## Statement of Deficiencies and Plan of Correction

### ID Prefix Tag
- **F 156**
- **SS=D**

### Provider's Plan of Correction

**Disclaimer Statement**

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State law.

The facility will continue to inform each resident in writing of Medicaid benefits and services available including charges not covered under Medicare.

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### Signature

**Keris B. Litt**

**Title**

**8-22-13**
**F 155** Continued From page 1

personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by
**F 156** Continued From page 2 such benefits.

This **REQUIREMENT** is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure an Advanced Beneficiary Notice (ABN) was issued to 1 of 5 (Resident #237) Medicare residents reviewed for ABN.

The findings included:

- Record review for Resident #237 documented and admission date of 2/19/13. Resident #237 was discharged on 3/23/13. The facility failed to issue an ABN.

- During an interview in the conference room on 8/1/13 at 12:30 PM, the Administrator stated, "We did not give him an ABN because we were not cutting him off. He was going home..."

**F 250**

**SS=D**

**483.15(g)(1) Provision of medically related social service**

- The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This **REQUIREMENT** is not met as evidenced by:
Based on review of the social worker’s job description, policy review, medical record review and interview, it was determined the facility failed...

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The facility will provide ABN notices to residents that request to be discharged home before their Medicare benefits exhaust. The facility will continue to issue ABN notices to residents that do not meet the skilled criteria. The business office was inserviced on this August 18, 2013 by the Administrator and the facility MDS consultant. The Administrator and/or designee will do a weekly audit tool of Medicare discharges to home to check for compliance for 30 days then monthly.

25% of Medicare discharges to home will be reviewed to ensure that the ABN has been issued. This will be reported monthly to the QA committee for 3 months and then thereafter as needed.

The facility will continue to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
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to provide medically related social services to attain the highest practical physical, mental and psychosocial well being as evidenced by the lack of initial social service (SS) assessments and progress notes for 7 of 25 (Residents #50, 90, 106, 148, 154, 199 and 338) sampled residents of the 37 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Social Services Director" job description documented, "...Identify and provide for each resident's social, emotional and psychological needs... assist in the planning for his/her discharge... provide timely and accurate completion of the Social Services portion of the MDS [Minimum Data Set]... Progress Notes as well as Social Services Assessments... maintain progress notes for each resident as required by company policy... Progress notes shall be recorded on the appropriate form and placed on the residents chart... make referrals to support agencies... participate in the development of discharge plans..."

2. Review of the facility's "Social Services" (SS) policy documented, "...The social services department is responsible for... assisting in providing corrective action for the resident's needs by developing and maintaining individualized social care plans... maintaining regular progress and follow-up notes... making referrals... maintaining appropriate documentation of referrals and providing social service data summaries to such agencies... participating in the planning... return to home and community..."
F 250

3. Medical record review for Resident #50 documented an admission date of 3/18/13 and a discharge date of 5/31/13 with diagnoses of Coronary Artery Disease, Cerebrovascular Accident, Osteoarthritis, Hypertension, Gastritis, Right Hemiplegia, Congestive Heart Failure, Insulin Dependent Diabetes Mellitus, Hyperlipidemia, Pulmonary Edema and Status Post Tracheostomy. Review of the admission MDS dated 4/10/13 documented that the resident expected to be discharged and active discharge planning is already occurring for the resident to return to the community.

Social services was inserviced on the regulatory compliance and timeliness of the documentation to be complete and on the medical record including the social history, social services progress notes, MDS, and the care plan by the Administrator. Discharge planning documentation will also be on the medical record timely. (Resident #50, #90, #154, #338 no longer resides in facility). Resident #108 will have a completed social history by 8/31/13.

The Corporate Social Services Consultant will be at the facility during the first week of September to work with the Social Workers to ensure they are aware of regulations and needs. Additional hours have also been added to Social Services to assist. New residents admitted will have weekly audits performed to ensure compliance for 30 days and then 25% will be audited monthly for 60 days. The results will be reported to the QA committee monthly for 3 months and then quarterly for 6 months.

Review of the initial social service history documented, "...Admission Date [blank].... DAILY PREFERENCES [blank]... ADMISSION TO THE FACILITY [blank]... MEDICAL AND PSYCHIATRIC HISTORY [blank]... DISCHARGE PLANNING [blank]... Signature of Person Completing [blank]. Title [blank]. Date [blank]." There were no SS progress notes in the medical record.

During an interview in the conference room on 7/30/13 at 5:25 PM, Social Worker (SW) #1 was asked why there was no social services documentation in the medical record. SW #1 stated, "...I keep them [SS progress notes] in my office... some in a box...."

During an interview in the conference room 7/31/13 at 2:50 PM, MDS Nurse #1 was asked where she got that information to answer the question on discharge planning in the MDS. MDS Nurse #1 stated, "Everyone has discharge planning started when they enter...[Resident #50] should have a care plan..." MDS Nurse #1 was asked if Resident #50 had a care plan for
Continued From page 5

discharge. MDS Nurse #1 stated, "I don't see one."

4. Medical record review for Resident #90 documented an admission date of 3/26/13 and a discharge date of 5/16/13 with diagnoses of Dementia, Diabetes Mellitus, Coronary Artery Disease, Atrial Fibrillation, History of Pulmonary Embolus, History of Urinary Tract Infection, Peripheral Vascular Disease, Anemia, History of Myocardial Infarction, History of Right Above the Knee Amputation, Chronic Renal Insufficiency, Diabetic Ketoacidosis, Hematuria, Urinary Retention, Gastro Esophageal Reflux Disease (GERD) and Hyperlipidemia. Review of a nurse's notes dated 5/16/13 documented, "...Resident discharged home [with symbol] son..." There was no initial social service history in the medical record.

During an interview in the conference room on 8/1/13 at 8:35 AM, SW #1 was asked if Resident #90 should have a social service history in the medical record. SW #1 stated, "It needs [SS history] to be on the chart..."

During an interview at the reception desk on 8/1/13 at 10:20 AM, SW #1 was asked if there is an initial SS history on the charts when a resident is readmitted. SW #1 stated, "No, I don't do a new history every time... not when they are readmitted..."

5. Medical record review for Resident #108 documented an admission date of 4/30/13 and a readmission date of 7/11/13 with diagnoses of Mental Status Change, Dehydration, Bladder Infection, Chronic Respiratory Failure, Bilateral Above the Knee Amputation, Carotid Stenosis,
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<td>Tracheostomy and Ventilator Dependent, Renal Insufficiency, Psychosis, Peripheral Vascular Disease, GERD and Diabetes Mellitus. There was no initial SS history in the medical record.</td>
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<td>During an interview in the conference room on 7/31/13 at 2:50 PM, SW #2 was asked if Resident #108 had an initial SS history. SW #2 stated, &quot;No, could not find one.&quot;</td>
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<td>6. Medical record review for Resident #146 documented an admission date of 6/26/13 with diagnoses of Sepsis, Urinary Tract Infection, Acute Kidney Injury, Chronic Kidney Disease, Cerebrovascular Accident, Pancreatitis, Diabetes Mellitus, Anemia, Hyponatremia, Hypokalemia, Psychosis, Candidiasis, GERD, Hypertension and Depression. The initial SS history was dated 7/31/13.</td>
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<td>During an interview in the conference room on 7/31/13 at 2:45 PM, SW #2 was asked if the social history was completed on 7/31/13. SW #2 stated, &quot;Yes.&quot;</td>
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F 250  Continued From page 7

During an interview at the reception desk on 8/1/13 at 10:20 AM, SW #1 was asked if there was an initial SS history on the charts when a resident is readmitted. SW #1 stated, "No, I don't do a new history every time... not when they are readmitted..."

