<table>
<thead>
<tr>
<th>F 242</th>
<th>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</th>
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<td>SS=D</td>
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The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review and interview, it was determined the facility failed to honor diet preferences for 1 of 3 (Resident #4) sampled residents of the 8 family interviews conducted for choices.

The findings included:

- Medical record review for Resident #4 documented an admission date of 10/19/10 with diagnoses of Hypertension, End Stage Dementia, Depression, Anxiety, History of Anorexia and Adult Failure to Thrive. Review of the care plan dated 5/30/12 documented, "...Nutritional status impaired or at risk for less than body requirement, risk for dehydration rt [related to] Adult Failure to thrive... Monitor food likes/dislikes..." Review of a physician's order dated 5/31/12 documented, "...Change diet to pureed diet..." Review of the dietary notes dated 6/4/12 documented, "...Gradual wt [weight] loss 128 to 122 # [pounds] Hospice consulted 5/1/12 for deconditioning, worsening dementia, continued anorexia..."
- Review of a physician order dated 6/18/12 documented the change from pureed to a

"The name for was passed 7/15/12 up per "

LABORATORY DIRECTORS OR PROVIDER/ SUPPLIER REPRESENTATIVE'S SIGNATURE

Title

DATE

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 patients. (See instructions). Except for nursing homes, the findings stated above are discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, a plan of correction is required to continued program participation.

TESTIMONY/RECEIVED

If continuation sheet Page 1 of 15
| F 242 | Continued From page 1 mechanical soft diet.  

During a telephone interview in the conference room on 6/19/12 at 12:08 PM, Resident #4's Responsible Party (RP) was asked, "Does the facility honor the resident's preferences on what he/she eats or drinks?" The RP stated, "No. We had a lot of trouble changing her diet to mechanical not pureed. The diet had not been changed this past Sunday when we were there. The diet change was suppose to be ordered back 2 weeks ago after a care plan meeting when I met with the dietician. They did another order on 6/18/12 because they had not changed her diet. She will not eat pureed food. This is a real concern...."  

During an interview in the B-wing charting room on 6/20/12 at 8:45 AM, Nurse #2 was asked how Resident #4 managed with her diet and medications. Nurse #2 stated, "...Her diet has just changed to mechanical soft. She likes to be able to recognize her food. Sometimes I crush her pills or sometimes she takes them whole. I will ask her first...."  

During an interview in the conference room on 6/20/12 at 3:40 PM, the Registered Dietician (RD) was asked why Resident #4's diet was not changed from puree back to mechanical soft following the care plan meeting on 6/7/12 as the RP had requested due to the resident not eating puree foods. The RD stated that the hospice nurse was new and didn't know she could write the order for the diet change. The dietician thought the nurse was writing it. The order didn't get written and the diet was not changed until 6/18/12. | F 242 | The Dietician and/or designee will update the residents care plan and diet preference sheet to reflect current dietary needs. An in-service was conducted by the Administrator on 7/10/2012 with the Dietician and care plan team members regarding the importance of addressing resident needs in a timely manner.  
4. The Dietician will review and monitor for compliance during monthly care plan conferences for the next three months and report findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Dietician and will continue monitoring until substantial compliance is achieved.  

Completion Date: 7/15/2012 | 7/15/2012 |
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON 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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<tbody>
<tr>
<td>F 278 SS=D</td>
<td>483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
<td>483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>06/21/2012</td>
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<td>The assessment must accurately reflect the resident’s status.</td>
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<td>Requirement:</td>
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<td></td>
<td>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
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<td>The assessment will accurately reflect the resident’s status.</td>
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<tr>
<td></td>
<td>A registered nurse must sign and certify that the assessment is completed.</td>
<td></td>
<td>A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
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<td>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</td>
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<td>A registered nurse will sign and certify that the assessment is completed.</td>
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<td>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.</td>
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<td>Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment.</td>
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<td>Clinical disagreement does not constitute a material and false statement.</td>
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<td>Corrective Action:</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td>1. Resident #36 MDS was modified on 6/21/2012 to reflect the previous falls. And Resident #65 MDS was modified on 6/21/2012 to reflect that the resident had dentures.</td>
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<td>Based on policy review, medical record review, observation and interview, it was determined the facility failed to accurately assess residents for falls or dentures for 2 of 16 (Residents #36 and 65) sampled residents reviewed of the 40</td>
<td></td>
<td>2. On 7/11/2012 and 7/13/2012 MDS Coordinators audited MDS related to falls and dentures to ensure for accuracy.</td>
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<td>3. The Director of Nursing in-serviced the MDS Coordinators on 7/11/2012 regarding the importance of accurately coding the MDS including coding for falls and dental needs.</td>
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<td></td>
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<td>4. The DON, Unit ADONs and/or designee will monitor for compliance through random chart audits for the next three months and report their findings to the QA Committee consisting of the Medical Director,</td>
<td></td>
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Continued From page 3 residents included in the Stage 2 review.

