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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 157</td>
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<td>This Plan of Correction is being submitted as required by Federal regulations. The submission of this Plan of Correction is not to be construed as an admission by the facility as to the accuracy of the citations or findings of facts. Please accept this as our Plan of Correction.</td>
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**F 157**

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharges the resident from the facility as specified in §483.12(e).

The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review and interview, it was determined the facility failed to ensure the residents’ physician was notified of psychiatric

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**Signature**

*Wilson*

**Title**

*Administrator*

**Date**

3-25-11

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**Notice**

Deficiencies are denoted with an asterisk (*) indicates a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are due before the survey must be completed. For nursing homes, the above findings and plans of correction are due before the survey must be completed. If deficiencies are cited, an approved plan of correction is required to continued participation in the Medicare program.
F 157

Continued from page 1 recommendations, bowel status change or blood glucose levels for 3 of 14 (Residents #1, 2, and 6) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 1/3/11 with diagnoses of Diabetes Mellitus, Mental Disorder, Dementia, Depression, Anxiety, Hypothyroidism and Vocal Cord Paralysis. Review of the (name of the psychiatric service) recommendations dated 2/7/11 documented, "...Recommendation: DC [discontinue] Navane to start Injectable medication - Pt [patient] doesn't take P.O. [oral] meds [medication] when given off- start Fluphenazine 12.5 mg [milligrams] IM [intramuscular] with re-eval [re-evaluation] in 2 wks [weeks] may be in need for 12.6 mg more at that time..." The facility was unable to provide documentation of physician notification for the recommendations by psychiatric services.

During an interview in room 101 on 3/8/11 at 9:30 AM, the Corporate Nurse Consultant stated, "...The recommendations were filed in the chart with no follow up [physician notification]..."

2. Medical record review for Resident #2 documented an admission date of 5/10/05 with diagnoses of General Osteoarthritis, Muscle Weakness, Difficulty Walking, Urinary Incontinence, Depressive Disorder and Hypertension. Review of the "Resident Care Plan" with an original date of 10/28/08 and updated on 1/14/11 documented, "...MONITOR REGULARITY OF BOWEL ELIMINATION, NOTIFY MD [Physician] IF > [greater than] 3 DAYS..." The nursing assistant flow sheet for

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a) Resident #1's Physician was notified on 03/24/11 per the MR (Medical Records) nurse of the recommendations. Physician reviewing recommendations with no new orders received at that time.

b) Resident #2's physician was notified of no BM documented more than three days on occasions during December 2010 - February 2011. MD notified of resident's refusal to receive laxatives to assist with bowel evacuation on 03/24/11 per Medical Records Nurse. New orders received on 03/25/11 for Dulcolax one po every three days PRN if no BM.

c) Resident #6's physician was notified on 03/24/11 per Medical Records Nurse of the blood glucose levels <50 from occasions during time frame of December 2010 - February 2011 with no new orders received.

Diabetic resident's records will be reviewed per Director of Nursing or designee on 03/30/11 to ensure MD notified of blood glucose <50.

2. Other residents with the potential to be affected will be identified by a review of psychiatric recommendations for the past two months, a review of the BM records for the past seven days, and a review of finger stick glucose for the month of March conducted by the Director of Nursing or designee on 03/25/11.
Lauderdale Comm Living CTR

Provider ID: F 157

Summary Statement of Deficiencies
(Each deficiency must be preceded by full regulatory or LSC identifying information)

- December 2010 documented no bowel movements (BM) on December 1, 2, 3, 4, 5, 6, 7 or 8. There was no documentation that Resident #2 had a BM for 8 days in a row. The nursing assistant flow sheet documented no BM on December 11, 12, 13, 14, 16, 16 or 17. There was no documentation that Resident #2 had a BM for 7 days in a row. The nursing assistant flow sheet for January 2011 documented no BM on January 3, 4, 5, 6, 7, 8 or 9. There was no documentation that Resident #2 had a BM for 7 days in a row. The nursing assistant flow sheet for January 2011 documented no BM for Resident #2 on January 14, 15, 16, 17, 18 or 19. There was no documentation that Resident #2 had a BM for 6 days in a row. The nursing assistant flow sheet for February 2011 documented no BM on February 1, 2, 3, 4 or 5. There was no documentation that Resident #2 had a BM for 5 days in a row. The nursing assistant flow sheet for February 2011 documented no BM on February 8, 9, 10, 11, 12, 13, 14 or 15. There was no documentation that Resident #2 had a BM for 8 days in a row. The February 2011 nursing assistant flow sheet documented no BM for Resident #2 on February 24, 25, 26, 27 or 28. There was no documentation that Resident #2 had a BM for 5 days in a row. There was no documentation of physician notification for no BM greater than 3 days.

During an interview with the Assistant Director of Nursing (ADON) at the A hall nurses' station on 3/8/11 at 11:51 AM, the ADON was asked if she expected the Physician to be notified based on the interventions found in the Resident's care plan. The ADON confirmed, "...mmanm every 3 days..."
Continued from page 3.

During an interview in the Minimum Data Set (MDS) office on 3/8/11 at 12:25 PM, the Corporate Nurse Consultant stated, "... could not find MD notification that MD notified of no BM in 3 days..."

3. Review of the facility's "DIABETIC THERAPEUTIC PROTOCOL" policy documented, "...the blood glucose is less than 50 (or as indicated by the physician)... 4. Notify the physician. The physician is notified even if the resident improves..."