8. Medical record review for Resident #199 documented an admission date of 8/11/11 with diagnoses of Alzheimer's Disease, Hypertensive Cardiovascular Disease, Hypokalemia, Remote Lung Surgery for Tuberculosis, Hyperlipidemia, Right Mild Renal Insufficiency, Dementia with Agitated and Confused Behavior, Vitamin B 12 Deficiency, Insomnia and Constipation. There was no initial SS assessment in the medical record.

During an interview in the conference room on 8/1/13 at 2:30 PM, SW #2 was asked if an initial social service assessment had been completed for Resident #193. SW #2 stated that she was "...unable to locate it..."

9. Medical record review for Resident #338 documented an admission date of 7/16/13 with diagnoses of Chronic Respiratory Failure, Abdominal Wall Abscess, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Diabetes, Atrial Fibrillation, Hypercholesterolemia, Anemia, Hypothyroid, Coronary Artery Disease and Mood Disorder. There was no initial SS assessment or SS progress notes in the medical record.

During an interview in the conference room on 7/30/13 at 2:45 PM, SW #2 was asked if there was an initial social assessment or SS progress
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<td>notes for Resident #338. SW #2 stated, &quot;No... could not find any...&quot;</td>
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<td>10. During an interview in the conference room on 8/1/13 at 8:30 AM, the Administrator was asked what she expected of the Social Worker. The Administrator stated, &quot;...part of the IDT [Interdisciplinary Team] handles grievances... do a social history on admission... quarterly and annual progress notes and when there is a significant change...&quot;</td>
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|     |            | During an interview in the conference room on 8/1/13 at 8:45 AM, SW #1 was asked what her job duties involved. SW #1 stated, "...On admission I complete a social history, visit the resident talk with them and family. I maintain contact with resident and family. I make notes in my tablet..." SW #1 was asked if she transferred the information from her tablet into the medical record. SW #1 stated, "No, not on chart and should be, should do quarterly notes. We meet weekly with transitional nurse and team to discuss discharge planning. She [transitional nurse] tells us when insurance is running out, decide on discharge date, we tell families and residents and make sure that is okay with them. Then we tell the doctors the discharge date and when to write the discharge orders..." SW #1 was asked if she is aware of the discharge date. SW #1 stated, "Yes, we know when resident is to be discharged. With all the changes and insurances DME [durable medical equipment] will not deliver equipment unless the resident is at home. Home Health agencies take different insurances. When we get the discharge notice and date from the managed care nurse we work the discharge around that date. Should document that on social notes..." SW #1 was asked if there should be a
F 250 Continued From page 9 care plan for discharge planning. SW #1 stated, "Yes, should be a discharge planning care plan..."

F 278 483.20(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 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, observation and interview, it was determined the facility failed...
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<td>F278</td>
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<td>to ensure a complete and accurate comprehensive assessment for vision, use of a foley catheter, use of a prosthetic device, use of antidepressant and/or a diagnosis of dehydration for 5 of 25 (Residents #45, 90, 146, 189 and 277) sampled residents of the 37 residents included in the stage 2 review. &lt;br&gt;&lt;br&gt;The findings included: &lt;br&gt;&lt;br&gt;1. Medical record review for Resident #45 documented an admission date of 2/21/13 with diagnoses of Stage 4 Sacral Decubitus, Chronic Kidney Disease, Altered Mental Status, Chronic Human Immunosuppressed Virus (HIV), Diabetes, Functional Paraplegia, Hypertension, Anemia, and Urinary Tract Infection (UTI). The admission nursing assessment dated 2/21/13 and the admission activity assessment dated 2/23/13 documented the resident had adequate vision. The discharge summary dated 4/10/13 documented the resident's vision and hearing was adequate. The admission minimum data set (MDS) assessment dated 2/28/13, the 14 day MDS assessment dated 3/7/13, and the 30 day MDS assessment dated 3/25/13 documented the resident with impaired vision. The MDS assessments inaccurately documented the resident's vision status. During an interview in the conference room on 7/30/13 at 2:15 PM, MDS Nurse #1 stated, &quot;If I documented vision impairment, I got that from my assessment. I physically assess and interview the resident, it could be that she told me she had cataracts or glaucoma. I don't keep notes I put it in right away after the interview...&quot; &lt;br&gt;&lt;br&gt;2. Medical record review for Resident #90</td>
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F278

MDS will be inserviced on the 08/31/13 accuracy and completeness of the MDS by the Corporate MDS Consultant and/or designee. The current residents with foley catheters, those who use a prosthetic device, wear glasses, or take an antidepressant will be reviewed by the DON or designee to ensure that the MDS accurately reflects the services the resident is receiving. 25% of these records will be reviewed in the next 30 days and 10% will be monitored over the next quarter to be submitted to the QA committee for review to maintain compliance monthly for 3 months and then quarterly for 6 months.

During an interview in the Activity of Daily Living (ADL) suite on 8/1/13 at 9:55 AM, the Registered Physical Therapist stated, "We got her [Resident #90] prosthesis and she had progressed to walking... I was able to train the family to walk with her..."

During an interview in the conference room on 8/1/13 at 10:53 AM, MDS Nurse #1 was asked if the catheter and prosthetic should be on the MDS. MDS Nurse #1 stated, "...She definitely had it [prosthetic device]... I missed her Foley and her prosthetics..."

3. Medical record review for Resident #145
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| F 278  | Continued From page 12 documented an admission date of 6/26/13 with diagnoses of Sepsis, Urinary Tract Infection (UTI), Acute Kidney Injury, Chronic Kidney Disease, Cerebral Vascular Accident (CVA), Percutaneous Endoscopy Gastrostomy (PEG), Pancreatitis, Diabetes, History of Dehydration, Anemia, Hyponatremia, Hypokalemia, Psychosis, Candidiasis, GERD, Hypertension, status post Gallbladder Surgery and Depression. A Physician's order dated 7/1/13 documented the antidepressant Effexor 37.5 milligrams twice a day. The admission MDS dated 7/10/13 did not document the resident was receiving an antidepressant. During an interview in the conference room on 7/30/13 at 2:50 PM, MDS Nurse #2 stated, "No the antidepressant is not marked on that MDS." 4. Medical record review for Resident #199 documented an admission date of 6/11/11 with diagnoses of Alzheimer's Disease, Hypertension, Dementia and Cardiovascular Disease. The MDS assessments dated 3/7/13 and 6/2/13 revealed Resident #199's vision was adequate and did not have corrective lenses. The MDS incorrectly documented the resident visual status. During an interview in Resident #199's room on 7/29/13 at 1:52 PM, Resident #199 stated "My glasses went missing about 2 weeks ago. Observations in Resident #199's room on 7/29/13 at 1:52 PM, revealed Resident #199 had no glasses in use. During a telephone interview on 7/31/13 at 2:52 PM, MDS Nurse #3 stated, "She had corrective lenses in January and April 2013 but had none on

Resident #199 is due an assessment the week of 8/25/13 and vision will be addressed correctly at this time.

Resident # 45, resident #90, and resident #277 no longer reside in facility.

Resident # 146 was due a 30 day on 8/22/13 and this was addressed that an antidepressant is being received.
Continued From page 13  
7/8/13."

