<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td>SSG</td>
<td>G</td>
<td><strong>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</strong> INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td>F 225</td>
<td></td>
<td></td>
<td>Nurse Manager and Social Service Director interviewed resident #156 on 10/29/13. Family was notified regarding residents concern by Administrator on 10/29/13. CNA was interviewed by Administrator 10/29/13. Physician of the patient was notified regarding residents concern by Administrator 10/29/13. All other residents were interviewed regarding any concerns of abuse on 10/29/13 by Social services. No other concerns were voiced. Overseen by Administrator, in-service training of the center's Patient Protection and Response Policy for Allegation of Abuse was held for all current partners. All inservice training was completed by 11/22/13. Also overseen by Administrator, any partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift. Overseen by Administrator, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, interviewing 5 random partners a week x 6 weeks for their understanding of their role in the center's Patient Protection and Response Policy for Allegation of Abuse.</td>
</tr>
</tbody>
</table>

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 6 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

---

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient(s). (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
**F 225** Continued From page 1

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

- Based on policy review, review of a personnel file, review of the facility's investigation, medical record review, observation and interview, it was determined the facility failed to protect residents from abuse by failing to ensure that all allegations of mistreatment or abuse, were reported immediately to the Administrator of the facility and a thorough investigation was conducted for 1 of 35 (Resident #156) sampled residents. The failure of the facility to ensure allegations were reported and thoroughly investigated resulted in actual harm to Resident #156 who became emotionally upset when asked if she had ever been abused by staff.

The findings included:

1. Review of the facility's "Patient Protection and Response Policy for Allegations / Incidents of Abuse, Neglect and Misappropriation of Property" policy documented, "...Abuse, Neglect, and Misappropriation of Patient Property... will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, visitor or any other individual in this center. The center administrator is responsible for assuring that patient safety, including freedom from risk of abuse or neglect, holds the highest priority... The center will train all partners, through orientation and ongoing in-services, on the prevention, identification, investigation and reporting of abuse, neglect, and misappropriation of patient property... In-service training will include... What constitutes abuse, neglect and misappropriation of patient property... The reporting obligation of each partner... Investigative system established by the center..."

All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers.

Each study and monitor will continue as directed by the Quality Assurance Committee.

11/23/13

---

**F 225**

- All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers.

Each study and monitor will continue as directed by the Quality Assurance Committee.
F 225 Continued From page 2

All supervisory partners who receive reports of
and/or identify inappropriate behaviors will take
immediate steps to correct such behaviors... The
center will seek and accept complaints from
patients, patient families and partners without
reproval... The right to report a concern or incident
is not limited to a formal, written grievance
process but includes any verbal complaint to
any center partner... Any patient event that is
reported to any partner by patient, family, other
partner or any other person will be considered an
allegation of either abuse, neglect, or
misappropriation of patient property if it meets
any of the following criteria... Any patient or family
complaint of physical or verbal harm, pain or
mental anguish resulting from the actions of
others... Any complaint of the use of oral, written
or gestured language that willfully includes
disparaging and derogatory terms to patients or
families or within their hearing distance... Any
instances of hitting, slapping, pinching, or kicking
or other potentially harmful action... Any partner
having either direct or indirect knowledge of any
event that might constitute abuse, neglect, or
misappropriation of patient property must report
the event immediately. All allegations of possible
abuse, neglect, or misappropriation of patient
property will be immediately assessed to
determine the appropriate direction of the
investigation... All alleged violations and all
substantiated incidents will be reported
immediately to the Administrator or her/his
designated representative and to other officials in
accordance with state and Federal law... All
events reported as possible abuse, neglect, or
misappropriation of patient property will be
investigated to determine whether the alleged
abuse, neglect, or misappropriation of patient
property did or did not take place... The
Continued From page 3

investigation is conducted immediately under the following circumstances: i. When it is identified that an alleged incident may have occurred. ii. As soon as any partner has knowledge and reports an alleged event... Any individual found to be in danger of injury will be removed from the source of the suspected abusive behavior... Partner(s) suspected of taking actions that would cause potential harm to a patient or other patients will be immediately placed on administrative leave..."

2. Medical record review for Resident #156 documented an admission date of 5/24/13 with diagnoses of Coronary Atherosclerosis, Hypertensive Heart Disease, Hyperlipidemia, Congestive Heart Failure, Diabetes Mellitus, Obesity, Candidiasis of Mouth and Hemiplegia. The admission Minimum Data Set Assessment (MDS) dated 5/31/13 documented the resident with a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident cognition is intact.

During an interview in Resident #156's room on 10/28/13 at 9:11 AM, Resident #156 was asked if staff, resident or anyone else here had abused you? Resident #156 paused, then began crying and stated, "Yes, I was verbally abused by [named certified nursing assistant (CNA) #10], she was on one side of my bed and threw my hairbrush across the room, [named CNA #9] was on the other side of my bed. Husband told the Administrator and the employee was fired." When asked if she had told staff? Resident #156 stated, "Yes, [named CNA #9]. A Nurse [unable to name] was told, and the Administrator was told by my husband."

Observations in Resident #156's room on
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td></td>
<td>Continued From page 4 10/28/13 at 9:11 AM, revealed Resident #156 in her room, in bed and began crying when asked about being abused.</td>
</tr>
</tbody>
</table>

   During an interview at the nurses' station on 10/28/13 at 2:30 PM, CNA #9 was asked about the incident with Resident #156. CNA #9 stated, "[Named CNA #10] was being verbally abusive to me in front of [Named Resident #156]... She [CNA #10] was brushing [Named Resident #156]'s hair and threw the brush across the room. I reported it to a Supervisor but don't remember who it was..."

   During an interview in the Social Service's office on 10/29/13 at 4:15 PM, the Social Services Director (SSD) and Abuse Prevention Coordinator was asked for investigations of allegations of abuse. The SSD stated, "We have not had an allegation of abuse in over 2 years."

   During an interview in the Director of Nursing's (DON) office on 10/29/13 at 4:00 PM, the DON was asked for investigations of allegations of abuse from Resident #156. The DON stated, "I am not aware of any abuse allegations."