Medical record review for Resident #6 documented an admission date of 9/12/10 with diagnoses of Pleural Effusion, Arthritis, Renal Dialysis, Hyperlipidemia, Diabetes with Complications, Hypertension, Anemia and Congestive Heart Failure. Review of a physician's order dated 2/24/11 documented, "...ACCUCHECK AC [before meals] AND HS [at bedtime] WITH NOVOLIN R SS [sliding scale insulin] SQ [subcutaneous] AS FOLLOWS: < [less than] 50= [what to do] PROTOCOL AND NOTIFY MD...". Review of Resident #6's diabetic administration record at 11:10 AM on 3/7/11 documented, the following:

a. 12/1/10 at 6:30 AM, an accuchek of 33.

b. 12/2/10 at 6:30 AM, an accuchek of 41.

c. 12/3/10 at 6:30 AM, an accuchek of 40.

d. 1/28/11 at 6:30 AM, an accuchek of 48.

e. 1/30/11 at 6:30 AM, an accuchek of 35.

f. 2/2/11 at 6:30 AM, an accuchek of 36.

g. 2/10/11 at 6:30 AM, an accuchek of 39. There was no documentation of physician notification for these blood glucose levels of less than 50.

During an interview at a hall nurses' station on 3/9/11 at 10:09 AM, Nurse #4 was asked...
Continued from page 4 procedure is followed when a resident's blood glucose is less than 50. Nurse #4 stated, "Call the doctor..."

**F 241**

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observations and interview, it was determined the facility failed to ensure 1 of 3 Certified Nursing Assistants (CNA #1) knocked on doors or gained permission prior to entering the resident's rooms.

The findings included:

Observations in B hall on 3/7/11 at 3:15 PM, CNA #1 entered room 123 without knocking or gaining permission to enter.

Observations in B hall on 3/7/11 at 3:30 PM, CNA #1 entered room 120 without knocking or gaining permission to enter.

During an interview in B hall on 3/8/11 at 5:30 PM, the Assistant Director of Nursing stated, “Expect staff to knock before entering, wait for reply if resident is alert.”

**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

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**F 241 SS=D**

1. CNA #1 was re-educated by the Director of Nursing regarding maintaining resident's dignity and respect to include knocking on doors.

2. Other residents with the potential to be affected will be identified through a resident council meeting on 03/29/11 to identify others who have had their room entered without knocking.

3. Staff was inservices on 03/23/11 by the Director of Nursing regarding promoting care for residents in a manner that maintains or enhances their dignity and respect including knocking on doors and gaining permission to enter. The Director of Nursing and the Social Services Director will make direct observations of staff entering residents' rooms to ensure compliance three times a week for one week, then weekly for three weeks, then monthly for two months, and then quarterly for two quarters.

4. The Director of Nursing will report the findings to the QA Committee monthly for three months and then quarterly for two quarters. The QA Committee will make any needed revisions to the plan. The QA Committee is comprised of the Administrator, the Director of Nursing, the Medical Director, Social Services Director, MDS Coordinator, Activities Director, Dietary Manager and other as deemed appropriate by the Administrator.
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO 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>COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td>Continued From page 5, incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</td>
<td>F 280</td>
<td>1. Resident #1's care plan was revised by the LPN Charge Nurse on 03/13/11 to reflect interventions for falls. Resident #3's care plan was revised by the Assistant Director of Nursing on 03/25/11 to reflect oxygen therapy. The foley catheter was discontinued on 03/07/11. Resident #8's care plan was revised by the Assistant Director of Nursing on 03/25/11 to reflect the history of GI bleeding.</td>
<td>4-9-11</td>
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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 ensure care plans were revised to reflect interventions for falls, oxygen (O2) therapy, Foley catheter or Gastrointestinal (GI) bleed for 4 of 14 (Residents #1, 5, 8 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 1/3/11 with diagnoses of Diabetes Mellitus, Mental Disorder, Dementia, Depression, Anxiety, Hypothyroidism and Vocal Cord Paralysis. Review of the physician fax communication dated 1/8/11 documented, "...Resident fell from bed..." Review of the nurses notes dated 1/9/11 documented,
F 280 Continued From page 6

"Resident fell attempting to get up..." Review of the physician fax communication dated 1/21/11 at 4:20 AM documented, "Resident observed lying in [on] the floor..." Review of the fall investigation dated 1/21/11 at 11:15 AM documented, "...Resident in [on] floor..." Review of the nurses note dated 2/9/11 documented, "Resident sitting in [on] the floor..." There was no documentation of care plan revisions for new fall prevention interventions following the documented falls.

During an interview in room 101 on 3/7/11 at 2:15 PM, the Assistant Director of Nursing (ADON) was asked if any of the falls between the dates of 1/8/11 through 3/4/11 had new interventions documented on the care plan. The ADON stated, "No."

2. Medical record review for Resident #5 documented an admission date of 2/21/05 with a readmission date of 10/12/05 with diagnoses of Renal Failure, Congestive Heart Failure, Hypertension, Asthma and Dysphagia. Review of the physician's recertification orders dated 2/24/11 documented, "...18 FR [French] 10 cc [cubic centimeters] FOLEY CATH [catheter] TO BSB [bedside bag], 02 @ [at] 3 L [liters] / [per] MIN [minute] BNC [binaural cannula] PRN [as needed] DYSPNEA..." Resident #5's care plan did not include the Foley or oxygen therapy.

During an interview in the dining room on 3/8/11 at 4:00 PM, the Minimum Data Set (MDS) coordinator stated, "...The Foley and oxygen had been taken off the care plan and not restarted. I missed it..."

3. Review of the facility's "CARE PLAN QUARTERLY REVIEWS" policy documented,
care plans. New physician's orders and the 24-hour report will be brought to the Administrative meeting five days a week. The Director of Nursing or designee will then review the care plan for interventions related to changes in condition reflected on these reports. The Director of Nursing or designee will audit four care plans per month for three months and then four quarterly for two quarters to ensure the plan of care is comprehensive.

4. The findings of the audit will be reported to the QA Committee by the Director of Nursing or designee monthly for three months and then quarterly for two quarters. The QA Committee will make any needed changes to the plan of action. The QA Committee is comprised of the Administrator, the Director of Nursing, the Medical Director, Social Services Director, MDS Coordinator, Activities Director, Dietary Manager and other as deemed appropriate by the Administrator.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 280</td>
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<td>Policy statement: It is the policy of this facility that each resident's care plan be reviewed at least quarterly. Procedure... 2. The Care Planning Committee/Team is responsible for the periodic review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the resident has been readmitted to this facility from a hospital stay; c. At least quarterly; and d. Annually.</td>
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Medical record review for Resident #8 documented an admission date of 1/4/05 and a readmission date of 7/30/10 with diagnoses of Diabetes with Neurological Manifestation, Malaise and Fatigue. Review of Resident #8's care plan dated 7/31/10 had not been updated quarterly as per facility's policy. Resident #9's care plan dated 7/31/10 documented, "...Problem: GI Bleed w/possible hemorrhage... 2. Diverticulosis w/u/lcer."

