F 164
SS=D
483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the residents records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure the resident's full visual privacy was maintained when the privacy curtain was not pulled for 1 of 1 (Resident #2) sampled residents.

The submission of this plan of correction is not to be construed in any way as an admission to the citations nor the finding of the facts and is submitted as mandated by federal law.

483.10(e), 483.75(1)(4)

Personal Privacy
Confidentiality of Records

1. Privacy curtains for Resident #2 was replaced on 7/13/11.

2. Nursing and housekeeping staffs interviewed 7/22/11.

3. The housekeeping Manager will replace privacy curtains on an as needed basis.

4. Findings will be reviewed by DNS weekly and reported to the monthly CQI meeting.

5. Administrator will review findings through monthly CQI meeting and revise POC as indicated by trends and findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE 7/22/11

ORIGIN CMS-2587(OCT-09) Previous Versions Obsolete
Event ID: XPM011
Facility ID: TN7921

If continuation sheet: Page 1 of 17
Continued From page 1 during a dressing change.

The findings included:

Review of the facility's "Clean Dressing Change Policy and Procedure" policy documented, "...Provide privacy with curtain and/or door..."

Observations in Resident #2's room on 7/12/11 at 11:35 AM, as Nurse #1 was performing a dressing change on Resident #2. Random Resident #1 opened the door to enter the room. Resident #2 was exposed when the door was opened.

During an interview in front of the Administration office on 7/12/11 at 5:15 PM, Nurse #1 confirmed Resident #2's privacy was not maintained. Nurse #1 stated, "The curtain does not pull all the way around [to maintain privacy]."

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure 1 of 8 (Nurse #4) and 1 of 8 Certified Nursing Assistants (CNA #1) knocked on the door and gained permission prior to entering the resident's room.

1. Nurse #4 and CNA #1 were instructed to knock before entering resident rooms.
2. On 7/12/11, ADON and Staffing Coordinator conducted QA rounds to ensure staff knocked on doors before entering resident rooms.
3. Nursing and housekeeping staffs were instructed on 7/22/11 to knock on resident room doors as a matter of dignity.
4. Findings were reviewed by DNS weekly and reported to the monthly CQI meeting.
5. Administrator will review findings through monthly CQI meeting and revise PCC as indicated by trends and findings.
Continued From page 2
The findings included:

1. Observations in Random Resident (RR) #4's room on 7/11/11 at 4:08 PM, Nurse #4 entered RR #4's room without knocking or gaining permission to enter.

2. Observations on B hall on 7/12/11 at 7:55 AM, CNA #1 entered room 65 without knocking or gaining permission to enter.

Observations on B hall on 7/12/11 at 8:08 AM, CNA #1 entered room 64 without knocking or gaining permission to enter.

3. During an interview in the Director of Nursing's (DON) office on 7/13/11 at 5:15 PM, the DON confirmed staff should knock on doors and gain permission prior to entering a resident's room.

F 332
SS=E

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.

This REQUIREMENT is not met as evidenced by:
Based on review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, It was determined the facility failed to ensure 4 of 8 (Nurses #2, 3, 5 and 6) nurses administered medications with a medication error rate of less than 5 percent (%).
A total of 4 errors were observed out of 40
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>Name of Provider or Supplier</th>
<th>Millington Healthcare Center</th>
</tr>
</thead>
</table>