   During an interview in the Administrator's office on 10/29/13 at 5:00 PM, the Administrator was asked if an allegation of abuse on Resident #156 had been reported. The Administrator stated, "No allegation of abuse had been reported."

   Review of the CNA #10's personnel file revealed a handwritten note of resignation dated 8/16/13 and documented, "found another job closer to home... last day worked is 8-25-13..." There was no documentation of the incident/investigation with Resident #156.
Continued from page 5

Review of the facility's investigation conducted after the Administrator was made aware of the allegation revealed a statement dated 10/29/13 and signed by the Administrator that documented an interview with the resident's son. There was no indication the son was aware of the allegation. Another statement dated 10/29/13 and signed by the Administrator documented an interview with CNA #9 who reported to the Administrator the incident between her and CNA #10 of speaking inappropriately in front of Resident #156. There was no documentation in the investigation of interviews with Resident #156, Resident #156's husband, other residents or other staff members.

The facility failed to protect residents from abuse by failing to ensure staff reported allegations of abuse/inappropriate behavior per facility protocol and failed to thoroughly investigate allegation of abuse which resulted in actual harm to Resident #156, who became emotionally upset when asked of any abuse.

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of new employee personnel files and interviews, it was determined the facility failed to train a new employee on the

Overseen by the Administrator, Nurse #7 was in-serviced regarding the center's Patient Protection and Response Policy on 11/1/13.

Beginning 10/29/13, Administrator immediately implemented a new process to train partners to meet the requirement of Patient Protection Policy prior to partner beginning work in the center.
F 226 Continued From page 6

to facility's abuse policy and procedures for 1 of 5
(Nurse #7) new employee files reviewed.

The findings included:

Review of the facility's "Patient Protection and
Response Policy for Allegations / Incidents of
Abuse, Neglect and Misappropriation of Property"
policy documented, "...Abuse, Neglect, and
Misappropriation of Patient Property... will not be
tolerated by anyone, including staff, patients,
consultants, volunteers, family members or legal
guardians, friends, visitor or any other individual
in this center... The center will train all partners,
through orientation and ongoing in-services, on
the prevention, identification, investigation and
reporting of abuse, neglect, and misappropriation
of patient property... In-service training will
include... What constitutes abuse, neglect and
misappropriation of patient property... The
reporting obligation of each partner..."

Review of Nurse #7's personnel file documented
a hire date of 8/1/13. The facility was unable to
provide documentation that Nurse #7 was given
abuse training.

During an interview in the Rehabilitation Director's
office on 10/29/13 at 11:25 AM, Employee #1 was
asked what the facility's procedure for a new
employee's orientation and training. Employee #1
stated, "[Named Nurse #7] has not received
orientation or abuse training at this time period."

During interview in the Rehabilitation Directors'
office on 10/30/13 at 4:25 PM, the Administrator
stated, "[Named Nurse #7] has not had
orientation nor abuse training at this time."

F 226 Overseen by Administrator, and
beginning 10/29/13, in-service
training of the center's Patient
Protection and Response Policy
for Allegation of Abuse was held
for all partners. All in-servicing
was completed by 11/22/13. Also
overseen by Administrator, any
partners that are on leave or
otherwise unavailable will be in-
serviced prior to their next shift
worked.

Overseen by Administrator, a
Quality Assurance study will be
conducted; beginning the week of
November 25, 2013, interviewing
5 random partners a week x 6
weeks for their understanding of
their role in the center's Patient
Protection and Response Policy
for Allegation of Abuse. Also,
overseen by Administrator, a
Quality Assurance study will be
conducted, beginning the week of
November 25, 2013, reviewing
training for all new partners
ensuring that each has received
training regarding the center's
Patient Protection and Response
Policy for Allegation of Abuse.
F 226
Continued From page 6
facility's abuse policy and procedures for 1 of 5
(Nurse #7) new employee files reviewed.

The findings included:

Review of the facility's "Patient Protection and
Response Policy for Allegations / Incidents of
Abuse, Neglect and Misappropriation of Property"
policy documented, "... Abuse, Neglect, and
Misappropriation of Patient Property... will not be
tolerated by anyone, including staff, patients,
consultants, volunteers, family members or legal
guardians, friends, visitor or any other individual
in this center... The center will train all partners,
through orientation and ongoing in-services, on
the prevention, identification, investigation and
reporting of abuse, neglect, and misappropriation
of patient property... In-service training will
include... What constitutes abuse, neglect and
misappropriation of patient property... The
reporting obligation of each partner..."

Review of Nurse #7's personnel file documented
a hire date of 8/1/13. The facility was unable to
provide documentation that Nurse #7 was given
abuse training.

During an interview in the Rehabilitation Director's
office on 10/29/13 at 11:25 AM, Employee #1 was
asked what the facility's procedure for a new
employee’s orientation and training. Employee #1
stated, "[Named Nurse #7] has not received
orientation or abuse training at this time period."

During interview in the Rehabilitation Directors'
office on 10/30/13 at 4:25 PM, the Administrator
stated, "[Named Nurse #7] has not had
orientation nor abuse training at this time."
Continued From page 7

F 241 483.15(s) 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 policy review, observation and interview, it was determined the facility failed to ensure residents were treated with dignity and respect when staff used referred to residents as "feeders" and residents were served juice and milk in cartons during 2 of 2 (10/27/13 lunch meal and 10/29/13 breakfast meal) dining observations.

The findings included:

1. Review of the facility's "USE OF COURTESY TITLES" policy documented, "It is the policy of this center to use courtesy titles (Mr., Ms.) when addressing patients in all written records and communication..."

Observations of the lunch meal on 10/27/13 at 12:13 PM, the Social Services Director (SSD) delivered a tray to room 41. The SSD asked a resident, "Would you like some lunch sweetheart?"

Observations of the breakfast meal on 10/29/13 at 8:08 AM, Nurse #1 stuck her head in room 39 and asked certified nursing assistant (CNA) #1, if the "feeders were the only trays left." CNA #1 retrieved the last meal tray and took it into room

Overseen by the Administrator, Social Service Director was inserviced on the center's policy regarding the "Use of Courtesy Tiles" on 11/18/13.