During an interview in the dining room on 3/8/11 at 4:00 PM, the MDS coordinator stated, "...she [Resident #6] had a GI bleed and Diverticulosis not resolved... It [care plan] is not up to date... yeah, no goals or approaches for GI and Diverticulosis... It has not been updated since July [2010]... care plans are to be reviewed every three months..."

4. Medical record review for Resident #11 documented an admission date of 6/11/07 with a readmission date of 4/9/09 with diagnoses of Cardiac Dysrhythmia, Osteoarthritis, Diabetes, Chronic Ischemic Heart Disease, Alzheimer's, Dementia, Hypertension, Hyperlipidemia and Congestive Heart Failure. Review of the nurse's notes dated 7/3/10 documented, "Resident noted to be lying in [on] the floor. No voiced olo..."
| F 280 | Continued From page 8
|       | [complaints of] pain..." Review of the care plan
|       | with a review date of 1/13/10 revealed no
|       | documentation or interventions for the fall on
|       | 7/3/10.
|       | During an interview in the ADON office on 3/9/11
|       | at 8:15 AM, the MDS Coordinator confirmed there
|       | were no care plan interventions for the fall on
|       | 7/3/10. The MDS Coordinator stated, "Nothing
|       | there, I missed it."

| F 315 | 483.25(c) NO CATHETER, PREVENT UTI,
|       | RESTORE BLADDER
|       | Based on the resident's comprehensive
|       | assessment, the facility must ensure that a
|       | resident who enters the facility without an
|       | indwelling catheter is not catheterized unless the
|       | resident's clinical condition demonstrates that
|       | catheterization was necessary; and a resident
|       | who is incontinent of bladder receives appropriate
|       | treatment and services to prevent urinary tract
|       | infections and to restore as much normal bladder
|       | function as possible.

| F 280 | F315 No Catheter, Prevent UTI,
|       | Restore Bladder SS=D
|       | 1. C.N.A. #3 was re-educated
|       | regarding the proper procedure of
|       | perineal care by the Director of
|       | Nursing on 03/23/11. Resident #7
|       | was evaluated by the Director of
|       | Nursing on 03/24/11 and no adverse
|       | affects were noted. Resident #5's
|       | foley was discontinued on 03/07/11
|       | per physician's order.

|       | 2. Other residents with the potential to
|       | be affected related to perineal care
|       | were identified through a review of
|       | the infection control report for the
|       | past three months conducted by the
|       | Director of Nursing on 03/25/11 to
|       | identify any trends related to
|       | incontinent/perineal care. Other
|       | residents with the potential to be
|       | affected related to supporting
|       | diagnosis for foley catheter were
|       | identified by a review of the medical
|       | record for residents with foley
|       | catheters conducted by the MDS
|       | Coordinator on 03/25/11 to ensure
|       | supporting diagnosis.

|       | 3. Licensed nurses were inserviced on
|       | 03/23/11 by the Director of Nursing
|       | regarding the need for residents with
|       | foley catheter to have a supporting
|       | diagnosis. Newly hired nurses will
|       | be inserviced upon hire. C.N.A.'s
|       | were inserviced by the Director of
|       | Nursing on 03/23/11 regarding the
|       |
CARE/PERINEAL CARE policy documented, "A. Clean perineal area, as applicable moving the patient to the back. Next, use a clean area of the washcloth or towel or use another clean washcloth or towel for each use. (Note: Not all products require rinsing. Follow instructions); B. Dry perineal area moving from front to back. Use a blotting motion with towel...

Medical record review for Resident #7 documented an admission date of 9/4/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Osteoporosis, Atrial Fibrillation and Flutter, Dysphagia, General Osteoarthritis, Abnormal Posture, Muscle Weakness, Hypertension and Urinary Tract Infection (UTI).

Observations in Resident #7's room on 3/6/11 at 3:30 PM, revealed Certified Nursing Assistant (CNA) #3 performing perineal care on Resident #7. CNA #3 cleansed the perineal area from the front to the back and then from back to the front using the same area of the wash cloth the entire time.

During an interview in B hall on 3/8/11 at 3:40 PM, CNA #3 was asked about the technique of perineal care. CNA #3 stated, "Her [Resident #7's] legs are so close together and difficult to separate, it is difficult to do peri-care [perineal care] any other way."

2. Medical record review for Resident #5 documented an admission date of 2/21/05 and a readmission date of 10/12/05 with diagnoses of Renal Failure, Congestive Heart Failure, Hypertension and Dysphagia. Review of Resident #5's physician's certification orders dated 2/24/11 documented, "...16 FR [french] 10 cc"
Continued From page 10
[cubic centimeters] FOLEY CATHETER [catheter] TO BSB [bedside bag].

Observations in Resident #5's room on 3/7/11 at 2:45 PM, revealed Resident #5 with a Foley catheter.

During an interview in the C hall nurses' station on 3/7/11 at 2:45 PM, Nurse #1 was asked why does Resident #5 have a Foley catheter. Nurse #1 stated, "no, there is no diagnosis for a Foley...

F 323
493.25(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.

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 that a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 8 (Resident #1) sampled residents identified with falls. Resident #1 sustained falls on 1/21/11 and 2/9/11. The facility failed to develop interventions after the falls, which resulted in a subsequent fall on 3/4/11, that resulted in actual harm when Resident #1 required medical intervention and sutures from that fall.

The findings included:

consists of the Medical Director, Administrator, and Director of Nursing, Social Services Director, Activity Director, Maintenance Director, MDS Coordinator, and Housekeeping Supervisor.