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>(X1) ID Prefix Tag</th>
<th>Continued from page 3 opportunities for error, resulting in a medication error rate of 10%. The findings included:</th>
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<tbody>
<tr>
<td>F 332</td>
<td>1. Review of the &quot;MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; documented, &quot;...Novolin R ...ONSET (in Hours, Unless Noted)... 0.5 [1/2] - [to] 1... TYPICAL ADMINISTRATION/COMMENTS... 30 minutes prior to meals... Novolin 70/30... ONSET (in Hours, Unless Noted)... 30 min [minutes]... TYPICAL ADMINISTRATION / COMMENTS... 30 minutes prior to meals... &quot;</td>
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<td>Observations in RR #5's room on 7/11/11 at 4:43 PM, Nurse #3 administered 8 units of Novolin R insulin and 12 units of Novolin 73/30 to RR #5. As of 5:35 PM, RR #5 still had not received a meal or a snack. The administration of the insulin more than 30 minutes before a meal or a snack was served resulted in medication error #1.</td>
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During an interview in the Director of Nursing office (DON) on 7/13/11 at 5:15 PM, the Assistant...
| --- |
| **4. Medical record review for RR #7 documented an admission date of 3/1/09 with diagnosis of Diabetes Mellitus, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Review of physician's order dated 5/27/11 documented, "GLIPZIDE 10MG BY MOUTH BEFORE SUPER." Observation in RR #7's room on 7/12/11 at 4:05 PM, Nurse #6 administered 5 mg of Glipizide to RR #7. The administration of this medication administered in medication error #5. During an interview at the ABH hall nurses' station on 7/13/11 at 2:30 PM, Nurse #6 was asked if there is an order for 5 mg of Glipizide in the chart. Nurse #6 stated, "No."

**ADON** was asked how soon a resident should receive a meal after insulin administration. The ADON stated, "Within 20 minutes." |
MILLINGTON HEALTHCARE CENTER

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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 332 | Continued From page 5 evening. Nurse #8 stated, "...no order..."
5. Medical record review for RR #8 documented an admission date of 1/14/10 with diagnoses of Hypertension, Dementia, Hypothyroidism, Encephalopathy and Muscle Weakness. Review of a physician's order dated 5/3/11 documented, "...CALCULUM 600 + [plus] D [vitamin D] 600MG-200 TABLET... TWICE DAILY WITH MEALS..."
Observation in RR #8's room on 7/12/11 at 4:25 PM; Nurse #2 administered 600 mg of Calcium with 400 international units (IU) Vitamin D without giving a meal. The administration of the incorrect dose of this medication and the failure to administer it with a meal resulted in medication error #4. | F 332 | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS
The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined the facility failed to ensure residents were free of significant medication errors. The nursing staff failed to administer insulin within the proper time frame related to meals for 1 of 2 Random Residents (RR #5) observed receiving insulin.

483.25(m)(2) Residents Free of Significant Med Errors

1. [Handwritten note: "Josiah"]
2. [Handwritten note: "Josiah"]
3. [Handwritten note: "Josiah"]
Continued From page 6

The findings included:

Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" documented, "...Novolin R...ONSET (In Hours, Unless Noted)...0.5 [1/2] - [to] 1...TYPICAL ADMINISTRATION / COMMENTS...30 minutes prior to meals...Novolin 70/30...ONSET (In Hours, Unless Noted)...30 min [minutes]...TYPICAL ADMINISTRATION / COMMENTS...30 minutes prior to meals..."

Medical record review for RR #5 documented an admission date of 5/28/08 with diagnoses of Hemiplegia, Cerebrovascular Accident, Diabetes Mellitus, Gastroesophageal Reflux Disease and Deep Vein Thrombosis. Review of a physician's order dated 5/31/11 documented, "...NOVOLIN R 100U [units] / [per] 1 ML [milliliter] SSI [Sliding Scale Insulin]...301-400 = [amount of insulin to be administered] 8 UNITS...NOVOLIN 70/30 100U/ML UNIT 12 UNITS SUB-Q [subcutaneous] EVERY EVENING..."

Observations in RR #5's room on 7/11/11 at 4:43 PM, Nurse #3 administered 8 units of Novolin R insulin and 12 units of Novolin 73/30 insulin to RR #5. As of 5:35 PM, RR #5 still had not received a meal or a snack. The administration of the insulin more than 30 minutes before a meal or a snack resulted in a significant medication error.

