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 policy review, medical record review, observation and interview, it was determined the facility failed to promote care for a resident in a manner that maintained or enhanced his dignity and respect for 1 of 35 (Resident #220) sampled residents included in the stage 2 review.

The findings included:
Review of the "RESIDENT BILL OF RIGHTS" provided by the facility documented, "...It is the objective of the Facility to herein forth the rights of Residents so as to assure the protection and preservation of dignity..."

Medical record review for Resident #220 documented an admission date of 11/19/12 with a readmission date of 8/12/13 with diagnoses of End Stage Renal Disease, Failed Kidney Transplant, Late Effects Hemiplegia, Convulsions, Atrial Fibrillation, Diabetes, Dysphagia, Anemia, Depressive Disorder, Hyperlipidemia, Hypertension and Gastrostomy. Review of the quarterly Minimum Data Set (MDS) dated 9/1/13 documented a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment.

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. (See Instructions.) Except for nursing homes, the findings stated above are dischargeable 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 dischargeable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 241</td>
<td>Each corrective action should be cross-referenced to the appropriate deficiency</td>
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| F 241  | Continued From page 1 10/21/13 at 12:00 PM, Certified Nursing Assistant (CNA) #2 and CNA #3 uncovered Resident #220, pulled the resident up in the bed and turned the resident to straighten the pad under him. The privacy curtain between the beds was not pulled and the door to the hall was open exposing the resident to anyone who entered or passed by the room. During an interview in the conference room on 10/24/13 at 3:00 PM, the Director of Nursing (DON) was asked what was expected of staff when providing care to residents in semi-private rooms. The DON stated, "I expect them to pull the curtain..." |

| F 253  | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES |

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<tr>
<th>ID</th>
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<tr>
<td>F 253</td>
<td>Each corrective action should be cross-referenced to the appropriate deficiency</td>
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| F 253  | Continued From page 1 10/21/13 at 12:00 PM, Certified Nursing Assistant (CNA) #2 and CNA #3 uncovered Resident #220, pulled the resident up in the bed and turned the resident to straighten the pad under him. The privacy curtain between the beds was not pulled and the door to the hall was open exposing the resident to anyone who entered or passed by the room. During an interview in the conference room on 10/24/13 at 3:00 PM, the Director of Nursing (DON) was asked what was expected of staff when providing care to residents in semi-private rooms. The DON stated, "I expect them to pull the curtain..." |

| F 253  | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES |

| SS=0  | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. |

| SS=D  | This REQUIREMENT is not met as evidenced by. Based on policy review, observation and interview, it was determined the facility failed to provide effective housekeeping services for resident rooms to maintain a sanitary, orderly and comfortable environment for 2 of 114 (resident rooms 1005 and 1007) resident rooms. The findings included: 1. Review of the facility's "JOB CARD Resident Room and Restroom Cleaning" policy documented, "...Daily Tasks... Wash restroom walls & [and] door... Sweep restroom floor w |

| 1. | Room 1007 and 1005 were immediately cleaned. Room 1007 will be stripped and waxed weekly to ensure it is kept clean and odor free. It will be checked 3 times a day and PRN in between. |

| 2. | All residents have the potential to be affected. |

| 3. | The Housekeeping Supervisor will re-in-service all of the floor techs and housekeepers on thoroughly cleaning rooms. This in-service was conducted 11-8-13. |

| 4. | Housekeeping supervisor and/or designee will audit 15 rooms a day for cleanliness. This will be done 5 times a week for one month. Rooms 1005 and 1007 will be included in this audit. Housekeeping supervisor and/or designee will audit 15 rooms a day twice a week for three months thereafter. Rooms 1005 and 1007 will be in included in the audit. All findings will be reviewed and discussed in monthly QA meeting. |
Continued from page 2:

[with] /broom-dust pan... Dust mop resident room floor... Damp mop resident room floor and restroom floor..."

2. Observations in room 1005's bathroom on 10/24/13 at 9:35 AM, revealed the tops of the white baseboard was dirty with a dark brownish substance.

3. Observations in room 1007 on 10/21/13 at 11:45 AM and 10/22/13 at 8:00 AM, revealed the room smelled of urine.

Observations in room 1007 on 10/23/13 at 10:00 AM, revealed a sticky substance on the floor.

Observations in room 1007 on 10/24/13 at 9:05 AM, revealed a sticky substance and black spots with a powdery appearance on the floor and a dirty glove in the corner of the room. The bathroom floor at the tub was dirty, there was a black substance around the edges of the walls, the walls had black marks above the baseboards, the floor around the base of the commode was stained with a black substance and a dirty washcloth was laying on the floor beside the commode.

During an interview in room 1007 on 10/24/13 at 9:20 AM, the Administrator was asked about the findings in room 1007. The Administrator stated, "...this resident constantly uses the bathroom on the floor and it has got into the tiles... they [tiles] are going to have to be pulled up and replaced. We are getting ready to completely gut all these bathrooms and have already started... they strip these floors frequently..."
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<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 253</td>
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<td>10/24/13 at 9:40 AM, the Director</td>
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<td>of Housekeeping was asked what</td>
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<td>the black marks on the floor</td>
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<td>were. The Director of Housekeep</td>
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<td>floor is sticky, it pulls the</td>
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<td>black off the wheelchair</td>
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<td>tires...&quot;</td>
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<td></td>
<td>4. During an interview in the</td>
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<td>1000 hall on 10/24/13 at 11:50</td>
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<td>AM, the Housekeeping Supervisor</td>
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<td>was asked how often resident</td>
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<td>rooms are stripped and waxed.</td>
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<td>The Housekeeping Supervisor</td>
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<td>stated, &quot;...every other week...&quot;</td>
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<td>The Housekeeping Supervisor was</td>
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<td>then asked what was the cleaning</td>
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<td>schedule of resident rooms. The</td>
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<td>Housekeeping Supervisor stated,</td>
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<td>&quot;...everyday we sweep and mop</td>
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<td>the rooms, we use a different</td>
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<td>mop for every room...&quot;</td>
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<th>ID PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 280</td>
<td>SS=D</td>
<td>483.20(d)(3), 483.10(k)(2)</td>
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<tr>
<td></td>
<td></td>
<td>RIGHT TO PARTICIPATE</td>
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<td>PLANNING CARE-REVISE CP</td>
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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.

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.

