HARBOR VIEW NURSING AND REHABILITATION CENTER, INC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

(x2) MULTIPLE CONSTRUCTION
A. BUILDING __________
B. WING __________

(X3) DATE SURVEY COMPLETED
09/20/2013

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

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

ID PREFIX TAG
F 225
F 225

SUMMARY STATEMENT OF DEFICIENCIES

483.12(c)(1)(ii)-(iii), (c)(2)-(4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

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

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

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

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F225
483.12(c)(1)(ii)-(iii), (c)(2)-(4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
SS=D

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

Corrective Action:
1. Resident #41 was assessed immediately after incident for signs and symptoms of injury, pain or discomfort with no adverse affects noted. Resident #113 was referred to Psychological services for recommendations and had medications reviewed and adjusted.
2. The charts of residents involved in an incident were review on 9/23/13 and 9/24/13 to ensure incident reports were recorded.
3. No other residents found to be affected by the alleged deficient practice.
3. On 9/30/13 nursing staff and nursing administrative staff were in-serviced on the abuse policy. This in-service included investigating alleged abuse, proper reporting of abuse, and the importance of completing the incident/investigative report. Incidents will be discussed and reviewed daily during morning meeting to ensure appropriate guidelines are being followed. All issues
F 225 Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to have evidence that an allegation of abuse was thoroughly investigated by failing to complete an incident/investigation report for 1 of 3 (Resident #41) investigations of abuse reviewed.

The findings included:

Review of the facility's "ABUSE" policy documented, "...ANY report of actual or suspected abuse MUST be acted upon immediately... Abuse may involve patients, family members, visitors, ancillary staff or employee(s). The important thing to remember is that all reports are treated in the same fashion. The first and most important step is ensuring the safety of patients. The next step is to conduct a THOROUGH investigation that is well documented... Investigation a. Complete an investigation on all occurrences to include appropriate information..."

Medical record review for Resident #41 documented an admission date of 9/15/10 with diagnoses of Sickle Cell Disease, Rheumatoid Arthritis, Mood Disorder, Cervical Spinal Stenosis, Constipation, Esophageal Reflux, Vitamin D Deficiency, Insomnia and Depressive Disorder. Review of the nurses' notes dated 7/8/13 documented, "Resident came to ADON [Assistant Director of Nursing] and c/o [complaint of] another resident hitting her in the chest. No injuries noted. No c/o pain. No bruising or swelling noted. No SOB [shortness of breath] noted..." The facility was unable to provide a completed incident report/investigation of this

completed by DON and Administrator. A report of the findings will be forwarded to the QA Committee for review.

4. QA Committee will review the report of findings to ensure proper follow through.

Completion Date: 10/2/13
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F225</td>
<td>Continued From page 2 reported incident.</td>
<td>During an interview in Resident #41's room on 9/16/13 at 11:56 AM, Resident #41 was asked, &quot;Has staff, a resident or anyone else here abused you...?&quot; Resident #41 stated, &quot;Yes, [named Resident #113] slapped me in my chest...&quot; Resident #41 was asked, &quot;Did you tell staff?&quot; Resident #41 stated, &quot;Told the administrator...&quot;</td>
<td>F225</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F253</td>
<td>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
<td>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</td>
<td>F253</td>
<td></td>
<td>Requirements: The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Statement of Deficiencies and Plan of Correction

**Harbor View Nursing and Rehabilitation Center, Inc.**

**Street Address, City, State, Zip Code:**
1913 N 2ND STREET
MEMPHIS, TN 38107

### Deficiency F253

**Prefix Tag:**
- **ID:** F253
- **Quality Indicator:** C

**Summary Statement of Deficiencies:**
Continued from page 3
dust and debris on 1 of 2 (700 hall standing lift) standing lifts.

**The Findings Included:**
Observations on the 700 hall on 9/16/13 at 3:45 PM, on 9/17/13 at 8:50 AM, on 9/19/13 at 2:15 PM and on 9/20/13 at 10:45 AM, revealed crumb-like debris on the standing platform and dust on the support bars of the standing lift.

During an interview on the 700 hall on 9/20/13 at 10:47 AM, Nurse #3 was asked who is responsible for cleaning the standing lift. Nurse #3 stated, "Housekeeping should clean them [standing lift]."