The findings included:

1. Medical record review for Resident #36 documented an admission date of 2/22/11 with diagnoses of Hypertension, Coronary Artery Disease, Diabetes, and Dementia. Review of the “Event Notes” dated 4/16/12 documented that Resident #36 fell on 4/6/12 with no injury sustained and new interventions put into place. The resident fell again on 4/15/12 and sustained a right hip fracture. Review of the 14-day Minimum Data Set (MDS) dated 5/6/12 and the 30-day MDS dated 5/21/12 documented in section J health conditions that Resident #36 had not had any falls since admission or prior assessment.

During an interview in the conference room on 6/21/12 at 8:20 AM, Nurse #3 was asked if Resident #36’s falls should have been recorded on the MDS. Nurse #3 stated, “Yes” confirming that the MDSs dated 5/6/12 and 5/21/12 were inaccurate.

2. Review of the facility’s "DENTAL SERVICES" policy documented, "...Oral health care and dental services will be provided to each patient by the facility and/or licensed dentist(s), as indicated... The nursing care staff will conduct ongoing oral health assessments... Patients with damaged or lost dentures will be promptly referred to a dentist..."

Medical record review for Resident #65 documented an admission date of 2/6/12 with diagnoses of Anemia, Coronary Artery Disease,
F 278
Continued From page 4
Heart Failure, Hypertension, Gastro Esophageal Reflux Disease and Dysphagia. Review of the 5-day MDS dated 2/13/12 and the quarterly MDS dated 5/13/12 documented in section L oraldental status that Resident #65 had no dental problems. Review of the speech/language pathology certification dated 2/10/12 documented, "...Wears upper & [and] lower dentures - Other: Currently bottom dentures are broken..."

Review of the facility's nurses' readmission assessment dated 3/14/12 documented,
"...MOUTH CONDITION: Teeth: Upper (checked) Lower (checked)..." Resident #65 was not assessed as having dentures. Review of "MDS/Care Plan Progress Notes" dated 5/10/12 documented, "...she wants dentures fixed..." Review of the social service notes dated 5/10/12 documented nothing related to dentures or dentures being broken. Review of facility's "INVENTORY OF PERSONAL ITEMS" documented, "...Dentures: Upper Plate, Lower Plate, Partial Plate," nothing marked.

Observations in Resident #65's room on 6/19/12 at 3:50 PM, revealed Resident #65 had upper dentures but no lower dentures.

Observations in the day area on 6/19/12 at 5:00 PM, revealed Resident #65 had upper dentures but no lower dentures.

During an interview in Resident #65's room on 6/19/12 at 3:50 PM, Resident #65 was asked, "Do you have any chewing or eating problems?" Resident #65 stated, "Yes" have a chewing problem due to broken dentures on the bottom
F 278  Continued From page 5
and have a swallowing difficulty. Resident #65 was also asked, "Do you have tooth problems, gum problems, mouth sores, or denture problems?" Resident #65 stated, "Yes, broken dentures on the bottom."

During an interview in the conference room on 6/20/12 at 10:15 AM, Nurse #3 and Nurse #4 were asked if Resident #65's dentures and problems with dentures should have been documented on the admission and ongoing nursing assessments. Nurse #4 stated, "Yes." Nurse #3 confirmed this and stated, "We are aware of the broken dentures." Nurse #3 was asked if the broken denture plate should have been on the MDS dated 5/13/12. Nurse #3 stated, "It should have been..."

F 279  483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

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

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

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under
**F 279** Continued From page 6 §483.10, including the right to refuse treatment under §483.10(b)(4).

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

Based on medical record review, observation and interview, it was determined the facility failed to develop a care plan to reflect the need of dental services for 1 of 16 (Resident #65) sampled of the 43 residents included in the Stage 2 review.