1. Resident #1's care plan was revised by the MDS Coordinator on 03/24/11 to reflect updated interventions for falls.
2. The care plans of residents who have sustained falls in the past two months will be reviewed by the MDS Coordinator on 03/31/11 to ensure updated fall interventions.
3. Nurses will be inserviced on 03/30/11 by the Director of Nursing regarding updating care plans with alternate preventive measures for falls after each fall. New nurses will be educated upon hire and existing staff will be inserviced no less than annually ongoing. An inservice by a consultant nurse will be conducted for all nursing staff on 03/30/11 regarding fall interventions. Incident reports and the 24-hour report will be brought to the Administrative meeting five days a week by the Director of Nursing or designee. The Director of Nursing, the MDS Coordinator, and/or the Medical Records nurse will review the care plans of residents who have sustained a fall to ensure updated fall interventions ongoing.
F 323: Continued From page 11

Review of the facility's "Faill Potential and Prevention Protocol" policy documented, "...All falls will be communicated on the 24 Hour Report for review at stand up meeting. The care plan will be updated..."

Medical record review for Resident #1 documented an admission date of 1/3/11 with diagnoses of Diabetes Mellitus, Mental Disorder, Dementia, Depression, Anxiety, Hypothyroidism and Vocal Cord Paralysis. Review of the fall investigation dated 1/21/11 (11:25 AM) documented, "Resident in [on] floor..." Review of the nurses notes dated 2/9/11 documented, "Resident sitting in [on] floor..." There was no documentation of modification of the interventions to prevent further falls in the medical record.

Review of the nurses note dated 3/4/11 at 7:10 AM documented, "...Resident fell on the floor face down. Laceration over R [right] eye, R arm/wrist appears to be injured. Skin tear to L [left] arm..." Nurses notes dated 3/4/11 at 2:05 PM documented, "...Resident has a laceration with stitches to R eye lid... R wrist.. swollen and bruised..."

Observations in room 125 on 3/7/11 at 8:55 AM, revealed Resident #1 with bruising around the right eye with sutures above the eyelid.

During an interview in room 101 on 3/7/11 at 2:15 PM, the Assistant Director of Nursing (ADON) was asked if any of the falls between 1/8/11 and 3/4/11 had new interventions on the care plan. The ADON stated, "No."

Resident #1 sustained falls on 1/21/11 and 2/9/11. The facility failed to develop interventions
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<td>Continued From page 12, after the falls, which resulted in a subsequent fall on 3/4/11, that resulted in actual harm when Resident #1 required medical intervention and sutures from that fall.</td>
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<tr>
<td>F 371</td>
<td>433.35(I) FOOD PROCURE, STORE/PREPARE/serve - SANITARY</td>
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<td>F 371</td>
<td>4.2-11 Food Procure, Store/PREPARE/serve—Sanitary SS=F</td>
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1. The facility will store, prepare, distribute, and serve food under sanitary conditions. The following items will be corrected as indicated:

   a) The large black non-covered pipe protruding through open exposed insulation above the two-compartment sink preparation area was repaired to ensure sanitary conditions on 03/24/11.

   b) The non-working A/C window unit was removed and the holes patched to ensure sanitary conditions on 03/24/11.

   c) The ice machine room broken tile floors will be replaced by 04/09/11. Ceiling tiles will be installed by 04/09/11. The ice machine cleaner is now being stored in the dietary chemical closet. The exposed wiring was corrected on 03/24/11. The receiving area—weather stripping was installed on the double exit doors on 03/24/11 to ensure sanitary conditions. The broken door handle was repaired on...
Continued From page 13

Observations in the kitchen on 3/7/11 beginning at 4:15 PM revealed the following:
a. Used wet cloth laying on the preparation (prep) table next to a container with peanut butter not being used.
b. Large black non covered pipe protruding through open exposed insulation above the two compartment sink preparation area.

during an interview in the kitchen on 3/7/11 at 4:25 PM, the Dietary Manager (DM) stated, "Yes the pipe is open with no cover and blows over the prep table."

during an interview in the kitchen on 3/8/11 at 8:05 AM, the DM was asked what she would expect staff to do with cloths that are not in use. The DM stated, "Cloths should be in the bucket of sanitizer when not being used."

2. Review of the facility's "Sanitation" policy documented, "1. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. 4. Ice which is used on connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner."

Observations in the kitchen on 3/8/11 beginning at 8:05 AM revealed the following:
a. Non-working air conditioner window unit open to the outside without a cover on the outside and missing cover on the inside,
b. Ice machine with a white/gray chalky color substance on the inside lid hinges and a brown substance on the white plastic above the ice.
c. Room where the ice machine was stored had

03/24/11. The hole in the wall was repaired on 03/24/11 to ensure sanitary conditions. e) Uncovered fluorescent light bulbs in kitchen were replaced with new fixtures on 03/24/11. Vapor proof globes were installed in the vent-a-hood on 03/24/11. The ceiling was scraped and painted to ensure sanitary conditions on 03/24/11. The hole in the ceiling was also repaired on 03/24/11. Drain covers were installed over open drains in the floor on 03/24/11. Rat and mice traps were removed on 03/24/11. We have contracted with a new pest control company. The fan boxes were removed on 03/24/11. Floors were repaired on 03/24/11. Exhaust fan was repaired and the hole was patched on 03/24/11. All residents have the potential to be affected by the deficient practice. Maintenance Director will monthly present to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Social Services Director, Activity Director, Maintenance Director, and Housekeeping Supervisor a detailed account of the physical plant and what areas of concern have been addressed or are being addressed.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** LAUDERDALE COMM LIVING CTR