During an interview in the conference room on 7/31/13 at 3:18 PM, Social Worker #1 confirmed the MDS was inaccurate and stated, "I just talked to resident [Resident #199] and her reading glasses and sunglasses are currently in the room... resident stated she had forgot where she put them."

5. Medical record review for Resident #277 documented and admission date of 3/6/13 with diagnoses of History of Late-Effect CVA, Left Hemiparesis, Diabetes Mellitus, Right Carotid Artery Stenosis, Hypertension, Lipid Disorder, History of Acute Left Subdural Hematoma with Midline Shift, History of Falls and Gastritis. The admission MDS dated 3/12/13 documented Resident #277's vision was moderately impaired with no corrective lenses being used; mechanically altered therapeutic diet and a Diuretic used during the last 7 days. The 14 day MDS dated 3/19/13 documented resident's vision was moderately Impaired with no corrective lenses used, Health conditions included vomiting and dehydrated, Mechanically altered diet and therapeutic diet. The discharge summary dated 3/21/13 documented Resident #277 was discharged to the hospital on 3/21/13 with "...Vision and hearing adequate..."

Review of a laboratory report dated 3/21/13 documented, "...Sodium... 132 L [low]... BUN 9 [WNL]... Creatinine... 0.7 [WNL]... RBC 3.44 L [low]... Hgb 10.3 L [low]... Hct 30.8 L [low]..."

F 278: Continued From page 14
Complaints or History of... [decreased] Appetite... N [no]... Weight loss... N... Nausea... N... Vomiting... N... SIGNS & SYMPTOMS OF HYDRATION... Tongue Turgor (normal appearance)... Y [yes]... Edema present... Y... 3+ [plus] edema noted to (L) [left] hand et [and] feet - edema prevalent...

A Physician's orders dated 3/6/13 documented, "...Furosemide 40 mg 1 tab po dly[daily]... Edema..." A Physician's order dated 3/21/13 documented, "...Send to ED[emergency department] for evaluation... severe abd. [abdominal] pain..."

Resident #277 was sent to the emergency room on 3/21/13 and never returned to facility.

The resident had adequate vision according to nursing assessment and the MDS inaccurately documented moderately impaired. There was no diagnosis of dehydration and the MDS inaccurately documented the resident was dehydrated.

During an interview in the conference room on 7/31/13 at 2:22 PM, MDS Nurse #1 was asked about the dehydration status documented on the MDS and about the impaired vision without corrective lenses. Nurse #1 stated, "...I do not chart visually impaired unless they [resident] tell me something... like they have glaucoma... If they can't see the newspaper I will show impaired..."

Nurse #1 was asked about the MDS documentation about dehydration. MDS Nurse #1 stated, "...I don't see anything saying dehydration but she was vomiting..."
### F-279

**SS-D**  
**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 §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 and interview, it was determined the facility failed to ensure a comprehensive care plan was developed to address discharge planning, urinary catheter and/or vision for 4 of 25 (Residents #50, 90, 189 and 220) sampled residents of the 37 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #50 documented an admission date of 3/18/13 and a discharge date of 5/31/13 with diagnoses of...
Summary Statement of Deficiencies:

During an interview in the conference room on 7/31/13 at 2:50 PM, MDS Nurse #1 was asked where she got the information to answer the question on discharge planning in the MDS. MDS Nurse #1 stated, "Everyone has discharge planning started when they enter... [Resident #50] should have a care plan..." MDS Nurse #1 was asked if Resident #50 had a care plan for discharge. MDS Nurse #1 stated, "I don't see one."

2. Medical record review for Resident #99 documented an admission date of 3/26/13 and a discharge date of 5/16/13 with diagnoses of...
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Dementia, Diabetes Mellitus, Coronary Artery Disease, Atrial Fibrillation, Peripheral Vascular Disease, History of Urinary Tract Infection, History of Pulmonary Embolus, History of Myocardial Infarction, Anemia, History of Right Above the Knee Amputation, Chronic Renal Insufficiency, Diabetic Ketoacidosis, Hematuria, Urinary Retention, Gastro Esophageal Reflux Disease (GERD) and Hyperlipidemia. Review of a physician's order dated 3/26/13 documented, "...indwelling #24 French - 3 way Foley... 30cc [cubic centimeter] bulb..." Review of the significant change MDS dated 4/2/13 did not include the use of a Foley catheter. The facility was unable to provide a care plan for the significant change MDS dated 4/2/13. Review of a nurse's note dated 5/16/13 documented, "...Resident discharged home [symbol for with] son..."

During an interview in the conference room on 8/1/13 at 8:35 AM, Social Worker (SW) #1 was asked if Resident #80 should have a discharge care plan. SW #1 stated, "It [discharge care plan] needs to be on the chart..."

During an interview in the conference room on 8/1/13 at 10:53 AM, MDS Nurse #1 was asked if the Foley catheter should be on the MDS. MDS Nurse #1 stated, "Definitely... I missed her Foley..." MDS #1 was asked if there should have been a care plan for the Foley catheter. MDS #1 stated, "Yes."

3. Medical record review for Resident #189 documented an admission date of 3/22/13 with diagnoses of Pneumonia, Dehydration, Acute Renal Insufficiency, Hypertension, History of Coronary Artery Disease, Anemia, Syncopal
F 279  Continued From page 18

Episodes, and Cellulitis of the Left Leg. Review of the admission MDS dated 3/29/13 documented that active discharge planning was already occurring for the resident to return to the community and had moderately impaired vision with no corrective lenses. Resident #189 was discharged to another long term care facility on 6/5/13. The facility was unable to provide a care plan for discharge planning or vision impairment for this resident.

During an interview in the conference room on 8/1/13 at 9:00 AM, SW #1 was asked if there should be a discharge care plan if the MDS indicated there is active discharge planning in place. SW #1 stated, "Yes."

During an interview in the conference room on 8/1/13 at 10:55 AM, MDS Nurse #1 was asked what was done to address Resident #189's vision impairment. MDS Nurse #1 stated, "Didn't do a care plan... didn't think it was really a problem... don't know why it triggered..."

4. Medical record review for Resident #220 documented an admission date of 5/15/13 with diagnoses of Urinary Tract Infection, Left Hip Wound Infection, Left Hip Repair, Osteoporosis, Osteoarthritis, Hypertension, Cerebrovascular Accident, Anemia and Vertebral Fracture. Review of the care plan dated 5/15/13 did not include discharge planning. Review of the initial social service history dated 5/17/13 documented, "DISCHARGE PLANNING... Anticipated length of stay: Short Term Current discharge goals/needs (include community resource, home health... resident's discharge goal is to return home w/ [with] family when she has completed therapy goals." There was no discharge planning to

Staff Development Coordinator and/or designee will review and educate Social Workers, MDS nurses, and Nurse Managers on facility policies regarding discharge planning, foley catheters, and special needs (vision)

Beginning 8/19/13 care plans of new admissions will have 25% reviewed during the next 30 days and then 10% for the next 90 days. These results will be reported monthly to the QA committee for 3 months and then quarterly for 6 months to sustain compliance.
Continued From page 19

include community resources when discharged.

F 279 483.20(d)(3) 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVIEW 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 policy review, medical record review
and interview, it was determined the facility failed
to revise the care plan for weight loss for 1 of 25
(Resident #357) sampled residents of the 37
residents included in the stage 2 review.

The findings included:

Review of the facility's weight monitoring program
policy documented, "...To identify residents who

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.