Overseen by Administrator, in-service training of the center's policy regarding the "Use of Courtesy Tiles" was held for all partners. All in-servicing was completed by 11/22/13. Also overseen by Administrator, any partners that are on leave or otherwise unavailable will be inserviced prior to their next shift worked.

Overseen by Administrator, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, interviewing 5 random partners a week x 6 weeks for their understanding of the center's policy regarding the "Use of Courtesy Tiles." All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietician, social
| F 241 | Continued From page 8 35.  

During an interview in the conference on 10/31/13 at 9:00 AM, the Director of Nursing (DON) was asked what she expected the staff to call residents. The DON stated "Mr., Mrs or Miss."  

2. Observations of the lunch meal on 10/27/13 at 12:52 PM, revealed a tray was delivered to room 48 with juice served in carton without a glass on the tray.  

Observations of the breakfast meal on the 40 hall on 10/29/13 at 8:05 AM, revealed trays were served with milk and juice in cartons without glasses. |

| F 241 | worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers. Each study and monitor will continue as directed by the Quality Assurance Committee. |

| F 260 | 483.20(d), 483.10(k)2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. |

| F 260 | Overseen by the DON resident #184's care was updated to include current plan of care, including falls prevention interventions on 11/14/13.  

Overseen by the DON, all other resident care plans were reviewed and updated, with emphasis on falls prevention, to include current plan of care. This was completed on 11/22/13.  

Overseen by the DON, all licensed nurse and interdisciplinary care plan team members were involved services regarding the center's policy for updating patient care plans with emphasis on falls prevention and post fall checklist. |
OVERSIGHT BY DON, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, reviewing 5 random patient care plans weekly x 6 weeks to ensure care plans are update as needed. All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers. Each study and monitor will continue as directed by the Quality Assurance Committee.
Continued From page 10

and the post falls investigations documented the following falls and interventions implemented:

a. 10/8/13 at 5:00 PM fall - "...Pt [patient] placed back in low bed with all interventions in place... All appropriate interventions in place..."

b. 10/12/13 at 3:45 PM fall - "...Pt not to be left unattended in dining room..."

c. 10/15/13 at 11:30 AM fall - "...Urine obtained in AM for UA / C&S [urinalysis / culture and sensitivity] D/T [due to] increased confusion... and Pt not to be up in WC [wheelchair] in room alone..."

d. 10/15/13 at 7:45 PM fall - "...ABT [antibiotic] started for UTI [urinary tract infection]... clip alarm to WC...."

e. 10/23/13 at 7:45 AM - "...fell from bed to go to bathroom... Resident was redirected towards an activity to keep his attention..."

The care plan dated 10/8/13 and revised on 10/24/13 did not include the intervention of laboratory tests and an antibiotic implemented after the fall on 10/15/13 and did not document the diversional activities intervention implemented after the 10/23/13 fall.

During an interview in the conference room on 10/29/13 at 10:40 AM, the Licensed Practical Nurse (LPN) Risk Manager was asked about Resident #184 falls and interventions. The LPN Risk Manager stated, "Regarding fall #1 we had put fall mats, bed alarm and low bed in place prior to his admission due to info [information] from the hospital that he was a high fall risk. No other interventions were put in place due to these were appropriate... Regarding fall #4 - the nurse was watching him, he was in the entrance to the dining room, she just could not get to him, he had 2 falls on that day (10/15/13). I put in place on the
<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Completed 11/14/13, overseen by the DON and Registered Dietitian. Residents 120 and 129 were reweighed and Registered Dietitian reviewed the patient's records. The resident's families and physicians were notified and any orders received were updated on the residents care plans.</td>
<td>F 280</td>
</tr>
<tr>
<td></td>
<td>Overseen by the DON and Registered Dietitian, All residents were reweighed for the month of November by 11/14/2013. Registered Dietitian reviewed all patient weights. Patients found to have significant weight loss were reviewed with the physician notified, care plan updated and families notified of the resident weight loss and care plan updates. This was completed 11/15/13.</td>
<td></td>
</tr>
</tbody>
</table>

### SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</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 280</td>
<td>Completed 11/14/13, overseen by the DON and Registered Dietitian. Residents 120 and 129 were reweighed and Registered Dietitian reviewed the patient's records. The resident's families and physicians were notified and any orders received were updated on the residents care plans.</td>
</tr>
<tr>
<td></td>
<td>Overseen by the DON and Registered Dietitian, All residents were reweighed for the month of November by 11/14/2013. Registered Dietitian reviewed all patient weights. Patients found to have significant weight loss were reviewed with the physician notified, care plan updated and families notified of the resident weight loss and care plan updates. This was completed 11/15/13.</td>
</tr>
</tbody>
</table>

---

**Continued From page 11**

17th to change alarms out due to him leaning... Regarding fall #5 he felt trying to go to the bathroom, his interventions were all in place and appropriate. We put in place the diversional activities... I see that addressing going to the bathroom should be addressed... yes, we do try to determine the cause of the falls.

**483.25(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PERS CARE PLAN**

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

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

- Based on policy review, review of tray cards, medical record review, observation and interview, it was determined the facility failed to follow and provide interventions on the care plans for nutrition for 2 of 19 (Residents #120 and 129) sampled residents of the 35 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Weights: Monthly and Significant Change of Status" policy documented. "...Weights will be obtained on all patients monthly... Weights will be obtained, following the determination of a significant change of status, on a weekly basis times four... Weigh Patient...

Reweight within 24 hours if significant change is noted (5% [percent] in 30 days).... Document in chart percentage of significant loss, observations, plans or interventions to occur in next 14 days...
**F 282** Continued From page 12

Progress notes and care plans should reflect current plan of care... Screen patients with significant weight loss and implement nutritional intervention...

2. Medical record review for Resident #120 documented an admission date of 8/30/13 with diagnoses of Rehabilitation for Fractured Hip and Left Clavicle, Congestive Heart Failure, Iron Deficiency Anemia, Atrial Fibrillation, Coronary Artery Disease, Anticoagulant use, Hypertension, Old Myocardial Infarction, Venous Embolism and Thrombosis, Pressure Ulcer Stage 2 on Buttocks, Dysphagia, Weakness, Anxiety, Pacemaker, Dementia without Behaviors, Yeast of skin and nails and Constipation. The record documented the resident went to the hospital on 9/9/13 due to increased International Ratios and returned to the facility on 9/11/13.