**Corrective Action:**
1. Standing lift was removed from 700 hall and cleaned on 9/20/13 and returned to the hall clean.
2. Standing lifts on the other halls were taken off the halls and cleaned. Lifts were returned back to the hall.
3. Housekeeping and Maintenance Director was in-serviced on 9/30/13 by the Administrator that standing lifts are to be dusted and cleaned by housekeeping staff. Standing lifts will be thoroughly cleaned outside by Maintenance Director twice a month.
4. Maintenance Director will monitor standing lifts weekly to assure they are cleaned and in compliance to F253.

**Provider's Plan of Correction:**
- **ID Prefix Tag:** F253
- **Quality Indicator:** C

**Completion Date:** 10/2/13

### Deficiency F278

**Prefix Tag:**
- **ID:** F278
- **Quality Indicator:** C

**Summary Statement of Deficiencies:**
483.20(g) - (j) Assessment
Accuracy/Coordination/Certified

**The Assessment Must Accurately Reflect the Resident's Status:**
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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

**Guideline:**

**Completion Date:** 10/2/13

**ASSESSMENT**

**Accuracy/Coordination/Certified**

**SS=D**

**Requirements:**
The facility must ensure assessment must accurately reflect the resident's status.
| F 278 | Continued From page 4 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.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess a resident for antidepressant medication for 1 of 19 (Resident #26) sampled residents reviewed of the 41 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #26 documented an admission date of 9/12/03 with diagnoses of Cerebral Palsy with Bowel and Bladder Incontinence, Diabetes Mellitus, Non-compliance, Leukocytosis, Hypertension, Nausea and Vomiting, Osteoporosis, Esophageal Reflux, Mood Disorder, Vitamin D Deficiency, Hyperlipidemia, Osteoarthritis, Chronic Pain Syndrome and Organic Affective Disorder. Review of a physician's order dated 8/27/13 documented, "Lexapro 10 mg [milligrams] 1 AM (ANXIETY)." Review of the annual Minimum Data Set (MDS) dated 9/12/13 did not document the use of antidepressants.

During an interview in the MDS office on 9/19/13 at 5:26 PM, MDS Nurse #1 was asked if the Lexapro should have been documented on

| F 278 | Corrective Action:

1. Resident #26 was assessed to ensure all diagnosis and medications requiring interventions and coding on the MDS was accurately coded. MDS assessment was modified to reflect the changes and resubmitted.

2. Chart audit per MDS nurse completed on 9/27/13 to ensure MDS accurately reflects residents.

No other residents found to be affected by the alleged deficient practice.

3. On 10/2/13 DON conducted an in-service with the MDS nurses on the importance of careful review of the resident's clinical record the 7 day look back period to ensure accuracy of coding for medications and diagnosis. This information must be included on the MDS. DON/ADON will randomly review the MDS assessment over the next 90 days to ensure accuracy in coding of diagnosis and medications for the look back period. Any issues identified will be corrected immediately by the MDS nurse and a report of the findings will be forwarded to the QA Committee for review.

4. QA Committee will review findings from the DON/ADON report to ensure care plans accurately reflect the resident's current status.

Completion Date: 10/3/13
| F278 | Continued From page 5  
Resident #26's annual MDS. MDS Nurse #1 stated, "Yes."  
F280  
SS=D  
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  
This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation and interview, it was determined the facility failed to revise the care plan to reflect the current status of resident related to the use of hand rolls and nothing by mouth (NPO) status for 1 of 19 (Resident #38) sampled residents of the 41 residents included in the stage 2 review.  
The findings included: | F278 | F280  
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISED CP  
SS=D  
Requirements:  
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  
Corrective Action:  
1. Resident #38 care plan was revised to reflect the current status including the peg tube feeding as the only form of nutrition.  
Care plan was also updated to reflect the use of hand rolls.  
2. Care plan team reviewed residents care plans to ensure accuracy of assessments.  
No other residents found to be affected by the alleged deficient practice.  
3. DON conducted an in-service with the Care plan team on the importance of accuracy of assessment needs to be reflected on the care plan. DON/ADON will randomly review care plans over the next 90 days to ensure the care plan accurately reflect the resident's current status. Any issues identified will be corrected. |
F 280  Continued From page 6