Comprehensive care plans must be developed
within 7 days after the completion of the
comprehensive assessment.

(Resident #357 no longer resides in
facility).

The R. D. and MDS nurses will be inserviced
on the facility policy for "significant weight
loss" by the Staff Development Coordinator
or designee. The Nurse Managers and the
Restorative nurse will also be inserviced
on the policy.

The Director of Nursing or her designee
and the Restorative nurse will continue to
address weight loss in weekly risk
management meetings.

MDS nurses will develop a plan of care
for weight loss in accordance to state and
federal law.

The DON and/or her designee will monitor
25% of new annual care plans and quarterly
care plans completed in the next 30 days and
then 10% over the next 90 days with the
(cont'd)
<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 Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 20 are at nutritional risk and intervene appropriately... Parameters for Evaluating Significant Weight Loss... 5% [percent] weight loss/gain in 1 month... Interventions for Weight Management... Residents will be weighed weekly X [times] 4, and reviewed until the residents weight has stabilized or the issue is resolved through other parameters...</td>
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Medical record review for Resident #357 documented an admission date of 6/1/13 and a discharge date of 6/6/13 with diagnoses of Left Total Knee Arthroplasty and Hypertension. Review of the interdisciplinary care plan dated 5/1/13 does not address nutritional concerns or weight loss. Review of the interact early warning tool dated 5/12/13 documented, "...Weight change [circled]... 192.0 [symbol for decrease] 183.4..." Review of the weight record documented, "...Admit Weight 192.0 [pounds #]...5-2-13... May... Week 2...183.4... Week 3... 182.4... Week 4... 178.4... 5th... 177.6..." The care plan was not revised to reflect the weight loss. Review of the 30-Day Minimum Data Set (MDS) dated 6/2/13 did not document weight loss.

During an interview in the conference room on 7/31/13 at 1:00 PM, the Clinical Registered Dietician (RD) #1 was asked about weight loss management. RD #1 stated, "...work closely with Restorative Aide... do weekly weights then stable for 4 weeks then monthly." RD #1 was asked about the interact early warning tool. RD #1 stated, "...may have been put in the book... I may have been verbally notified... see the nurse signed it [pointed to the form]... we have at risk meeting... [named Resident #357] had some edema... probably should have documented it..."

with the results reported monthly to the QA committee for 3 months and then quarterly for the next to ensure compliance. 8/31/13
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>ID TAG</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 21 During an interview in the conference room on 8/11/13 at 9:15 AM, the Director of Nursing confirmed that the care plan had not been revised to reflect the weight loss.</td>
<td>F 280</td>
<td>F 284</td>
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<td>F 284</td>
<td>483.20[i][3] ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</td>
<td>F 284</td>
<td>When the facility anticipates discharging a resident a discharge summary will include a post-discharge plan of care that is developed with the participation of the resident to adjust to his/her new living environment.</td>
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</table>

**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 post-discharge plan of care was developed for 5 of 25 (Residents #60, 90, 122, 154 and 220) sampled residents of the 37 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "DISCHARGE PLANNING" policy documented, "...assessment... may begin... no later than at the time of the admission nursing assessment... all disciplines are involved in the assessment and planning for after discharge healthcare needs of the resident and/or family... The purpose of discharge planning is to identify the resident's continuing physical, emotional, social, housekeeping, transportation and safety needs and to arrange services to meet those needs... It is the responsibility of each discipline assessing Social Services will evaluate new residents upon admission at the time of assessment to ensure that discharge planning is identified and that needs will be met. This process will be interdisciplinary and documented on the medical chart. (Resident #50, #90, #154, and #220 no longer reside in the facility). At this time resident #420 requires long term care and a meeting is being set up with the family to discuss..."
Continued From page 22  

The patient, a 75 year old female, was admitted to the facility on May 24, 2013 with a primary diagnosis of Right Hemiplegia status post cerebrovascular accident. She was admitted from the hospital after a successful post-operative recovery from a right side stroke and was referred to the facility for rehabilitation therapy. The patient was scheduled for an inpatient stay of 30 days. The initial assessment conducted on admission revealed the patient to be a medically complex patient who required close monitoring and specialized care. The patient had a history of diabetes mellitus, hypertension, and chronic obstructive pulmonary disease.

On admission, the patient was oriented to person, place, and time. However, she had difficulty with language and had difficulty following simple commands. She was able to walk with a walker but had difficulty with transfers. The patient was receiving oxygen therapy and was on a high dose of insulin for diabetes management. The patient's primary care physician had prescribed a discharge plan that included transfer to a long-term care facility.

The patient's physical therapy goals were to improve mobility, strengthen the right side of the body, and increase endurance. Occupational therapy focused on improving hand function and daily living skills. Speech therapy aimed at improving communication and swallowing. The patient's plan was to be discharged to a skilled nursing facility with a home health care provider.

The patient's family was engaged in the discharge planning process and was made aware of the resources available at the facility. They were encouraged to participate in decision-making and to express their wishes. The patient had previously expressed a desire to remain at home with support from family and community resources. The interdisciplinary team worked closely with the patient and family to ensure that the patient's wishes were considered in the discharge planning process.

The discharge summary dated 5/31/13 is not signed by the nurse, resident or the responsible party and does not document the reason for discharge. The facility was unable to provide a discharge care plan or a discharge planning form.
During an interview in the conference room 7/31/13 at 2:50 PM, MDS Nurse #1 was asked where she got the information to answer the question on discharge planning in the MDS. MDS Nurse #1 stated, "Everyone has discharge planning started when they enter... [Resident #50] should have a care plan..." MDS Nurse #1 was asked if Resident #50 had a care plan for discharge. MDS Nurse #1 stated, "I don't see one."

3. Medical record review for Resident #90 documented an admission date of 3/26/13 and a discharge date of 5/16/13 with diagnoses of Dementia, Diabetes Mellitus, Coronary Artery Disease, Atrial Fibrillation, History of Pulmonary Embolus, History of Urinary Tract Infection, Anemia, Peripheral Vascular Disease, History of Myocardial Infarction, History of Right Above the Knee Amputation, Chronic Renal Insufficiency, Diabetic Ketoacidosis, Hematuria, Urinary Retention, Gastro Esophageal Reflux Disease and Hyperlipidemia. Review of a nurse's note dated 5/16/13 documented, "...Resident discharged home [symbol for with] son..." The facility was unable to provide a discharge care plan or a discharge planning form.

During an interview in the conference room on 8/1/13 at 8:35 AM, Social Worker (SW) #1 was asked if Resident #90 should have a discharge plan. SW #1 stated, "...It needs to be on the chart..."

4. Medical record review for Resident #122 documented an admission date of 6/5/13 with diagnoses of Acute Respiratory Insufficiency, Slow Ventilator Weaning, Left Femur Fracture,
F 284  Continued From page 24

Anoxic Encephalopathy, Cardiomyopathy with Congestive Heart Failure and Neurogenic Bladder. The "Discharge Evaluation & [and] Plan" in the medical record was blank.

During an interview at the 400 hall nurses' station on 7/30/13 at 5:10 PM, Nurse #1 was asked if there were any discharge plans for Resident #122. Nurse #1 stated, "The Doctor does talk to the family about discharge plans..."