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<tr>
<td>F 371</td>
<td>Continued From page 14 broken floor tiles, missing ceiling tiles, a gallon bottle of ice machine cleaner with a 1/2 gallon of cleaner in it and non covered wires leading from the ceiling into the back of the ice machine. d. Receiving area next to the dry storage room with a large gap under the doors, a broken door handle and a basketball size hole in the exterior wall open to the outside. e. Non covered fluorescent light bulbs in kitchen over two chest freezers, two uncovered fluorescent bulbs in the kitchen outside the dish wash room, four uncovered fluorescent bulbs in the clean dish storage area, two uncovered fluorescent bulbs over the dish wash area, bare light bulb in the clean pot pan storage room, three non covered light bulbs under the vent a hood behind the stove and over the #4 chest freezer. f. Stained white in color with black flecks plastic ceiling cover over the pot and pan, cooking utensil drying area sagging down revealing a hole in the ceiling and peeling paint. g. Open pipes without a cover in the floor; under the food preparation table with the food processor and can opener, under the long food preparation table, behind the stove, in front of chest freezer #4, in front of the old walk in cooler and under the three compartment sink. h. One large rat trap and two mouse traps on the floor of the pot and pan storage room, black rodent droppings around the trap, four mouse traps and a mouse bait box on the floor of the storage room. Both rooms had no doors and opened directly to the stove area of the kitchen. i. Gross amount of dust, dirt and grime covering the back of a non used fan box over the clean pot pan storage rack. j. In the dish wash room; a large hole in the floor under the dish wash table and many missing tiles.</td>
<td>F 371</td>
<td>4-9-11</td>
</tr>
</tbody>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 216 LACKEY LANE

RIPLEY, TN 38063

**DATE SURVEY COMPLETED:** 03/09/2011
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC-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>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 15 a dirty and partially covered vent open to the outside, and a hole in the wall under the breaker box with cold air rushing through. During an interview in the kitchen on 3/8/11 at 8:05 AM, the DM was asked about the open access to the outside through the nonworking air conditioner without a cover. The DM stated, &quot;...I said something to maintenance because it was open to the outside and he said it would be okay...&quot; During an interview in the kitchen on 3/8/11 beginning at 8:10 AM, the DM was asked about the substance in the ice machine. The DM stated, &quot;...you can wipe it off and it comes back...&quot; During an interview in the kitchen on 3/8/11 beginning at 8:10 AM, the DM was asked about the receiving area. The DM stated, &quot;...maintenance is aware of the large hole in the outside wall, I saw a mouse running down the dry storage wall in the past when I first came 6 months ago...&quot; During an interview in the kitchen on 3/8/11 beginning at 8:15 AM, the DM stated, &quot;...I have told maintenance about this and it has not been corrected yet...&quot; During an interview in the kitchen on 3/8/11 at 8:15 AM, the cook was asked about the sagging ceiling and paint peeling over the pot and pan drying areas. The cook stated, &quot;...only if it rains a lot then water drips down...&quot; The DM was asked about the open pipes in the floor. The DM stated, &quot;...yes, they are all open and need a cover...&quot; During an interview in the kitchen on 3/8/11 at 8:20 AM, the DM was asked about the rat trap, mouse traps, and rodent droppings. The DM...</td>
<td>F 371</td>
<td>4-2-11</td>
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Lauderdaile COMM LIVING CTR

F 371

Continued from page 16 stated, "...I am not gonna lie, they had rats, mice and roaches when I first came. I saw them..."

During an interview in the kitchen on 3/8/11 at 9:45 AM, the interim administrator stated, "I would say we got mice."

During an interview in the kitchen on 3/8/11 at 9:45 AM, the assistant administrator was asked about the open insulation hanging over the preparation table. The assistant administrator stated, "Yes I see the insulation."

During an interview in the kitchen on 3/8/11 at 9:00 AM, the DM was asked about the dirt covering the non-used fan box over the clean pot and pan storage rack. The DM stated, "...yes that is dirty..."

During an interview in the dish wash room on 3/8/11 at 9:10 AM, the DM was asked about the dirty vent and hole in the wall with air rushing through. The DM stated, "...yes that vent goes outside and air rushes in. I don't know where that air is from coming through that hole..."

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with current accepted...
LAUDERDALE COMM LIVING CTR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

LAUDERDALE COMM LIVING CTR

STREET ADDRESS, CITY, STATE, ZIP CODE
216 LACKEY LANE
RIPLEY, TN 38063

DATE SURVEY COMPLETED
03/09/2011

ID TAG
F 431

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

445354

ID PREFIX TAG
F 431

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

ID PREFIX TAG
F 431

COPIES: 4 - 9 - 11

3. a) Licensed Nurses were re-educated on 03/23/11 on medication carts and medication storage rooms and destroying medication per facility policy. b) Licensed Nurses will be educated upon hire and annually.

4. Medication carts and medication rooms will be monitored weekly per the Director of Nursing or RN Supervisor. The findings will be reported to the QA Committee monthly for three months, then quarterly for the next three quarters. The QA Committee consists of the Administrator, Medical Director, Director of Nursing, Medical Records, Dietary Manager, Activities Director, Pharmacy, MDS Coordinator and others.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure that multidose medication vials were dated when opened and discarded 30 days after opening and failed to ensure that medications were not stored past their expiration dates in 2 of 6 (A hall medication room and B/C hall medication room) medication storage areas.

The findings included:

1. Review of the facility's "VIALS AND AMPULES OF INJECTABLE MEDICATIONS" policy documented, "...The date opened and the initials..."
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</thead>
</table>
| F 431 | Continued From page 18 of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose... Medications in multidose vials may be used until the manufacturer's expiration date, for the length of time allowed by state law, or according to facility policy for thirty days, depending on which date supersedes... a. Observation in A hall medication room on 3/8/11 at 3:40 PM, revealed an opened 10 milliliter (ml) multidose vial of Novolin R Insulin and a 1 ml multidose vial of Tubersol Purified Protein Derivative (PPD) with no notation of when the vials were opened. b. Observation in B/C hall medication room on 3/8/11 at 3:50 PM, revealed 3 opened 10 ml vials of Novolin R Insulin with open dates of 1/20/11, 1/21/11 and 1/26/11. These vials were stored more than 30 days past the open dates. During an interview in hall B/C medication room on 3/8/11 at 3:55 PM, Nurse #5 was asked how long a multidose vial of insulin could be used after being opened. Nurse #5 stated, "30 days." 2. Review of the facility's "STORAGE OF MEDICATIONS" policy documented, "...Outdated... medications... are removed from stock, disposed of according to procedures for medication disposal..." a. Observations in the A hall medication room on 3/8/11 at 3:40 PM, revealed 2 doses of Vancomycin 1250 milligram (mg) reconstituted in 250 ml of 0.9 percent (%) Sodium Chloride Intravenous Solution on 12/10/10 stored past the expiration date of 12/24/10; 5 Acetaminophen 650...
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<tr>
<td>F 431</td>
<td>Continued From page 19</td>
<td>mg Rectal Suppositories stored past the expiration date of 2/10; and a 1 ml vial of Tubersol PPD stored past the expiration date of 2/11. b. Observation in the B/C hall medication room on 3/8/11 at 3:50 PM, revealed 6 Acetaminophen 650 mg Rectal Suppositories stored past the 10/10 expiration date and 8 Acetaminophen 650 mg Rectal Suppositories stored past the 12/10 expiration date.</td>
<td>F 441</td>
<td>SS=D</td>
<td>483.55 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>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.</td>
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<td>(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.</td>
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<td>(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.</td>
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</table>
**Lauderdales Comm Living CTR**

**F 441** Continued From page 20:

(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 2 of 6 nurses (Nurses #3 and 6) and 4 of 5 Certified Nursing Assistants (CNA #1, 2, 3 and 4) failed to follow proper infection control practices to prevent the potential spread of infection during a dressing change, during dining or after providing pericare.

The findings included:

1. Review of the facility's "Dressings/Clean" policy documented, "...3. Tape a biohazard or plastic bag on the bedside stand or open on the bed... 7. Perform hand hygiene. 8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Discard gloves and dressing. 10. Perform hand hygiene..."

Observations in Random Resident (RR) #1's room on 3/8/11 at 10:30 AM, revealed Nurse #3 removed the soiled dressing with gloved hands from RR #1's left stump and discarded the soiled dressing in a red biohazard bag on the floor. Nurse #3 then sprayed a 4 by (x), 4 gauze pad with wound cleanser and cleansed the wound.

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**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Date of Completion</th>
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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 20:</td>
<td>(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 2 of 6 nurses (Nurses #3 and 6) and 4 of 5 Certified Nursing Assistants (CNA #1, 2, 3 and 4) failed to follow proper infection control practices to prevent the potential spread of infection during a dressing change, during dining or after providing pericare. The findings included: 1. Review of the facility's &quot;Dressings/Clean&quot; policy documented, &quot;...3. Tape a biohazard or plastic bag on the bedside stand or open on the bed... 7. Perform hand hygiene. 8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Discard gloves and dressing. 10. Perform hand hygiene...&quot; Observations in Random Resident (RR) #1's room on 3/8/11 at 10:30 AM, revealed Nurse #3 removed the soiled dressing with gloved hands from RR #1's left stump and discarded the soiled dressing in a red biohazard bag on the floor. Nurse #3 then sprayed a 4 by (x), 4 gauze pad with wound cleanser and cleansed the wound.</td>
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<td>F 441</td>
<td>Continued From page 21</td>
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<tr>
<td>Nurse #3 did not remove gloves or perform hand hygiene after discarding the soiled dressing and prior to cleansing the wound.</td>
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<tr>
<td>During an interview in A/B hall nurses' station on 3/8/11 at 11:15 AM, Nurse #3 confirmed she did not remove gloves or perform hand hygiene after discarding the soiled dressing and prior to cleansing the wound. Nurse #3 stated, &quot;I usually take my gloves off and dispose with the dressing and then wash my hands. I forgot.&quot;</td>
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<tr>
<td>2. Review of the facility's &quot;HAND WASHING&quot; policy documented, &quot;...1. Hands should be thoroughly washed before and after providing resident care. 2. Proper hand-washing techniques must be followed at all times...&quot;</td>
<td></td>
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<tr>
<td>a. Observations in Resident #5's room on 3/7/11 at 3:15 PM, CNA #1 did not wash her hands before donning gloves, she performed perineal care, did not remove her gloves after care and used the same dirty gloved hands, touched Resident #5's head, body, bed linen, side rails and placed the shampoo/body wash bottle back on the hallway linen cart. CNA #1 re-entered Resident #5's room, did not wash her hands and repositioned Resident #5, and touched the side rails and call light.</td>
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| Observations in room 114 on 3/7/11 starting at 5:23 PM, revealed CNA #1 placed the supper tray on the bedside table, turned the crank on the resident's bed, then continued to set up the tray and prepared an egg salad sandwich, touching the bread with her bare hands. CNA #1 left this room, walked to the cart, obtained a supper tray, entered room 104, and set up the meal tray. CNA #1 left this room, walked to the cart, obtained a...
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<td>F 441</td>
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<td>Continued From page 22 supper tray, entered room 103A, and placed the tray on the bedside table. CNA #1 moved the table, turned the light on, and then continued to set up the tray, touching the straw with her bare hands. CNA #1 left this room, walked to the cart, obtained a supper tray, entered room 103B, and placed the tray on the bedside table. CNA #1 then assisted this resident to position in bed, then continued to set up the tray and prepared an egg salad sandwich touching the bread with her bare hands. CNA #1 was never observed to perform hand hygiene. Observations in room 124B on 3/7/11 at 5:10 PM, CNA #1 delivered a meal tray to the resident, touched the resident and then continued to set up the meal tray. CNA #1 left this room, walked to the cart, obtained a meal tray and delivered the tray to the resident in room 124A. CNA #1 was never observed to perform hand hygiene. b. Observations in the dining room on 3/7/11 at 6:15 PM, CNA #2 touched the resident's crackers with her bare hand during tray preparation. c. Observations in room 123B on 3/7/11 at 5:10 PM, CNA #3 delivered a supper tray, raised the head of the bed using a crank, then lowered the right side rail, and placed the bedside table in front of the resident using her bare hands. CNA #3 then proceeded to prepare the resident's meal tray. CNA #3 did not wash her hands or use hand sanitizer prior to preparing the resident's tray. Observations in room 115 on 3/7/11 at 5:25 PM, CNA #3 delivered a meal tray, set up the tray, raised the head of the bed, left the resident's room and delivered a meal tray to room 113 without washing her hands.</td>
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<td>ID Prefix Tag</td>
<td>SUMMARY: STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td>ID Prefix Tag</td>
<td>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</td>
<td># (Completion Date)</td>
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<td>F 441</td>
<td>Continued From page 23</td>
<td>d. Observations in room 114 on 3/8/11 starting at 11:18 AM, revealed CNA #4 placed the lunch tray in the bedside table, applied a clothing protector to the resident, then continued to set up the tray. CNA #4 left this room, walked to the cart, obtained a lunch tray, and entered room 115. CNA #4 applied a clothing protector to the resident and set up the tray, removing a cookie from package with her bare hands. CNA #4 was never observed to perform hand hygiene.</td>
<td>F 441</td>
<td>P465 Safe/Functional/Sanitary/Comfortable Environment &lt;br&gt; a) The facility will ensure that the resident's environment will be safe, functional, sanitary, and comfortable. The following items will be corrected as indicated: The fabric sofa in the sitting area between A hall and the main dining room was removed on 03/25/11. Other sofas in the facility were inspected by the housekeeping supervisor for odors. Sofas found with odors will be removed. Employees will be inserviced by the Director of Nursing on April 8, 2011. Rounds will be done by housekeeping supervisor or designee monthly. Any findings will be reported to the QA Committee at least quarterly. &lt;br&gt; b) On the A hall men and women's shower room between rooms 104 and 105, the area was cleaned on 03/10/11. Shower rooms will be inspected for odors daily. Any findings will be reported to the housekeeping supervisor. Employees will be inserviced on April 8, 2011 regarding shower odors.</td>
<td>4-9-11</td>
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<tr>
<td>F 465</td>
<td>483.70(h) &lt;br&gt; SS=F Safe/Functional/Sanitary/Comfortable Environment</td>
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F 465 Continued From page 24
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide an a safe, functional and sanitary environment as evidenced by odors; trash on the floor; mouse droppings; clothes and personal items on the floor; dirty and stained floors; broken ceramic tiles; brown material (appearance of feces) on the floor; holes in the walls; a vent cover hanging freely; missing, warped, and stained ceiling tiles; trash and lint behind the washer or the presence of a roach on 3 of 3 halls (A, B and C halls), the hallway leading to the kitchen, the receiving hall, the ice machine room and the laundry room.

