**FE CARE CENTER OF MORRISTOWN**

**SUMMARY STATEMENT OF DEFICIENCIES**

- **F 272**: 483.20(b)(1) COMPREHENSIVE ASSESSMENTS
- **SS=D**: Corrective Action:

  - For resident #122 the MDS was corrected on 3/13/14 to reflect resident #122's missing and decayed teeth by MDS Coordinator.
  - Residents with Potential to be Affected:
    - All residents have the potential to be affected. A 100% audit of all current residents Dental Status are compared to their MDS to assure accurate coding and completion of the MDS completed by 3/19/14 by DON, ADON, and other Nursing Administration.
  - Systematic Changes:
    - Review and Education was provided to MDS Coordinators on proper and accurate coding by DON on 3/13/14, MDS Coordinator educated to assess residents dental status and review the oral assessment when completion of the dental section of the MDS.

**PROVIDER'S PLAN OF CORRECTION**

- Each Corrective Action should be cross-referenced to the appropriate deficiency.

**SIGNATURES**

- **Executive Director**

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LIFE CARE CENTER OF MORRISTOWN

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This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to accurately assess dental status for one resident (#122) of twenty-nine residents reviewed.

The findings included:

Resident #122 was admitted to the facility on October 16, 2013, with diagnoses including Alzheimer's Disease, Parkinson's Disease, Anxiety Disorder, and Chronic Lung Disease.

Review of an Admission Minimum Data Set (MDS) dated October 23, 2013, revealed the resident was severely cognitively impaired and did not have any missing or decayed teeth.

Observation of the resident on March 4, 2014, at 9:55 a.m., in the resident's room, revealed the resident had multiple missing and decaying teeth.

Interview with Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 on March 5, 2014, at 9:58 a.m., in the Conference Room, confirmed the resident had multiple dental problems and the MDS assessment dated October 23, 2013, was inaccurate.

F 309 483.25 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.

Monitoring:

A Performance Improvement Plan was initiated on 3/5/14 addressing education, audit and monitoring of Dental Assessments for MDS being completed appropriately on all residents. DON, ED, Medical Director, ADON, other Nursing Administration and other facility Department Managers reviewed the Performance Improvement plan during monthly Performance Improvement Meeting on 3/14/14. An audit will be completed weekly on all new admissions' MDS's for six weeks by DON, ADON and other Nursing Administration to ensure accurate MDS dental assessments with a completion date of 4/24/14. The MDS dental assessments will then be audited by DON, ADON, and other Nursing Administration randomly and as needed.

Corrective Action:

For resident #117 foot rests were immediately applied to residents Broda chair on 3/3/14 by RN unit Manager.

Education was immediately completed by RN unit Manager to staff caring for resident #117 on the necessity for foot rests to be applied to Broda chair.
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<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X9) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 2 and plan of care.</td>
<td>F 309</td>
<td>Residents with Potential to be Affected: All residents have the potential to be affected. A 100% audit of all residents was completed on 3/17/14 by DON, ADON, DOR, Therapy Staff, and other Nursing Admin to ensure residents have proper positioning devices in place with their wheelchairs. A 100% audit was completed on 3/17/14 by DON, ADON, and other Nursing Administration to compare residents positioning devices to the listing of ordered positioning devices from our pharmacy. A 100% audit was completed on 3/17/14 by DON, ADON, and other Nursing Administration to ensure all positioning devices listed on care plans, care directives and physician orders match what is physically in place for residents. Systematic Changes: Review and Education was completed with all staff on 3/14/14 by Director of Rehab and Physical Therapy about positioning devices procedures. As of 3/5/14 any new order for positioning devices will be reviewed daily during clinical meeting with DON, ED, ADON, and Nursing Administration to ensure they are placed on care directives, physician orders and care plans.</td>
<td>3/17/14</td>
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This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to maintain proper body positioning for one resident (#117) of twenty-nine residents reviewed.

The findings included:

Resident #117 was admitted to the facility on March 1, 2012, with diagnoses including Alzheimer's Disease, Unspecified Psychosis, Abdominal Aortic Aneurysm, and Gastric Reflux.

Review of the Quarterly Minimum Data Set (MDS) dated November 29, 2013, revealed the resident was severely cognitively impaired, dependent for transfers, and at risk for the development of pressure ulcers.

Observation of the resident on March 3, 2014, from 11:24 a.m. to 12:15 p.m., revealed the resident seated in the resident's room, in a broda chair (a specialty chair that is used to maintain body position for dependent residents). Continued observation revealed the resident's lower legs and feet were dangling unsupported off the end of the chair approximately twelve inches. Continued observation revealed the end of the broda chair's leg supports were in contact with the resident's legs above mid-calf bilaterally. Continued observation revealed the resident's legs were lying against the straps of the leg supports and no padding or support, other than the straps was present. Continued observation
Continued From page 3

revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (swollen) at the ankles. Continued observation revealed the resident was severely cognitively impaired, was unable to follow commands, and spoke in garbled sentences. Continued observation revealed the resident could not reposition the lower extremities independently in the chair.

Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broda chair, and did not attempt to reposition the resident's legs.

Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broda chair in the same position as previously observed, being assisted by a staff member with the meal.

Observation with Registered Nurse #2 (RN #2) who was the unit manager, on March 3, 2014, at 12:26 p.m., in the dining area, revealed the posterior surface of the resident's calves bilaterally exhibited red marks identical in size and shape to the straps of the chair.

Interview with RN #2 on March 3, 2014, at 12:27 p.m., in the dining area, confirmed the chair was to have a footrest attached, the resident's legs and feet were not properly supported in the chair, and the facility failed to maintain proper body positioning of the dependent resident.

Monitoring:

A 100% audit will be completed daily for two weeks to ensure all ordered positioning devices are in place for residents by DON, ADON, and other Nursing Administration with completion date of 3/19/14. A 100% audit will be completed weekly for a month to ensure all ordered positioning devices are in place for residents by DON, ADON, and other Nursing Administration with completion date of 4/1/14, and then they will be audited randomly and as needed. A Performance Improvement Plan was initiated 3/5/14 to address procedure for position devices and reviewed during facility Performance Improvement meeting on 3/14/14 with attendance by ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers.
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<th>F 371</th>
<th>Continued From page 4</th>
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<tr>
<td>SS=F</td>
<td>STORE/PREPARE/SERVE - SANITARY</td>
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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 observation and interview, the facility failed to ensure outdated foods were not available for residents, and failed to ensure dirty food carts were not stored in clean areas of the kitchen.

The findings included:

Observation on March 3, 2014, at 9:15 a.m., in the kitchen, revealed one jar of Pimento Cheese in the refrigerator labeled, "...opened February 24, 2014...discard February 27, 2014..."

Interview with the Dietary Manager on March 3, 2014, at 9:15 a.m., in the kitchen, confirmed the Pimento Cheese was expired and was available for the residents.

Observation on March 4, 2014, at 2:00 p.m., in the dishwashing area of the kitchen, revealed one uncovered dirty food storage cart with dirty food trays stored on the cart. Further observation revealed the uncovered dirty food storage cart was stored in the same area where clean plates, clean cooking pans, and clean serving trays were

<table>
<thead>
<tr>
<th>F 371</th>
<th>Corrective Action:</th>
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<tbody>
<tr>
<td>Jar of pimento cheese was immediately discarded by Dietary Manager on 3/3/14.</td>
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<tr>
<td>Residents with Potential to be Affected:</td>
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<tr>
<td>All residents have the potential to be affected. A 100% audit of all food items in refrigerator, freezer, and dry storage was completed by Dietary Manager on 3/3/14 to ensure all food was stored under sanitary conditions.</td>
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<tr>
<td>Systematic Changes:</td>
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<td>Review and Education completed with all dietary staff on 3/12/14 by Dietary Manager on Policies and procedures for storing food under sanitary condition. All food must have label with name of product, date made or brought out of freezer and use by date. All items must not be used later than the use by date. If food item is past use by date it must be disposed of immediately and not used.</td>
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<tr>
<td>Monitoring:</td>
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<td>A Performance Improvement Plan was initiated 3/3/14 to address procedures for sanitary storage of food items. The Performance Improvement Plan was reviewed during facility Performance Improvement Meeting on 3/14/14 and attended by ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers. A 100% audit of all food items in refrigerator, freezer, and dry storage will be completed by Dietary Staff and Manager daily for two weeks with a completion date of 3/17/14. A 100% audit will then be completed weekly by Dietary Staff and manager during kitchen weekly audit indefinitely.</td>
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F 371  Continued From page 5

Interview with the Dietary Manager on March 4, 2014, at 2:05 p.m., in the kitchen, revealed, "...the food storage carts may be brought into the kitchen through the back door or through the dining room door...there should be only one way the dirty food storage carts come into the kitchen..." Further interview confirmed the uncovered dirty food cart was stored in the same area where clean plates, cooking pans, and serving trays are located and stored.

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.

(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 coming into contact with residents.

Corrective Action:
On 3/4/14 dirty tray carts were immediately removed from area housing clean plate storage to dishwashing area of kitchen by dietary staff. All dietary staff were instructed on 3/4/14 by dietary manager to not receive dirty carts and trays from clean plate storage area of kitchen.

Residents with Potential to be Affected:
All residents have the potential to be affected.