5. Medical record review for Resident #154 documented an admission date of 6/1/13 and discharged on 7/30/13 with diagnoses of Questionable Old Stroke, Degenerative Joint Disease, Hypertension, Malnutrition and Osteoarthritis. Review of a physician's order dated 7/29/13 documented, "...Home Health for PT/OT/CNA ... (Pt. [patient] has own walker, wheelchair)... May D/C home in AM c [symbol for with] above arranged, c family c 24 [symbol for hour] care. Review of the admission MDS dated 6/18/13 documented that active discharge planning is already occurring for the resident to return to the community. The facility was unable to provide a care plan for discharge or a discharge planning form.

6. Medical record review for Resident #220 documented an admission date of 5/15/13 with diagnoses of Urinary Tract Infection, Left Hip Wound Infection, Left Hip Repair, Osteoporosis, Osteoarthritis, Hypertension, CVA, Anemia and Vertebral Fracture. Review of the "INITIAL SOCIAL SERVICE HISTORY DATED 5/17/13 documented, "DISCHARGE PLANNING... Anticipated length of of stay: Short Term Current discharge goals/needs (include community resource, home health... resident's discharge..."
F 284 Continued From page 25

goal is to return home w [with] family when she has completed therapy goals..." There was no discharge planning to include community resources when discharged. Review of the MDS dated 5/30/13 documented that active discharge planning was already occurring for the resident to return to the community. Review of the care plan dated 5/15/13 did not include a discharge planning care plan and the facility was unable to provide a discharge planning form.

7. During an interview in the conference room on 7/31/13 at 9:43 AM, SW #1 was asked about the discharge planning process. SW #1 stated, "...realize the discharge planning process is broken..."

F 309 483.25 PROVIDE CARE/SERVICES FOR 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 medical record review, observation and interview, it was determined the facility failed to ensure a physician's order to provide assistance with all meals was followed for 1 of 25 (Resident #154) sampled residents with nutritional risks.

The findings included:
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 309 Continued From page 25</td>
<td>468.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</td>
<td>F 309 (Resident #154 no longer resides in facility. The Nurse Managers will check new orders daily for two weeks then 10% of new orders will be checked each month for 90 days and then 5% will be checked for the next quarter to ensure continued compliance. The results will be reported and discussed in the monthly QA meeting for 6 months. 8/31/13 and ongoing)</td>
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<td>F 313 SS=D</td>
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<td>F 313</td>
<td>The facility will promote care for the residents in a manner and in an environment that maintains or enhances each resident's treatment to maintain hearing, vision through use of devices.</td>
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Medical record review for Resident #154 documented an admission date of 6/11/13 with diagnoses of Questionable Old Stroke, Malnutrition, Hypertension, Degenerative Joint Disease and Osteoarthritis. A Physician’s order dated 6/13/13 documented, "...Assist Resident c [with] all meals...". Observations in Resident #154's room on 7/30/13 at 8:20 AM, revealed Resident #154 eating breakfast unassisted. The facility failed to follow the order to assist the resident with all meals.

During an interview in the conference room on 8/1/13 at 9:30 AM, the Director of Nursing (DON) was asked what her expectations are for the staff to follow doctor orders. The DON stated, "...I expect them to follow them...".

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure residents received assistive devices to maintain
 **F 313** Continued From page 27

vision ability for 1 of 3 (Resident #189) sampled residents of the 83 residents with visual impairments.

The findings included:

Medical record review for Resident #189 documented an admission date of 3/22/13 with diagnoses of Pneumonia, Dehydration, Acute Renal Insufficiency, Hypertension, History of Coronary Artery Disease, Anemia, Syncopeal Episodes, and Cellulitis of the Left Leg. Review of the Minimum Data Set (MDS) dated 3/29/13 documented, Resident #189 had moderately impaired vision with no corrective lenses. There was no documentation the facility had addressed Resident #189's visual impairment.

During an interview in the conference room 8/1/13 at 10:05 AM, Social Worker (SW) #1 was asked if she does the vision assessment section of the MDS. SW #1 stated, "Yes." SW #1 was asked what she did if someone had moderately impaired vision. SW #1 stated, "...normally referred to vision if they complain or the Doctor write the order..."

During an interview in the conference room 8/1/13 at 10:10 AM, the Director of Nursing (DON) was asked if the MDS Nurse does the vision section of the MDS. The DON stated, "...They [MDS Nurse] use to... they have been instructed to just do the nursing part..."

During an interview in the conference room on 8/1/13 at 10:55 AM, MDS Nurse #1 was asked what was done to address Resident #189's vision impairment. MDS Nurse #1 stated, "...didn't do a care plan... didn't think it was really a problem..."

Social Worker #1 and MDS nurse will reassess resident #189 regarding vision impairment by 8/31/13. Social Worker #1 will notify mobile eye service to come and assess resident #189 for services. Administrator and/or designee will review and educate Social Services and MDS on procedures for vision and hearing services. The Administrator and/or designee will audit 10% of new resident's careplans and MDS for the next 30 days and then 5% for 90 days. The results will be reported to the QA committee for review to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities.
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<td>F 313</td>
<td>Continued From page 28</td>
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<tr>
<td></td>
<td>don't know why it [vision] triggered...</td>
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<tr>
<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO</td>
<td>F 314</td>
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<td></td>
<td>PREVENT/HEAL PRESSURE SORES</td>
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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 medical record review, observation and interview, it was determined the facility failed to ensure 1 of 3 (Resident #122) residents reviewed with pressure sores received the care and services to promote healing and prevent new sores from developing.

The findings included:

Medical record review for Resident #122 documented an admission date of 6/5/13 with diagnoses of Acute Respiratory Insufficiency, Slow Ventilator Weaning, Left Femur Fracture, Anoxic Encephalopathy, Cardiomyopathy with Congestive Heart Failure and Neurogenic Bladder. A physician's order dated 7/10/13 documented, "...Float heels (calves on pillow)..." A physician's order dated 7/21/13 documented, "...Float heels (...nothing to touch... calves area)."

Observations in Resident #122's room on 7/30/13

Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with following the physician orders.

Staff Development Coordinator will inservice all licensed nurses on checking physician orders daily to ensure staff is aware of orders and that the orders are being carried out.

8/31/13
**F 314**

Continued From page 29 at 5:15 PM, revealed Resident #122 in bed with the feet elevated but heels were not floating.

Observations in Resident #122's room on 7/31/13 at 8:55 AM, revealed Resident #122 in bed with the left leg touching bed, not on a pillow.

During an interview in Resident #122's room on 7/31/13 at 8:55 AM, Licensed Practical Nurse (LPN) #1 was asked what it meant if you have a physician order to float heels and keep pressure off the heels and not to touch. LPN #1 stated, "Then we are to follow physician's orders regardless." LPN #1 was asked if Resident #122's heels were touching the mattress. LPN #1 stated, "Yes, they are..."

During an interview in the conference room on 7/31/13 at 10:10 AM, the Treatment Nurse stated, "She [Resident #122] was admitted with her wounds. The ones on her heels, one is a stage 2 and the other heel is preventative healing."

The facility failed to follow physician's orders to float Resident #122's heels.

**F 325**

483.25(i) MAINTAIN NUTRITION STATUS 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.

Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with facility policy, state, and federal regulation.
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 each resident received nutritional interventions to prevent weight loss for 1 of 3 (Resident #357) sampled residents reviewed of the 9 residents with nutritional concerns.

The findings included:

Review of the facility’s weight monitoring policy documented, "...To identify residents who are at nutritional risk and intervene appropriately...

Parameters for Evaluating Significant Weight Loss... 5% [percent] weight loss/gain in 1 month...