The findings included:

Medical record review for Resident #65 documented an admission date of 2/8/12 with diagnoses of Anemia, Coronary Artery Disease, Heart Failure, Hypertension, Gastro Esophageal Reflux Disease and Dysphagia. Review of the "Speech/Language Pathology Certification dated 2/10/12 documented, "...Wears upper & [and] lower dentures - Other: Currently bottom dentures are broken..." Review of the "MDS [minimum data set] /Care Plan Progress Notes" dated 5/10/12 documented, "...she wants dentures fixed..." The care plan dated 3/23/12 documented, "...Nutritional Status impaired risk for less than required mt [related to] difficulty eating/drinking, risk for dehydration and risk for aspiration... update 5/4/12..." The care plan was not revised to include dentures or that the resident's lower denture plate was broken.

Observations in Resident #65's room on 6/18/12 at 3:50 PM, revealed Resident #65 had upper dentures but no lower dentures.

**Corrective Action:**

1. Resident # 65 care plan was updated on 6/21/2012 to accurately reflect the need for dental services. Dentures were sent for repair on 6/30/2012.
2. On 7/9, 7/10 and 7/11/2012 a chart audit was completed by the Dietician and/or designee to ensure dietary needs including denture issues have been addressed. Any concerns identified were addressed immediately and care plans will be updated to accurately reflect current needs.
3. The Administrator and Director of Nursing in-serviced the Dietician, MDS Coordinators and Social worker on 7/10/2012 regarding the importance of updating the care plan to reflect the current needs and dental needs of each resident.
4. The Dietician, MDS Coordinators and Social Worker will monitor to ensure that dental needs are accurately care planned for compliance during care plan conferences for the next three months and report findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Dietician, MDS Coordinators and Social Worker and continue monitoring until substantial compliance is achieved.

**Completion Date:** 7/15/2012
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| F 279             | Continued From page 7
Observations in the day area on 6/19/12 at 5:00 PM, revealed Resident #65 had upper dentures but no lower dentures. During an interview in Resident #65's room on 6/18/12 at 3:50 PM, Resident #65 was asked, "Do you have any chewing or eating problems?" Resident #65 stated, "Yes" have a chewing problem due to broken dentures on the bottom and have a swallowing difficulty. Resident #65 was also asked, "Do you have tooth problems, gum problems, mouth sores, or denture problems?" Resident #65 stated, "Yes, broken dentures on the bottom."
During an interview in the conference room on 6/20/12 at 10:15 AM, Nurses #3 and Nurse #4 confirmed that there was not a care plan for Resident #65's dentures and/or broken lower denture plate. | F 279 | | |
| 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 medical record review and interview, it was determined the facility failed to follow the care plan for 1 of 16 (Resident #52) sampled residents of the 40 residents included in the Stage 2 review. The findings included. | F 282 | F282
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN SS=D Requirements:
The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action:
1. On 6/20/2012 Resident #52 as per the care plan received the appropriate supplement available per resident preference. | | |
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<th>F 282</th>
<th>Continued From page 8</th>
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<td><strong>Medical record review for Resident #52 documented an admission date of 4/17/12 with diagnoses of Functional Quadruplegia, Muscle Spasms, Osteomyelitis in Great Right Ankle, Neurofibromatosis and Decubitus Ulcers. Review of the care plan dated 4/25/12 documented, &quot;...Adhere to food preferences... Supplements as directed by M.D. [medical doctor]...&quot; Review of the Medication Administration Record (MAR) dated June 1 through 30, 2012 documented, &quot;...Ensure 240 ml [milliliters] BID [twice a day] 8 AM and 4 PM...&quot; The date 6/15/12 was circled on the MAR for 8:00 AM and 4:00 PM and 6/20/12 was blank for 8:00 AM. Review of the back of the MAR documented, &quot;...6/15/12 Ensure... no Ensure available...&quot;</strong></td>
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During an interview in Resident #52's room on 6/20/12 at 10:05 AM, Resident #52 was asked if he received his diet supplements. Resident #52 stated, "...not my ensure because the only favor I can tolerate is chocolate and they [facility] don't have that. The other [vanilla and strawberry ensure] taste like baby formula..." |

During an interview on the 600 hall on 6/20/12 at 10:10 AM, Nurse #1 was asked if Resident #52 had received his ensure this morning. Nurse #1 stated, "No, we don't have chocolate ensure..." |

