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</tr>
</thead>
<tbody>
<tr>
<td>F 167</td>
<td>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</td>
<td>F 167</td>
<td>This plan of correction is submitted as required under State and Federal law. The submission of this plan does not constitute an admission on the part of NHC HealthCare Lawrenceburg as to the accuracy of the surveyor's findings nor the conclusions drawn there from. The Center's submission of the Plan of Correction does not constitute an admission on the part of the Center that the findings cited are accurate, the findings constitute a deficiency, or that the scope and severity regarding any deficiencies cited are correctly applied.</td>
<td>12/21/13</td>
</tr>
<tr>
<td>SS=C</td>
<td>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</td>
<td></td>
<td>F 167: The Center will make all survey results available for examination and post readily accessible to patients and post a notice of their availability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</td>
<td></td>
<td>An additional sign was placed on the lobby table to signify the location of the results.</td>
<td></td>
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<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the survey results were placed in a location readily accessible for the residents and failed to post a notice for the location of the results in a location convenient for the residents and public. The facility census was 91 residents.</td>
<td></td>
<td>Quarterly at the Patient Council Meeting, the Recreation Supervisor will remind the patients where the survey results are located for examination.</td>
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<td>The findings included: Observations on the administrative hall on 11/19/13 at 3:50 PM and 11/20/13 at 4:05 PM, revealed a document posted on an information board that contained a paragraph regarding the location of the survey results. The paragraph documented survey results were located in a blue notebook in the right hand drawer of one of the tables in the front lobby.</td>
<td></td>
<td>QA log will be compiled to document as compliant or non-compliant with F 167 regulations. Monitoring will be performed weekly X 4 and then monthly X 2 until no trending is noted. Observations will be presented to the Center's Quality Assurance Committee.</td>
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<td>During an interview in Resident #50's room on 11/20/13 at 3:40 PM, Resident #50, the Resident Council Vice-President, was asked if survey results were available to read without having to</td>
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F 167
Continued From page 1
ask for them. Resident #50 stated, "...if you asked."

During an interview at the 100 hall nurses' station on 11/21/13 at 10:00 PM, the Director of Nursing (DON) was asked about the accessibility of the survey results. The DON stated, "It [written notice] is on the bulletin board where to find them from the main lobby." The DON was asked if there is a sign in the lobby stating where to find the survey results. The DON stated, "No."

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 observation, it was determined the facility failed to serve milk in a manner enhancing the residents' dignity when milk was served in cardboard cartons without the availability of a drinking glass in 2 of 2 (11/18/13 and 11/20/13 lunch meals) dining observations.

The findings included:
1. Observations in the dining room on 11/18/13 at 12:45 PM, revealed 4 of 9 residents during the 2nd seating of the lunch meal service were served milk in the cardboard cartons without a drinking glass.
2. Observations on the 300 hall on 11/20/13

F 241: The Center will promote care for patients in a manner that maintains dignity and respect in full recognition of his or her individuality.

The staff will be in-service on 12/17/13 to ensure the promotion of independence and dignity in dining.

The Dietary Manager and Nursing House Supervisor will conduct a QA to document as compliant or non-compliant with F 241 regulations. Monitoring will be performed weekly X 4 and then until no trending is noted. Observations will be presented to the Center’s Quality Assurance Committee.
**NHC HEALTHCARE, LAWRENCEBURG**

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<td>F 241</td>
<td></td>
<td>Continued From page 2 beginning at 12:10 PM, revealed Licensed Practical Nurse (LPN) #2 served lunch trays to residents in rooms 310, 317D and 319A. The milk on the trays was served in the cardboard cartons without a drinking glass.</td>
<td>F 241</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 244</td>
<td>SS=E</td>
<td>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</td>
<td>F 244</td>
<td></td>
<td>The Center will comply with 483.15(c)(6) Listen/Act on Group Grievance/Recommendations 12/21/13</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on review of the facility’s patient rights booklet, review of the resident council meeting minutes, medical record review, observation and interview, it was determined the facility failed to respond to a repeated grievance voiced by Resident #34 during 3 of 6 (September, October and November 2013) resident council meetings reviewed.

The findings included:

1. Review of the facility’s patient rights booklet documented, "...GRIEVANCE PROCEDURE Your comfort, safety, health and happiness are
**F 244** Continued From page 3

our concern and we presume that you will give us
the opportunity to assist you should a problem
arise... You are welcome to present the problem
verbally or in writing. You may expect a response
at each level as quickly as possible, certainly
within 5 working days..."

2. Review of the September 2013 resident
council meeting minutes documented, "...A few of
the members discussed and agreed that there
needs to be another bathroom on 300 hall
because they have to wait for others to come out
of the one bathroom on the hall..."

Review of the October 2013 resident council
meeting minutes documented, "...Unresolved
concerns from September: Patients state that
they wish to have more bathrooms on 300 hall..."

Review of the November 2013 resident council
meeting minutes documented, "...[Named
Resident #34] states that "Everyone uses that
bathroom and sometimes it is hard to get in there
when I need to go..."

3. Medical record review for Resident #34
documented an admission date of 12/15/12 with
diagnoses of Personal History of Fall, Aftercare
Hip Joint Replacement, Lack of coordination,
Difficulty Walking, Stiffness of Hip Joint,
Long-term Use of Aspirin, Peripheral Neuropathy,
Lumbosacral Neuritis and History of Malignant
Neoplasm of Ovary. Review of the Minimum Data
Set (MDS) dated 9/25/13 documented in Section
C, Cognitive Status, a cognitive score of 15 out of
a possible 15 indicating the resident was
cognitively intact and in Section G, Functional
Status, the resident required extensive assistance
by facility staff for transferring, ambulation,
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<tr>
<td>F 244</td>
<td>Continued From page 4 dressing, toilet use and bathing.</td>
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Observations on the 300 hall on 11/18/13 at 12:45 PM, revealed Resident #34 sitting in a wheelchair and staff assisting her into the 300 hall common restroom.

Observations in Resident #34's room on 11/19/13 at 8:28 AM, revealed Resident #34 was out of the room. A facility staff member stated the resident was washing up in the 300 hall common restroom.

During an interview in Resident #34's room on 11/19/13 at 9:58 AM, Resident #34 was asked to participate in an individual interview concerning the kind of care she received at the facility. Resident #34 stated she would, but the only complaint she had was, "...We have to stand in line for the bathroom [300 hall common restroom]. Men and women both have to use it. We need another bathroom..." Resident #34 was asked if she attended resident council or if she had mentioned her complaint to anyone. Resident #34 stated, "...At Resident Council, I put it down every time I go down to that..." Resident #34 was then asked if anyone from the facility had gotten back in touch with her concerning her complaint. Resident #34 stated, "They never have said a word about it, what they are gonna do..."

During an interview in Resident #34's room on 11/20/13 at 3:30 PM, Resident #34 was asked if she was having problems getting into the 300 hall restroom today. Resident #34 stated, "...I had to wait today for the bathroom after lunch. It is an ongoing problem waiting for the bathroom..."
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<tr>
<td>F 244</td>
<td>Continued From page 5</td>
<td>11/21/13 at 1:00 PM, Resident #34 was asked if she was getting up earlier in the mornings to be able to use the restroom on the 300 hall. Resident #34 stated, &quot;...I get up early every morning...&quot; Resident #34 continued, &quot;...That is my only complaint, having to wait for the restroom. I have kidney problems and get infections easily. I have to empty my bladder...drink a lot of water. It's hard on the girls [certified nursing assistants (CNAs)], but I have to do it. I'm not complaining just for me but for everybody... They've taken me up to the other restrooms up front. It takes two to help me get up and there is not room in those restrooms for two to help...&quot;</td>
<td>F 244</td>
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4. Medical record review for Resident #50 documented an admission date of 8/31/09 with diagnoses of Status Post Cerebrovascular Accident with left hemiparesis, Dementia, Subdural Hematoma, Diabetes Mellitus, Hypertension, Asthma, Gait Disturbance, Seizures, Osteopenia, Degenerative Joint Disease Lumbar Spine, Lumbar Stenosis, Diverticulosis, Depression and Urge Incontinence and Ataxia. Review of the MDS dated 9/23/13 documented in Section C, Cognitive Status, a cognitive score of 9 out of possible 15 indicating the resident was moderately impaired and in Section G, Functional Status, the resident required extensive assistance by staff for transferring, ambulation, dressing and toilet use. Review of the "Monthly Nursing Summary Report" dated 11/9/13 documented, "Mental Status: Awake, Alert, Oriented..."