Interventions for Weight Management...

Residents will be weighed weekly X times 4, and reviewed until the residents weight has stabilized or the issue is resolved through other parameters..."

Medical record review for Resident #357 documented an admission date of 5/1/13 and a discharge date of 6/5/13 with diagnoses of Left Total Knee Arthroplasty and Hypertension. Review of the 30 day minimum data set (MDS) dated 6/2/13 did not reflect the resident's weight loss. Review of the interdisciplinary care plan dated 5/1/13 does not address nutritional concerns or weight loss. Review of the interact early warning tool dated 5/12/13 documented, "...Weight change [circled]... 192.0 [symbol for decrease] 183.4..." There was no nurses note reflecting the weight change noted in the interact early warning tool dated 5/12/13. Review of the weight record

Resident #357 no longer resides in facility.

DON and/or designee will review significant weight loss policy with the dietitians. Staff Development Coordinator and/or will provide education to Nurse Managers and direct care staff on the facility’s policy’s Significant Weight Loss Policy which relates to the RAI manual. The Director of Nursing and/or designee will audit all significant weight losses to ensure that nursing and dietary staff are following the facility policy for 30 days, then 50% of significant weight losses for the next 30 days, and then 10% for the next 90 days. The following audit results will be reported to the monthly QA committee for review to ensure that continued compliance is maintained.
F-325 Continued From page 31

Documented, "...Admit Weight 192.0 [pounds]...5-2-13... May...Week 2...183.4... Week 3...182.4... Week 4...178.4... 5th...177.6..."

During an interview in the conference room on 7/31/13 at 1:00 PM, the Clinical Registered Dietician (RD #1) was asked about weight loss management. RD #1 stated, "...work closely with Restorative Aide... do weekly weights then stable for 4 weeks then monthly..." RD #1 was asked about the interact early warning tool. RD #1 stated, "...may have been put in the book... I may have been verbally notified... see the nurse signed it (pointed to the form)... we have at risk meeting... [named Resident #122] had some edema... probably should have documented it..."

During an interview in the conference room on 7/31/13 at 3:07 PM, Restorative Aide (RA) #1 was asked what her role consisted of. RA #1 stated, "Do weights on the 3rd floor... let nurse sign it and give to Restorative Manager." 

During an interview in the conference room on 8/1/13 at 9:05 AM, the Director Nursing (DON) was asked if any interventions had been put into place to address Resident #357's weight loss. The DON provided a nurse's note dated 5/10/13, but the resident's name was blank and was not documented elsewhere in the note. The DON confirmed that there was no other interventions for weight loss.

F-332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

The facility will ensure that it is free of medication error rate of 5 percent or greater.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CWA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>445149</td>
<td>A. BUILDING:</td>
<td>08/01/2013</td>
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<td>B. WING:</td>
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**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE AT SAINT FRANCIS

STREET ADDRESS, CITY, STATE, ZIP CODE

6007 PARK AVE
MEMPHIS, TN 38119

**SUMMARY STATEMENT OF DEFICIENCIES**

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

**F 332** Continued From page 32

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of Medication Guide for Long-Term Care Nurse, medical record review and observation, it was determined the facility failed to ensure 3 of 4 (Nurses #1, 3, and 4) nurses administered medications with a medication error rate of less than 5 percent (%).

A total of 17 errors were observed out of 26 opportunities, resulting in an error rate of 65.3846%.

The findings included:

1. Review of facility's "Medication Administration - Nasogastric Tubes, Gastrostomy and Jejunostomy Tubes" policy documented, "...Medication will be provided for residents requiring feeding through an artificial opening into the stomach via nasogastric tube... 7. Medications are never added directly to the feeding solution. Keep in mind any possible fluid restrictions and appropriate fluid requirements the resident may have and adjust accordingly. a. Administer liquid medications first, then those that need to be diluted. Reserve thick medication... for last. b. Allow medication to flow down tube via gravity. c. Give gentle boosts with the plunger... if the medication will not flow by gravity. Repeat as necessary... 8. Follow medication with water..."

Staff Development Coordinator will re-inservice nurse #1, nurse #3, nurse #4, and nurse #5 on correct administration of medication via oral inhalation, peg tube, proper crushing and diluting medication. These nurses will also be re-inserviced with the facility policy, state and federal regulations. The remaining of the licensed nurses will be re-inservice on this also.

The facility will ensure that any resident receiving a steroid oral inhalant will rinse out mouth after administering, all medications will be properly crushed and diluted not leaving any residue in cup to delivery via peg tube.

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<td>F332</td>
<td>Continued From page 33 syringe and allow to flow by gravity into the tube; never force fluid into the tube. Rinse medication cup with water or prescribed diluent and administer to assure delivery of the complete dose...&quot; Medical record review for Resident #383 documented an admission date of 6/19/13 with diagnoses of Stage 2 Sacrum Ulcer, Atrial Fibrillation, Muscle Weakness, Diverticulitis, Congestive Heart Failure, Chronic Kidney Disease, Diabetes, Respiratory Failure, Lower Gastrointestinal Bleed and Urinary Tract Infection. A physician's order dated 7/3/13 documented the following medications: &quot;Buspirone 30 milligrams [mgs] (2) tabs [tablets] by mouth twice daily, Multivitamin 1 tab by mouth daily, Aspirin 81 mg 1 tab by mouth daily and Lisinopril 40 mg 1 tab by mouth daily.&quot; Observation on the 4th floor on 7/30/13 beginning at 9:05 AM, Nurse #1 gathered and crushed the following medications for Resident #383: 1 Multivitamin, 1 Chewable Aspirin 81 milligrams, 1 Vitamin C 500 milligrams, 1 Lisinopril 40 milligrams, and 1 Buspirone HCl 30 milligrams. Nurse #1 mixed the crushed medication in 30 cubic centimeters (cc's) of water spilling some of the medication mix. Nurse #1 poured the medication mix into a larger cup of water and administered the medications per Nasogastric tube leaving residue in the smaller cup and the larger cup. Nurse #1 failed to give 2 Buspirone, and giving Vitamin C without an order and the failure to give all of the crushed medication mixture resulted in medication errors #1, 2, 3, 4 and 5.</td>
<td>The Director of Nursing and/or designee will perform audits to ensure correct medication administration of oral inhalants, peg tubes, proper crushing and diluting of medications. These audits will be performed weekly for 2 weeks, then monthly for three months. The results of the audits will be reported monthly to the QA committee for review for 3 months.</td>
<td>08/01/2013</td>
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2. Medical record review for Resident #104
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