During an interview in the 700 hall chart room on 6/20/12 at 10:15 AM, the Registered Dietician (RD) was asked if Resident #52's food preferences were honored. The RD stated, "I talked to him and he told me yesterday that he only likes chocolate ensure, but I didn't know he wasn't getting it [ensure]." |

| 2. The Dietician on 7/9, 7/10 and 7/11/2012 reviewed diet preferences of residents to ensure that these were reflective on dietary recommendations made regarding supplements. Any identified issues were corrected immediately and care plan updated as needed. |
| 3. The Administrator and Director of Nursing in-serviced the Dietician on 7/10/2012 regarding the importance of following diet preferences when determining diet recommendation for supplements. |
| 4. The Dietician and MDS Coordinators will monitor monthly to ensure accuracy and consistency of care plans and physician ordered dietary supplement recommendations for three months and report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Dietician, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the team will re-in-service the Dietician and will continue monitoring until substantial compliance is achieved. |

**Completion Date: 7/15/2012**
F 282 Continued From page 9

During an interview in the conference room on 6/20/12 at 10:35 AM, the Assistant Director of Nursing (ADON) #2 was asked to review the MAR and determine if Resident #65 was receiving his ensure. ADON #2 stated, "No, I can't excuse it [not giving ensure]. I don't know what to say, except we have to fix it. There is no reason why we can't give choleas. We have cases of it [chocolate ensure]."

F 309

SS-D HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to effectively communicate with the dialysis clinic as evidenced by failure to obtain pre and post dialysis weights for 1 of 1 (Resident #42) sampled residents receiving dialysis of the 40 residents included in the Stage 2 review.

The findings included:

Review of the facility's "Dialysis" policy documented... Communication is essential to the care of a dialysis patient... Nursing documentation required: Pre and Post dialysis...
F 309 Continued From page 10

weights..."

Medical record review for Resident #42 documented an admission date of 2/17/12 with diagnoses of Adult Failure to Thrive, End Stage Renal Disease, Renal Dialysis Shunt, Secondary Diabetes Mellitus, Hypertension, Senile Dementia and Pressure Ulcers. Review of a physician order dated 6/19/12 documented, "...Dialysis 3 x [times] week and PRN [as needed]..." Review of the transfer forms dated from 3/30/12 through 6/18/12 revealed no documentation of pre and post dialysis weights. Review of the medication administration records dated March 2012 through June 2012 revealed no documentation of pre and post dialysis weights.

During an interview in the chart room on the 200 hall on 6/20/12 at 11:35 AM, Nurse #5 was asked how the dialysis facility and the nursing facility communicated. Nurse #5 stated, "...the vital signs and the pre and post dialysis weight should be on the yellow copy of the transfer form and kept in the resident's chart... the yellow copy is returned to the facility. The dialysis unit obtains the weights and writes on the yellow copy..."

During an interview in the conference room on 6/20/12 at 12:05 PM, the Assistant Director of Nursing (ADON) #1 was asked how the dialysis clinic and the facility communicated pertinent information that could affect the resident's care such as pre and post dialysis weights and vital signs. ADON #1 confirmed Resident #42's weights were not on the transfer form and stated, "...the pre and post weights should be on the MAR [medication administration record] if not on the transfer form... I don't see it [weights] on the..."
F 309 Continued From page 11

MAR, they are suppose to be on there... They [dialysis clinic] will call us or the EMT [Emergency Medical Technician] will tell us [if something significant happens during the dialysis treatment], if we don't hear anything we assume it was a good visit... if there is a medication change they will fax a sheet to us and we will write an order on our sheet..."

F 325

483.25(i) MAINTAIN NUTRITION STATUS

SS=D

UNLESS UNAVOIDABLE

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 medical record review and interview, it was determined the facility failed to follow a physician orders for a diet supplement or provide a recommended supplement for 2 of 3 (Residents #52 and 95) sampled residents reviewed of the 5 residents reviewed in Stage 2 with nutritional issues.

The findings included:

Medical record review for Resident #52 documented an admission date of 4/17/12 with...
F325 Continued From page 12
diagnosis of Functional Quadriplegia, Muscle
Spasms, Osteomyelitis in Great Right Ankle,
Neurofibromatosis and Decubitus Ulcers. Review
of a physician order dated 9/13/12 documented,
"...Ensure 240 ml [milliliters] BID [twice a day]..."
Review of the Medication Administration Record
(MAR) dated June 1 through 30, 2012
documented,"...Ensure 240 ml BID 8 AM and 4
PM..." The date of 6/15/12 was circled on the
MAR for 8:00 AM and 4:00 PM and was left blank
on 6/20/12 for 8:00 AM. Review of the back of the
MAR documented, "...6/15/12 Ensure... no
ensure available...