During an interview in the Director of Nursing office on 7/13/11 at 5:15 PM, the Assistant Director of Nursing was asked how soon a resident should receive a meal after insulin administration. The ADON stated, "...within 30 minutes."
### F 441, SS-D

**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- **Infection Control Program**
  - The facility must establish an Infection Control Program under which it:
    1. Investigates, controls, and prevents infections in the facility;
    2. Decides what procedures, such as isolation, should be applied to an individual resident; and
    3. Maintains a record of incidents and corrective actions related to infections.

- **Preventing Spread of Infection**
  - When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
  - The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
  - The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

- **Linens**

  Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

---

**Provider's Plan of Correction**

- F 441

  1. Nurses will be reassigned
     8/8/11 and CNAs reinserviced
  2. 7/22/11 on proper hand washing technique and wearing of gloves as a means of infection control.
  3. Nurses will be reassigned 8/8/11 on proper glucometer cleaning technique and creation of barrier while in resident rooms.
  4. In-services will be conducted quarterly at a minimum on infection control practices such as hand washing with repeat demonstration.
  5. Random audits will be conducted by DON and ADON for glucometer barrier placement when obtaining blood sugars.
  6. Findings will be reviewed by DNS weekly and reported to the monthly CQI meeting.
  7. Administrator will review findings through monthly CQI meeting and revise POC as indicated by trends and findings.
F 441 Continued From page 8

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure 3 of 9 Certified Nursing Assistants (CNAs #1, 2 and 4) failed to prevent the potential spread of infection by not washing hands or handled food with their bare hands and 3 of 8 (Nurses #2, 3 and 4) nurses failed to set up a barrier for glucometer testing.

The findings included:

1. Review of the facility's "HANDWASHING" policy documented; ",...3. Wash hands well for approximately 30 seconds to aid in the mechanical removal of bacteria... 7. Turn off water with dry paper towel..."

a. Observations in the B hall on 7/12/11 at 7:50 AM, CNA #1 delivered a breakfast tray to room 65, moved a wheelchair and turned the crank on the bed to adjust the head of the bed. CNA #1 then washed her hands and turned off the faucet with her bare hands.

Observations in the B hall on 7/12/11 at 8:05 AM, CNA #1 delivered a breakfast tray to room 64W and set up the tray. CNA #1 then washed her hands and turned off the faucet with her bare hands. CNA #1 left this room, obtained a breakfast tray from the cart, delivered and set up the tray to room 64D. CNA #1 then rinsed her hands with soap and water and turned off the faucet with her bare hands.

Observations in the B hall on 7/12/11 at 8:16 AM,
Continued From page 9
CNA #1 delivered a breakfast tray to room 590, assisted the resident up to the side of the bed and set up the breakfast tray. CNA #1 did not perform hand hygiene. CNA #1 then went to 59W and assisted CNA #2 to reposition the resident in bed. CNA #1 did not perform hand hygiene. CNA #1 left the room, obtained a breakfast tray from the cart, delivered the breakfast tray to room 57, assisted the resident to position in bed and continued to set up the breakfast tray. CNA #1 did not perform hand hygiene after direct resident contact.

Observations in the B hall on 7/12/11 at 8:20 AM, CNA #1 delivered a breakfast tray to room 55W. CNA #1 then went to room 55D and assisted CNA #2 to reposition the resident in bed. CNA #2 then continued to set up the breakfast tray for the resident in 55D, and did not perform hand hygiene after resident contact. CNA #1 then assisted the resident in 55W to reposition in bed and continued to set up the breakfast tray without performing hand hygiene.

b. Observations in the B hall on 7/12/11 at 8:00 AM, CNA #2 touched her left eye, pulled the food and beverage cart down the hall and obtained the next tray. CNA #2 did not wash her hands. CNA #2 obtained a beverage and went to the next room, picked up the toast with her bare hands to spread jelly for the resident, picked up the loaf bare-handed and moved it around the plate, washed her hands with soap and water very quickly and turned off the faucet with her bare hands.