Systematic Change:
All dietary staff were in serviced on 3/12/14 by Dietary manager on procedure for receiving dirty tray carts. Dirty tray carts will only be received through main dining room door into dishwashing side of kitchen. All staff will be in serviced by Staff Development Coordinator on 3/14/14 on procedure for taking dirty tray carts to dietary through dining room entrance.

Monitoring:
Performance Improvement plan was initiated on 3/13/14 to address procedure for dirty tray carts being brought to Dietary. A daily audit will be conducted by Dietary Manager to ensure procedure for dirty tray carts is followed for one month with a completion date of 4/3/14, then the audit will be completed randomly and as needed.
Continued from page 6:

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 observation, review of facility policy, and interview, the facility failed to perform hand hygiene during incontinence care for one resident (#23) of twenty-nine residents reviewed.

The findings included:

Resident #23 was admitted to the facility on December 31, 2012, with diagnoses including Hypertension, Dementia, Anxiety, Depression, Chronic Obstructive Pulmonary Disease, and Pressure Ulcer.

Review of the Quarterly Minimum Data Set dated January 10, 2014, revealed the resident had a urinary catheter and required extensive assistance with all activities of daily living.

Observation of incontinence care on March 4, 2014, at 2:45 p.m., in the resident’s room, revealed Licensed Practical Nurse (LPN) #2 donned gloves and wiped large amounts of loose feces from the resident’s gluteal area using
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<td>F 441</td>
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<td>Continued From page 7 disposable wipes. Continued observation revealed LPN #2 opened the drawer of the resident's bed side table and obtained additional supplies, without removal of the soiled gloves or washing the hands, and resumed wiping additional feces from the resident's gluteal area and perineum. Review of the facility policy Hand Hygiene revised May 1, 2012, revealed, &quot;...when hands are visibly dirty or contaminated...or are visibly soiled with blood or other body fluids...wash hands...&quot; Interview with LPN #2 on March 4, 2014, at 3:40 p.m., at the nursing station, confirmed the LPN failed to remove the soiled gloves or wash the hands prior to opening the resident's bedside table, and failed to follow the hand hygiene policy during the procedure.</td>
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<td>3/4/14</td>
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<td>F 502</td>
<td>SS=D</td>
<td>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure laboratory tests were obtained as ordered for one resident (#42) out of twenty-nine residents reviewed. The findings included: Resident #42 was admitted to the facility on September 3, 2010, and readmitted to the facility</td>
<td>For resident #42 physician was immediately notified by the DON on 3/4/14. The lab was drawn on 3/4/14 for Hepatic function per physician orders with no concern noted per physician. The Lipids and TSH lab was drawn per physician order on 3/5/14 due to fasting necessary, with no concerns noted per physician with results.</td>
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F 502 Continued From page 8 on March 28, 2011, with diagnoses including Muscle Weakness, Explosive Personality Disorder, Depressive Disorder, Anxiety, Unspecified Psychosis, Obstructive Hydrocephalus, Osteochondroma, Organic Traumatic Brain Syndrome, and History of Deep Vein Thrombosis.

Review of the Physician's monthly recapitulation orders dated March 2014, revealed laboratory orders for Lipids and TSH (Thyroid Stimulating Hormone blood test used to determine how well the thyroid gland is functioning) every three months (October/January/April/July), with an origin date of April 27, 2011, and orders for Hepatic Function Panel every three months (October/January/April/July), with an origin date of June 9, 2011.

Medical record review revealed no laboratory results for the Lipids, TSH, and Hepatic Function Panels for the months of January or February 2014.

Interview with the Director of Nursing on March 5, 2014, at 10:45 a.m., at the East Wing nursing station, confirmed the Hepatic Function Panel, TSH, and Lipids had not been obtained in January as ordered.

Residents with Potential to be affected:
All residents with labs ordered per physician have the potential to be affected. A 100% Audit was completed by DON, ADON, and Nursing Administration of all ordered labs to be compared with listing of ordered labs per physicians to ensure completion and accuracy with a completion date of 3/12/14.

Systematic Changes:
Review and Education to Nursing Administration by DON on 3/13/14 of any new lab order will be reviewed during clinical meeting daily and compared with lab notebook for each unit to assure that lab requisitions, and documentation of labs has been completed.

Monitoring:
A Performance Improvement Plan was initiated on 3/4/14 to ensure that labs are drawn per physician orders. The Performance Improvement Plan was reviewed during the facility Performance Improvement Meeting on 3/14/14 with ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers. Ordered labs listings are to be included in weekly reports from pharmacy and will be audited by DON, ADON, and other Nursing Administration weekly for any changes for two months with a completion date of 5/7/14, then monthly for two months with a completion date of 7/9/14.