During an interview in Resident #50's room on 11/20/13 at 3:40 PM, Resident #50 was asked about any grievances discussed in the resident council meetings. Resident #50 stated, "...we do
F 244  Continued From page 6

need another bathroom on this floor [300 hall] because the men started using it too and makes it very inconvenient..."

5. During an interview in the recreation office on 11/21/13 at 9:40 AM, the Recreation Coordinator, who assists residents during resident council meetings, was asked if Resident #34 had voiced a grievance related to the 300 hall common restroom. The Recreation Coordinator stated during the September 2013 resident council meeting, concerns had been voiced by Resident #34 that another resident was taking a long time in the restroom in the mornings to get ready. The idea was mentioned of working on the ladies' routines and one of them get up early, the other later. In the meeting both said that would be okay. The grievance was discussed at the "Department - Head meeting" in September [2013] at which the Administrator and all the Department Heads would be present. Nursing mentioned working on the ladies' routines and possibly taking residents to the 200 hall bathroom.

During an interview on the 300 hall on 11/21/13 at 9:55 AM, CNA #1 and CNA #2 were asked which residents used the 300 hall common restroom and were they having to wait to go the restroom. The CNAs named 5 residents that regularly use the 300 hall restroom and sometimes 1 or 2 other residents. CNA #1 stated, "...It gets backed up right after lunch with 2 to 3 [residents] waiting..."

During an interview on the 300 hall on 11/21/13 beginning at 10:15 AM, the Administrator was asked if he was aware of a grievance from a resident concerning the need for another restroom for the residents on the 300 hall. The Administrator stated, "...That has not been
### F 244

Continued From page 7

brought to me that I can remember... I will find out." A short time later the Administrator
returned to the 300 hall and stated, "...Sounds like preference, someone in there longer than
someone else wants... Encourage staff to take to other halls..." The Administrator was informed
grievances concerning the restroom and the waiting involved were again voiced during the
October and November, 2013 resident council meetings. The Administrator stated,...Don't want
to drop the ball..."

### F 246

<table>
<thead>
<tr>
<th>SS=D</th>
<th>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</th>
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</table>

A resident has the right to reside and receive services in the facility with reasonable
accommodations of individual needs and preferences, except when the health or safety of
the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on review of the facility's patient rights booklet, review of the resident council minutes,
medical record review, observation and interview, it was determined the facility failed to attempt to
accommodate the needs of 1 of 15 (Resident #34) sampled residents interviewed during the
stage 1 review and for Resident #50, the vice president of the resident council.

The findings included:

1. Review of the facility's patient rights booklet documented, "...This center attempts to
Continued From page 8

F 246 accommodate the needs of all of its patients as comfortable as possible... Every effort will be made to accommodate your preferences and requests..."

2. Review of the September 2013 resident council meeting minutes documented, "...A few of the members discussed and agreed that there needs to be another bathroom on 300 hall because they have to wait for others to come out of the one bathroom on the hall...."

Review of the October 2013 resident council meeting minutes documented, "...Unresolved concerns from September: Patients state that they wish to have more bathrooms on 300 Hall...."

Review of the November 2013 resident council meeting minutes documented, "...[Named Resident #34] states that "Everyone uses that bathroom and sometimes it is hard to get in there [300 hall bathroom] when I need to go...."

3. Medical record review for Resident #34 documented an admission date of 12/15/12 with diagnoses of Personal History of Fall, Aftercare Hip Joint Replacement, Lack of coordination, Difficulty Walking, Stiffness of Hip Joint, Long-term Use of Aspirin, Peripheral Neuropathy, Lumbosacral Neuritis, and History of Malignant Neoplasm of Ovary. Review of the Minimum Data Set (MDS) dated 9/25/13 documented in Section C, Cognitive Status, a cognitive score of 15 out of a possible 15 indicating the resident was cognitively intact and in Section G, Functional Status, the resident required extensive assistance by facility staff for transferring, ambulation, dressing, toilet use and bathing.
Continued From page 9

Observations on the 300 hall on 11/18/13 at 12:45 PM, revealed Resident #34 sitting in a wheelchair and staff assisting her into the 300 hall common restroom.

Observations in Resident #34's room on 11/19/13 at 8:28 AM, revealed Resident #34 was out of the room. A facility staff member stated the resident was washing up in the 300 hall common restroom.

During an interview in Resident #34's room on 11/19/13 at 9:58 AM, Resident #34 was asked to participate in an individual interview concerning the kind of care she received at the facility. Resident #34 stated she would, but the only complaint she had was, "...We have to stand in line for the bathroom [300 hall common restroom]. Men and women both have to use it. We need another bathroom..." Resident #34 was asked if she attended resident council meetings or if she had mentioned her complaint to anyone. Resident #34 stated, "...At resident council, I put it down every time I go down to that..." Resident #34 was then asked if anyone from the facility and gotten back in touch with her concerning her complaint. Resident #34 stated, "They never have said a word about it, what they are gonna do..."

During an interview in Resident #34's room on 11/20/13 at 3:30 PM, Resident #34 was asked if she was having problems getting into the 300 hall restroom today. Resident #34 stated, "...I had to wait today for the bathroom after lunch. It is an ongoing problem waiting for the bathroom..."

During an interview in the recreation office on 11/21/13 at 9:40 AM, the Recreation Coordinator,
Continued From page 10

who assists residents during resident council meetings, was asked if Resident #34 had voiced a grievance related to the 300 hall common restroom. The Recreation Coordinator stated during the September 2013 resident council meeting concerns had been voiced by Resident #34 that another resident was taking a long time in the restroom in the mornings to get ready. The idea was mentioned of working on the ladies' routines and one of them get up early, the other later. In the meeting both said that would be okay. The grievance was discussed at the "Department - head meeting" in September, 2013 at which the Administrator and all the Department Heads would be present. Nursing mentioned working on the ladies' routines and possibly taking residents to the 200 hall bathroom.

During an interview in Resident #34's room on 11/21/13 at 1:00 PM, Resident #34 was asked if she was getting up earlier in the mornings to be able to use the restroom on the 300 hall. Resident #34 stated,...I get up early every morning..." Resident #34 continued,"...That is my only complaint, having to wait for the restroom. I have kidney problems and get infections easily, I have to empty my bladder... drink a lot of water. It's hard on the girls [certified nursing assistants (CNAs)], but I have to do it. I'm not complaining just for me but for everybody... They've taken me up to the other restrooms up front. It takes two to help me get up and there is not room in those restrooms for two to help..."

4. Medical record review for Resident #50 documented an admission date of 8/31/09 with diagnoses of Status Post Cerebrovascular Accident with Left Hemiparesis, Dementia, Subdural Hematoma, Diabetes Mellitus,
F 246 Continued From page 11

Hypertension, Asthma, Gait Disturbance, Seizures, Degenerative Joint Disease Lumbar Spine, Lumbar Stenosis, Diverticulosis, Osteopenia, Depression and Urge Incontinence and Ataxia. Review of the MDS dated 9/23/13 documented in Section C, Cognitive Status, a cognitive score of 9 out of possible 15 indicating the resident was moderately impaired and in Section G, Functional Status, the resident required extensive assistance by staff for transferring, ambulation, dressing and toilet use. Review of the "Monthly Nursing Summary Report" dated 11/9/13 documented, "Mental Status: Awake, Alert, Oriented..."

During an interview in Resident #50's room on 11/20/13 at 3:40 PM, Resident #50 was asked about any grievances discussed in the patient council meetings. Resident #50 stated, "...we do need another bathroom on this floor because the men started using it too and makes it very inconvenient..."