Review of the admission physician orders dated 8/30/13 documented a diet of Regular Mechanical Soft diet with Nectar thick Liquids, no straws and house supplement twice a day (BID) with medication pass. Physician orders upon return from hospital on 9/11/13 documented the same diet ordered and meds pass supplement with morning and evening medications.

Review of Resident #120's weight record documented the following weights:
- a. 8/30/13 - 102 pounds.
- b. 9/11/13 - 104 pounds.
- c. 10/6/13 - 96.7 pounds - indicating a 7.01% significant weight loss in less than one month.

The care plan dated 9/3/13 and revised 9/23/13 documented the problem / need of "At risk for malnutrition..." and Intervention "...Weigh weekly /
Continued From page 13

monthly and pm [as needed] and intervene if significant weight loss occurs..." The facility was unable to provide documentation of weekly weights per the facility's protocols and care plan. There were no new interventions documented after the 10/6/13 significant weight loss as indicated on the care plan.

Observations in Resident #120's room on 10/27/13 at 5:10 PM, revealed Resident #120 was thin and confused.

Observations in Resident #120's room on 10/28/13 at 6:00 AM, revealed a cooler at Resident #120's bedside with nectar thick water in it.

Observations of the breakfast tray in Resident #120's room on 10/30/13 at 8:35 AM, revealed Resident #120 was served and ate her egg, bacon and approximately 75% of the oatmeal. Resident #120 did not drink the thickened orange juice or eat the toast. There were no supplements or high calorie / protein milkshakes on the tray per the initial nutritional assessment.

3. Medical record review for Resident #129 documented an admission date of 6/7/13 with diagnoses of Senile Dementia, Diabetes Mellitus, Essential Hypertension, Depressive Disorder, Constipation, Esophageal Reflux Disease, Pressure Ulcer Stage 2 and Urinary Tract Infection. Review of care plan dated 8/11/13 and updated 9/11/13 documented at risk for malnutrition... with goals... will maintain CBW [current body weight] +/- [plus or minus] 5 # [pounds] through 9/30/13 with intervention... weigh weekly / monthly and pm [as needed] and intervene if significant weight loss occurs..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 282 | Continued From page 14  
Review of the dietary progress notes did not document any entries form 6/13/13 through 9/12/13.  
Review of the tray card dated 10/30/13 documented Regular, Nutrition Intervention Program (NIP) for breakfast, lunch and dinner.  
Review the facility's "The Weight List" dated August 2013 and September 2013 documented Resident #129's weight on 8/6/13 was 135 pounds and on 9/21/13 was 111 pounds indicating a loss of 24 pounds a 17.7 % weight loss in 45 days.  
Review of the "DIET RECORD" dated October 2013 was blank for HS snack. The facility was unable to provide documentation of Resident #129's food and fluid intake consumed for August 2013 and September 2013.  
During an interview in the conference room on 10/29/13 at 4:00 PM, the Director of Nursing (DON) was asked why were weekly weights not being done and what interventions were put in place for residents with weight loss. The DON stated, "We were not aware of the weight loss until she was weighed 9/21/13... at risk residents are put on the Nutrition Intervention Program (NIP)... the committee discusses weight loss and interventions... we do not keep the documentation's from the meetings... we keep intake percentages of meals for 30 days then they are shredded."  
During an interview in the conference room on 10/29/13 at 4:30 PM, the DON was asked where was the documentation for meal intake for the... |
| F 282 | |

**NAME OF PROVIDER OR SUPPLIER**

NHC HEALTHCARE, SPRINGFIELD

608 8TH AVE EAST
SPRINGFIELD, TN 37172

**STREET ADDRESS, CITY, STATE, ZIP CODE**

10/30/2013
**F 282** Continued From page 15

months of August and September 2013. The DON stated, "We shred them after 30 days... we do not have them..."

During an interview in the hall by the conference room on 10/29/13 at 6:05 PM, Nurse #8 was asked what she did she expect the Certified Nursing Assistants (CNA) or nurses do if a resident was not eating and where would it be documented. Nurse #8 stated "...I would expect the CNA to report that to the charge nurse... it would have documented on the intake sheet which is summarized in the nurse's charting..."

During an interview in the conference room on 10/30/13 at 9:30 AM, the DON was asked why this resident was not being fed in 45 days and was made aware that she was not eating. The DON stated, "I did not realize she was had not been eating... We realized there was a breakdown in the way we do weights... weights were not getting charted... we were not getting notified when there changes noted in the weight or resident's intake had decreased..."

**F 323**

483.25(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:

Overseen by the DON, residents #95 and #184 care plans were reviewed and updated as needed on 11/14/13, with emphasis on intervention to prevent falls and promote patient safety.

Overseen by the DON all other resident Care plans were reviewed and update with emphasis noted to interventions to prevent falls and promote resident safety.

These reviews were completed on 11/22/13.
F 323
Continued From page 16

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure the residents' environment remains as free of accident hazards as is possible; and each resident received adequate supervision and assistance to prevent potential accidents for 2 of 4 (Residents #95 and 184) sampled residents of the 35 residents included in the stage 2.

The findings included:

1. Review of the facility's "...Falls Program" policy documented, "...To identify patients at risk for falling and to implement the appropriate interventions... To reduce the patients' risk of falling and related injuries... Complete the Fall Risk Assessment... Initiate a falls care plan... Implement appropriate interventions... Evaluate the effectiveness of the interventions."

Review if the facility's "Meal ROUNDS" policy documented, "...Check to see if the patients are positioned appropriately for eating. Note appropriate table height, bedside table within reach, head of bed elevated.""

2. Medical record review for Resident #95 documented an admission date of 6/11/69 with diagnoses Hypertension, Spinal Stenosis Lumbar Region, Senile Dementia with Depressive Features, Affective Psychosis- Major Depressive Disorder, Palliative Care, Depressive Disorder, Anxiety, Difficulty In Walking, Nuclear Sclerosis, Constipation, Osteoporosis and History of Lumbar 1 Fracture. A fall risk assessment last updated 7/16/13 documented Resident #95's score as 22 indicating the resident was at high risk for falls.