Observations in the B hall on 7/12/11 at 12:00 PM, CNA #2 delivered a lunch tray to room 57.
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:**
445425

**Multiple Construction**

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**Date Survey Completed:**
07/13/2011

### Name of Provider or Supplier
MILLINGTON HEALTHCARE CENTER

### Summary Statement of Deficiencies

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<th>TAG</th>
<th>Description</th>
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<tbody>
<tr>
<td>F441</td>
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<td>Continued From page 10 turned the crank on the bed, applied a clothing protector to the resident, then continued to set up the lunch tray, touching the straws bare handed. CNA #2 did not perform hand hygiene after touching the inanimate objects. Observations in the B hall on 7/12/11 at 12:07 PM, CNA #2 delivered and set up a lunch tray to room 62, applied a clothing protector to the resident, left this room and did not perform hand hygiene. CNA #2 then obtained a lunch tray from the cart, delivered the lunch tray to room 71 and set up the tray touching the straws bare handed. c. Observations in the small dining room on 7/12/11 at 11:52 AM, CNA #4 brought another resident into the dining room, placed him at the table, washed her hands, turned the faucet off with her bare hands and dried her hands with a paper towel. During an interview in the Director of Nursing's (DON) office on 7/13/11 at 12:15 PM, the Assistant Director of Nursing (ADON) stated, &quot;... staff should use alcohol gel or wash hands after resident contact, touching objects, and in between passing trays...&quot;</td>
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### Provider's Plan of Correction

<table>
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<th>Description</th>
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<td>2. Observations in Random Resident (RR) #2's room on 7/12/11 at 3:40 PM, Nurse #2 placed the glucometer on a overbed table without a barrier. 3. Observations in RR #3's room on 7/12/11 at 3:50 PM, Nurse #3 placed the glucometer on the overbed table without a barrier. 4. Observations in RR #4's room on 7/12/11 at 4:00 PM, Nurse #4 placed the glucometer on the</td>
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Continued From page 11
overbed table without a barrier.

During an interview in the DON's office on 7/13/11 at 6:15 PM, the ADON confirmed the glucometer should be placed on a barrier.

F 469
483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to keep the facility free of pests as evidenced by the presence of flies in patient care areas on 3 of 3 (A, B and G halls) halls, the AB nurses' station, G hall nurses' station and the small and main dining room on G hall.

The findings included:

1. Observations in resident room 32, on A hall, on 7/11/11 at 9:30 AM, revealed 1 fly crawling on a bedside table and then flying around the resident's head.

During an interview in the A hall on 7/12/11 at 2:00 PM, Nurse #7 stated, "...I think the flies say well it is cooler inside and they (flies) come in."

2. Observations in resident room 75, on B hall, on 7/11/11 at 9:30 AM, revealed 1 fly crawling on the back of a resident.
F 469 Continued From page 12

Observations outside resident room 71, on B hall, on 7/11/11 at 9:40 AM, revealed 1 fly flying around and 1 fly flying around a resident's head.

Observations in resident room 52, on B hall, on 7/11/11 at 9:50 AM, revealed 1 fly crawling on the resident's blanket.

Observations in resident room 63, on B hall, on 7/11/11 at 10:05, revealed 1 fly flying around a resident's face and 1 fly crawling on the blanket.

Observations in resident room 59, on B hall, on 7/11/11 at 10:15 AM, revealed 1 fly on the overbed table in front of the resident and 2 flies crawling on the bed blanket.

Observations in resident room 63, on B hall, on 7/11/11 at 2:00 PM, revealed 1 fly crawling on top of the bed sheet and 1 fly crawling on the resident's blanket.

Observations in resident room 63, on B hall, on 7/12/11 at 8:10 AM, revealed 1 fly on the resident's blanket, 1 fly on the resident's gown and 1 fly flying around the resident's face.

Observations in resident room 63, on B hall, on 7/12/11 at 12:20 PM, revealed 1 fly flying around the resident's head while the resident was being fed.