5. During an interview on the 300 hall on 11/21/13 at 9:55 AM, CNA #1 and CNA #2 were asked which residents used the 300 hall common restroom and were they having to wait to go the restroom. The CNAs named 5 residents that regularly use the 300 hall restroom and sometimes 1 or 2 other residents. CNA #1 stated, "...It gets backed up right after lunch with 2 to 3 waiting..."

During an interview on the 300 hall on 11/21/13 beginning at 10:15 AM, the Administrator was asked if he was aware of a grievance from a resident concerning the need for another restroom for the residents on the 300 hall. The Administrator stated, "...That has not been
Continued From page 12
brought to me that I can remember... I will find out..." A short time later the Administrator returned to the 300 hall and stated, "...Sounds like preference, someone in there longer than someone else wants... Encourage staff to take to other halls..." The Administrator was informed grievances concerning the restroom and the waiting involved were again voiced during the October and November, 2013 resident council meetings. The Administrator stated,"...Don't want to drop the ball...

F 253: The Center will comply with 483.15(h)(2) to maintain a sanitary, orderly, and comfortable interior.

Maintenance Supervisor changed the scal under the toilet to minimize any odor.

Staff will be in-serviced on 12/17/13 regarding the proper procedures to follow when an odor is present.

The Housekeeping Supervisor will conduct a QA to document as compliant or non-compliant with F 253 regulations. Monitoring will be performed weekly X 4 and then monthly X 2 until no trending is noted. Observations will be presented to the Quality Assurance Committee.
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<tbody>
<tr>
<td>F 253</td>
<td>Continued From page 13 has been like that the last couple of days. We've had housekeeping clean the room.</td>
<td>F 253</td>
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<td>During an interview in the 300 hall common restroom on 11/21/13 at 10:20 AM, the Administrator confirmed there was a lingering urine odor in the restroom and stated housekeeping would be called down to the restroom to clean it.</td>
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<tr>
<td>F 278</td>
<td>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
<td>F 278: The Center will comply with 483.20(g)-(j) to ensure that the Resident’s assessment accurately reflects the resident’s status.</td>
<td>12/21/13</td>
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<tr>
<td>SS=D</td>
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<td>Resident # 25’s MDS dated 7/7/13 has been corrected to reflect the psychological therapy received on 7/3/13.</td>
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<td>The assessment must accurately reflect the resident's status.</td>
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<td>All resident’s with psychological therapy will be reviewed to assure the MDS reflects psychological services if applicable.</td>
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<td>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
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<td>Director of Nurses met with the MDS coordinator to assure the residents with psychological services have their MDS coded correctly.</td>
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<td>A registered nurse must sign and certify that the assessment is completed.</td>
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<td>The Director of Social Services will conduct a QA weekly x 4 or until no trending noted to assure that resident’s with psychological services have their MDS coded correctly to reflect services received.</td>
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<td>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</td>
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<td>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.</td>
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<td>Clinical disagreement does not constitute a</td>
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<tr>
<td>F 278</td>
<td>Continued From page 14 material and false statement.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess psychological services for 1 of 30 (Resident #25) sampled residents of the 33 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #25 documented an admission date of 11/12/12 and a readmission date of 6/21/13 with diagnoses of Psychosis, Pneumonia, Diabetes Mellitus, Cardiovascular Accident, Hemiplegia, Depression, Abnormal Involuntary Movements, Seizure Disorder, Microvascular Ischemia, Hyperlipidemia, Hypertension, Acute Renal Failure, Hypothyroidism, Contractures Upper and Lower Extremities and Left Above - the - Knee Amputation. Review of a mental health progress note dated 7/3/13 documented, "...Continue supportive psychotherapy to help alleviate symptoms of depression... changes to treatment plan... no." Review of the quarterly minimum data set (MDS) dated 7/7/13 documented in Section O Special Treatments and Programs, that Resident #25 had not received psychological therapy in the last 7 days.

During an interview at the 300 hall nurses station on 11/21/13 at 5:55 PM, Nurse #1 and the Assistant Director of Nursing (ADON) were asked if Resident #25 was receiving psychological services. The ADON and Nurse #1, both confirmed the resident had a history of behaviors...
F 278: The Center will assure a comprehensive plan of care is developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

Patient #50's plan of care has been updated to include insomnia as a problem. All patients with a diagnosis of insomnia plan of care have been reviewed to assure that insomnia was addressed on the plan of care.

The Director of Nurses met with the MDS Coordinator regarding the need for a problem of insomnia to be added in the plan of care of all patients with a diagnosis of insomnia.

All Licensed Nurses will be in-serviced regarding the need to add insomnia to the plan of care if a new diagnosis of insomnia is added.

The Director of Nurses or designee will perform QA to assure that insomnia is added to the plan of care weekly x 4 or until no trending is noted. Results of the QA will be presented to the Center's Quality Assurance Committee.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to develop a care plan for insomnia for 1 of 5 (Resident #50) sampled residents reviewed for unnecessary medications, of the 30 care plans reviewed, of the 33 residents included in the stage 2 review.

F 278: Continued From page 15
and had received psychological services. Nurse #1 stated, "...Had Psych [psychiatric] Services, it's documented on the chart for...7/3/13..."

F 279: DEVELOP

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to develop a care plan for insomnia for 1 of 5 (Resident #50) sampled residents reviewed for unnecessary medications, of the 30 care plans reviewed, of the 33 residents included in the stage 2 review.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 279</td>
<td>Continued From page 16</td>
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<td>The findings included:</td>
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<td>Review of the facility's &quot;Care Plan Development&quot; policy documented, &quot;...The center will ensure an interdisciplinary and comprehensive approach to the development of the patient's plan of care...&quot;</td>
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<td>Medical record review for Resident #50 documented an admission date of 8/31/09 with diagnoses of Diabetes Type II, Hypertension, Asthma, Seizures, Dementia, Insomnia and Depression. Insomnia was not included as a problem on the care plan dated 10/7/13.</td>
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<td>During an interview in the Minimum Data Set (MDS) office on 11/21/13 at 5:40 PM, the MDS Coordinator was asked why the care plan did not address Resident #50's insomnia. The MDS Coordinator stated, &quot;...I know it's not on this care plan... I usually do... I didn't on this one... If I don't have it on here, I don't have it on here...&quot;</td>
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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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<td>F 280</td>
<td>The resident has the right, unless adjudged incompetent or found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</td>
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| F 280 | 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
F 280 Continued From page 17
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 ensure the resident or representative participated in care planning for 1 of 30 (Resident #78) sampled residents and failed to revise the care plan to include a decline in continence level and/or an increase in falls for 2 of 30 (Residents #65 and 110) sampled residents with care plans reviewed of the 33 residents included in the stage 2 review.

The findings included:
1. Medical record review for Resident #78 documented an admission date of 7/9/13 with diagnoses of Benign Hypertension, Vitamin D Deficiency, Osteoporosis, History of Parathyroid Cancer, Muscular Weakness and Unspecified Dementia without Behavior. Review of the resident's durable power of attorney (POA) for health care documented Resident #78's grandson was appointed, "...as my Attorney-in-fact (my "Agent") to make health care and other decisions for me as authorized in this document...", and was signed by Resident #78 on 4/4/13.

Review of a "Patient Care Plan Approval Form" documented the stamped name, medical record number, admission date and room number of Resident #78. This form revealed spaces for the

Resident 110's plan of care was reviewed to assure the interventions on the plan of care are appropriate.

All residents with a fall, their plan of care will be reviewed to assure that immediate and appropriate interventions were put into place following the fall.

All residents with incontinence, plan of care will be reviewed to assure the plan of care accurately reflects their continence status.

All resident's medical record will be reviewed to assure that the resident or resident's family has participated in the development or review of the plan of care.

The Director of Nurses will conduct an In-service for all licensed nurses on updating the plan of care with a new intervention following a fall.

The Director of Nurses will in-service the restorative nurses regarding the updating of the plan of care when a resident's continence status changes and prompt voiding programs are discontinued.