1. Resident #11's care plan was immediately updated.
2. All residents have the potential to be affected.
3. MDS Director re-serviced all care plan nurses on updating care plans with an emphasis on anti-coagulation therapy. This was completed 10-23-13.
4. MDS Director and/or designee will conduct a facility audit for anti-coagulation care plans by 11-22-13 and will conduct monthly audits for three months. All findings will be reported to the QA committee.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to revise the care plan for the use of coumadin for 1 of 20 (Resident #11) sampled residents of the 36 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #11 documented an admission date of 11/12/11 with a readmission date of 6/4/12 with diagnoses of Failure to Thrive, Congestive Heart Failure, Hyperlipidemia, Hypertension, Senile Dementia with Behaviors, Dysphagia Oral Phase, Herpes Zoster, Muscle Weakness, Chronic Airway Obstruction, Gastrostomy, Anxiety Disorder, Hypothyroidism, Depressive Disorder, Insomnia, Lack of Coordination, Abnormal Coagulation, Sinusoidal Node Dysfunction and Psychosis.
Review of the 30 day Minimum Data Set (MDS) dated 8/19/13 and the 60 day MDS dated 9/16/13 documented Resident #11 received anticoagulant (warfarin, heparin). Review of the physician's orders dated 10/3/13 documented "...Coumadin... 5 mg [milligrams]... QD [every day]..." The care plan dated 11/27/12 was not updated to include the resident was at risk for bleeding due to the use of coumadin or anticoagulant therapy.

During an interview in the MDS office on 10/23/13 at 11:30 AM, the MDS Coordinator stated "...coumadin therapy should be on the care plan... it's not there..."
**Summary Statement of Deficiencies**

**F 282**

**SS=D**

**483.20(k)(3)(ii) services by qualified persons/per 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, medical record review, observation and interview, it was determined the facility failed to ensure care plan interventions were followed for oral care or falls for 2 of 20 (Residents #59 and 233) sampled residents reviewed of the 36 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "ACCIDENT & [and] INCIDENT DOCUMENTATION & INVESTIGATION" policy documented, "...Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents..."

2. Medical record review for Resident #59 documented an admission date 6/26/07 with diagnoses of Dysphagia, Anxiety, Hypertension, Osteoarthritis, Diabetes, Depression, Pain, Constipation, Peripheral Vascular Disease, Insomnia and Diarrhea. Review of the care plan dated 9/23/10 and updated 9/23/13 documented, "...Problem... Alteration in ADL [Activities of Daily Living] function... Approaches... Encourage to... brush teeth... Assure oral care daily and PRN [as needed]."

**F 282**

1. Resident #59 has been getting her teeth brushed routinely beginning 10-25-13. Occupational therapy began treatment with resident to assist them with oral care beginning 11-18-13. Resident #233 had a sensor pad and tab alert wheelchair alarm installed on their chair on 10-23-13.

2. All residents have the potential to be affected.

3. DNS and/or designee will in-service all nurses and cnas on following physician orders and care plans with an emphasis on fall prevention and oral care. This in-service was conducted on 11-8-13.

4. DNS and/or designee will audit all residents with care plans and orders for fall interventions as well as oral care. This will be 15 residents a day times four weeks. Thereafter, it will be 15 residents a week times for 3 months. All findings from these audits will be reported to QA committee for three months.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 282  | Continued From page 6

During an interview in Resident #59's room on 10/22/13 at 2:05 PM, Resident #59 was asked how often her teeth / dentures / mouth was cleaned. Resident #59 stated, "...they [nursing home staff] don't brush my teeth and I don't brush my teeth. I would like for someone to brush my teeth..."

During an interview in the west hall on 10/23/13 at 2:55 PM, Certified Nursing Assistant (CNA) #4 was asked about providing AM care and brushing Resident #59's teeth. CNA #4 stated, "...I come in and wash her face and swab out her mouth with a sponge toothette." CNA #4 was asked if she brushed Resident #59's teeth. CNA #4 stated, "Well, here lately, well, I just haven't done it, nothing else to say about it."

3. Medical record review for Resident #233 documented an admission date of 9/18/13 with diagnoses of Failure to Thrive, Hypertension, Diabetes, Urinary Tract Infection and Cerebral Arterial Occlusion. Review of nurses' notes dated 10/8/13 documented, "...SUMMONED TO ROOM PER CNA, RESIDENT FOUND ON FLOOR ON KNEES. RESIDENT ASSISTED TO BED PER STAFF AND ASSESSED FOR INJURIES. NO OPEN AREA OR BRUISES NOTED. RESIDENT UNABLE TO SAY WHAT SHE WAS TRYING TO DO... NEW ORDERS FOR NEUROS [neurochecks], BED SENSOR AND TAB ALERT..." Review of the physician's orders dated 10/8/13 documented, "...SENSOR PAD TO BED, TAB ALERT TO WHEELCHAIR..." Review of the "INSTANT CARE PLAN" dated 10/8/13 documented, "...Fall...[checked]... Found on Floor... Bed [circled]... alarm [underlined]... Sensor pad to bed D/C [discontinue wheelchair...

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F 282 Continued From page 7
alarm...

Observations at the central nurses' station on 10/21/13 at 3:15 PM, revealed Resident #233 sitting in a wheelchair (wc) at the nurses' station with a wand guard on the wc arm, and no clip alarm noted.

Observations in Resident #233's room on 10/22/13 at 7:55 AM, revealed Resident #233 sitting up in bed with no sensor pad on the bed.

Observations at the central nurses' station on 10/22/13 at 1:00 PM and on 10/23/13 at 4:50 PM, revealed Resident #233 sitting in a wc at the nurses' station with no clip alarm noted.

Observations in Resident #233's room on 10/23/13 at 4:55 PM, revealed no sensor pad on Resident #233's bed.

During an interview at the west nurses' station on 10/23/13 at 4:50 PM, Nurse #3 was asked to show this surveyor the bed alarm and the tab alert on Resident #233. Nurse #3 stated, "...she went out to the hospital since her fall and when she came back everything started new so what she gets right now is monitoring..." (The fall occurred 10/8/13 after the readmission date of 10/7/13 according to the nurses' notes.)

During an interview at the central nurses' station on 10/23/13 at 5:00 PM, the Assistant Director of Nursing (ADON) was asked why Resident #233 did not have a clip alarm on or a sensor pad on her bed. The ADON stated, "...Because if she goes to the hospital and comes back everything starts new. She [Resident #233] went to the hospital on 10/1/13 and returned 10/7/13..." (The
**Continued From page 8**

Fall occurred 10/8/13 after her return from the hospital.

During an interview in Resident #233's room on 10/23/13 at 5:05 PM, the ADON confirmed there was no sensor pad on the bed or clip alarm to the WC and the only thing the resident had on her was a wanderguard.

