without washing her hands. CNA #4 entered room 17A with a meal tray, adjusted the bed with the control touching the bed, and continued to set up the meal tray without washing her hands.

6. Review of the facility's "Instillation of Eye Drops" policy documented, "...Purpose... The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes... 2. Wash and dry your hands thoroughly. 3. Put on gloves..."

Observations in Resident #98's room on 3/24/14 at 3:35 PM, Nurse #2 knocked on the door, gave Resident #98 her medications by mouth, touched the overbed table as she placed the eyedrops on a tissue on the overbed table, applied gloves, and administered an eyedrop to Resident #98's right eye without performing hand hygiene.

During an interview in the north nurses' station on 3/26/14 at 2:45 PM, the Director of Nursing (DON) was asked about what would be expected of staff when administering eye drops. The DON stated, "[Staff] should wash hands prior to administering the eye drops."

7. Observations in front of room 2 on 3/26/14 at 8:20 AM, Nurse #3 cleansed an accuchek machine with gloves on, removed the gloves, entered room 3 and washed her hands, and turned off the faucet with her bare hands after washing her hands, then prepared and administered medications to Resident #73.

8. During an interview in the north nurses' station:

Facility will maintain infection control program related to handwashing.

1. Certified nursing assistants and licensed nurses involved were inserviced on handwashing policy and procedure.

2. All current certified nursing assistants and licensed nurses have been inserviced on handwashing policy and procedure.

3. DON/UM will perform random handwashing audits 5 x week x 4 weeks then weekly x 4 to assess handwashing technique.

4. Results of audits will be presented to QA committee monthly x 3 to assess effectiveness of plan.
**F 441** Continued From page 23

on 3/26/14 at 2:20 PM, the DON was asked what her expectations were when staff washed their hands. The DON stated, “After washing their hands they are supposed to dry them with a paper towel and then use another paper towel to turn the water off. They are not to turn the water off with their bare hand.”

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**RECEIVED**

APR 21 2014