The Director of Nurses met with the MDS Coordinator regarding the participation of the patient in care plan meetings. The patient is to be involved in the meeting unless the patient has been adjudged incompetent or found to be incapacitated or refuses to participate in the development and review of the care plan.
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<th>F 280</th>
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<td>date of the care plan meeting, name of the staff member who reviewed care plan, name of the resident, name of the resident's legal representative and the date signed. All these spaces on the form were left blank.</td>
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<td>During an interview in Resident #78's room on 11/18/13 at 1:50 PM, Resident #78 was asked if the facility staff involved the resident in decisions about daily care. Resident #78 stated, &quot;No.&quot;</td>
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<td>During an interview in the conference room on 11/21/13 at 9:27 AM, the Minimum Data Set (MDS) Coordinator verified Resident #78's grandson was documented as the resident's POA. The MDS Coordinator verified there was no documentation the resident's plan of care was addressed with the resident or her POA.</td>
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<td>2. Medical record review for Resident #85 documented the resident was admitted to the facility 7/24/13 with diagnoses including Severe Back Pain, Urinary Tract Infection, Aftercare following Compression Fracture Thoracic (T) 10, T12, Lumbar (L) 2, L3, History of Fall, Rheumatoid Arthritis (RA), Spondylitis, Vitamin B Deficiency, Degenerative Disc Disease, Delusional Disorder, Osteoporosis, Depression, Iron Deficiency Anemia, Hypokalemia, Difficulty Walking and Dysphagia. Review of the admission MDS dated 7/31/13 documented in Section G Functional Status the resident was always continent of bowel and bladder. Review of the MDS dated 9/19/13 documented the resident was frequently incontinent and was on a bowel and bladder toileting program. Review of the MDS dated 10/25/13 documented the resident was always incontinent of bowel and bladder and was no longer on a toileting program.</td>
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F 280

Review of the nurse's notes documented Resident #85 was incontinent of bowel and bladder on 10/17/13, 10/20/13, 10/21/13, 10/23/13, 10/28/13, 10/27/13, 10/26/13 and 10/30/13.

Review of the care plan dated 11/8/13 documented, "ADL's [Activities of Daily Living] dependent on staff... assist with hygiene needs as occ [occasionally] incontinent of bowel and encourage pt of ask for assistance to bathroom..."

During an interview in the conference room on 11/21/13 at 2:25 PM, the Assistant Director of Nursing (ADON) was asked if Resident #85 had experienced a change in her continence level. The ADON stated Resident #85 has, "...experienced a general decline as well as her diagnosis of RA, does not like to get out of bed... will occasionally ask for bedpan but doesn't realize she has already flooded the bed."

There was no documentation the care plan had been updated to address Resident #85's decline in continence of bowel and bladder.

3. Medical record review for Resident #110 documented the resident was admitted to the facility 4/29/12 with diagnoses of History of fall, Diabetes Mellitus, Hypertension, Macular Degeneration, Anemia, Urinary Retention, Osteoarthritis of Knees, Urethral Stricture, Dementia, Hospice Care, Constipation, Urinary Incontinence, Vitamin D Deficiency and Calcium Deficiency. Review of the care plan dated 1/23/13 documented, "Fall risk, potential for injury r/t [related to] unsteady gait, cognitive deficits."

(continued from pg. 18)

A QA will be performed by the DON or designee to assure resident's, resident's family or resident's legal representative are participating in the planning of care and that the plan of care is revised with the resident's incontinence status changes and new interventions are added after each fall weekly x 4 or until no trending is noted. Observations will be presented to the Center's Quality Assurance Committee.
F 280 Continued From page 20

weakness, impaired safety awareness AEB [as evidenced by] l/o [history of] falls...


A "Post Falls Nursing Assessment" dated 5/26/13 documented, "CNA's [certified nursing assistants] were starting round and found pt in [on] the floor on the fall mat on door side of bed... Fell out of bed... Safety devices in use: Low bed, alarm, fall mat... Intervention initiated: Bed alarm." No injury occurred. A "Post Falls Nursing Assessment" dated 9/13/13 documented, "...Nurse entered room to administer meds to pt and found pt lying on fall mat on pt's right side with pt's head at the foot of the bed... Fell from bed... Safety devices in use: Low bed, alarm, fall mat... What immediate interventions were initiated to prevent future falls?... Bed alarm..." No injury occurred.

Review of the nurse's notes dated 4/25/13, 5/5/13, 5/28/13, 6/1/13, 6/2/13 and 8/5/13 documented, "...fall precautions in place..."

During an interview in the Director of Nursing's (DON) office on 11/21/13 at 2:13 PM, the DON was asked, "What does fall precautions mean?" The DON stated, "It is the interventions on the care plan that should be in place."

There was no evidence Resident #110's care plan was updated with new interventions to help prevent future falls following the falls occurring on 5/26/13 and 9/13/13. The bed alarm documented as "initiated" was already in place as of 1/23/13.
**F 314: TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

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

- Based on policy review, closed medical record review and interview, it was determined the facility failed to ensure physician's orders were obtained for a treatment provided for 1 of 2 (Resident #76) sampled residents reviewed of the 2 residents with pressure ulcers.

The findings included:

- Review of the facility's "PRESSURE ULCER MANAGEMENT" policy documented, "...Physician receives accurate assessment data to assure that orders are appropriate to the stage and condition of the pressure ulcer... Notify timely for new orders... pertinent pressure ulcer information to include... Physician contact and specific orders obtained..."

Medical record review for Resident #76 documented and admission date of 9/5/13 and a discharge date of 9/19/13 with diagnoses of Congestive Heart Failure, Coronary Artery Disease, Chest Pain, Systemic Hypertension, Bradycardia, Long-Term Aspirin Use, Diabetes,
### Summary Statement of Deficiencies

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<th>Description</th>
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| F 314 | Continued From page 22
  Gastroparesis, Gastritis, Abdominal Pain, Thyroid Disease, Chronic Renal Impairment, Benign Prostatic Hypertrophy, Lack of Coordination, Difficulty in Walking, Depression and Gouty Arthritis. Review of the "Admission Nursing Assessment Report" dated 9/5/13 documented a stage II pressure ulcer 2.5 by 1 to the left buttock. Review of the weekly skin assessment progress note dated 9/5/13 documented, "...Stage II 2.5 x 1 cm [centimeter] on L [left] Buttock."
  Review of the weekly wound assessment records documented the following:
  a. 9/11/13 - "...Stage II 2.5 x 1.0... Stage II on L [left] buttock, wound red granulation tissue, moist c [with] no drainage..."
  b. 9/18/13 - "...Stage II 2.4 x 1.0...Stage II Lt buttock red & [and] moist. O [no] drainage noted..."
  Review of the medication and treatment administration record report dated September 2013 documented, "LEFT BUTTOCK APPLY LANTISEPTIC TWICE DAILY... LEFT BUTTOCK STAGE II APPLY LANTISEPTIC TWICE DAILY." There was no physician's order documented for treatment of the stage II pressure ulcer on the left buttock.
  During an interview at the 100 hall nurses' station on 11/20/13 at 10:37 AM, Nurse #3 was asked if there were any orders for wound care for Resident #76's stage II pressure ulcer on the left buttock. Nurse #3 stated, "...You're correct... I don't see any [physician orders] either..." Nurse #3 was asked why there were no orders for treatment of the pressure ulcer. Nurse #3 stated, "Not sure... I would think we should have orders..." |
F 314: Continued From page 23 for a stage 2...

During an interview in the conference room on 11/20/13 at 11:35 AM, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), were asked for standing orders for treatments and about the treatment of a Stage II pressure ulcer without a physician's order. The DON stated, "...we don't have standing orders for Lantiseptic..." The DON and ADON were asked if there is a treatment being provided for an open wound or pressure ulcer, should the physician be notified and made aware of the treatment plan. The DON and ADON confirmed the physician should be aware of treatments on wounds and pressure ulcers. The ADON stated, "...there should be a doctor's order for treatments..."

F 319: The Center will ensure that a resident who displays mental or psychosocial adjustment difficulties receive appropriate treatment and services to correct the assessed problem.

Resident #25 was seen by psych services on 12/5/13.

All residents with an order for psych services will be reviewed to assure that they have received psychological services as ordered by the physician.