The findings included:

1. Observations of A hall revealed strong urine odors in the following locations:
   a. On 3/8/11 at 4:20 PM, the fabric sofa in the sitting area between A hall and the main dining room.

2. Observations of C hall revealed strong urine odors in the following locations:
   a. On 3/7/11 at 10:35 AM, upon entry into the locked unit.
   b. On 3/6/11 at 8:05 AM, the nurses’ station.
   c. On 3/8/11 at 8:05 AM, around room 133 the small dining room.

F 465 Housekeeping supervisor or designee will make daily rounds to inspect for odors in shower rooms. Any findings will be reported to the QA Committee at least quarterly.

1. a) The locked unit was cleaned on 03/10/11. b) The nurses’ station was cleaned on 03/10/11. C) Around room 133 the small dining room was cleaned on 03/10/11. d) Room 126 was cleaned on 03/10/11 and was stripped and waxed on 03/16/11. Facility rounds were made throughout the facility to ensure no odors were found. Any odors that are found will be cleaned immediately.

Employees will be instructed by the housekeeping supervisor by April 8, 2011. Housekeeping supervisor or designee will make daily rounds to inspect for odors. Any findings will be reported to the QA Committee at least quarterly.

2. a) The eye wash station room on B hall was cleaned on 03/09/11, and we have contracted with a new pest control company whose first visit was 03/23/11. b) The clean linen room under the step stool on the floor and under the bottom shelf of the rack was cleaned on 03/24/11. c) The eye
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Lauderdale Comm Living CTR

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 215 Lackey Lane
Ripley, TN 38063

**ID** | **PREFIX** | **TAG** | **SUMMARY STATEMENT OF DEFICIENCIES**
---|---|---|---
F 465 | | | Continued From page 25

| | | **ID** | **PREFIX** | **TAG** | **PROVIDERS PLAN OF CORRECTION**
---|---|---|---|---|---
F 465 | | | wash station room, under the sink and beside the hopper commode was cleaned on 03/08/11. Facility rounds will be made daily. Findings will be cleaned immediately. Pest control company will be notified of findings. Employees will be inserviced by the Director of Nursing by April 8, 2011. Findings will be reported to the QA Committee at least quarterly.

3. **Observations in the B hall revealed the following:**

   a. On 3/7/11 at 9:15 AM, the eye wash station room had trash on the floor, mouse droppings under the sink, beside the hopper commode and in the corner beside the door.
   b. On 3/7/11 at 9:18 AM, the clean linen rom had clothes and personal linen (crocheted afghan and a green throw with red polka dots) under the step stool on the floor and under the bottom shelf of the rack.
   c. On 3/8/11 at 7:56 AM, the eye wash station room had a dirty floor with broken pieces of ceramic material, stains on the floor, mouse droppings under the sink and beside the hopper commode and a small ball of brown material with the appearance of feces.

   During an interview in the B hall eye wash station room on 3/8/11 at 9:00 AM, the housekeeping staff #1 and the Assistant Director of Nursing (ADON) were asked if the substance on the floor looked like mouse droppings and if the round brown material was fecal material. Housekeeping staff #1 and the ADON both shook their heads affirmatively and stated, "...yes..."