**ADL CARE PROVIDED FOR DEPENDENT RESIDENTS**

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure 1 of 1 (Resident #59) sampled resident who is unable to carry out activities of daily living (ADL) received assistance with oral hygiene.

The findings included:

Medical record review for Resident #59 documented an admission date 8/28/07 with diagnoses of Peripheral Vascular Disease, Dysphagia, Hypertension, Osteoarthritis, Diabetes, Anxiety, Depression, Constipation, Insomnia, Pain and Diarrhea. Review of the care plan dated 9/23/10 and updated 9/23/13 documented, "...Problem... Alteration in ADL function... Approaches... Encourage to... brush teeth... Assure oral care daily and PRN [as

<table>
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</table>
| F 282 | 1. Resident #59 has been getting teeth brushed since 10-25-13. Occupational therapy began treatment on resident 11-18-13 for assistance with oral care.  
2. All residents have the potential to be affected.  
3. DNS and/or designee in-serviced all CNAs and licensed personnel on oral care on 11-8-13.  
4. DNS and/or designee will conduct an audit residents receiving oral care to ensure it is being conducted. This will be 15 residents a day times four weeks and thereafter 15 residents a week times three months. All findings will be reported to QA&A for three months. |
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<th>(X5) COMPLETION DATE</th>
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| F 312 |        |     | F 312 |        |     | Continued From page 9 needed]["

During an interview in Resident #59's room on 10/22/13 at 2:05 PM, Resident #59 was asked how often her teeth / dentures / mouth was cleaned. Resident #59 stated, "...they [nursing home staff] don't brush my teeth and I don't brush my teeth. I would like for someone to brush my teeth...

During an interview in the west hall on 10/23/13 at 2:55 PM, Certified Nursing Assistant (CNA) #4 was asked about providing AM care and brushing Resident #59's teeth. CNA #4 stated, "...I come in and wash her face and swab out her mouth with a sponge toothette." CNA #4 was asked if she brushed Resident #59's teeth. CNA #4 stated, "Well, here lately, well, I just haven't done it, nothing else to say about it."

F 314 |        |     | F 314 | 483.25(c) TREATMENT/SVCS TO PREVENT/HEEL 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 review of the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy
Continued from page 10

Review, medical record review, observation and interview, it was determined the facility failed to identify pressure ulcers before they became unstageable for 3 of 6 (Residents #1, 17 and 195) sampled residents reviewed of the 6 residents included in stage 2 with pressure ulcers. The failure to identify a pressure ulcer before it became unstageable resulted in actual harm and substandard quality of care for Residents #1, 17 and 195.

The findings included:

1. Review of the "National Pressure Ulcer Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "[page] 9 ... Unstageable / Unclassified: Full thickness skin or tissue loss-depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV... [page] 12...3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darter pigmented skin... [page] 13... 6. Observe the skin for pressure damage caused by medical devices... Many different types of medical devices have been reported as having caused pressure damage... 7. Document all skin assessments, noting details of any pain possibly related to pressure damage..."

| F 314 | 1. Head to toe skin assessments have been completed on Residents #1, 17, 195. The area on #1 was healed 10-16-13. The area on resident #17 healed 11-1-13. The area on resident #195 has an appropriate treatment and is being monitored daily by the treatment nurse/designee.
|       | 2. All residents have the potential to be affected.
|       | 3. 100% head to toe skin assessments will be completed on all residents by 11-22-13. All residents wearing a cast or immobilizer have been assessed for proper fitting and placement of device. Nursing staff were re-in-serviced on the importance of completing the weekly skin assessments with focus on early detection of pressure ulcers. Nursing staff were also re-in-serviced on daily skin assessments for residents with casts, immobilizers, etc. These in-services were conducted on 11-8-13 and 11-13-13. The treatment nurses were in-serviced 10-28-13 to assess all new admissions/re-admissions for skin issues.
|       | 4. Weekly head to toe skin assessments will be audited weekly for compliance and will be reported weekly for four weeks at the daily morning meeting and monthly at the QA meeting for 6 months. Skin assessments for new admissions/re-admissions will be audited 2x a week for four weeks. Findings will be reported monthly at the QA meeting for 6 months. All new casts/immobilizers will be reviewed daily in morning meeting. A list of residents with these medical devices will be discussed month at the QA meeting for six months. All of the above will be done by DNS/designee. The treatment nurse/designee will report daily of new pressure ulcers at morning meeting daily and monthly at the QA meeting for six months. | 11-25-13 | 11-25-13 | 11-25-13 |
F 314

2. Review of the facility's "WEEKLY SKIN AUDIT" policy documented, "...PROCEDURE: 1. Every resident will have a head to toe skin evaluation performed and documented on a weekly basis..."

Review of the facility's "PRESSURE ULCER & SKIN CONDITIONS GUIDE FOR WOUND EVALUATION DOCUMENTATION" policy documented, "...It is the practice of this facility to ensure residents with pressure ulcers receive necessary evaluation and treatment to promote healing, prevent infection and prevent new ulcers from developing... DEFINITIONS: PRESSURE ULCER... UNSTAGEABLE Full thickness tissue loss in which the base of the ulcer is covered by... and/or eschar (tan, brown or black) in the wound bed..."

3. Medical record review for Resident #1 documented an admission date of 11/13/1995 and a readmission date of 1/17/2013 with diagnoses of Alzheimer's Disease, Multiple Sclerosis, Osteoporosis, Dementia, Anemia, Anxiety, Hypothyroidism, Hyperlipidemia, Diabetes, Depression, Hypertension, Esophageal Reflux, Dysphagia, Epilepsy, Peripheral Neuropathy, Constipation, Neurogenic Bladder and Pressure Ulcers.

Review of a significant change Minimum Data Set (MDS) dated 1/24/13 documented Resident #1 was at risk to develop pressure ulcers. Review of the quarterly MDS dated 4/21/13 documented one (1) stage 4 (IV) pressure ulcer.

Review of the care plan dated 2/11/13 documented, "Impaired skin Integrity... LLE [Left Lower Extremity] - Stage IV... Approaches..."
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</table>
| F 314       |     | Continued From page 12 weekly skin audits...

Review of a physician's order dated 1/18/13 documented, "...Knee immobilizer at all times...
Review of a physician's order dated 2/20/13 documented, "Knee immobilizer that fits better (shorter)..."