The Director of Social Services will perform a QA weekly X 4 or until no trends noted on all residents with orders for psych services to ensure they received psychological services as ordered. Observations will be presented to the Center’s Quality Assurance Committee.
Continued From page 24

Medical record review for Resident #25 revealed an admission date of 11/12/12, and a readmission date of 6/21/13 with diagnoses of Psychosis, Pneumonia, Diabetes Mellitus, Cardiovascular Accident, Hemiplegia, Depression, Abnormal Involuntary Movements, Leukocytosis, Microvascular Ischemia, Hyperlipidemia, Hypertension, Seizure Disorder, Hypothyroidism, Contractures Upper and Lower Extremities, Left Above-the-Knee Amputation and Acute Renal Failure. Review of the current physician's orders dated 11/2/13 documented, "...Psych [Psychological] Services to treat..." with a beginning date of 6/21/13. Review of the psychiatric section of the medical record documented mental health visits on 7/3/13 and 7/17/13.

During an interview at the 300 hall nurses' station on 11/21/13 at 5:55 PM, Nurse #1 and the Assistant Director of Nursing (ADON) were asked if Resident #25 was receiving psychiatric services. Nurse #1 stated, "...Had Psych [psychiatric] services, it's documented on the chart for 7/17/13 and 7/3/13..." The ADON stated, "...I don't see anything after this [psychiatric visit on 7/17/13] in July..."

F 329: The Center will ensure each Resident's drug regimen is free from Unnecessary drugs.

The pharmacy consultant has reviewed Resident # 50 medications and has made recommendation to the resident's physician regarding the need for Trazadone.

The Director of Nurses met with the Pharmacy Consultant regarding dose reductions and the documentation required if there is indication the med does not need to be reduced.
F 329 Continued From page 25 combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

- Based on policy review, medical record review, pharmacy review and interview, it was determined the facility failed to ensure each resident was free of unnecessary medication (med) usage for 1 of 5 (Resident #50) residents reviewed for unnecessary meds of the 33 residents included in the stage 2 review.

The findings included:

- Review of the facility's "POLICIES AND PROCEDURES - Pharmacy Services for Nursing Facilities" policy documented, "Consultant Pharmacist Reports... Monthly Reports... Procedures... B. The consultant pharmacist reviews the medication regimen of each resident at least monthly... Documentation... indicating progress toward or maintenance of goals of therapy... The prescribed dose is appropriate to
F 329 Continued From page 26
the resident's clinical status... The duration of therapy is indicated and is appropriate for the resident... Medical condition and response to drug therapy are evaluated to assure the appropriateness of the medication regimen... If no irregularities are found, consultant pharmacist also documents this in the resident's active record and signs and dates such documentation..."

Medical record review for Resident #50 documented an admission date of 8/31/09 with diagnoses of Diabetes Type II, Hypertension, Asthma, Seizures, Dementia, Insomnia and Depression.

Review of the "Clinical Pharmacy Review" dated 5/8/12 and a physician's order dated 5/8/12 documented Resident #50's Trazodone dosage was decreased from 50 mg to 25 mg on 5/8/12. Review of the current physician's orders dated 11/1/13 documented, "...TRAZODONE 50 MG [milligram] TAB [tablet]... one-half (1/2)... AT BEDTIME..."

Review of the Minimum Data Set (MDS) dated 9/23/13 documented in Section D, an interview was conducted with Resident #50 during which the resident indicated she was having no symptoms related to depression.

During an interview in the conference room on 11/21/13 at 6:40 PM, regarding the reduction of Trazodone for Resident #50, the Assistant Director of Nursing stated, "...5/8/12 was the only reduction... 25 mg was what it was... It hasn't been reduced since..."
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<td>Continued From page 27 PM, the facility's Consultant Pharmacist verified there had been no further dose reduction for Trazadone since 5/8/12.</td>
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<td>F 364</td>
<td>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on review of a dietary recipe, review of a test tray, medical record review, observation and interview, it was determined the facility failed to ensure food was served that was palatable and at the proper temperature for 5 of 11 Residents 24, 71, 81, 96 and 97 sampled residents of the 11 residents interviewed during the stage 1 review. On 11/20/13 thirty-one (31) of 89 residents were potentially affected by food served at the improper temperature. The findings included: 1. Medical record review for Resident #24 documented an admission date of 9/6/13 with diagnoses of Chronic Hypoxia, Oxygen Dependent, Hypertension, Cardiomegaly, Pressure Ulcer Bilateral Buttocks and Urinary Incontinence. The Minimum Data Set (MDS) dated 9/10/13 documented a cognitive status score of 13 of 15 indicating the resident was cognitively intact.</td>
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<td>F 364</td>
<td>483.35(d)(1)-(2) The Center will provide food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.</td>
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| F 364 | The Center will provide food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature. |
| 12/21/13 | 483.35(d)(1)-(2) |
| The Dietary Manager will ensure all foods are held at the proper temperature. Dietary Manager will in-service all dietary partners regarding correct hot food temperatures for tray line service. R.D. will conduct in-room meal rounds during meals to ensure patients are receiving hot foods based on patient preference, palatability and preferred temperature weekly x 4 or until no trends noted regarding proper temperatures. Dietary Manager will monitor tray line and perform a QA weekly X 4 or until no trends noted on tray line temps below the required temperature. Observations will be presented to the Center's Quality Assurance Committee. |
F 364

Continued From page 28

During an interview in Resident #24's room on 11/18/13 at 3:49 PM, Resident #24 was asked if food was served at the proper temperature. Resident #24 stated, "...Mine is always cold...I haven't had a warm meal since I been here..."

2. Medical record review for Resident #71 documented and admission date of 5/24/10 with diagnoses of Bilateral Pulmonary Emboli, Hypertension, Anxiety, Renal Failure, Diabetes and Osteoarthritis. The MDS dated 10/3/13 documented a cognitive status score of 13 of 15 indicating the resident was cognitively intact.

During an interview in Resident #71's room on 11/19/13 at 10:16 AM, Resident #71 was asked if food was served at the proper temperature. Resident #71 stated, "...[food] cold, and [staff] don't offer to warm it up..."

3. Medical record review for Resident #81 documented an admission date of 7/17/12 with diagnoses of Chronic Kidney Disease, Atrial Fibrillation, Iron Deficiency Anemia, Anxiety, Depression, Hypertension and Osteoporosis. Review of the MDS dated 9/27/13 documented a cognitive status score of 15 of 15 indicating the resident was cognitively intact.

During an interview in Resident #81's room on 11/19/13 at 9:47 AM, Resident #89 was asked if food was served at the proper temperature. Resident #81 stated, "...[food is] cold..."

4. Medical record review for Resident #95 documented an admission date of 12/21/11 with diagnoses of Hypertension, Esophageal Reflux, Pressure ulcer, Anxiety, Osteoporosis and Old Fracture Lumbar (L-1 and L-4). Review of the
F 364  Continued From page 29
MDS dated 9/5/13 documented a cognitive status score of 11 of 15 indicating the resident was cognitively intact.

During an interview in Resident #95’s room on 11/18/13 at 4:20 PM, Resident #95 was asked if food was served at the proper temperature. Resident #95 stated, "...Sometimes it's [food] cold...

5. Medical record review for Resident #97 documented and admission date of 7/26/12 with diagnoses Seizures New Onset Unknown Cause, Hypertension, Hyperlipidemia and Chronic Radicular Pain. Review of the MDS dated 10/10/12 documented a cognitive status score of 12 of 15 indicating the resident was cognitively intact.

During an interview in Resident #97’s room on 11/18/13 at 3:37 PM, Resident #97 was asked if food was served at the proper temperature. Resident #97 stated, "...the vegetables, some are cold..."

6. Review of the facility’s “Spiced Curried Fruit” recipe documented, “Mix fruit... Place over medium heat and boil for 5 minutes... Bake uncovered in preheated 350 F [Fahrenheit] over for 1 hour...”

Observations in the dietary department on 11/20/13 at 11:30 AM, revealed the tray line temperature of the curried fruit was 126 degrees, 9 degrees below the acceptable temperature for a hot food.