4. **During tour with the Interim Administrator and Assistant Administrator on 3/8/11 beginning at 9:40 AM revealed the following:**

   a. The hole in the wall in the receiving hall was repaired on 03/24/11. b. The ceiling tiles in the laundry will be replaced by April 8, 2011. The trash and lint was removed from behind the washer on 03/24/11. The hole in the laundry room wall will be...
F 465  Continued From page 26

a. In the receiving hall behind dietary revealed a large hole in the wall extending to the outside to the left of the exit door, with a vent cover hanging from the wall. The double exit doors had an open gap between the doors and under the lower part of the doors at the threshold that allowed this surveyor to see outside. The kitchen staff used a room off of this hall for the dry storage area.

b. The ice machine room had broken, warped and missing tiles that exposed the crawl space of the ceiling, broken floor tiles and naked wires connected to the back side of the ice machine.

c. Hall had air entering into the building from the outside. The air was entering in between the two doors and under the bottom of the doors at the threshold.

6. During a tour with the Plant Operations Representative on 3/9/11 beginning at 10:00 AM revealed the following:

a. The receiving hall had a large hole in the interior wall of the building beside the exit door extending to the outside, open spaces in the joint of the exit door.

b. The laundry department had missing, warped and stained ceiling tiles and trash and lint on the floor behind the washer.

During an interview with the Corporate Plant Operations Representative on 3/9/11 beginning at 10:00 AM, the Representative stated the hole is "about 12 by 12... we need to fix that with a little plaster, sheet rock and paint... we need to tape up and remove some of this insulation... replace these ceiling tiles and clean up a little..."

6. Observations in the meeting room (room 101) on 3/9/11 at 3:25 PM revealed a roach crawling up the wall.

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<tr>
<td>F 465</td>
<td>Continued From page 26</td>
<td>a. In the receiving hall behind dietary revealed a large hole in the wall extending to the outside to the left of the exit door, with a vent cover hanging from the wall. The double exit doors had an open gap between the doors and under the lower part of the doors at the threshold that allowed this surveyor to see outside. The kitchen staff used a room off of this hall for the dry storage area.</td>
<td>F 465</td>
<td>repaired by April 8, 2011. All residents have the potential to be affected by the deficient practice. Maintenance staff reviewed the facility for additional areas of concern and will address those issues. Maintenance Director will make weekly rounds to ensure compliance with F465 and report any deficient practices to the QA Committee. Maintenance Director will monthly present to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Social Services Director, Activity Director, Maintenance Director, and Housekeeping Supervisor a detailed account of the physical plant and what areas of concern have been addressed or are being addressed.</td>
<td>4-9-11</td>
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</table>

5. In room 101, observation revealed a roach crawling up the wall; we have contracted with a new pest control company whose first visit was 03/22/11. Facility rounds were made by the Assistant Administrator and the Maintenance Director to ensure no visible signs of pests were observed. Pest control service was initiated on 03/22/11. Monthly pest control services have been initiated. Maintenance director will make weekly rounds to ensure compliance with F465 and report any deficient practices to the QA Committee at least quarterly.
F 502
SS-D
483.75(i)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY

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, it was determined the facility failed to ensure laboratory (lab) tests were obtained according to physician orders for 1 of 14 (Resident #7) sampled residents.

The findings included:
Medical record review for Resident #7 documented an admission date of 3/4/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Osteoporosis, Atrial Fibrillation/Flutter, Dysphagia, General Osteoarthritis, Abnormal Posture, Muscle Weakness and Hypertension.
Review of a physician's order dated 12/8/10 documented, "...Stools for FOB [f]rank occult blood x [times] 3...". The facility was unable to provide documentation that a FOB was obtained nor were results available.

During an interview in room 101 on 3/8/11 at 8:30 AM, the Assistant Director of Nursing (ADON) stated, "I can't find the results [of the FOB]..."

F 514
SS-D
483.75(i)(1) RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional practice.
Continued From page 28

standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident’s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure medical records were accurately documented for 1 of 14 (Resident #1) sampled residents.

The findings included:

Medical record review for Resident #1 documented an admission date of 1/3/11 with diagnoses of Diabetes Mellitus, Mental Disorder, Dementia, Depression, Anxiety, Hypothyroidism and Vocal Cord Paralysis. Review of the physician fax communication dated 1/6/11 documented, "...Resident fell from bed..." Review of the nurses noted dated 1/3/11 documented, "Resident fell attempting to get up..." Review of the physician fax communication dated 1/21/11 (4:20 AM) documented, "Resident observed lying in [on] the floor..." Review of the fall investigation dated 1/21/11 (11:15 AM) documented, "...Resident in [on] floor..." Review of the nurses note dated 2/9/11 documented, "Resident sitting in [on] the floor..." Review of the fall care plan dated 1/7/11 and updated 3/4/11, provided to the surveyor on 3/7/11 at 1:00 AM documented no...
<table>
<thead>
<tr>
<th>ID: F 514</th>
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<tbody>
<tr>
<td><strong>SUMMARY STATEMENT OF DEFICIENCIES</strong></td>
</tr>
<tr>
<td>Each deficiency must be preceded by full regulatory or LSO identifying information</td>
</tr>
<tr>
<td><strong>PROVIDER'S PLAN OF CORRECTION</strong></td>
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<td>Each corrective action should be cross-referenced to the appropriate deficiency</td>
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<td><strong>COMPLETION DATE</strong></td>
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<td>4/9/11</td>
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**Continued From page 29**

Revisions for new fall prevention interventions following the documented falls.

During an interview in room 101 on 3/7/11 at 2:15 PM, when asked if any of the falls between the dates of 1/6/11 through 3/4/11 had new interventions documented in the care plan, the Assistant Director of Nursing (ADON) stated, "No."

Another fall care plan was provided to the surveyor on 3/8/11 at 9:53 AM that had interventions in place for the falls after it had been brought to their attention.

During an interview in room 101 on 3/8/11 at 9:58 AM, the Minimum Data Set (MDS) nurse was asked about the fall care plan that had been provided the day before. The MDS nurse stated, "I still have that one."