Review of Resident #1's nurse's notes documented the following:
  a. "...1/17/13... full skin assessment performed..."
  b. "...1/18/13... immobilizer in place check for skin breakdown under the immobilizer..."
  c. "...1/21/13... immobilizer in place to [left] leg, resident ask several times... to look at her leg stating "I [I think there's something wrong with it" did c/o [complain of] pain to leg..."
  d. "...1/22/13... full skin assessment performed...
  e. "...1/29/13... Full skin assessment performed. Resident has no new skin issues to report..."
  f. "...2/2/13... immobilizer in place... removed every 2 hours to check for pinching, discoloration, pulses..."
  g. "...2/11/13... this morning the CNA [Certified Nursing Assistant] noted dry scab to old scratched spots with pink color around... MD [Medical Doctor] notified new order for wound care to evaluate..."
  h. "...2/11/13... Full skin assessment performed... Healed scratched under immobilizer red in color. 
  i. "...2/12/13... Alerted by charge nurse of a dried scab to resident left leg. Upon inspection this nurse noticed two areas with firm black eschar R/T [related to] immobilizer which is worn at all times. Wound #1 measures 1.8cm [centimeters] X [by] 0.7cm x < [less than] 0.1cm depth. The wound bed is 100% [percent] firm black eschar... Wound #2 measures 2.5cm X 1.5cm X <0.1cm
<table>
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<tr>
<th>F 314</th>
<th>Continued From page 13 depth. The wound bed is 100% firm black eschar... Current tx orders: skin prep areas and leave open to air daily... Will refer to therapy for proper fitting and padding of immobilizer...</th>
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<tbody>
<tr>
<td></td>
<td>Review of the &quot;24 HOUR NURSING REPORT&quot; dated 2/2/13 documented, &quot;...Check skin under Immobilizer Q [every] Shift for any Abnormalities. None noted this shift [7am to 7pm]...&quot;</td>
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<tr>
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<td>Observations in Resident #1's room on 10/24/13 at 8:25 AM, the wound care physician and the wound care nurse were at the bedside and assessed the left ankle area. The wound area was red fragile skin with no broken skin. The wound care physician stated, &quot;It is resolved.&quot; Resident #1 had Prevalon boots on both feet.</td>
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<td>During an interview at the south central nurses' station on 10/23/13 at 11:15 AM, Nurse #1 stated, &quot;...She [Resident #1] was on a 24 hour schedule while she wore the immobilizer... someone should be checking her skin under the immobilizer at least daily... the report book should have instructions for staff to check skin and report breakdown under the immobilizer...&quot;</td>
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<td>During an interview in the conference room on 10/24/13 at 9:35 AM, the Director of Nursing (DON) stated, &quot;...the immobilizer was never removed for bathing or skin checks. We treated it like a cast.&quot; The DON was asked what she would do to assess the skin under the immobilizer on this resident. The DON stated, &quot;I would be nervous to undo it. I would stick my hand up there to see, the 2 finger rule like with a cast...&quot;</td>
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<tr>
<td></td>
<td>During a telephone interview in the conference room on 10/24/13 at 10:55 AM, the Medical</td>
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F 314 Continued From page 14
Director was asked about Resident #1 and if he expected the nursing staff to do skin assessments under the immobilizer. The Medical Director stated, "...that is a tough thing to answer... skin assessments need to be done..." The Medical Director was asked if he would expect the nurses to undo the velcro to inspect the skin. The Medical Director stated, "...No, I would not expect them to undo the velcro to look..."

During an interview at the south central nurses’ station on 10/24/13 at 11:30 AM, Nurse #2 was asked about the care of the skin under the immobilizer for Resident #1. Nurse #2 stated, "...I stuck my finger in the edges to check for skin, you can see under the immobilizer where it is open. On the lower end I could see the red area... I noticed [named physician] by telephone... I don’t remember if the Treatment Nurse saw it that day or the next day..." Nurse #2 was asked if she has had any training on how to care for a patient with an immobilizer. Nurse #2 stated, "...I have had immobilizer training in school... but no training here on immobilizers..."

During an interview in the Assistant Director of Nursing’s (ADON) office on 10/24/13 at 5:00 PM, the Treatment Nurse stated, "...The immobilizer was long and would slide down the leg. When the immobilizer was pulled all the way up to her hip, you could see the wound and every day I would skin prep it and leave it open to air, until we got the shorter knee immobilizer. Every day I had to pull it up but I did not loosen it. There was some metal that was inside it that we could feel and we are pretty sure that caused the rubbing and the pressure ulcer. We padded it until we got a new one [immobilizer]."
During an interview in the conference room on 10/25/13 at 7:50 AM, the Staff Educator was asked what is done to educate the staff when a resident comes in with patient care equipment like an immobilizer. The Staff Educator stated, "No one ever told me that I needed to do an in-service on immobilizers. I usually get the manufacturer or rep [representative] to come in and do in-services on equipment... PT [Physical Therapy] comes around and does individual in-services..."

During an interview in the conference room on 10/25/13 at 8:00 AM, the Director of PT stated, "We taught the nursing staff how to position the immobilizer on [named Resident #1]..."

The failure to identify a pressure ulcer before it became unstageable resulted in actual harm to Resident #1.

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<tr>
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</table>
| F 314 | MOISTENED HYDROFERA BLUE AND FOAM DRSG Q 3 D... | Review of the "ADMISSION / READMISSION EVALUATION" dated 6/113 documented, "Full Leg Cast to Rt [right] lower extremity..." Review of the care plan dated 6/18/13 documented, "Problem/Need... (new, shorter cast placed 6/14/13) 6/20/13 open area (R) [right] achilles R/T [related to] previous cast over area..." Review of the care plan dated 7/4/13 documented, "Problem/Need... Skin Integrity Impaired Actual... unstageable to R Achilles..."
| F 314 | Continued From page 16 | Review of Resident #17's nurses' notes documented the following:
| a. | 6/1/13 - "New admit... full leg cast extending from (R) hip to (R) foot..." |
| b. | 6/13/13 - "Resident approached this nurse with concerns of soreness to his posterior thigh and right achilles... upon inspection of resident right achilles this nurse noticed cast was tight... c/o [complaining of] pain in the area... This nurse called [named] Orthopedic Group / [Named Doctor]. An appt [appointment] is scheduled for Friday June 14, 2013..."
| c. | 6/20/13 - "Notified by PT [physical therapy] that resident c/o pain to his right achilles. Upon inspection this nurse noticed resident has an open area to his right achilles measuring 3.0 x 3.0 x 0.2 cm [centimeters] depth. The wound bed is 100% slough/fibrin with no drainage... Resident has a cast to his right leg, and went to an Ortho [orthopedic] appt on 6/14/13 and had the cast shortened. This wound is a result of the cast..."
| | | Review of the "Weekly Skin" assessment in the computer system dated 6/18/13 documented, "No Skin Issues Present..." |
F 314 Continued From page 17

Review of the June 2013 Treatment Administration Record documented wound care was started to this wound on 6/20/13. This wound was discovered with 100% slough on 6/20/13 after the cast was shortened 6/14/13 (6 days after the cast was shortened).