F 323
Overseen by the DON, beginning 11/01/13 Nursing in-services were provided regarding following falls intervention and the need to update care plan and implement interventions as care planned. These in-services were completed on 11/22/13.

Overseen by DON, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, reviewing 5 random patient care plans weekly x 6 weeks to ensure care plans are update as needed and falls intervention are in place care planned. All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietitian, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers. Each study and monitor will continue as directed by the Quality Assurance Committee.
F 323 Continued From page 17

Observation and interview in Resident #95's room of the lunch meal on 10/27/13 at 12:13 PM. the Social Service Director (SSD) delivered a tray to the resident. Resident #95 was sitting up on the side of the bed with her legs dangling. Resident #95 was unable to touch her feet to the floor. The surveyor located Nurse #9 and asked her to come to Resident #95's room. Nurse #9 was asked if Resident #95's position was appropriate. Nurse #9 stated, "No, it's a little high...feet should touch floor..."

During an interview in the conference room on 10/29/13 at 11:05 AM, Nurse #9, the west unit manager, was asked what position Resident #95 should be placed in when eating meals in her room. Nurse #9 stated, "She likes to sit up on the side of her bed... put it up to a comfortable height for her..." Nurse #9 was asked if it was appropriate for the resident's feet to hang off the bed and not reach the floor. Nurse #9 stated, "No, her feet should be able to touch the floor."

During an interview in the conference room at 4:01 PM, the Director of Nursing (DON) was asked if all staff should follow the "Meal Rounds" policy when serving trays to residents. The DON stated, "Yes." The DON was asked if Resident #95's feet should touch the floor when sitting on the side of the bed to eat. The DON stated, "Yes, feet should touch the floor."

3. Medical record review for Resident #184 documented an admission date of 10/8/13 with diagnoses of Alzheimer's Disease, Dementia, Psychosis, Diabetes, Coronary Artery Disease, Hyperlipidemia, Hypertension, Pacemaker, Asthma, Degenerative Disc Disease, Weakness,
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/COLA ID NUMBER:
445088

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
10/30/2013

NAME OF PROVIDER OR SUPPLIER
NHC HEALTHCARE, SPRINGFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE
608 8TH AVE EAST
SPRINGFIELD, TN 37172

(X4) ID
PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 323
Continued From page 18
Urinary Tract Infection and Urinary Retention.
The Brief Interview for Mental Status (BIMS)
dated 10/14/13 documented the resident with a
summary score of 5 indicating the resident with
severe mental impairment. The fall risk evaluation
completed on 10/8/13 documented a score of 19
indicating the resident was a high risk for falls.

Review of the post falls nursing assessment's
and the post falls investigations documented the
following falls and interventions implemented:
a. 10/8/13 at 5:00 PM fall - "...Pt [patient] placed
back in low bed with all interventions in place... All
appropriate interventions in place...
b. 10/12/13 at 3:45 PM fall - "...Pt not to be left
unattended in dining room..."
c. 10/15/13 at 11:30 AM fall - "...Urine obtained in
AM for UA / C&S [urinanalysis / culture and
sensitivity] DT [due to] increased confusion... and
Pt not to be up in WC [wheelchair] in room
alone..."
d. 10/15/13 at 7:45 PM fall - "...ABT [antibiotic]
started for UTI [urinary tract infection]... clip
alarm to WC..."
e. 10/23/13 at 7:45 AM - "...fell from bed to go to
bathroom... Resident was redirected towards an
activity to keep his attention..."

There was no documentation of a new
intervention implemented after the 10/8/13 fall.
The intervention implemented after the 10/23/13
fall was inappropriate and did not address the
root cause of that fall (resident going to the
bathroom).

During an Interview in the conference room on
10/29/13 at 10:40 AM, the Licensed Practical
Nurse (LPN) Risk Manager was asked about
Resident #184 falls and interventions. The LPN

FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: XG0511
Facility ID: TN7405

If continuation sheet Page 10 of 33

RCA
F 323  Continued From page 19
Risk Manager stated, "Regarding fall #1 we had put fall matts, bed alarm and low bed in place prior to his admission due to info [information] from the hospital that he was a high fall risk, no other interventions were put in place due to these were appropriate... Regarding fall #4 - the nurse was watching him, he was in the entrance to the dining room, she just could not get to him, he had 2 falls on that day (10/15/13). I put in place on the 17th to change alarms out due to him leaning... Regarding fall #5 he fell trying to go to the bathroom, his interventions were all in place and appropriate. We put in place the diversional activities... I see that addressing going to the bathroom should be addressed... Yes, we do try to determine the cause of the falls."

F 325  Completed 11/14/13, overseen by the DON and Registered Dietitian, Residents 120 and 129 were reweighed and Registered Dietitian reviewed the patient's records. The resident's families and physicians were notified and any orders received were updated on the residents care plans.

Overseen by the DON and Registered Dietician, All residents were reweighed for November by 11/14/2013. Registered Dietitian reviewed all patient weights. Patients found to have significant weight loss were reviewed with the physician notified, care plan

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

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of a tray card, medical record review, observation and interview. It was determined the facility failed to maintain acceptable parameters of nutritional status for 2
<table>
<thead>
<tr>
<th>(E4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(E3) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 325             | Continued From page 24 of 4 (Residents 120 and 129) sampled residents reviewed of the 7 residents reviewed with nutritional issues. The failure of the facility to implement interventions to prevent a significant weight loss resulted in actual harm to Resident #120. Resident #120 was assessed as malnourished and at a high risk for weight loss and had a significant weight loss. 

The findings included:

1. Review of the facility's policy provided by the Director of Nursing on 10/29/13 and entitled "RD [Registered Dietician] would make recommendations and send to MD [Medical Doctor]. MD would agree or disagree and send back to RD. If MD agreed with RD recommendations, the RD would write the task on the MAR [Medication Administration Record]. RD would continue to observe the patient's weight and intake and communicate to the MD as needed."