Medical record review for Resident #38 documented an admission date 9/19/05 with diagnoses of Right Hemiparesis, Arteriosclerotic Cardiovascular Disease, Vascular Dementia with Depression, Alzheimer's Disease, Aphasia, Behavioral Disturbance, Urinary Incontinence and Percutaneous Endoscopic Gastrostomy Tube. Review of a physician's order dated 9/4/13, documented, "...Jevity 1.5 45ml [milliliters] / [per] hour x [times] 22 [symbol for hours]..." Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/15/12 and a quarterly MDS with an ARD of 7/25/13 documented, Resident #38's cognitive skills for daily decision making were severely impaired. There were no behavioral symptoms or rejection of care concerns documented. Functional limitations in range of motion documented impairment on one side of the upper extremities. Feeding tube is the only documented nutritional approach. Review of the care plan with an effective date of 11/19/12 documented interventions to "...limit choices to 2 options (clothing, food, activities)... orient resident to location of dining room and meal times... Encourage 75- [to] 100% [percent] of diet..." There was no intervention related to use of hand rolls.

Observations in Resident #38's room on 9/18/13 at 10:36 AM, revealed Resident #38 lying in bed. Resident #38's right hand was noted to be contracted and an enteral tube feeding of Jevity 1.5 was infusing via pump at 45 milliliters per hour (ml/hr).

Observations in Resident #38's room on 9/20/13 at 10:53 AM, revealed Resident #38 lying in bed immediately by the Care plan nurse and a report of findings will be forwarded to the QA Committee for review.

4. QA Committee will review findings from the DON/ADON report to ensure care plans accurately reflect the resident’s current status.

Completion Date: 10/3/13  10/3/13
Continued From page 7
with a rolled up washcloth in the right hand.

During an interview in the MDS office on 9/20/13 at 1:30 PM, MDS Nurse #2 was asked why the hand roll was not on the care plan. MDS Nurse #2 stated, "...wouldn't put it on the care plan unless there was an order for it..." MDS Nurse #2 was asked why interventions for encouraging diet, orienting to location of dining room and given food choices was on the care plan when there was no order for this. MDS Nurse #2 stated, "...could refuse... tube feeding...."

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, observation and interview, it was determined the facility failed to follow the care plan interventions for a toileting schedule, fall mats or stop signs for 1 of 19 (Resident #84) sampled residents reviewed of the 41 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #84 documented an admission date of 4/1/11/13 with diagnoses of Late Effect Cerebrovascular Disease, Muscle Weakness, Hyperlipidemia, Hypertension, Dysphagia, Dysarthria, Late Effect Hemiplegia and Depressive Disorder. Review of
<table>
<thead>
<tr>
<th>F 282</th>
<th>Continued From page 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the nurses' event notes dated 4/15/13, 4/18/13, 5/31/13, 7/19/13 and 8/11/13 documented Resident #84 had falls with no injuries on those dates. Review of the care plan dated 4/22/13 documented, &quot;...Fall 4/15/13... no injury. Intervention: Floor mat implemented to right side of bed... Fall 4/18/13... no injury... Intervention: Evaluate resident for an individualized toileting schedule... Fall 7/19/13 no injury. Intervention: Place stop signs in her room for visual cueing reminders to ask for assistance.&quot;</td>
</tr>
<tr>
<td></td>
<td>Observations in Resident #84's room on 9/19/13 at 10:40 AM, revealed no mat to the right side of the bed noted, and no stop signs observed in the room.</td>
</tr>
<tr>
<td></td>
<td>Observations in Resident #84's room on 9/19/13 at 3:00 PM, revealed Resident #84 lying in bed on her back, with no floor mats or stop signs observed in the room.</td>
</tr>
<tr>
<td></td>
<td>Observations in Resident #84's room on 9/19/13 at 5:15 PM, revealed Resident #84 seated in a wheelchair, with no floor mats or stop signs observed in the room.</td>
</tr>
<tr>
<td></td>
<td>During an interview in the conference room on 9/19/13 at 11:30 AM, Nurse #4 was asked about the toileting program for Resident #84. Nurse #4 stated, &quot;She [Resident #84] was evaluated. She did not kick out for scheduled toileting, I did not document this, have no documentation, failed on my part...&quot;</td>
</tr>
<tr>
<td></td>
<td>During an interview in the Resident #84's room on 9/19/13 at 5:15 PM, the Director of Nursing (DON) was asked about no floor mats or stop signs in Resident #84's room. The DON confirmed there were no floor mats or stop signs</td>
</tr>
<tr>
<td>F 282</td>
<td>3. DON conducted an in-service with the Care Plan team on the importance of accuracy of assessment needs to be reflected on the care plan. DON/ADON will randomly review care plans over the next 90 days to ensure the care plan accurately reflect the resident's current status. Any issues identified will be corrected immediately by the Care plan nurse and a report of the findings will be forwarded to the QA Committee for review.</td>
</tr>
<tr>
<td></td>
<td>4. QA Committee will review findings from the DON/ADON report to ensure care plans accurately reflect the resident's current status.</td>
</tr>
<tr>
<td></td>
<td>Completion Date: 10/3/13</td>
</tr>
</tbody>
</table>
F 282 Continued From page 9 present in Resident #84's room. The DON then asked Resident #84 if she had ever had floor mats. Resident #84 stated, "No." The DON then asked Resident #84 if she had ever had stop signs. Resident #84 stated, "No."