445149

**NAME OF PROVIDER OR SUPPLIER:**

SIGNATURE HEALTHCARE AT SAINT FRANCIS

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

6007 PARK AVE
MEMPHIS, TN 38119

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

08/01/2013

**(X3) DATE SURVEY COMPLETED**

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<thead>
<tr>
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<tbody>
<tr>
<td>F332</td>
<td>F332</td>
<td>Continued From page 34 documented an admission date of 8/5/09 with diagnoses of Cerebral Vascular Accident, Hypertension, and Gastroesophageal Reflux Disease. A physician's order dated 7/1/13 documented the medication Senna Plus Tablet (for Peri-colace tablet) 2 tablets per tube twice daily. Observations on the 5th floor on 7/30/13 beginning at 8:30 AM, Nurse #4 gathered and crushed 2 Geri-Kot 8.6 grams for Resident #104. Nurse #4 mixed the Geri-Kot in water and administered per Percutaneous Gastrostomy Tube (PEG) leaving residual medication in the cup. Nurse #4 stated, &quot;Sometimes it leaves a lot of that brown coloring...&quot; This resulted in medication error #6. 3. Review of facility's &quot;Medication Administration Oral Inhalations&quot; policy documented, &quot;...To allow for correct administration of oral inhalers to residents, and for instruction in proper technique for those residents able to administer the medication to themselves... 14. Immediately following inhalation of a steroid, have resident rinse mouth and spit out the rinse water.&quot; Review of facility's &quot;Medication Administration-Use of Inhalants&quot; policy documented, &quot;...Medications will be used as per specific physician's order...&quot; Review of the &quot;Medication Guide for the Long-Term Care Nurse&quot; fourth edition, page 71 documented, &quot;...Spacing and Proper Sequence of Inhaled Medications... Rinse the mouth out following use... to help prevent oropharyngeal fungal infections.&quot;</td>
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</table>
F 332: Continued From page 35

Medical record review for Resident #336 documented an admission date of 4/10/13 with diagnosis of Traumatic Head Injury. A physician's order dated 7/11/13 documented the following medications: "Citalopram HBR 10 mg tablet 1 tablet orally / per Tube daily, Diazepam 5 mg Tablet 1/2 tablet (2.5 mg) per tube twice daily, DOK 100mg capsule (for Colace 100mg capsule) 1 capsule per tube daily, Propranolol 10 mg tablet... 1 tablet per tube three times daily... Risperidone 0.5 mg... 1 tablet orally twice daily, Therems Tablet (Multivitamins, therapeutic) 1 tablet per tube daily, Vitamin C 500 mg tablet... 1/2 T [tablet] PT [per tube] QD [every day]. Zinc sulfate 220 mg capsule... 1 capsule per tube daily, and Spiriva 18mcg [micrograms] per inhal [inhale] daily."

Observations on 7/30/13 beginning at 9:48 AM, Nurse #3 gathered and crushed the following medications for Resident #336: 1 Florastor 250 milligrams, 1 Diazepam 5 mg, 1 Docusate Sodium 100 mg, 1 Propranolol 10 mg, 1 Thera-tab multivitamin, 2 Vitamin C 250 mg, 1 Zinc Sulfate 220 mg, 1 Risperidone 0.25 mg and 1 Citalopram HBR 20 mg. Nurse #3 mixed the crushed medications in a cup and administered per PEG leaving medication residue in the bottom of the cup. Nurse #3 did not administer Citalopram HBR, Diazepam, Risperidone, and Vitamin C as ordered, administered Florastor without an order which resulted in medication errors #7, 8, 9, 10, 11, 12, 13, 14 and 15.

Observations in Resident #336's room on 7/30/13 at 9:55 AM, Nurse #3 administered Proventil HFA 90 micrograms inhaler 2 puffs to Resident #336. There was no physician's order for the Proventil. This resulted in medication error #16.
<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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 36 Observations in Resident #338's room on 7/30/13 at 9:58 AM, Nurse #3 administered Spiriva 18 micrograms handinhaler 1 puff to Resident #336. Nurse #3 failed to have the resident rinse his mouth after administering the Spiriva inhaler which resulted in medication error #17.</td>
<td>F 332</td>
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<tr>
<td>F 371</td>
<td>483.35(i) FOOD PROCURE, STORE/prepare/serve - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</td>
<td>F 371</td>
<td>All expired items (milk, juice, thicken-n-easy) were immediately removed and discarded from all refrigerators. Microwave on 3rd floor was cleaned immediately. CNA's were re-inserviced on proper handwashing during meal service immediately once concern was made known. Staff Development Coordinator or designee will continue to inservice staff on proper handwashing during meal service. Staff Development and/or designee will do random audits to ensure proper handwashing technique continues. These audits will be submitted monthly to QA for 3 months and then quarterly as needed. The Food Service Manager re-inserviced dietary aides on checking for dates on items to ensure safety and wholesomeness.</td>
<td>8/31/13</td>
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</table>

This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure food was safe for consumption by having expired and open food items in the resident nourishment kitchens on 2 of 4 (2nd and 3rd floor resident kitchens) floor resident kitchens and failed to prevent the cross contamination of food by failing to ensure appropriate handwashing during 2 meals observed in 1 of 8 (2nd floor dining area) dining areas.

The findings included:

1. Review of the facility's food and supply storage procedures policy documented, "All food,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>445149</td>
<td>A. BUILDING</td>
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<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE AT SAINT FRANCIS

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

6007 PARK AVE
MEMPHIS, TN 38119

**DATE SURVEY COMPLETED**

08/01/2013

<table>
<thead>
<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>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 37 non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption... The [use by] date is the last date that a food can be consumed... Remove from storage any items for which the expiration date has expired...</td>
<td>9/30/13</td>
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</table>

a. Observations in the 2nd floor kitchen on 7/29/13 at 7:25 AM, revealed 3 cartons of 1 percent (%) low fat milk with an expiration date of July 24, 2013; a quart can of grape juice with a "Use by" date of July 24, 2013; 2 containers of Thick and (8) Easy with a "Use by" date of 3/29/13; and 2 containers of Thick & Easy with a "Use by" date of 8/11/13. There was an opened half pint container of milk with no label or date.

During an interview in the 2nd floor kitchen on 7/29/13 at 7:30 AM Human Resource staff member #1 confirmed the expired dates by saying an affirmative "mrmr-mrmr."

b. Observations in the 3rd floor kitchen on 7/29/13 at 7:10 AM, revealed the microwave was dirty, there were 15 (8 ounce) containers of Thick & Easy with a "Use by" date of 3/5/13; 15 (8 ounce) containers of Thick & Easy with a "Use by" date of 6/11/13; 11 (8 ounce) containers of Thick & Easy with a "Use by" date of 6/28/13; and 2 cans of Osmolite 1.5 Calorie with a "Use by" date of July 1, 2013.

During an interview in the D main hall on 7/30/13 at 7:50 AM, the Director of Nursing stated, "...I have a system... they [supplements and milk] must have been brought over on Friday that way... I check them myself every Friday..."
Continued From page 38

During an interview in the conference room on 7/31/13 at 4:20 PM, the Food Service Manager (FSM) was asked what the delivery days are for patient nourishment on each floor. The FSM stated, "...the unit secretary fills out a request and tubes the information to us at the hospital on Monday and Thursday and they are delivered the same day... expiration dates are checked daily by the dietary department and before bringing the items over... use by dates are treated as expiration dates... it is out of date if use by date is out..."

2. Review of the facility's "Handwashing" policy documented, "Staff and residents will wash their hands as necessary to prevent the spread of infections or germs. Appropriate Times for Staff to Wash Hands- Before and after caring for each resident and/or their units. This includes handling anything the resident has touched. Before handling a resident's food or food tray..."

a. Observations on the 2nd floor, during the breakfast meal, on 7/29/13 at 7:54 AM, certified nursing assistant (CNA) #1 moved a wheelchair and bedside table in room 206 and then opened ensure, milk and juice without washing hands.

b. Observations on the 2nd floor, during the supper meal, on 7/30/13 at 4:30 PM, CNA #8 dropped the top of the cooler on the floor, picked it up and put it back on the cooler. CNA #8 then took a tray to room 206 and opened the resident's milk, salt and set the tray up without washing hands.