2. Review of the facility's Nutrition Intervention Program (NIP) policy documented "...Patients will receive the highest practicable level of nutritional care through aggressive interventions... An initial assessment will be completed on all patients by the Registered Dietitian or designee. Each patient will be reviewed for the risk factors... Patients who demonstrate one or more of the following risk factors will be considered for inclusion in the Nutrition Intervention Program: 1. Meal intake less than 50% [percent] for 7 days. 2. Pressure ulcers, other wounds, or delayed wound healing... 5. BMI [Body Mass Index] < [less than] 21. 6. Unplanned, progressive weight loss... 7. Weight loss of > [greater than] 3% during the past 10/30/13. | F 325 | updated and families notified of the resident weight loss and care plan updates. This was completed 11/15/13. Overseen by the DON and Registered Dietitian, Nurses and CNA's were in-serviced regarding the center's policy for obtaining patient weights, documentation of patient intakes and policy for care plan updates. This was completed 11/22/13. Overseen by the DON and Registered Dietitian, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, reviewing 5 random residents weekly x 6 weeks for compliance with the center's policy for obtaining patient weights, documentation of patient intakes and policy for care plan updates. All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietitian, social worker, health information...
**Continued From page 21**

30 days...

Review of the facility's percent meal intake policy documented, "...Patients' percent meal intake will be properly evaluated... appropriate nursing partner will evaluate the patient's meal tray after meal is finished being consumed... Partner will estimate the amount of total meal consumed and will record the amount of the total meal consumed on appropriate worksheet."

Review of the facility's Weights: Monthly and Significant Change of Status policy documented, "...Weights will be obtained on all patients monthly... Weights will be obtained, following the determination of a significant change of status, on a weekly basis times four... Weigh Patient... Reweigh within 24 hours if significant change is noted (5% in 30 days)... Document in chart percentage of significant loss, observations, plans or interventions to occur in next 14 days... Progress notes and care plan should reflect current plan of care... Screen patients with significant weight loss and implement nutritional intervention."

2. Medical record review for Resident #120 documented an admission date of 8/30/13 with diagnoses of Rehabilitation for Fractured Hip and Left Clavicle, Congestive Heart Failure, Iron Deficiency Anemia, Coronary Artery Disease, Atrial Fibrillation, Anticoagulant use, Hypertension, Old Myocardial Infarction, Venous Embolism and Thrombosis, Pressure Ulcer Stage 2 on Buttocks, Dysphagia, Weakness, Pacemaker, Dementia without Behaviors, Anxiety, Yeast of skin and nails and Constipation. The record documented the resident went to the hospital on 9/2/13 due to increased International...
**F 325**
Continued From page 22

Ratios and returned to the facility on 9/11/13.

Review of the admission physician orders dated 8/30/13 documented a diet of Regular Mechanical Soft diet with Nectar thick Liquids, no straws and house supplement twice a day (BID) with medication pass. Physician orders upon return from hospital on 9/11/13 documented the same diet ordered and med pass supplement with morning and evening medications.

Review of Resident #120's weight record documented the following weights:
- a. 8/30/13 - 102 pounds.
- b. 9/11/13 - 104 pounds.
- c. 10/6/13 - 96.7 pounds - indicating a 7.01% significant weight loss in less than one month.

The Registered Dietician (RD) documented an initial nutritional assessment dated 9/23/13 assessed Resident #120 with a "...current body weight of 104 pounds... BMI of 17.849...
Underweight... Mech [Mechanical] soft Nectar thick liquids... House supplement BID... RD offers high cal [calorie] / pro [protein] milkshake... MNA [mini-nutritional assessment] indicates pt [patient] is malnourished, Interventions: Will add scheduled HS [bedtime] snack for additional cal [calories]..." The most current dietary progress notes were dated 9/23/13 by the RD and documented, "5-day complete & [and] accurate..." There were no other dietary progress notes or assessments in the medical record. There was no documentation the resident had been placed on the NIP program per protocol.

There was no documentation of weekly weights per facility protocols. There were no new interventions documented after the 10/6/13
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE appropriate DEFICIENCY)</th>
<th>DUE COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 325</td>
<td>Continued From page 23</td>
<td></td>
<td>significant weight loss. There was no documentation the Physician or RD were aware of the significant weight loss.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Observations in Resident #120's room on 10/27/13 at 5:10 PM, revealed Resident #120 was thin and confused.

- Observations in Resident #120's room on 10/28/13 at 8:00 AM, revealed a cooler at Resident #120's bedside with nestor thick water in it.

- Observations of the breakfast tray in Resident #120's room on 10/30/13 at 8:36 AM, revealed Resident #120 was served and ate her egg, bacon and approximately 75% of the oatmeal. Resident #120 did not drink the thickened orange juice or eat the toast. There were no supplements or high calorie / protein milkshakes on the tray per the initial nutritional assessment.

- On 10/30/13 the surveyor requested Resident #120 be weighed and her weight was recorded at 65.8 pounds indicating additional weight loss.

- Review of the tray cards used in dietary to prepare the trays revealed no documentation of nourishments or scheduled of HS snacks for Resident #120.

- Review of the September 2013 and October 2013 diet records completed by the Certified Nursing Assistants (CNA) revealed the HS snack areas were blank for both months.

- During an interview in the conference room on 10/30/13 at 9:30 AM, the Director of Nursing (DON) was asked to describe the facility's weight
F 325 Continued From page 24

loss prevention program. The DON stated, "Weekly weights are gotten weekly times 4 and/or til [until] a stable weight. Our procedure was the RD and weight tech [technician] worked together obtaining weights and reviewing weights. If the RD was not here the weight tech notified the charge nurse of weight loss. RD was here 3 days a week on Monday, Tuesday and Thursdays. She left in late September of this year and at the same time the weight tech also left. At that point communications fell off. We identified we had a problem with the weights. We were not getting weights in the charts, we have today revised our procedure..." The DON was asked for the monthly significant weight loss report and proactive weight loss report per facility protocol. The DON stated, "The significant weight loss report is for residents with significant weight loss. The proactive weight loss reports are for residents trending down on their weights, those reports are not actively being done at present, not sure when the last one was done. Not sure if I kept copies of any... Med Pass... is given during medication pass by the nurses. The house supplement is mighty shakes and put on their trays by the kitchen. HS snacks are routinely offered to all residents at HS. We do have some that get specific HS snacks from the kitchen. The CNA's document meal intake on the meal cards and they document meal and HS snack intake on the diet record. These are only kept for 30 days...."