Observations in Resident #17's room on 10/25/13 at 9:00 AM, the Treatment Nurse removed the dressing to Resident #17's right Achilles, a nickel size wound observed, red in color, white to center, with very small amount of depth noted, and no erythema noted.

During an interview in the conference room on 10/24/13 at 5:05 PM, the Treatment Nurse was asked about the development of this wound with 100% slough 6 days after cast was shortened. The Treatment Nurse stated there is nothing documented concerning a wound until this date and confirmed treatments were started on 6/20/13 for this wound.

During an interview in the conference room on 10/24/13 at 5:45 PM, the DON was asked what is the process for skin assessments and where the skin assessments should be documented. The DON stated, "...[Skin assessments] are done weekly and documented in the nurses' notes or in [name of computer software program]." The DON was asked who is responsible for these assessments. The DON stated, "The charge nurses are responsible and assigned by rooms, the same nurse assesses certain residents the same day each week." The DON was asked what is done if a resident leaves for an appointment or on leave of absence when the resident returns to the facility for skin
<table>
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<th>COMPLETION DATE</th>
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| F 314 | Continued From page 18 assessments. The DON stated, "...skin assessments are not done routinely in this instance. I would do it, but it is not done consistently."

During an interview in the conference room on 10/24/13 at 6:00 PM, Nurse #1 viewed the medical record in the computer and confirmed there was a skin assessment dated 6/18/13 with no skin issues, then on 6/20/13 the wound to the R achilles was documented with 100% slough.

During an interview in the conference room on 10/24/13 at 6:05 PM, the Treatment Nurse was asked about skin assessments from the time the cast was shortened (6/14/13) and the discovery of the pressure ulcer with 100% slough (6/20/13). The Treatment Nurse stated, "...it [charting] doesn't address the skin assessments... I can say I know it was from the cast, because he had swelling, the assessment on the 18th [6/18/13]. I plead nurse ignorance..."

During an interview in the conference room on 10/24/13 at 6:15 PM, the DON was asked what would be expected after a resident comes back from a procedure such as cast shortened, would she expect the staff to assess the area where the cast had been. The DON stated, "I would." As the Treatment Nurse was asked about the cast being shortened on 6/14/13 and a wound discovered 6/20/13 with 100% slough, and there being no skin issues documented during this time period. The DON stated, "...can not argue that, that is right..."

During an interview in conference room on 10/25/13 at 9:20 AM, CNA #1 was asked if skin is examined with daily care. CNA #1 stated, "Yes, is
Continued From page 19

examined with daily bathing..." CNA #1 was asked what is the skin observed for. CNA #1 stated, "...observe for dry skin, scratches, red marks, splits between toes... if see anything, would tell the charge nurse." CNA #1 was asked if she ever saw any skin issues after this resident had cast shortened or removed. CNA #1 stated, "...never did see anything prior to the wound being treated with a dressing..."

The failure to identify a pressure ulcer before it became unstageable resulted in actual harm to Resident #17.

6. Medical record review for Resident #195 documented an admission date of 12/5/11 and a readmission date of 7/19/13 with diagnoses of Cerebrovascular Accident, Senile Dementia, Hypertension, Percutaneous Esophageal Gastrostomy Tube, Edema, Joint Pain, Atrial Fibrillation, Dysphagia, Pressure Ulcer to Right Lateral Ankle, Diabetes Mellitus, Carotid Artery Occlusion, Hypercholesterolemia and Congestive Heart Failure. Review of the care plan dated 12/2/11 documented, "...Problem/Need... At risk for skin impairment t/t incontinent... Stage 4 wound to (R) lateral ankle [not dated]..."

Review of the nurses' notes dated 6/4/13 documented, "...Weekly Summary / Skin Assessment... Continue to monitor excoriation to buttocks and scrotum. Barrier cream applied after each incontinent episode. Scabbed area noted to bilateral knees and shins of both legs. Heel protected on both heels to prevent any further redness..." There was no documentation of redness or skin breakdown to the heels in this skin assessment. Review of the nurses' notes dated 8/6/13 documented, "...Alerted by staff that..."
**F 314**

Continued From page 20

resident has an open area to his right ankle. Upon inspection this nurse noticed an open area to resident right lateral ankle with necrotic tissue. The wound measures 1.6cm x 0.9cm x 0.1cm depth. The wound bed is 100% necrotic tissue with serosanguinous drainage..."


Observations in Resident #196's room on 10/24/13 at 8:42 AM, the Treatment Nurse removed the dressing from Resident #196's R lateral ankle, the wound was approximately 1 cm in diameter, red-pink in color, with a small amount of serous drainage noted.

During an interview at the west nurses' station on 10/24/13 at 9:21 AM, the Treatment Nurse and the Wound Care Physician were asked if staff should have seen this area as redness or skin breakdown prior to this area becoming 100% eschar. The Treatment Nurse and the Wound Care Doctor stated, "Yes."

During an interview in the conference room on 10/24/13 at 10:35 AM, the DON was asked how is the resident's skin assessed. The DON stated, "...Two aides check this resident everyday... nurses do weekly skin assessments..."
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Clinic Identification Number:
446197

#### (X2) Multiple Construction
A. Building
B. Wing

#### (X3) Date Survey Completed:
10/26/2013

#### Name of Provider or Supplier:
Quince Nursing and Rehabilitation Center

#### Street Address, City, State, Zip Code:
5733 Quince Road
Memphis, TN 38119

<table>
<thead>
<tr>
<th>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>(X5) Completion Date</th>
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</table>
| F 314         | Continued From page 21

   During a telephone interview in the conference room on 10/24/13 at 11:25 AM, the Wound Care Doctor was asked if there should have been redness or some type of skin breakdown present prior to eschar. The Wound Care Doctor stated, "Yes, should see redness before eschar..."

   The failure to identify a pressure ulcer before it became unstageable resulted in actual harm to Resident #195.

| F 323         | 463.25(h) Free of Accident Hazards/Supervision/Devices

   The facility must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

   This REQUIREMENT is not met as evidenced by:

   Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure care plan interventions were followed for falls for 1 of 3 (Resident #233) sampled residents reviewed of the 4 residents included in stage 2 with falls.