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

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

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to follow the care plan interventions for a toileting schedule, fall mats or stop signs for 1 of 4 (Resident #84) sampled residents reviewed of the 5 residents with falls.

The findings included:

Medical record review for Resident #84 documented an admission date of 4/11/13 with diagnoses of Late Effect Cerebrovascular Disease, Muscle Weakness, Hypertension, Diabetic Retinopathy, Diabetic Neuropathy. Review of the nurses' event notes dated 4/15/13, 4/18/13, 5/31/13, 6/19/13 and 8/11/13 documented Resident #84 had falls with no injuries on these dates. Review of the care plan dated 4/22/13
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 10 documented, &quot;...Fall 4/15/13... no injury. Intervention: Floor mat implemented to right side of bed... Fall 4/18/13... no injury... Intervention: Evaluate resident for an individualized toileting schedule... Fall 7/19/13 no injury. Intervention: Place stop signs in her room for visual cueing reminders to ask for assistance.&quot; Observations in Resident #84's room on 9/19/13 at 10:40 AM, revealed no mat to the right side of the bed noted, and no stop signs in the room. Observations in Resident #84's room on 9/19/13 at 3:00 PM, revealed Resident #84 lying in bed on her back, with no floor mats or stop signs observed in the room. Observations in Resident #84's room on 9/19/13 at 5:15 PM, revealed Resident #84 seated in a wheelchair, with no floor mats or stop signs observed in the room. During an interview in the conference room on 9/19/13 at 11:30 AM, Nurse #4 was asked about the toileting program for Resident #84. Nurse #4 stated, &quot;She [Resident #84] was evaluated. She did not kick out for scheduled toileting. I did not document this, have no documentation, failed on my part...&quot; During an interview in the Resident #84's room on 9/19/13 at 5:15 PM, the Director of Nursing (DON) was asked about no floor mats or stop signs in in Resident #84's room. The DON confirmed there were no floor mats or stop signs present in Resident #84's room. The DON then asked Resident #84 if she had ever had floor mats. Resident #84 stated, &quot;No.&quot; The DON then asked Resident #84 if she had ever had stop issues identified will be corrected immediately by the Care plan nurse and a report of the findings will be forwarded to the QA Committee for review. 4. QA Committee will review findings from the DON/ADON report ensure care plans accurately reflect the resident's current status. Completion Date: 10/2/13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Prefix Tag</td>
<td>Summary Statement of Deficiencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 323</td>
<td>Continued From page 11 signs. Resident #84 stated, &quot;No.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 325</td>
<td>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE SS=D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, observation and interview, it was determined the facility failed to record meal intakes for 1 of 2 (Resident #79) sampled residents reviewed with nutritional issues.

The findings included:
Medical record review for Resident #79 documented an admission date of 9/12/11 and a readmission date of 8/26/13 with diagnoses of Bronchiolitis, Pneumonia, Atrial Fibrillation, Bacteremia, Acute Kidney Failure, Hypertension, Sepsis, Muscle Weakness, Anemia, Benign Prostatic Hypertrophy, Gastroesophageal Reflux Disease and Gastroparesis. Review of care plan dated 3/7/13 documented, "...Problems... At risk for dehydration and other complications related to abnormal lab [laboratory] results and decreased

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F325</td>
<td>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE SS=D</td>
<td></td>
</tr>
</tbody>
</table>

Requirements:
The facility must ensure that a resident maintain 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 receives a therapeutic diet when there is a nutritional problem.