During an interview in the conference room on 10/30/13 at 10:30 AM, the DON confirmed the resident had a significant weight loss with additional weight loss noted on 10/30/13 and no interventions had been put in place.
The facility failed to ensure Resident #120, who was assessed as malnourished and at a high risk for nutritional complications on admission, received interventions to prevent a significant weight loss which resulted in actual harm for Resident #120.

3. Medical record review for Resident #129 documented an admission date of 8/7/13 with diagnoses of Senile Dementia, Diabetes Mellitus, Essential Hypertension, Depressive Disorder, Constipation, Esophageal Reflux Disease, Pressure Ulcer Stage 2 and Urinary Tract Infection.

Review of care plan dated 6/11/13 and updated 9/11/13 documented at risk for malnutrition...with goals... will maintain CBW [current body weight] +/- [plus or minus] 5 # [pounds] through 9/30/13 with intervention... weigh weekly / monthly and prn [as needed] and intervene if significant weight loss occurs..."

Review the facility’s "The Weight List" dated August 2013 and September 2013 documented Resident #129's weight on 8/6/13 was 135 pounds and on 9/21/13 was 111 pounds indicating a loss of 24 pounds a 17.7% weight loss in 45 days.

Review of the diet record dated October 2013 was blank for HS snack. The facility was unable to provide documentation of Resident #129's food and fluid intake consumed for August 2013 and September 2013.

Review of the dietary progress notes did not document any entries from 6/13/13 through 9/12/13.
Review of the tray card dated 10/30/13 documented Regular, Nutrition Intervention Program (NIP) for breakfast, lunch and dinner.

During an interview in the conference room on 10/29/13 at 4:00 PM, the DON was asked why were weekly weights not being done and what interventions were put in place for residents with weight loss. The DON stated, "We were not aware of the weight loss until she was weighed 9/21/13... at risk residents are put on the Nutrition Intervention Program (NIP)... the committee discusses weight loss and interventions... we do not keep the documentation's from the meetings... we keep intake percentages of meals for 30 days then they are shredded."

During an interview in the conference room on 10/29/13 at 4:30 PM, the DON was asked where was the documentation for meal intake for the months of August and September 2013. The DON stated, "We shread them after 30 days... we do not have them..."

During an interview in the hall by the conference room on 10/22/13 at 6:05 PM, Nurse #6 was asked what she did she expect the CNAs or nurses to do if a resident was not eating and where would it be documented. Nurse #6 stated "...I would expect the CNA to report that to the charge nurse... It would have documented on the intake sheet which is summarized in the nurse's charting..."

During an interview in the conference room on 10/30/13 at 9:30 AM, the DON was asked why this resident was not weighted in 45 days and was she made aware that she was not eating.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREPEND TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>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>
</tr>
</thead>
<tbody>
<tr>
<td>F 325</td>
<td>Continued From page 27 The DON stated, &quot;I did not realize she was had not been eating... We realized there was a breakdown in the way we do weights... weights were not getting charted... we were not getting notified when there changes noted in the weight or resident's intake had decreased...&quot;</td>
<td>F 325</td>
<td>Overseen by the Administrator, Social Service Director was in-serviced regarding proper hand hygiene related to dining on 11/18/13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 371</td>
<td>483.35(l) FOOD PROCURE, STORE/prepare/SERVE - SANITARY The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</td>
<td>F 371</td>
<td>Overseen by DON, training regarding proper hand hygiene related to dining, serving in resident rooms during isolation situations and not touching straws with bare hands was held for all partners. All in-servicing was completed by 11/22/13. Also overseen by Administrator, any partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift worked.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure food was protected from sources contamination by failing to serve food under sanitary conditions during 2 of 2 (10/27/13 lunch meal and 10/29/13 breakfast meal) dining observations.

The findings included:
1. Review of the facility's "HANDWASHING" policy documented, "...1. When to wash hands...d. After any contaminated contact..."
2. Observations of the lunch meal on 10/27/13 at 12:13 PM, the Social Services Director (SSD)
Continued From page 26

delivered a tray to room 41. The SSD touched the resident’s linens; raised the bed and set up the tray without washing his hands.

3. Observations of the lunch meal served on the 30 hall on 10/27/13 beginning at 12:25 PM revealed the following:
   a. Certified nursing assistant (CNA) #1 entered room 26, moved items off the table, touched the resident to awaken and then set up the tray without performing proper hand hygiene.
   b. CNA #1 entered room 36, set up the tray and removed paper from the straw and handled the mouthpiece of the straw using bare hands.
   c. CNA #2 entered room 35, placed the tray on the table top, removed lids and covers and placed plate covers on the bed and leaving it there exiting the room.

4. Observations of the lunch meal on the 40 hall on 10/27/13 beginning at 12:52 PM revealed the following:
   a. CNA #5 entered room 41, touched the wheelchair then set up the tray without washing hands.
   b. CNA #6 entered room 44, with only gloves and mask in the contact isolation room. The tray was not disposable and CNA #8's clothing touched the bed linens.
   c. CNA #6 dropped a bottle of hand sanitizer: bottle on floor picked it up and placed it in her pocket without washing her hands and proceeded to set up a tray.
   d. CNA #6 removed a tray from the cart with one hand adjusted the bottom of her shirt with the other hand and entered room 48 to deliver and set up the tray.
   e. CNA #6 entered room 46 adjusted resident in the bed then assisted the resident with eating partners a week x 6 weeks will be observed serving meals. All Quality Assurance studies and monitors will be reported to the center’s monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers. Each study and monitor will continue as directed by the Quality Assurance Committee.
F 371 Continued From page 29 without washing her hands.

5. Observations of the breakfast meal on the 40 hall on 10/29/13 at 8:05 AM revealed the following:
   a. Nurse #6 entered room 46, adjusted the bed and did not wash hands.
   b. CNA #6 entered room 44 (contact isolation room) with mask and gloves only.