   The findings included:

   1. Review of the facility's "ACCIDENT & [and] INCIDENT DOCUMENTATION & INVESTIGATION" policy documented, "...Accidents and incidents will be analyzed for

1. Resident #233 had a tab alert and sensor pad applied to her wheelchair on 10-23-13.
2. All residents have the potential to be affected.
3. DNS and/or designee in-serviced all nurses and care staff on fall prevention with a particular emphasis on tab alerts and sensor pads. This in-service was conducted on 11-8-13 and 11-13-13.
4. DNS and/or designee will conduct an audit on all residents with orders and care plans for fall interventions to ensure they are in place. This audit was completed 11-8-13. DNS and/or designee will review 15 residents a day for four weeks and 15 residents a week for three months thereafter. All findings will be reported to the QA&A committee for review and follow up.
Continued From page 22

trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents...

2. Medical record review for Resident #233 documented an admission date of 9/16/13 with diagnoses of Failure to Thrive, Hypertension, Diabetes, Urinary Tract Infection and Cerebral Arterial Occlusion. Review of nurses' notes dated 10/8/13 documented, "...SUMMONED TO ROOM PER CNA, RESIDENT FOUND ON FLOOR ON KNEES. RESIDENT ASSISTED TO BED PER STAFF AND ASSESSED FOR INJURIES. NO OPEN AREA OR BRUISES NOTED. RESIDENT UNABLE TO SAY WHAT SHE WAS TRYING TO DO... NEW ORDERS FOR NEUROS [neurochecks], BED SENSOR AND TAB ALERT..." Review of the physician's orders dated 10/8/13 documented, "...SENSOR PAD TO BED, TAB ALERT TO WHEELCHAIR..." Review of the "INSTANT CARE PLAN" dated 10/8/13 documented, "...Fall... [checked]. Found on Floor... Bed [circled]... alarm [underlined]. Sensor pad to bed D/C [discontinue wheelchair] alarm..."

Observations at the central nurses' station on 10/21/13 at 3:15 PM, revealed Resident #233 sitting in a wheelchair (wc) at the nurses' station with a wander guard on the wc arm, and no clip alarm noted.

Observations in Resident #233's room on 10/22/13 at 7:55 AM, revealed Resident #233 sitting up in bed with no sensor pad on the bed.

Observations at the central nurses' station on 10/22/13 at 1:00 PM and on 10/23/13 at 4:50 PM, revealed Resident #233 sitting in a wc at the
<table>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 23 nurses' station with no clip alarm noted.</td>
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<tr>
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<td>Observations in Resident #233's room on 10/23/13 at 4:55 PM, revealed no sensor pad on Resident #233's bed.</td>
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<td></td>
<td>During an interview at the west nurses' station on 10/23/13 at 4:50 PM, Nurse #3 was asked to show this surveyor the bed alarm and the tab alert on Resident #233. Nurse #3 stated, &quot;...she went out to the hospital since her fall and when she came back everything started new so what she gets right now is monitoring...&quot; (The fall occurred 10/8/13 after the readmission date of 10/7/13 according to the nurses' notes.)</td>
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<td>During an interview at the central nurses' station on 10/23/13 at 5:00 PM, the Assistant Director of Nursing (ADON) was asked why Resident #233 did not have a clip alarm on or a sensor pad on her bed. The ADON stated, &quot;...Because if she goes to the hospital and comes back everything starts new. She [Resident #233] went to the hospital on 10/1/13 and returned 10/7/13...&quot; (The fall occurred 10/8/13 after her return from the hospital.)</td>
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<td>During an interview in Resident #233's room on 10/23/13 at 5:05 PM, the ADON confirmed there was no sensor pad on the bed or clip alarm to the wo and the only thing the resident had on her was a wandeguard.</td>
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<tr>
<td>F 371</td>
<td>483.35(1) FOOD PROCURE, STORE/PREPARE/SERVE - Sanitary</td>
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<td>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</td>
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Continued from page 24

(2) Store, prepare, distribute and serve food under sanitary conditions.

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 stored under sanitary conditions as evidenced by dirty nourishment rooms, food stored past the expiration date and opened food was not labeled on 4 of 5 (10/21/13, 10/22/13, 10/23/13 and 10/24/13) days of the survey.

The findings included:

1. Review of the facility's "Date Marking" policy documented, "...All foods stored... will be properly labeled according to the following guidelines... Date marking for refrigerated storage food items... Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current recommended storage times or by the manufacturers expiration date... Date marking for freezer storage items... Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the recommended storage times or by the manufacturer's expiration date... Prepared food or opened food items should be discarded when... The food item is older than the expiration date..."

2. Observations in the kitchen on 10/21/13 at 9:40 AM, revealed a carton of soy milk in the walk-in cooler store past the manufacturer's
**QUINCE NURSING AND REHABILITATION CENTER**

6733 QUINCE ROAD
MEMPHIS, TN 38119

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 26 expiration date of 10/3/13 and a container of sour cream in the flat cooler stored past the manufacturer's expiration date of 10/7/13.</td>
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During an interview in the kitchen on 10/21/13 at 9:50 AM, the Dietary Manager (DM) was asked about expired containers of food. The DM confirmed these items were expired and removed them. The DM stated, "...The milk man should have rotated them, but did not..."

Observations of the west hall nourishment room on 10/21/13 at 9:40 AM, revealed the wall was stained with liquid streaks and the white cabinet under the sink had liquid run down streaks and had a strong coffee smell. There was an opened cola drink, a Styrofoam cup with a frozen drink, an open bottle of 15.2 ounce bottled apple juice and an opened ice cream cup that were not labeled or dated in the freezer compartment of the refrigerator. There was a dirty paper towel with food splatters in the microwave and the inside top of the microwave had dried food splatters on it.

3. Observations of the east hall nourishment room on 10/22/13 at 8:00 AM, revealed liquid stains down the front of the sink vanity.

Observations of the central hall nourishment room on 10/22/13 at 9:15 AM, revealed liquid stains down the front of the sink vanity.

4. Observations of the west hall nourishment room on 10/23/13 at 9:15 AM, revealed liquid stains down the front of the sink vanity and the wall to the left of the sink.

Observations of the west hall nourishment room
### Summary Statement of Deficiencies

**F 371** Continued From page 26 on 10/23/13 at 12:10 AM, revealed the microwave had dried food on top of the microwave and stains on the vanity cabinet under the sink.

5. Observations in the east hall nourishment room on 10/24/13 at 8:55 AM, revealed a note on the refrigerator dated 8/7/13 documented, "...Attention All Staff All items placed inside of this refrigerator must be properly labeled with a NAME and DATE..." There were 3 1/2 sandwiches and 1 carton of Chinese food not labeled or dated in the refrigerator. In the freezer, there was an opened quart of ice cream not labeled or dated, the microwave had dried food splatters, there were liquid run down stains on front of the cabinet and a bag of trash laying on the floor beside the trash can.