Observations on the 2nd floor, during the supper meal, on 7/30/13 at 4:53 PM, CNA #8 opened the...
| F 371 | Continued From page 39
|       | lld from the cooler, removed milk and took it to room 222 where she opened the milk, juice and salt without washing hands.
|       | c. Observations on the 2nd floor, during the supper meal, on 7/30/13 at 4:40 PM, CNA #9 moved a wheelchair and shoes and then opened the dessert and spices for a resident in room 212 without washing hands.
|       | During an interview in the conference room on 7/31/13 at 1:32 PM, the Director of Nursing (DON) stated, "I expect staff to wash hands after moving tables and wheelchairs. When top of cooler was dropped on floor staff should have taken it to the kitchen and come back and sanitize their hands. When they moved the shoes and wheelchair they should have washed their hands."

| F 431 | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
|       | The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

|       | Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

The facility will employ or obtain the services of a licensed pharmacist who establishes a system to ensure that all medications are kept and stored in their originally received containers, to ensure med carts are kept cleaned of any medication residue and free of any loose pills, to ensure that emergency supply box is kept locked, to ensure that all medications will be dated when opened.
F 431  Continued From page 40

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

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

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored properly as evidenced by loose tablets and dirty medication drawers in 10 of 15 (2nd floor cart 1, 2nd floor cart 2, 2nd floor medication preparation (prep) room, 3rd floor cart 1, 3rd floor cart 2, 3rd floor cart 3, 3rd floor medication preparation room, 4th floor intermediate care (ICF) floor cart 1 and 4th floor ICF floor cart 2 and 5th floor cart 2) medication storage areas.

The findings included:

1. Review of the facility's "Medication Administration-Medication Storage" policy documented "...4. Medications are kept and stored in their originally received containers..."

All licensed nurses will be re-inserviced by the Director of Nursing, Staff Development Coordinator and/or designee in accordance with State and Federal laws, the facility will ensure that all medications will be kept and stored in their original containers, and dated when opened to ensure that all med carts are kept clean of any medication residue and loose pills. Also to make sure the emergency supply box is locked at all times.
Continued From page 41

2. Observations of the 2nd floor cart 1 on 8/1/13 at 2:00 PM, revealed part of an unidentified capsule and powder residue in the top right drawer.

During an interview on 2nd floor on 8/1/13 at 2:00 PM, Licensed Practical Nurse (LPN) #5 stated, "I don't know what that [unidentified capsule and powder residue] is."

3. Observations of the 2nd floor cart 2 on 8/1/13 at 2:15 PM, revealed a bottle of iron supplement and a bottle of Loperamide Hydrochloride bottle covered with a sticky residue; the top drawer had paper and powder residue in a corner and an unidentified red pill was loose in the second drawer. There was a powder residue in the second and third drawers.

During an interview on the 2nd floor on 8/1/13 at 2:15 PM, LPN #6 stated, "...I don't see a red one [tablet] like that one..."

4. Observations in the 2nd floor medication preparation room 8/1/13 at 2:00 PM, revealed the emergency supply box was unlocked. LPN #5 stated, "...It looks like it just got unlocked..."

5. Observations of the 3rd floor cart #1 on 8/1/13 at 2:17 PM, revealed paper and residue in top drawer and the second drawer.

During an interview on the 3rd floor on 8/1/13 at 2:17 PM, LPN #7 stated, "...[cart] cleaned every shift..."

6. Observations of the 3rd floor medication prep room on 8/1/13 at 2:17 PM, revealed a red bucket with white residue in refrigerator. There was a
F 431 Continued From page 42

bottle of Nitrostat with expiration date of 8/12, an open bottle of Normal Saline with no open date documented.

During an interview in the 3rd floor med prep room on 8/1/13 at 2:17 PM, LPN #7 stated, "...I don't know when it [bottle of normal saline] was opened..."

7. Observations of the 3rd floor cart 2 on 8/1/13 at 2:29 PM, revealed paper and powder residue in the top drawer, 3 unidentified pills in the second middle drawer and 3 unidentified pills in left side of the drawer.

During an interview on the 3rd floor on 8/1/13 at 2:29 PM, LPN #6 stated, "...I don't know... they come out of those packs..."

8. Observations of the 3rd floor cart 3 on 8/1/13 at 2:37 PM, revealed the 1st and 2nd drawers had paper and residue in them.

During an interview on the 3rd floor on 8/1/13 at 2:37 PM, LPN #9 was asked how often are the medication carts cleaned. LPN #9 stated, "...as often as needed..."

9. Observations of the 4th floor ICF cart 1 on 8/1/13 at 2:51 PM, revealed the top right drawer had an unidentified loose pill and paper residue in it, The second middle drawer had a powder and paper residue.

During an interview on the 4th floor on 8/1/13 at 2:51 PM, LPN #10 was asked what the loose pill was. LPN #10 stated, "...I have no idea... carts are cleaned weekly or every day if it's dirty..."
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<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>
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<tr>
<td>F 431</td>
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<td>Continued From page 43</td>
<td>F 431</td>
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<td>10. Observations of the 4th floor ICF cart 2 on 8/1/13 at 3:02 PM, revealed an open bottle of Nitrostat with no open date.</td>
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<td>During an interview on the 4th floor on 8/1/13 at 3:02 PM, LPN #10 was asked about the open date of the Nitrostat. LPN #10 stated, &quot;...I don't know how long it's been open...&quot;</td>
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<td>11. Observations of the 5th floor cart 2 on 8/1/13 at 3:31 PM, revealed the top drawer with powder residue, second drawer had a straw paper stuck to the bottom of the drawer with a pink sticky liquid and an unidentified loose pill in the 3rd drawer.</td>
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<td>During an interview on the 5th floor on 8/1/13 at 3:331 PM LPN #11 was asked about the cleaning of the cart. LPN #11 stated, &quot;...clean it after each shift.&quot;</td>
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<td>12. During an interview in the conference room on 8/1/13 at 3:50 PM, the Director of Nursing (DON) was asked how often med carts are cleaned. The DON stated, &quot;...Those med carts are cleaned every week by our 11-7 supervisor... Nurses must wipe the bottles down... As far as med carts being cleaned it is the 11-7 supervisor responsibility.&quot; The DON was asked if it was okay to have loose pills and residue in the drawers of the medication carts. The DON stated, &quot;No, it's not.&quot;</td>
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<tr>
<td>F 520</td>
<td></td>
<td>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</td>
<td>F 520</td>
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<td>SS=0</td>
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<td>A facility must maintain a quality assessment and</td>
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<td>F 520</td>
<td>Continued From page 44</td>
<td>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.</td>
<td>F 520</td>
<td>The facility will continue to maintain a quality assessment and assurance committee consisting of the Director of nursing, a physician, and at least 3 other members of the facility staff. The facility meets monthly or at least every two months to review.</td>
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Continued From page 45

Social services was inserviced on the regulatory compliance and timeliness of the documentation to be complete and on the medical record including the social history, social services progress notes, MDS, and the care plan by the Administrator. Discharge planning documentation will also be on the medical record timely. (Resident #50, #90, #154, #338 no longer resides in facility).
Resident #108 will have a completed social history by 8/31/13.
The Corporate Social Services Consultant will be at the facility during the first week of September to work with the Social Workers to ensure they are aware of regulations and needs.
Additional hours have also been added to Social Services to assist. New residents admitted will have weekly audits performed to ensure compliance for 30 days and then 25% will be audited monthly for 60 days.
The results will be reported to the QA committee monthly for 3 months and then quarterly for 6 months.