Corrective Action:
1. Resident #79 was assessed by nursing and by the Dietician to ensure nutritional needs are being met. Dietician recommendations are being followed appropriately.
2. An audit of current residents with weight loss was conducted on 9/30/13 to identify other residents with the potential to be affected. No other residents found to affected by the alleged deficient practice.
3. DON conducted an in-service on 9/30/13 with the nursing staff including the nurse aides on the importance of documenting the meal intake after each meal. Also on the importance of notification to the charge nurse in the event the nurse aide is unable to document before the end of shift. In-service included the importance of the charge nurse
Continued From page 12

po [by mouth] intake... Interventions... Monitor meal intake..." Review of the significant change Minimum Data Set (MDS) with an assessment reference date of 9/5/13 documented Resident #79 had a weight loss of 5 percent (%) or more in the last month or loss of 10% or more in last 6 months. Review of the recorded weights for Resident #79 documented weights as follows: 4/8/13 and 6/15/13 - 164 pounds (lbs), 8/5/13 - 157 lbs and 9/9/13 - 137 lbs.


Observations in Resident #79's room on 9/17/13 at 8:30 AM and 9/18/13 at 8:30 AM, revealed Resident #79 eating breakfast.

During an interview on the 200 hall on 9/18/13 at 4:20 PM, Certified Nursing Assistant (CNA) #1 was asked about documentation of meal percentages. CNA #1 stated, "I document the percentage of food eaten after meals in the kiosk..." CNA #1 was asked when would meals not be documented. CNA #1 stated, "When I don't have time... we are supposed to pass it on to the charge nurse if we don't do it..."

During an interview on the 200 hall on 9/18/13 at 4:30 PM, the Director of Nursing (DON) was to monitor caregiver documentation report prior to end of each shift and correct any issues identified immediately. The charge nurse will forward all caregiver documentation reports including what corrections were completed to the ADON over the next 90 days for review. The ADON will review caregiver documentation reports daily over the next 90 days to ensure completion of documentation in a timely manner. Any additional issues identified will be corrected immediately by the charge nurse. A report of findings will be forwarded to the QA Committee for review.

4. QA Committee will review the report of findings to ensure proper documentation of meal intake.

Completion Date: 10/1/13
F 325  Continued from page 13
asked if she expected the CNAs to document meal intake after meals. The DON stated, "Yes,
they [staff] should documented it in the kiosk or they could right it down... they have up to 24
hours to document or they tell the charge nurse..."

F 502  483.75(j)(1) ADMINISTRATION
SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The
facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to obtain
laboratory (lab) tests as ordered for 1 of 19 (Resident #92) sampled residents reviewed of the
41 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #92 documented an admission date of 9/6/10 with
diagnoses of Senile Dementia, Hypertension, Hyperlipidemia, Psychosis, Anxiety, Senile
Delusions, Abnormality of Gait, Osteoarthritis, Insomnia, Depressive Disorder and Gastro
Esophageal Reflux Disease. Review of the physician's recertification orders dated 8/24/13
documented, "...CBC [Complete Blood Count], CMP [Complete Metabolic Panel]... EVERY 6
MONTHS..." A Basic Metabolic Panel (BMP) was documented as done on 9/9/12. There was no
CBC or CMP results after this date. The facility was unable to provide documentation the CBC or

F 502  483.75(j)(1) ADMINISTRATION
SS=D

Requirements:
The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

Corrective Action:
1. Resident #92 had clinical record reviewed by the charge nurse to ensure all physician orders including laboratory orders were
being followed.
2. Lab audit completed by Nursing Administration to ensure all physician orders were drawn. All issues identified were corrected. No other residents found to be affected by the alleged deficient practice.
3. DON conducted an in-service with the licensed nurses on 9/30/13 on the
importance of following physician orders including laboratory orders. In-service also
included revised laboratory protocols as outlined in the facility standing orders for
laboratory tests. Laboratory protocols were revised by the DON and placed in binders at
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 502</td>
<td></td>
<td>Continued From page 14. CMP were obtained as ordered. During an interview in the conference room on 9/20/13 at 3:00 PM, the Medical Records Nurse confirmed the CBC and CMP labs were not present in the medical record and were not obtained as ordered.</td>
<td>F 502</td>
<td></td>
<td>each nurse’s station as a reference guide. The staffing coordinator will train new hire nurses on the laboratory protocol during the orientation period. ADON will maintain a lab log and audit labs daily to ensure physician ordered labs are being obtained timely. Any issues identified will be corrected by the ADON and a report of findings will be forwarded to the QA Committee for review. 4. QA Committee will review the report of the findings from the ADON to ensure laboratory orders are being followed.</td>
</tr>
</tbody>
</table>