Observations of the temperature and palatability test tray on the 300 hall on 11/20/13 at 12:30 PM,
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<td>F 364</td>
<td>Continued From page 30 revealed the curried fruit which was considered a hot food was served at 71 degrees F.</td>
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<td>F 371</td>
<td>Dictory Manager will ensure food is prepared under sanitary conditions by ensuring carbon is removed from pans, oven mitt are not on the floor, any broken windows are repaired, return vent is free from dust, and walls are without stuff and gouges. Chemical bucket will be free of white substance on top of container.</td>
<td>12/21/13</td>
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This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure that food was prepared under sanitary conditions as evidenced by staff entering the kitchen, staff not washing their hands, staff not wearing hair restraints to effectively keep their hair from potential contaminating the food, carbon on pots and pans, an oven mitt on the floor, a broken window pane, dust in the return vent above a prep table, scuffed and gouged wall, while material on top of a bucket under the 3 compartment sink and hot food served and delivered below the proper temperature during 3 of 3 (11/18/13, 11/19/13 and 11/20/13) days of kitchen observations.
The findings included:

1. Observations during the initial tour of the kitchen on 11/18/13 beginning at 10:51 AM revealed:
   a. Three pots with carbon on the bottoms and sides.
   b. White material on a bucket of "Strike Force" cleaner under the drain board area of the 3 compartment sink.
   c. Scruffed and gouged indentations in the wall next to the dish machine room.

During an interview in the Dietician's office on 11/21/13 at 3:10 PM, the Dietary Manager (DM) was asked what she expected concerning the wall scuffs and gouges and carbon on the pots and pans. The DM stated, the wall should be "...clean, painted, filled in and fixed... [the pots and pans]... to be carbon free...

3. Review of the facility's "Handwashing" policy documented, "...The basic practice of hand washing is the single most important action that can be taken to prevent the spread of disease... GUIDELINES: 1. Hands should be washed... after touching money; after leaving and returning to a food preparation area... after touching anything that might contaminate hands..."

Observation in the kitchen on 11/19/13 beginning at 7:35 AM revealed:
   a. Laundry employee #4 entered the kitchen and got coffee at the coffee/tea table located in front of the steam table, without washing her hands upon entering the kitchen.
   b. "Strike Force" bucket of cleaner with white substance on the top under the drain board area

(continued from pg. 31)

Dietary Manager will ensure dietary partners will handle food under sanitary conditions by in-servicing dietary partners on proper storage of cleaning equipment, cleaning of pots with carbon, and on proper food storage per our food storage policy. Dietary Manager will monitor proper storage and cleaning procedures weekly x 4 and then until no trends are noted. Observations will be presented to the Center's Quality Assurance Committee.

The Dietary Manager will ensure hot foods are held at proper temperature. The Dietary Manager will in-service all dietary partners regarding correct hot food temperatures for tray line service.

The Center will store, prepare, distribute and serve food under sanitary conditions as outlined in the NHC Policy and Procedure for hair restraints which is in compliance with the 2009 Food Code 2-402.11 as required by the Tennessee Department of Health, Division of Health Care Facilities Standards for Nursing Home Chapter 1200-08-06-.06.

Certified Dietary Manager will conduct in-service training with all dietary staff regarding policy and procedure related to hair restraints.

Dietary staff will ensure all staff entering the kitchen production area will be required to don hair restraints as required by the 2009 Food Code 2-402.11.
**Summary Statement of Deficiencies**

- **(c)** Laundry employee #2 entered the kitchen, ordered her breakfast and dropped her money in a bowl kept on top of the steam table which was used to collect money from staff and visitors who entered the kitchen area.
- **(d)** Laundry employee #1 returned to the kitchen and got more breakfast, without washing her hands upon entering the kitchen.
- **(e)** Certified Nursing Assistant (CNA) #3 entered the kitchen and got coffee for a resident without washing hands upon entering the kitchen.
- **(f)** Housekeeping Supervisor entered the kitchen and got a cup of coffee without washing hands upon entering the kitchen.

During an interview outside the dietary department on 11/18/13 at 11:58 AM, the DM was asked about a partner coming into the kitchen. The DM stated, "...They come in to get something to eat... They come in with their hair nets on..."

4. Review of the facility's "Personal Hygiene" policy documented, "...Partners must have an understanding of safety and sanitation guidelines and put into practice those guidelines in order to provide a safe product... GUIDELINES: 3... Dietary partners shall wear hair restraints such as hats, hair coverings, or nets... designed and worn to effectively keep their hair from contacting exposed food...

Observations in the kitchen on 11/20/13 beginning at 8:03 AM revealed:

- **(a)** A health information management staff member had 4 to 5 inches of hair hanging out of her hair net getting a biscuit sandwich for breakfast.

(continued from pg. 32)

Weekly, the Registered Dietitian will monitor the appropriate use of hair restraints.

QA log will be compiled to document as compliant or non-compliant with F 371 regulations. Monitoring will be performed weekly X 4 and then monthly X 2 until no trending is noted. Observations will be presented to the Center's Quality Assurance Committee.
F 371 Continued From page 33

b. The dietician had approximately an inch of hair hanging out of her hair net getting tea for herself while standing in front of the steam table of food.
c. Carbon build-up on 5 cake pans resting on the rack by the wall in front of a dish machine room.

During an interview in the Dietician's office on 11/21/13 at 3:10 PM, the DM was asked what she expected concerning the carbon on pots and pans. The DM stated, "... [the pots and pans]... to be carbon free..."

5. Review of the facility's "Handwashing" policy documented, "...The basic practice of hand washing is the single most important action that can be taken to prevent the spread of disease... GUIDELINES: 1. Hands should be washed... after... sneezing, coughing..."

Review of the facility's "Standard Precautions" policy documented, "...There are three new elements of Standard Precautions which focus on protection of patients. They include: Respiratory Hygiene/Cough Etiquette... one of the new components of standard precautions, targets patients, family members, and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion... 2. Elements of Respiratory Hygiene/Cough Etiquette include: a. Education of healthcare staff, patients, and visitors b. Posting signs, in language appropriate to the population being served. c. Source control measures (...covering the mouth/nose with a tissue when coughing and proper disposal of used tissues, using surgical masks on the coughing person...) d. Hand hygiene after contact with respiratory secretions e. Spatial separation, ideally > [greater than] 3 feet, of persons with..."
| F 371 | Continued From page 34
|       | respiratory infections in common waiting areas when possible...
|       | Observations in the kitchen during review of the
|       | tray line temperatures on 11/20/13 beginning at
|       | 11:30 AM revealed:
|       | a. A visitor entered the kitchen, used her right
|       | hand to cover her mouth as she coughed, then
|       | placed her right hand on the tea/coffee counter
|       | without washing her hands.
|       | b. An oven mitt was on the floor under the drain
|       | area by 3 compartment sink.
|       | c. A "Strike Force" floor cleaner bucket with white
|       | material on the top was under the drain area.
|       | d. A dietary staff member picked up a small mop
|       | cleaning utensil laying on the clean pan rack and
|       | placed it on the window sill which was dusty.
|       | e. Tomato soup, chicken noodle soup and 3 cups
|       | of chicken broth were sitting on the drying rack
|       | beside the 3 compartment sink used for storage
|       | of clean pans.
|       | f. A window by the hand washing sink was
|       | cracked from the top of the pane to bottom of the
|       | pane.
|       | g. Dust in the return air vent located above the
|       | food prep table. The table had a pan with graham
|       | crackers sitting on it.
|       | During an interview in the kitchen on 11/20/13 at
|       | 11:50 AM, the DM was asked how the dish mop
|       | was used. The DM stated, "It [mop] is used for
|       | coffee pot cleaning. It usually is laid in window
|       | sill."
|       | During an interview in the Dietician’s office on
|       | 11/21/13 at 3:10 PM, the DM was asked what she
|       | expected concerning the dirty vent and broken
|       | window pain. The DM stated, "...[the vent]... to be
|       | kept clean... [the broken window pane]... would
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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| F 371 | | Continued From page 35 expect the broken window to be replaced..."