During an interview in Resident #52's room on
6/20/12 at 10:05 AM, Resident #52 was asked if
he received his diet supplements. Resident #52
stated,"...not my ensure because the only favor I
can tolerate is chocolate and they [facility] don't
have that. The other [vanilla and strawberry
ensure] taste like baby formula..."

During an interview on the 600 hall on 6/20/12 at
10:10 AM, Nurse #1 was asked if Resident #52
received his ensure this morning. Nurse #1
stated, "No, we don't have chocolate ensure..."

During an interview in the 700 hall chart room on
6/20/12 at 10:15 AM, the Registered Dietician
(RD) was asked if Resident #52's food
preference was honored. The RD stated, "I talked
to him and he told me yesterday that he only likes
chocolate ensure but, I didn't know he wasn't
getting it [ensure]..."

During an interview in the conference room on
6/20/12 at 10:35 AM, the Assistant Director of
Nursing (ADON) #2 was asked to review the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:** 445428

**(X2) MULTIPLE CONSTRUCTION**

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<thead>
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**(X3) DATE SURVEY COMPLETED:** 06/21/2012

**NAME OF PROVIDER OR SUPPLIER:** HARBOR VIEW NURSING AND REHABILITATION CENTER, INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1513 N 2ND STREET, MEMPHIS, TN 38107

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**SUMMARY STATEMENT OF DEFICIENCIES**

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

<table>
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Continued From page 13

MAR and determine if Resident #65 was receiving his ensure. ADON #2 stated, "No, I can't excuse it [not giving ensure]... I don't know what to say except we have to fix it... There is no reason why we can't give choices. We have cases of it [ensure]."

2. Medical record review for Resident #95 documented an admission date of 9/2/11 with diagnoses of Alzheimer's, Hypertension, Kidney Disease, History of Cerebrovascular Accident, Depression, Anemia, Failure to Thrive and Encephalopathy. Review of the dietary progress notes documented the following:

a. 3/5/12 - "...Gradual wt. [weight] loss since Admit Sept. [September] 2011... Wt. may vary d/t [due to] Dx. [diagnosis]. Fed in Assisted Dining... Will start Hi-Cal [High-Calorie nutritional supplement] 4 oz [ounces] bid [twice a day] c [with] med pass [medication pass] and weekly weights... Notified FNP [Family Nurse Practitioner] of gradual wt. loss And supplement order..."

b. 3/13/12 - "...Can't [continue] c Hi-Cal 4 oz BID..."

c. 3/27/12 - "...Can't c Assisted Dining And Hi-Cal 4 oz BID..."

Review of a physician's order dated 5/29/12 documented, "...Order Clarification: Hi-Cal 4 oz BID c med pass..." Review of the MARs dated from March through May, 2012 did not document that Hi-Cal had been given until 5/30/12.

During an interview in the conference room on 6/20/12 at 3:30 PM, the RD confirmed Resident #95 was not getting the Hi-Cal until 5/30/12. The RD stated, "...I remember this coming up, we..."
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<th>(X5) COMPLETION DATE</th>
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<td>F 325</td>
<td>Continued From page 14 realized she was not getting the Hi-Cal, I knew I had written the order, but we could not find the order, so I went on 5/29/12 and wrote that clarification order...</td>
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<td>F 371</td>
<td>483.35(i) FOOD PROCURE STORE/PREPARE/SERVE - SANITARY</td>
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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

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that food was served under sanitary conditions during 1 of 2 (6/20/12) dining observations in the B-wing assisted-dining room during the Stage 2 review.

The findings included:
Observations in the 8 unit assisted dining room on 6/20/12 at 8:10 AM, revealed Certified Nursing Assistant (CNA) #1 assisted Resident #4 to eat breakfast. CNA #1 tore the resident's toast apart and pushed the resident's food onto her spoon with her bare hands. CNA #1 then wiped her visibly soiled fingers on the cloth napkin that had been placed on the resident's chest.

During an interview in the 8 unit charting room on
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6/21/12 at 1:10 PM, the Assistant Director of Nursing (ADON) #1 was asked if the staff should touch a resident’s food with their bare hands. ADON #1 stated, “No.”

F 411
483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist’s office, and promptly refer residents with lost or damaged dentures to a dentist.

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 provide dental services for a resident receiving skilled medicaid services for 1 of 1 (Resident #65) sampled residents with broken dentures of the 40 residents included in the Stage 2 review.