Observations of the south hall nourishment room on 10/24/13 at 9:10 AM, revealed a dirty paper towel stained with food in the microwave.

Observations of the west hall nourishment room on 10/24/13 at 9:15 AM, revealed the refrigerator freezer compartment had 2 open containers of ice cream not labeled or dated, the refrigerator had 2 1/2 sandwiches and 2 slices of pizza between 2 Styrofoam plates that were not dated or labeled and the white cabinet under the sink had liquid run down stains.

Observations of the central hall nourishment room on 10/24/13 at 9:10 AM, revealed dried food in the microwave. A half of a sandwich, a large Styrofoam cup, a box of partially eaten chicken with a biscuit and an open container of jelly in the refrigerator and a solo cup of ice cream in the freezer; none of these items were labeled or dated. There were liquid run down stains on the
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<th>[X9] COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 27 white cabinet.</td>
<td>F 371</td>
<td>1. All unlabeled medication was immediately discarded on 10-24-13.</td>
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<tr>
<td>F 431</td>
<td>SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td>2. All residents have the potential to be affected.</td>
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<td>3. DNS and/or designee will in-service all licensed personnel on medication storage. This will include expiration dates and open by dates. This will also include properly discarding medication. Nurses will contact the pharmacy immediately if bottles are not labeled. This in-service was done 11-13-13.</td>
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<td>4. The Consultant Pharmacist and/or designee will conduct a audit of all medication storage areas weekly for one month and monthly for three months to ensure there are no expired medications. All findings will be reviewed monthly in QA &amp; A meeting.</td>
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Continued From page 28
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 liquid medications dispensed by the pharmacy were labeled with expiration dates and opened medications were dated when opened in 9 of 13 (800 East hall medication cart, East hall medication room, 300 West hall medication cart, 200 West hall medication cart, 900 East medication cart, Central 400-700 hall medication cart, Central 600 medication cart, South Central medication cart 1 and South Central medication cart 2) medication storage areas.

The findings included:

1. Review of the facility's "MEDICATION STORAGE" policy documented, "...The following medications must be removed from stock and disposed of properly on a continuing basis: outdated, contaminated, recalled, deteriorated, unlabeled medications..."

2. Observations of the 800 east hall medication cart on 10/24/13 at 6:30 PM, revealed (2) opened 450 milliliter (ml) bottles of Valproic Acid liquid and an opened 473 ml bottle of Lactulose liquid with no expiration date on the bottle or label. These bottles were dispensed by the pharmacy.

During an interview in the 800 east hall
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>445197</td>
<td>A. BUILDING</td>
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<tr>
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<td>B. WING</td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**QUINCE NURSING AND REHABILITATION CENTER**

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

5733 QUINCE ROAD  
MEMPHIS, TN 38119

**DATE SURVEY COMPLETED**

10/25/2013

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<th>(X4) ID PREFIX TAG</th>
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<th>(X5) COMPLETION DATE</th>
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</table>
| F 431              | Continued From page 29  
medication cart on 10/24/13 at 6:30 PM, Nurse #5 confirmed there was no expiration date on the liquid medications.  
3. Observations of the east hall medication room on 10/24/13 at 6:30 PM, revealed a 473 ml bottle of Lactulose liquid with no expiration date on the bottle or the label. This was dispensed by the pharmacy.  
During an interview in the east hall medication room on 10/24/13 at 6:30 PM, Nurse #3 confirmed there was no expiration date on the Lactulose liquid.  
4. Observations of the 300 west hall medication cart on 10/24/13 at 8:40 PM, revealed an opened 1800 ml bottle of Lactulose liquid, a 450 ml bottle of Lactulose liquid, a 450 ml bottle of Levetiracetam liquid, a 280 ml bottle of Nystatin liquid, and a 240 ml bottle of Generalac liquid with no expiration date on the bottle or the label. These bottles were dispensed by the pharmacy.  
5. Observations of the 200 west hall medication cart on 10/24/13 at 6:40 PM, revealed an opened 550 ml bottle of Carafate liquid, a 240 ml bottle of Lactulose liquid, a 300 ml bottle of Levetiracetam liquid, a 450 ml bottles of Lactulose liquid, a 450 ml bottles of Generalac liquid and a 540 ml bottle of Phenytoin liquid with no expiration date on the bottle or the label. These bottles were dispensed by the pharmacy.  
During an on the west hall on 10/24/13 at 7:45 PM, Nurse #6 confirmed there was no expiration date on the liquid medications noted above.  
6. Observations of the 900 east hall medication | F 431 | |

**FORM CMS-2567(02-99) Previous Versions Obsolete**  
Event ID: 26X811  
Facility ID: TN7603  
If continuation sheet Page 30 of 35
Continued From page 30

cart on 10/24/13 at 11:00 AM, revealed an opened 225 ml bottle of Potassium Chloride liquid and an opened 225 ml bottle of Generalac liquid with no expiration date on the bottle or the label. These bottles were dispensed by the pharmacy.

During an interview in the 900 hall on 10/24/13 at 11:00 AM, Nurse #4 confirmed there was no expiration date on the labels or bottles of the opened medications noted above.

7. Observations of the central 400-700 hall medication cart on 10/25/13 at 10:45 AM, revealed an opened 50 ml bottle of Phenytoin liquid with dated when it was opened, an opened 150 ml bottle of Phenytoin liquid with no date when it was opened and there was no expiration date on the bottle or label, an opened 300 ml bottle of Phenytoin liquid with no date on the bottle when it was opened and there was no expiration date on the bottle or label, and an opened 450 ml bottle of Potassium Chloride liquid with no date when the bottle was opened. These bottles were dispensed by the pharmacy.

8. Observations of the central 600 hall medication cart on 10/25/13 at 11:00 AM, revealed (2) opened 150 ml bottles of Leveliracetam liquid with no date when it was opened and no expiration date on the bottle or label, an opened 946 ml bottle of Generalac liquid with no date when it was opened and no expiration date on the bottle or label and a 225 ml bottle of Potassium Chloride liquid with no expiration date on the bottle or the label. These bottles were dispensed by the pharmacy.