6. Review of the facility's "Safety & [and] Sanitation Best Practice Guidelines" policy documented, "TEMPERATURE CONTROL... Vegetables & Fruits... Vegetables and fruits that are cooked and held for service must be held at 135 [symbol for degrees] F [Fahrenheit]..."

Observations in the kitchen during review of the tray line temperatures on 11/20/13 beginning at 11:30 AM, revealed the curried fruit was 126 degrees F.

Observations on the 300 hall during test tray evaluation on 11/20/13 at 12:30 PM, revealed the curried fruit was 76 degrees F.

During an interview on the 300 hall on 11/21/13 at 12:30 PM, the DM verified the curried fruit was cold.

During an interview in the conference room on 11/21/13 at 12:58 PM, when asked if the curried fruit was a hot food. The Dietary Manager stated, "Yes."

During an interview in the Dietician's office on 11/21/13 at 3:10 PM, the DM was asked what she would expect the curried fruit to be on the trayline and test tray. The DM confirmed the trayline temperature of the curried fruit and the curried fruit on the regular diet lunch test tray were not at the proper temperature.

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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 428</td>
<td></td>
<td>483.50(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</td>
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The drug regimen of each resident must be
F 428: Continued From page 36
reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to
the attending physician, and the director of
nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review,
pharmacy review and interview, it was determined
the pharmacist failed to identify and report
antipsychotic medication use for 1 of 5 (Resident
#50) sampled residents reviewed for unnecessary
medications of the 33 residents included in the
stage 2 review.

The finding included:

Review of the facility's "POLICIES AND
PROCEDURES - Pharmacy Services for Nursing
Facilities" policy documented, "Consultant
Pharmacist Reports... Monthly Reports...
Procedures... B. The consultant pharmacist
reviews the medication regimen of each resident
at least monthly... Documentation... indicating
progress toward or maintenance of goals of
therapy... The prescribed dose is appropriate to
the resident's clinical status... The duration of
therapy is indicated and is appropriate for the
resident... Medical condition and response to
drug therapy are evaluated to assure the
appropriateness of the medication regimen... If no
irregularities are found, consultant pharmacist
also documents this in the resident's active
## F 428

Continued From page 37

record and signs and dates such documentation..."

Review of the facility's "CONSULTANT PHARMACIST REPORTS" policy documented, 
"...The consultant pharmacist identifies irregularities through a variety of sources... The consultant pharmacist's evaluation includes... The duration of therapy is indicated and is appropriate for the resident... When possible, non-pharmacologic interventions are considered before initiating a new medication... Medical condition and response to drug therapy are evaluated to assure the appropriateness of the medication regimen... If no irregularities are found, consultant pharmacist also documents this in the resident's active record and signs and dates such documentation..."

Medical record review for Resident #50 documented an admission date of 8/31/09 with diagnoses of History of Lumbar (L) 2 Compression Fracture Lumbar Spine, Long-Term Use of Aspirin, Diabetes, Hypertension, Asthma, Seizures, Chronic Constipation, Osteoporosis, Chronic Obstructive Pulmonary Disease, Stress Urinary Incontinence, Chronic Urinary Tract Infections, Severe Pain Left Hip, Severe Pain Low Back, Gastroesophageal Reflux Disease, Status Post Cerebrovascular Accident with Left Paresis, Dementia, Subdural Hematoma without Midline Shift, History of Fall, Detrusor Instability, Gait Disturbance, Degenerative Joint Disease Lumbar Spine, Lumbar Stenosis, Left Adnexal Mass Pelvis, Diverticulosis, Insomnia, Osteopenia, Depression, Atrophic Vaginitis, Urge Incontinence, and Ataxia. Physician's orders dated 5/6/12 documented, "...D/C [discontinue] trazodone 50mg [milligrams] po [by mouth] @ [at]
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>F428</td>
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<td>Continued From page 38</td>
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<td>HS [hour of sleep]. Trazodone 25 mg po @ HS...</td>
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<td>Physician's orders dated 11/1/13 documented,</td>
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<td>&quot;...TRAZODONE 50MG... ONE-HALF... PO AT BEDTIME...&quot;</td>
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<td>Review of the &quot;Clinical Pharmacy Review&quot; dated 5/8/12 documented Resident #50's Trazodone</td>
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<td>dosage was decreased from 50 mg to 25 mg on 5/8/12. There was no other documentation in regards to</td>
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<td>gradual dose reduction.</td>
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<td>Review of the Minimum Data Set (MDS) dated 9/23/13 documented in Section D, an interview</td>
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<td>was conducted with Resident #50 during which the resident indicated she was having no</td>
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<td>symptoms related to depression.</td>
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<td>During an interview at the 100 hall nurses' station on 11/21/13 at 5:56 PM, the Assistant Director of</td>
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<td>nursing (ADON), was asked about the order for Trazodone and if there had been a change since 5/8/12. The</td>
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<td>ADON stated, &quot;...I don't see where it's been changed...&quot;</td>
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<td>During an interview in the conference room on 11/21/13 at 6:40 PM, the ADON, was asked about any Trazodone</td>
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<td>reductions. The ADON stated, &quot;...5/8/12 was the only reduction...25 mg was what it was...It hasn't been</td>
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<td>reduced since...&quot;</td>
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<td>During a telephone interview on 11/21/13 at 7:00 PM, the Pharmacist was asked if a dosage reduction is</td>
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<td>not required for Trazodone. The Pharmacist stated, &quot;...Dosage reduction is not actually required... if a</td>
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<td>patient is stable it may be that it doesn't need reduction... usually we go based on what's</td>
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<td>documented by the nurses... she has a behavior sheet... lowest effective dose with absence of</td>
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<td>F 428</td>
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<td>Continued From page 39 side effects...&quot; The Pharmacist was asked if she writes progress notes, why there was no documentation for the review of the Trazodone since 5/8/12, and why the Pharmacist determined it did not need to be reduced. The Pharmacist stated, &quot;...No [progress notes]... If she was falling, not eating... if she was having other issues I would put a note in to the doctor... if there aren't any side effects and she's having a benefit from the drug... pretty much she is on the lowest dose you can get...&quot;</td>
<td>F 428</td>
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<tr>
<td>F 441</td>
<td>SS=F</td>
<td>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 direct contact with residents or their food, if F 441: The Center will ensure proper infection control practices are maintained. 12/21/13</td>
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F 441  Continued From page 40

direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure proper infection control practices were maintained in the facility kitchen, resident hallways, common bathrooms and resident rooms during 3 of 4 (11/19/13, 11/20/13 and 11/21/13) days of observations of the facility during the recertification survey.

The findings included:

1. Review of the facility's "Handwashing'' policy documented, "...The basic practice of hand washing is the single most important action that can be taken to prevent the spread of disease... GUIDELINES: 1. Hands should be washed...after touching money; after leaving and returning to a food preparation area...after touching anything that might contaminate hands..."

Observation in the kitchen on 11/19/13 beginning at 7:38 AM revealed:
a. Laundry employee #1 entered the kitchen and got coffee at the coffee/tea table located in front of

(continued from pg. 40)
The Director of Nurses will in-service all partners regarding hand washing policy, handling of soiled linen, proper disposal of soiled disposables, infection control related to meal service, and respiratory hygiene/ cough etiquette.