During an interview on the 40 hall on 10/29/13 at 8:05 AM, Nurse #8 was asked about the type of isolation in room 44. Nurse #8 stated "...MRSA [methicillin resistant staphylococcal aureus] in the sputum... contact isolation..."

During an interview in the Director of Nursing’s (DON) office on 10/30/13 at 7:00 PM, the DON was asked what her expectations were for staff hand hygiene during dining. The DON stated, "If they [staff] come into contact with any items on the overlaid table or in the room or the patient they should wash their hands."

F 431 Overseen by the DON, on 10/29/13, KY Jelly was disposed, the Vaseline and two suppositories were separated from oral medications and the sani-cloth cleaner was removed from the snack drawer.

F 431 Overseen by the DON, all five med carts were audited on 10/29/13 specifically in relation expired meds and externals stored...
<table>
<thead>
<tr>
<th>(X1) PROVIDER/Supplier/Clinic Identification Number:</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>445088</td>
<td></td>
<td>10/30/2013</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**
NHC HEALTHCARE, SPRINGFIELD

**STREET ADDRESS, CITY, STATE, ZIP CODE**
608 8TH AVE EAST
SPRINGFIELD, TN 37172

<table>
<thead>
<tr>
<th>(X4) Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>with internals and no storage issues found of internals, externals, chemicals and or expired meds found.</td>
<td></td>
</tr>
</tbody>
</table>

Overseen by the DON, beginning 11/01/13 and completed on 11/22/13, in-service training of all nursing partners in regards to medication storage policy and procedure and snack storage on the resident floors. Also overseen by DON, any nursing partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift worked.

Overseen by DON, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, reviewing medication carts and resident floor snack storage areas x 6 weeks to ensure adherence to proper storage. All Quality Assurance studies and monitors will be reported to the center’s monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietitian, social worker, health information

**F 431 Continued from page 30**
appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure internal and external medications and preparations for human use were not stored together in 2 of 8 (15 hall medication cart and Baby cart) medication storage areas.

The findings included:
1. Review of the facility's medication storage policy documented, "...Orally administered medications are kept separate from externally used medications... Potentially harmful substances such as... cleaning supplies, disinfectants are... stored in a locked area
F 431 Continued From page 31

2. Observations and interview on the the 15 hall on 10/29/13 at 5:22 PM, revealed the 15 Hall medication cart had one tube of KY Jelly with an expiration date of "Dec [December] 05" in the 8th drawer. Nurse #4 confirmed the date on the KY jelly was December 2005. The 9th drawer had snack food items stored with sanicloth cleaner. Nurse #4 was asked if it was appropriate to store chemical items with food items. Nurse #4 stated, "No."

3. Observations on the 14 hall on 10/29/13 at 5:30 PM, revealed the Baby Cart (medication cart for 14 hall rooms 11 through 108) had Vaseline and two suppositories stored with pills in the top right drawer. Nurse #14, was asked if these items should be stored together. Nurse #14 stated, "No, they shouldn't be [stored] together."

4. During an interview in the Director of Nursing's (DON) office on 10/29/13 at 5:45 PM, the DON confirmed internal and external medications should be stored separately, chemicals and food should not be stored together and expired medications should not be stored on the medication carts.

F 518

493.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using these procedures.
This REQUIREMENT is not met as evidenced by:
Based on review of a new employee's personnel file and interview, it was determined the facility failed to train new employees on emergency preparedness for 1 of 5 (Nurse #7) new employee files reviewed.

The findings included:
Review of Nurse #7's personnel file documented a hire date of 8/1/13. The facility was unable to provide documentation that Nurse #7 received training on emergency preparedness.

During an interview in the Rehabilitation Director's office on 10/29/13 at 11:25 AM, Employee #1 was asked what the procedure was for a new employee's orientation and training. Employee #1 stated, "[Named Nurse #7] has not received orientation or training on emergency preparedness at this time period."

During interview in the Rehabilitation Directors' office on 10/30/13 at 4:25 PM, the Administrator stated, "[Named Nurse #7] has not had orientation... training at this time."

Beginning 10/29/13, Administrator immediately implemented a new process to train partners to meet the requirement of Patient Protection Policy and Emergency Preparedness Plan prior to partner beginning work in the center.

Overseen by Administrator, and beginning 10/29/13, in-service training of the center's Patient Protection and Response Policy for Allegation of Abuse and Emergency Preparedness Plan was held for all partners. All in-service training was completed by 11/22/13. Also overseen by Administrator, any partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift worked.

Overseen by Administrator, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, interviewing 5 random partners a week for their understanding of their role in the center's Patient Protection and
Continued From page 32

This REQUIREMENT is not met as evidenced by:
Based on review of a new employee's personnel file and interview, it was determined the facility failed to train new employees on emergency preparedness for 1 of 5 (Nurse #7) new employee files reviewed.

The findings included:
Review of Nurse #7's personnel file documented a hire date of 8/1/13. The facility was unable to provide documentation that Nurse #7 received training on emergency preparedness.

During an interview in the Rehabilitation Director's office on 10/29/13 at 11:25 AM, Employee #1 was asked what the procedure was for a new employee's orientation and training. Employee #1 stated, "[Named Nurse #7] has not received orientation or training on emergency preparedness at this time period."

During interview in the Rehabilitation Directors' office on 10/30/13 at 4:25 PM, the Administrator stated, "[Named Nurse #7] has not had orientation... training at this time."

Response Policy for Allegation of Abuse and Emergency Preparedness Plan. Also, Overseen by Administrator, a Quality Assurance study will be conducted, beginning the week of November 25, 2013, reviewing training for all new partners ensuring that each has received training regarding the center's Patient Protection and Response Policy for Allegation of Abuse and Emergency Preparedness Plan. This monitor will be reported to the QA committee X 2 months. All Quality Assurance studies and monitors will be reported to the center's monthly Quality Assurance committee which consists of the administrator, DON, medical director, registered dietitian, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director and Nurse Managers. Each study and monitor will continue as directed by the Quality Assurance Committee.