F 280

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 current care plan consistent with the resident's abilities for activities for 1 of 20 (Resident #3) sampled residents.

The findings included:

- Medical record review for Resident #3 documented an admission date of 6/16/06 with a readmission date of 6/13/11 with diagnoses of Cerebrovascular Accident, Dementia, Bipolar which were not accepted by the facility.

This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The plan of Correction is submitted to meet requirement established by state and federal law.

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 will 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 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

Care Plan for resident #3 was revised on 11/1/11 to reflect his medical condition.

11-1-11

Social Worker and Activity Coordinator were provided with one to one education that included developing, revising and implementing care plans on 11/3/11 by the Director of Clinical Services.

11-3-11

Nurse educator and Quality Assurance Nurse will provide education to IDT regarding care planning process which will include need for current plan of care to reflect resident's current condition by 11/19/2011 or upon employee's return to work.

The Quality Assurance Nurse will audit 25% of the Care Plans Completed by the IDT each month for 90 days and 10% each month the second quarter to ensure that the plan of care accurately reflects the resident's condition. Any care plan that does not accurately reflect the resident's condition will be corrected immediately and education provided to the IDT member immediately. Those results will be reported to the quality improvement committee meeting for review and continued compliance.

11-19-11

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 disclosable 90 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.
F 280 Continued From page 1
Disorder and Encephalopathy. Review of the quarterly Minimum Data Set with an observation end date of 9/9/11 documented, "...Cognitive Skills for Daily Decision Making... Made decisions regarding tasks of daily life... 3... Severely impaired - never/rarely made decisions..." Review of the care plan dated 9/21/11 documented, "... Social Service and Activities to coordinate supplies for him to use so that he can have opportunity to write when "thinking" and unable to stop. Encourage/offer paper/journal and pen to him when having difficulty and once obtained, provide book if he would like to read in an attempt to redirect..."

Observations in Resident #3's room on 10/17/11 at 10:20 AM, revealed Resident #3 lying supine in bed with no verbal response to questions.

Observations in Resident #3's room on 10/17/11 at 3:00 PM and on 10/18/11 at 7:30 AM, revealed Resident #3 lying supine in bed. Resident #3 awakened to verbal greeting but made no verbal response to questions.

During an interview in the board room on 10/19/11 at 1:30 PM, the Activities Director was asked about Resident #3's cognitive status and the activities for him that were documented on the care plan. The Activities Director confirmed that Resident #3's activities should have been revised to reflect his decline in condition.

F 282 483.20(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.
F 282 Continued From page 2 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 for floating heels to prevent skin breakdown for 1 of 20 (Resident #3) sampled residents.

The findings included:

Medical record review for Resident #3 documented an admission date of 6/16/06 with a readmission date of 8/13/10 with diagnoses of Diabetes Mellitus, Dementia, Bipolar Disorder, Acute Encephalopathy and Cerebrovascular Accident. Review of Resident #3's care plan dated 9/21/11 documented, "...Potential alteration in skin integrity... Approaches... Float heels in bed..."

Observations in Resident #3's room on 10/18/11 at 7:30 AM and 9:15 AM, revealed Resident #3 was lying in bed with his heels not floated.

During an interview at the 300 nurses' station on 10/19/11 at 10:45 AM, Nurse #3 confirmed Resident #3's heels should be floated.

During an interview in the board room on 10/19/11 at 1:15 PM, the Director of Nursing confirmed Resident #3's heels should be floated.

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must

Resident #3 moves self in bed and was observed on the morning of 10/18 with heels not floated.

Nurse educator will provide education to IDT and charge nurses that will include: implementing and/or following a written plan of care by 11/19/11 or upon the employees' return to work.

Charge nurses will monitor residents during rounds to ensure that the heels of residents are floated that are care planned. In addition Nursing Administrative staff will monitor on daily rounds to ensure that plan of care continues compliance.

- The Quality Assurance Nurse will audit 25% of the Care Plans Completed by the IDT each month for 90 days and 10% each month the second quarter to ensure that the plan of care is provided by a qualified person. Those results will be reported at the quarterly QA committee meeting for review and continued compliance.
F 309 Continued From page 3

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 ensure that a physician's order for neuro checks was followed for 1 of 20 (Resident #4) sampled residents.

The findings included:

Review of the facility's "Neurological Assessment" policy documented, "...neurological assessment shall be completed... and documented... Timing... Every 15 minutes times 4... Every 30 minutes times 2... Every 1 hour times 6..."

Medical record review for Resident #4 documented, an admission date of 12/11/06 and a readmission date of 9/22/11 with diagnoses of Syncope, Acute Encephalopathy, Urinary Tract Infection, Sepsis, Urinary incontinence and Depressive Disorder. Review of a physician's telephone order dated 8/14/11 documented, "...Neuro [neurological] [symbol for check's] per facility protocol. Review of the "Neuro checks Roster", "NEURO CHECK SHEET" and the nurses notes documented that the nurse was "...unable to get..." neuro checks at 12:30 PM, 2:30 PM, and 3:30 PM on 8/14/11.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 4</td>
<td>During an interview in the 2nd floor conference room on 10/19/11 at 9:10 AM, the Director of Nursing confirmed the neurological checks were not completed as ordered by the physician.</td>
<td>F 309</td>
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<td>F 322</td>
<td>F 322</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcers and to restore, if possible, normal eating skills.</td>
<td></td>
<td></td>
<td>Based on the comprehensive assessment of a resident, the facility will ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcers and to restore, if possible, normal eating skills.</td>
<td>11-19-11</td>
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<tr>
<td>SS=0</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined that the facility failed to follow physician's orders for Percutaneous Endoscopy Gastrostomy (PEG) tube feedings for 1 of 4 (Resident #5) sampled residents receiving PEG tube feedings. The findings included: Medical record review for Resident #5 documented an admission date of 7/15/11 with diagnoses of Cerebrovascular Accident, Normal Pressure Hydrocephalus, Cardiac Pacermaker, Gastrostomy, History of a Cranotomy, Deep Vein Thrombosis, Acute Kidney Failure and Septicemia. Review of a physician's order dated 9/5/11 documented, &quot;...NEVITY 1.5 @ [at] 80 ML [milliliters] ON AT 4PM WITH 300 CC [cubic centimeters] H2O [water] Q [every] 6HR [hours]</td>
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| F 322 | Continued From page 5  
(TUBE FEEDING TO BE OFF AT 10AM)..." |
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<tr>
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<td>Observations in Resident #5's room on 10/17/11 at 5:20 PM, revealed Resident #5's PEG feeding was not infusing as ordered.</td>
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<td>During an interview in Resident #5's room on 10/17/11 at 5:20 PM, Nurse #1 confirmed that she had not started Resident #5's PEG feeding.</td>
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<tr>
<td></td>
<td>Observations in Resident #5's room on 10/18/11 at 5:00 PM, revealed Resident #5's PEG feeding was not infusing as ordered.</td>
</tr>
<tr>
<td></td>
<td>During an interview in Resident #5's room on 10/18/11 at 5:00 PM, Nurse #1 validated that she had not started Resident #5's PEG feeding.</td>
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