The findings included:
Review of the facility’s "DENTAL SERVICES" policy documented, "...oral health care and dental services will be provided to each patient by

MDS Coordinator, Medical Records, Staffing Coordinator, Bookkeeper, Dietician, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the team will re-in-service the Licensed Nurses/CNA staff and will continue monitoring until substantial compliance is achieved.

Completion Date: 7/15/2012

7/15/2012

F 411
483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
SS=D

Requirement:
The facility will assist residents in obtaining routine and 24-hour emergency dental care.

Corrective Action:
1. Resident #65 dentures were sent for repair on 6/30/2012.
2. On 7/9, 7/10 and 7/11/2012 a chart audit was completed by the Dietician and/or designee to ensure dietary needs including denture issues have been addressed. Any concerns identified were immediately addressed.
3. The Administrator and Director of Nursing in-serviced the Dietician, Social worker, Licensed Nurses and CNAs on 7/13/2012 regarding the importance of conducting on-going oral health assessments and promptly report any damaged or lost dentures to a dentist. The Licensed Nurses were in-serviced on 7/13/2012 by the Administrator and Director of Nursing to refer to the MD or FNP for dental consults.

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the facility and/or licensed dentist(s), as indicated... The nursing care staff will conduct ongoing oral health assessments... Patients with damaged or lost dentures will be promptly referred to a dentist...

Medical record review for Resident #65 documented an admission date of 2/6/12 with diagnoses of Anemia, Coronary Artery Disease, Heart Failure, Hypertension, Gastro Esophageal Reflux Disease and Dysphagia. Review of the "Speech/Language Pathology Certification" dated 2/10/12 documented, "...Wears upper & [and] lower dentures - Other: Currently bottom dentures are broken..." Review of the Minimum Data Set (MDS) / care plan progress notes dated 5/10/12 documented, "...she [Resident #65] wants dentures fixed. S.S. [Social Services] was present. To consult c [with] Mobile Dental about dentures..." Review of the social service notes dated 5/10/12, documented nothing related to dentures or dentures being broken.

Observations in Resident #65's room on 6/19/12 at 3:50 PM, revealed Resident #65 had upper dentures but no lower dentures.

Observations in the day area on 6/19/12 at 5:00 PM, revealed Resident #65 had upper dentures but no lower dentures.

During an interview in Resident #65's room on 6/19/12 at 3:50 PM, Resident #65 was asked, "Do you have any chewing or eating problems?" Resident #65 stated, "Yes" have a chewing problem due to broken dentures on the bottom and have a swallowing difficulty. Resident #65 was also asked, "Do you have tooth problems,

as needed on any identified gum problems, mouth sores, broken teeth, or denture issues.

On 7/10/2012 the social worker was in-serviced by the Administrator and Director of Nursing to promptly follow-up on all dental referrals.

4. Social Worker will monitor for the next six months to validate that dental needs are being addressed timely by ensuring that residents on the dental recommendation list are seen as scheduled. A report of findings will be forwarded to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Dietician, Social Worker, Licensed Nurse and CNAs and will continue monitoring until substantial compliance is achieved.

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gum problems, mouth sores, or denture problems?" Resident #65 stated, "Yes, broken dentures on the bottom."

During an interview in the conference room on 6/20/12 at 10:15 AM, Nurse #3 was asked if they were aware that Resident #65's lower denture plate was broken. Nurse #3 confirmed this and stated, "...We are aware of the broken dentures... Documentation in the chart for May 10, 2012 states the resident brought the problem to the care plan committee herself..." Nurse #3 was asked, "What is the process for getting dentures fixed when a resident has no family to assist them?" Nurse #3 stated, "...The dentist will see her when he comes... The Social Worker (SW) keeps a list of people who want to see the dentist..."

During an interview in the conference room on 6/20/12 at 11:00 AM, the SW was asked if Resident #65 was going to get her dentures fixed. The SW stated Resident #65's medicare had just been approved and the dentist office was working on her paperwork.

During an interview in the conference room on 6/21/12 at 11:30 AM, while discussing Resident #65's broken bottom denture plate and the payer source for dental services, the SW stated that Resident #65 was receiving medicare skilled services through the end of May 2012 until medicare was approved, and that medicare would not pay for her dental services so the facility would have been responsible.

The facility failed to promptly refer a medicare recipient (Resident #65) to a dentist when it was
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<tr>
<th>(X4) 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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<tbody>
<tr>
<td>F 411</td>
<td>Continued From page 18 determined the resident's lower denture plate was broken.</td>
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