The Director of Nurses, Dietary and Dietary Manager will perform a QA weekly x 4 or until no trending noted to ensure proper infection control practices are followed. Observations will be reported to the Center’s Quality Assurance Committee.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NHC HEALTHCARE, LAWRENCEBURG**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
374 BRINK ST PO BOX 906
LAWRENCEBURG, TN 38464

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<tr>
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| F 441 | Continued From page 41 of the steam table, without washing her hands upon entering the kitchen. b. Laundry employee #2 entered the kitchen, ordered her breakfast and dropped her money in a bowl kept on top of the steam table which was used to collect money from staff and visitors who entered the kitchen area. c. Laundry employee #1 returned to the kitchen and got more breakfast, without washing her hands upon entering the kitchen. d. Certified Nursing Assistant (CNA) #3 entered the kitchen and got coffee for a resident without washing hands upon entering the kitchen. e. Housekeeping Supervisor entered the kitchen and got a cup of coffee without washing hands upon entering the kitchen. During an interview outside the dietary department on 11/18/13 at 11:58 AM, the Dietary Manager (DM) was asked about a partner coming into the kitchen. The DM stated, "...They come in to get something to eat... They come in with their hair nets on..." 2. Review of the facility's "Personal Hygiene" policy documented, "...Partners must have an understanding of safety and sanitation guidelines and put into practice those guidelines in order to provide a safe product. GUIDELINES: 3... Dietary partners shall wear hair restraints such as hats, hair coverings, or nets... designed and worn to effectively keep their hair from contacting exposed food... Observations in the kitchen on 11/20/13 beginning at 8:03 AM revealed: a. A health information management staff member had 4 to 5 inches of hair hanging out of her hair net getting a biscuit sandwich for
**F 441** Continued From page 42

b. The dietician had approximately an inch of hair hanging out of her hair net getting tea for herself while standing in front of the steam table of food.

3. Review of the facility's "Handwashing" policy documented, "...The basic practice of hand washing is the single most important action that can be taken to prevent the spread of disease... GUIDELINES: 1. Hands should be washed... after... sneezing, coughing..."

Review of the facility's "Standard Precautions" policy documented, "...There are three new elements of Standard Precautions which focus on protection of patients. They include: Respiratory Hygiene/Cough Etiquette... one of the new components of standard precautions, targets patients, family members, and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion... 2. Elements of Respiratory Hygiene/Cough Etiquette include: a. Education of healthcare staff, patients, and visitors b. Posting signs, in language appropriate to the population being served. c. Source control measures (...covering the mouth/nose with a tissue when coughing and proper disposal of used tissues, using surgical masks on the coughing person...) d. Hand hygiene after contact with respiratory secretions e. Spatial separation, ideally > [greater than] 3 feet, of persons with respiratory infections in common waiting areas when possible..."

Observations in the kitchen during review of the tray line temperatures on 11/20/13 beginning at 11:30 AM revealed:

a. A visitor entered the kitchen, used her right
Continued From page 43

hand to cover her mouth as she coughed, then placed her right hand on the tea/coffee counter without washing her hands.

b. An oven mitt was on the floor under the drain area by 3 compartment sink.

c. A dietary staff member picked up a small mop cleaning utensil laying on the clean pan rack and placed it on the window sill which was dusty.

d. Tomato soup, chicken noodle soup and 3 cups of chicken broth were sitting on the drying rack beside the 3 compartment sink used for storage of clean pans.

e. A window by the hand washing sink was cracked from the top of the pane to bottom of the pane.

f. Dust in the return air vent located above the food prep table. The table had a pan with graham crackers sitting on it.

During an interview in the kitchen on 11/20/13 at 11:50 AM, the DM was asked how the dish mop was used. The DM stated, "It [mop] is used for coffee pot cleaning. It usually is laid in window sill."

During an interview in the Dietician's office on 11/21/13 at 3:10 PM, the DM was asked what she expected concerning the dirty vent and broken window pain. The DM stated, "...[the vent]... to be kept clean... [the broken window pane]... would expect the broken window to be replaced..."

4. Observations during lunch tray service for the 100 hall on 11/20/13 at 12:53 PM, revealed CNA #4 entered room 116 with a lunch tray and placed the tray on the overbed table beside a urinal. The urinal was not removed from the overbed table.
F 441 Continued From page 44

Transmission Based Precautions" policy documented, "...2. LINEN AND LAUNDRY
Although soiled linen may be contaminated with pathogenic microorganism, the risk of disease
transmission is negligible if it is handled,
transported... in a manner that avoids transfer of
microorganisms to patients, personnel, and
environments... hygienic and common sense
storage and processing of clean and soiled linen
are recommended... Key principles for handling
soiled laundry are: ...2. Avoiding contact of one's
body and personal clothing with the soiled items
being handled. 3. Containing soiled items in a
laundry bag or designated bin."

Observations on the 200 hall revealed the
following:
  a. 11/20/13 at 12:36 PM - CNA #5 exited the
     bathroom with a soiled brief in her hand with no
gloves on.
  b. 11/21/13 at 10:00 AM - CNA #6 transported
     soiled linens down the 200 hall to the soiled linen
     room without the linen being bagged.
  c. 11/21/13 at 10:04 AM - CNA #5 transported
     soiled linens down the 200 hall to the soiled linen
     room without the linen being bagged.
  d. 11/21/13 at 10:20 AM - revealed an underpad
     was in the wastebasket beside the commode with
washcloths on top of it; CNA #5 folded the
     underpad to contain the washcloths, removed the
bundle from the wastebasket, and transported it
down the hall to the soiled linen room, unbagged.
     Used gloves and paper towels were observed in
the wastebasket and a brown substance was
observed on the roll of toilet paper in the
bathroom after the bundle of soiled linen was
removed.

Observations on the 300 hall on 11/21/13 at
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<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 441</td>
<td>Continued From page 45 10:05 AM, revealed CNA #1 carrying unbagged used bed linens down the hall to the soiled linen room.</td>
<td>F 441</td>
<td>F 514: The Center will ensure that clinical records are maintained on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized.</td>
<td>12/21/13</td>
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<td>F 514 SS=D</td>
<td>483.75((1(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
<td>F 514</td>
<td>Resident #81’s skin assessment was updated to include the bruise noted on the right elbow and arm.</td>
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<td>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</td>
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<td>All residents with bruises will be reviewed to ensure that the bruise is addressed on the weekly skin assessment.</td>
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<td>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.</td>
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<td>All Licensed Nurses will be in-serviced regarding the documentation of bruises on the skin assessment form weekly until healed.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to accurately document the skin assessments for bruises for 1 of 3 (Resident #81) residents reviewed for non-pressure related skin conditions of the 33 residents included in the stage 2 review.</td>
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<td>The Director of Nurses or designee will perform a QA on skin assessment’s weekly x 4 to ensure bruises are addressed on skin assessment or until no trending is noted. Observations will be presented to the Center’s Quality Assurance Committee.</td>
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<td>The findings included: Medical record review for Resident #81 documented an admission date of 7/17/12 with diagnoses of Chronic Kidney Disease, Iron Deficiency Anemia, Severe Dorsal Kyphosis, Anxiety, Depression, Hypertension, Osteoporosis, Gastro Esophageal Reflux Disease and Anorexia.</td>
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Review of the nurse's notes documented "8/7/13 530 AM Rt [patient] ambulating to BR [bathroom] & [and] bumped Rt [right] arm on Door frame this caused small hematoma (.5 x [by] .5) to Rt elbow and small bruise to Rt [symbol for upper] arm. Culoplast ordered for hematoma Daily... 8-11-13 12 AM - 0 [symbol for empty set or none] c/o [complaint of] voiced R/T [related to] hematoma Rt elbow & bruise to Rt arm & hand. Will monitor..." Review of Resident #81's weekly skin assessment records documented the resident was free from skin issues on 8/12/13, 8/19/13, 8/26/13, 9/2/13, 9/19/13, 9/23/13, 9/30/13, 10/7/13, 10/14/13, 10/21/13, 10/28/13, 11/4/13, 11/11/13 and 11/18/13.

Review of Resident #81's care plan dated 10/11/13 documented, "Skin Integrity, at risk alteration. Assess skin weekly and document changes..."

Review of the Physician's active orders dated 11/15/13 through 11/30/13 documented, "...Tasks. WEEKLY SKIN ASSESSMENT..."

Observation in Resident #81's room on 11/19/13 at 9:58 AM, revealed bruising on Resident #81's right elbow and arm.

During an interview in the Director of Nursing's (DON) office on 11/21/13 at 5:30 PM, the DON was asked would she expect the nurses to document a resident's skin issues on the weekly skin assessment. The DON stated, "...Would expect them to put a yes under alteration in skin integrity and describe it on the back...

During an interview on the 100 hall nurses' station...
F 514 Continued From page 47 on 11/21/13 at 5:45 AM, the Assistant Director of Nursing (ADON) stated, "...the weekly skin assessment is done on all patients... this is a nursing task..."