F 278
SS=D
483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) was coded for a fall for 1 of 23 (Resident #14) sampled residents.

The findings included:

Requirement:
The assessment will accurately reflect the resident's status.

Corrective Action:

1. Resident #14 MDS was corrected by the MDS coordinator on 04/08/10 to reflect the resident's hygiene and bathing needs.

2. The DON, ADON, MDS Coordinators, and Risk Manager will audit the MDS’s to ensure they accurately reflected bathing and hygiene needs by 04/15/10.

3. MDS Nurses were reinserviced on 04/18/10 by the DON on accurate coding of ADL needs on the MDS.

4. Random MDS audits by the DON, ADON, and Risk Manager on the accuracy of the MDS will be completed weekly for one month and then monthly x 3 to ensure compliance and will report findings to the QA Committee which consists of the Medical Director, Administrator, DON, ADON, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Activity Director, Medical Records, Admissions, and Bookkeeper.

Title: Administrator

4-15-10
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 278 | Continued From page 1 | Medical record review for Resident #14 documented an admission date of 11/21/08 with diagnoses of Anemia, Hypertensive Heart Disease, Cardiac Dysrhythmias, Cardiac Arrest, Infections of the Kidney and aftercare for a healing Traumatic Fracture of the Hip. Review of the hospital History and Physical (H&P) documented Resident #14 had a history of left hip pinning in November 2008 and removal of gamma nail to the left hip on 12/29/08. The H&P also stated Resident #14 had a history of a right hip fracture years ago. A nurse's note for Resident #14 documented "...Date: 2-11-10. Time: 8:30 ...p.m...Detailed Description of Occurrence: This nurse was in the hall during med pass & heard 'Help me Please' In rm[room] 142 pt [patient] was sitting upright in [on] floor in front of wardrobe. [Resident #14] Stated 'I knocked the wafer pitcher over. And I scooted over here to door'. Pt. unsure how she fell, stated 'I just don't know.' Review of a MDS with an assessment reference date of 3/5/10 documented,"...4. ACCIDENTS... a. Fell in the past 30 days... [was not coded] ...e. NONE OF ABOVE... [was coded for Resident #14 indicating no fall had occurred in the MDS assessment period]."

During an interview in the MDS office on 4/7/10 at 8:20 AM, MDS Nurse #1 stated, "I over looked it [coding for fall]. It's sure not here."

F 280 | 483.20 | 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
F 280 Continued From page 2
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 and interview, it was determined the facility failed to revise the comprehensive care plan to reflect Activities of Daily Living (ADL) and interventions for falls for 4 of 23 (Residents #2, 5, 6 and 17) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 7/29/09 with diagnoses of Senile and Presenile Organic Psychotic Conditions, Senile Dementia, Alzheimer's Disease, Chronic Ischemic Heart Disease, Coronary Atherosclerosis, Personal History of other Musculoskeletal Disorders and Care Involving use of Rehabilitation Procedures. Review of the Minimum Data Set (MDS) with a assessment reference date of 8/3/09

F 280 Corrective Action:

1. Resident #2 care plan was accurately coded on 04/07/10 to address hygiene and bathing needs. Resident #6 care plan was updated to reflect interventions after each fall on 04/08/10. The care plan on Resident #6 and #17 was updated to reflect the fall and interventions regarding the falls on 04/08/10. The care plans were accurately coded by the MDS Coordinators.

2. The DON, ADON, Risk management and MDS Coordinator will audit charts and check for accuracy of care plans regarding falls and bathing and hygiene needs by 05/16/10.

3. On 04/19/10 the MDS nurses were inserviced on the accuracy of Care Plans. The MDS nurse will check updates from nurses daily to reflect changes on the Care Plans. The MDS nurse verified understanding of these areas.

4. The Administrator, DON, ADON and risk management will randomly audit the accuracy of MDS's and Care Plans through daily chart reviews weekly times one month and monthly times three months. The QAQA team which consists of the Medical Director, Administrator, DON, ADON, Risk Management, Social Director, Food Services Supervisor, Activity Director, and Staffing Coordinator will review the results quarterly.

Completion Date: 04/16/10
Continued From page 3

...[Resident Assessment Protocol (RAP)]; COGNITIVE LOSS / DEMENTIA... TRIGGERS... [Resident #2 with] Impaired decision making* [B4=3] [assessed as being] Severely Impaired... RAP... [Resident #2]
Personal Hygiene-not independent [G1A=4]
[assessed as being] Total Dependent... [Resident #2] Bathing-not independent [G2A=4] [assessed as being] Total dependent." Review of the nursing care plans dated July 2009, September 2009, October 2009 and January 2010 revealed the facility failed to care plan for Resident #2's hygiene and bathing needs. Resident #2 was assessed as being totally dependent on the facility for her personal hygiene and bathing needs during the 8/3/09 MDS assessment period.

During an interview in the MDS office on 4/7/10 at 8:20 AM, MDS Nurse #2 stated, "I did not see it [Resident #2's care plans for hygiene and bathing]."