9. Observations of the south central hall medication cart 1 on 10/25/13 at 11:15 AM,
F 431  |  Continued From page 31  
revealed an opened 150 ml bottle of Megesterol 
liquid with no date when it was opened, an 
opened 300 ml bottle of Ranitidine liquid with date 
when it was opened and there was no expiration 
date on the bottle or label, an opened 225 ml 
bottle of Potassium Chloride liquid with no date 
when it was opened and no expiration date on the 
bottle or label, an opened 450 ml bottle of 
Generalcac liquid with no date when it was opened 
and there was no expiration date on the bottle or 
label, an opened 225 ml bottle of Generalcac liquid 
with no date when it was opened and no 
expiration date on the bottle or label and an 
opened 473 ml bottle of Generalcac liquid with no 
date when it was opened and there was no 
expiration date on the bottle or the label. These 
bottles were dispensed by the pharmacy. 

10. Observations of the south central hall 
m济ication cart 2 on 10/25/13 at 11:45 AM, 
revealed an opened 300 ml bottle of 
Levetiracetam liquid with no date when it was 
opened, (2) opened 225 ml bottles of Potassium 
Chloride liquid with no date when it was opened 
and no there was expiration date on the bottle or 
label, an opened 225 ml bottle of Lactulose liquid 
with no date when it was opened and there was 
no expiration date on the bottle or label, and an 
opened 125 ml bottle of Dianitin liquid with no 
date when it was opened and there was no 
expiration date on the bottle or the label. These 
bottles were dispensed by the pharmacy. 

11. During an interview in the conference room 
on 10/24/13 at 7:00 PM, the Assistant Director of 
Nursing (ADON) was asked what were her 
expectations of nurses administering 
medications. The ADON stated, "...check 
expiration dates..." The ADON was then asked if
<table>
<thead>
<tr>
<th>ID</th>
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<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>
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<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 32</td>
<td>liquid medications dispensed by the pharmacy should have an expiration date on the label. The ADON stated, &quot;Yes.&quot;</td>
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<td>During an interview at the west hall nurses' station on 10/24/13 at 7:20 PM, the Pharmacist was asked if the liquid medications in the amber bottles should have an expiration date on the label. The Pharmacist stated, &quot;Yes it should.&quot; The Pharmacist was asked to look at the bottles of liquid medications. The Pharmacist confirmed there was not an expiration date on the labels by stating, &quot;No, it doesn't.&quot;</td>
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<tr>
<td>F 460</td>
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<td>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY</td>
<td>F 460</td>
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<td>SS=D</td>
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<td>Bedrooms must be designed or equipped to assure full visual privacy for each resident.</td>
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<td>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure full visual privacy could be maintained in 3 of 114 (Rooms 307, 606 and 2011) resident rooms.</td>
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| | | The findings included: 1. Review of the "RESIDENT BILL OF RIGHTS" provided by the facility documented, "It is the
Continued From page 33

objective of the Facility to herein forth... assure the... preservation of dignity... A... Residents have the right to... 1. Privacy in treatment and personal care..."

2. Observations in room 605 on 10/24/13 at 8:30 AM and 12:00 PM, revealed the A bed privacy curtain was hanging down on the floor and was only being held by a few hooks.

3. Observations in room 307 on 10/21/13 at 9:30 AM, revealed the privacy curtain between the two beds was laying on the floor with only a few hooks holding it up.

4. Observations in room 2011 on 10/21/13 at 9:55 AM and on 10/24/13 at 9:10 AM, revealed there was no privacy curtain between the A and B beds.

5. During an interview in the conference room on 10/24/13 at 6:15 PM, the Director of Housekeeping stated, "If a worker notices curtains that are off the hook they should notify maintenance and get it fixed."

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
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</table>
| F 520         | Continued From page 34  
issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  
A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  
This REQUIREMENT is not met as evidenced by:  
Based on review of the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy review, medical record review, observation and interview, it was determined the quality assurance committee failed to identify issues and failed to develop and implement appropriate plans of actions to assist staff in recognizing skin conditions before they become an unstageable pressure ulcer for 3 of 6 (Residents #1, 17 and 195) sampled residents reviewed of the 6 residents included in stage 2 with pressure ulcers. The failure to identify a pressure ulcer before it became unstageable resulted in actual harm and substandard quality of care for Residents #1, 17 and 195.  
The findings included:  
1. The Quality Assurance (QA) committee staff failed to identify and address the failure of the |

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<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(D) COMPLETION DATE</th>
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| F 520         | 1. Head to toe skin assessments were done on residents #1, 17 and 195 on 10-25-13.  
Resident #1's wound was healed 10-16-13. Resident #17's wound was healed 11-1-13. Resident #175's wound is being treated by our Treatment/Wound Care nurses and is improving. All three residents were identified in our QA &A committee meeting 10-31-13.  
Identifying and treating skin conditions before they become unstageable was identified as an opportunity for improvement and correction plans were put into place.  
2. All residents have the potential to be affected.  
3. Executive Director in-serviced QA team on identifying skin issues before they become unstageable on 10-31-13. This in-service included cast care and care and treatment of residents with immobilizers. Resident #1, 17 and 195 were discussed.  
4. Weekly head to toe assessments will be audited weekly for compliance and will be reported weekly for four weeks at the daily morning meeting and monthly at the QA meeting for six months. Skin assessments for new admissions/re-admissions will be audited 2x a week for four weeks. Findings will be reported monthly at the QA meeting for 6 months. All new casts/immobilizers will be reviewed daily in morning meeting. A list of residents with these medical devices will be discussed monthly at the QA meeting for six months. All of the above will be done by DNS/designee. The treatment nurse/designee will report daily of new pressure ulcers at morning meeting daily and monthly at the QA meeting for six months. | 11-25-13 |
Continued from page 35:
staff to recognize pressure ulcers before they became unstageable for Residents #1, 17 and 195 which resulted in substandard quality of care. Refer to F314.

2. During an interview in the Administrator's office on 10/25/13 at 3:40 PM, the Administrator was asked about the quality assurance and the tracking and trending of identified issues. The Administrator stated, "...nurse managers and the RD [Registered Dietitian] meet on Thursdays regarding skin weights... They review the care plans and make sure interventions have been updated."

During an interview in the Director of Nursing's (DON) office on 10/26/13 at 4:00 PM, the DON was asked if pressure ulcers had been identified as a problem in the QA meetings. The DON stated, "We had identified the problem of inconsistent weekly skin assessments in April this year [2013] and I added the issue to the QA minutes in April." The Administrator stated, "Yes, we identified a glitch [problem] in [name of computer software program] in January of this year and we went to manual skin assessments at that time. Then IT [Information Technology] fixed it and we went back to computer. The Regional Nurse Consultant stated, "I receive and review the weekly skin assessments."

The failure to identify skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm and substandard quality of care for Residents #1, 17 and 195.