2. Medical record review for Resident #5 documented an admission date of 1/4/02 with diagnoses of Macular Degeneration, Alzheimer's Disease, Lymphoma and Breast Cancer. Review of a nurse's note dated 2/3/10 for Resident #5 documented "...CNA [Certified Nursing Assistant] found pt [patient] sitting on floor by bed. Pt stated she was walking back to bed when her feet slipped because of her slippers. Pt c/o [complained of] hip pain with rotation minimal." Resident #5 was admitted to the hospital on 2/3/10 with a diagnosis of Hip Fracture. Review of the nurse's note dated 2/20/10 documented, "I [nursing staff] was walking past pt's room and looked in and saw pt sitting on floor next to bed. She [Resident #5] said I slid off the bed." Review of the nurse's note dated 3/7/10 documented,
<table>
<thead>
<tr>
<th>F 280</th>
<th>Continued From page 4</th>
</tr>
</thead>
</table>

"...Resident sitting up on bottom on floor in room. Resident fell, slipped out of w/c [wheelchair]. Resident [#5] stated was trying to get up by myself and slipped out of her w/c..." Review of Resident #5's care plan dated 2/22/10 was not updated to include the interventions put in place after each fall to prevent further falls.

During an interview in the conference room, on 4/7/10 at 3:30 PM, the Director of Nursing (DON) stated, "I would expect the interventions to be included in the care plans and updated after each fall."

3. Medical record review for Resident #6 documented an admission date of 7/15/09 and a readmission date of 3/13/10 with diagnoses of Alzheimer's Disease, Dementia and Urinary Tract Infection. Review of the nurses' note dated 2/22/10 documented "...Observed PT [patient] on his knees next to his bed. PT STS [states], "Need some help to get up." I assisted PT to his feet with assistance of [named CNA]. Redness noted to both knees only." Review of Resident #6's care plan did not include the documented fall on 2/22/10 nor were there any interventions put in place after the fall on 2/22/10.

During an interview in the conference room on 4/7/10 at 4:20 PM, MDS Nurse #1 stated, "Just put it on there [documented the fall and interventions on the care plan today]."

4. Medical record review for Resident #17 documented an admission date of 10/16/09 with diagnoses of Osteoarthritis, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Failure and Gastrointestinal Reflux Disease.
<table>
<thead>
<tr>
<th>TAG</th>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 280 | F 260 | Continued From page 5  
Review of the nurses' note dated 12/17/09 documented "...[Resident #17] Was observed in [on] floor beside bed in Rm [room] states he slipped out of w/c..." Review of Resident #17's care plan last updated on 12/4/09 and 1/28/10 did not address the fall that occurred 12/17/09 nor were interventions put in place for the fall that occurred on 12/17/09. Review of the nurses' notes dated 3/31/10 documented "...Called to pts [patient's] rm by CNA pt lying on rt [right] side in [on] floor upon assessment pt d/o [complaint of] rt hip pain pt. stated, "I was trying to get my shoe out from under the bed..." Review of the care plan updated from 1/28/10 through 4/30/10 had no documented fall or interventions put in place for the fall that occurred on 3/31/10.  

During an interview in the conference room on 4/7/10 at 2:20 PM, with MDS Nurse #1 confirmed that the Charge Nurse is responsible for putting the falls on the care plan then Physical Therapy is notified the next day. The MDS nurses follow up within a week to make sure that falls and the interventions are on the care plan. | F 441 | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS |
| F 441 | 484.41 | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS |
| | SS=D | Requirement:  
The facility will 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,
| F 441 | Continued From page 6 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, observations and interview, it was determined the facility failed to ensure infection control practices were used to prevent the potential spread of infection when 1 of 8 (Nurse #1) nurses observed administering medications turned the faucet off with her bare hands. The findings included: Review of the facility's "Skill 1-Handwashing" policy documented "...10. Dries hands on clean | **Corrective Action:** 1. Licensed nurse #1 was inserviced on 04/08/10 on facility hand washing procedure and return demonstration observed by the Director of Nursing. 2. LPN's and RN's were inserviced on 04/15/10 on facility hand washing procedures and return demonstration observed by the Director of Nursing or Assistant Director of Nursing or Staffing Coordinator. 3. The Director of Nursing, Assistant Director of Nursing and Risk Management Nurse will monitor for compliance through facility rounds weekly for one month and monthly for three months. Audits will be reported to the Patient Care and Services Committee monthly, and the QA&A Committee, consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staffing Coordinator, Medical Records Nurse, Risk Management Nurse, Bookkeepers, Food Service Supervisor, Social Worker, Admission Coordinator and Activity Director quarterly and as needed. **Completion Date:** 04/15/10 |
Continued From page 7
paper towel(s) 11. Turns off faucet with a
SECOND (last) clean paper towel of a DRY
section of previously used paper towel."

Observations in Random Resident (RR) #1's
room on 4/5/10 at 4:06 PM, revealed Nurse #1
administered eye drops in RR's left eye with
ungloved hands then washed her hands and
turned the faucet off with her bare hands.

Observations in Room 329 on 4/5/10 at 4:20 PM,
Nurse #1 washed her hands then turned the
faucet off with her bare hands.

During an interview in the 300 hall on 4/5/10 at
4:25 PM, Nurse #1 confirmed that she turned the
faucet off with her bare hands.