Observations in resident room 63, on B hall, on 7/12/11 at 1:45 PM, revealed 2 flies on the resident's gown and 2 flies on the resident's blanket.
Continued From page 13
Observations outside resident room 75, on B hall, on 7/13/11 at 12:25 PM, revealed 1 fly on the wall.

Observations in resident room 63, on B hall, on 7/13/11 at 4:25 PM, revealed 6 flies crawling on the resident's blanket.

During an interview in the B hall on 7/12/11 at 12:15 PM, Nurse #5 was asked what she was swatting at with her hand. Nurse #5 stated, "A fly, they are just swarming."

3. Observations outside resident room 7, on G hall, on 7/13/11 at 8:15 AM, revealed 1 fly on a resident's back while she was sitting in her wheelchair.


Observations of the AB hall nurses' station on 7/11/11 at 2:10 PM, revealed 1 fly flying around the nurses station and land on a resident's wheelchair beside the desk.

Observations of the AB hall nurses' station on 7/11/11 at 6:15 PM, revealed 1 fly flying around the nurses station.

Observations of the AB hall nurses' station on 7/12/11 at 2:00 PM, revealed 1 fly crawling on the computer monitor.

Observations of the AB hall nurses' station on 7/13/11 at 10:30 AM, revealed 1 fly sitting on the desk.
<table>
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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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<tbody>
<tr>
<td>F 469</td>
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<td>Continued From page 14</td>
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<td>5. Observations in the G hall nurses' station on 7/13/11 at 10:40 AM, revealed 1 fly flying around the nurses station.</td>
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<td>Observations of the G hall nurses' station on 7/13/11 at 1:50 PM, revealed 1 fly flying around a resident sitting in her wheelchair beside the nurses station.</td>
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<td>6. Observations in the small dining room, on G hall, on 7/12/11 at 11:45 AM, revealed 1 fly flying around a resident's plate.</td>
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<tr>
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<td></td>
<td>Observations in the small dining room, on G hall, on 7/12/11 at 11:55 AM, revealed 1 fly flying around a resident's food.</td>
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<tr>
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<td>Observations in the small dining room, on G hall, on 7/12/11 at 12:05 PM, revealed 1 fly sitting on a roll on the resident's plate.</td>
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<td>7. Observations of the main dining room door, on G hall, on 7/11/11 at 5:25 PM, revealed 1 fly flying between the surveyor and a staff member during an interview.</td>
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<td>8. During an interview in the Rehabilitation Services office with the Administrator on 7/13/11 at 8:25 AM, the Administrator stated &quot;...I think it is just so not outside; it's [so many flies] embarrassing...&quot;</td>
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<tr>
<td>F 497</td>
<td>483.75(e)(8)</td>
<td>NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</td>
<td>F 497</td>
<td>483.75(e)(8)</td>
<td>Nurse Aide Perform Review-12 HR/YR Inservice</td>
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<tr>
<td>SS=D</td>
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<td>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service</td>
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<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR JSC IDENTIFYING INFORMATION)</td>
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| F 497         | Continued From page 15 education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on policy review, review of Certified Nursing Assistants (CNA) in-service attendance records for 2010 and interview, it was determined the facility failed to ensure 2 of 18 (CNA #1 and CNA #3) CNAs employed the entire year of 2010 received at least 12 hours of in-service training for the year. The findings included: Review of the facility's 'IN - SERVICE EDUCATION PROGRAMS' policy documented, "...In-service Educational Programs will be conducted regularly to ensure facility staff are knowledgeable of policies, procedures, and resident care. Programs are developed to provide a minimum of 12 hours for nursing assistants. Programs will comply with Federal and State Regulations..." Review of the CNA in-service attendance records recorded the in-service hours for 2010 as follows: a. CNA #1 with a hire date of 6/23/08 had 6... | F 497 | Continued from page 15

1. CNAs were inserviced 7/22/11 on the necessity of obtaining a minimum of 12 (12 service hours per year as a regulatory condition of their certification.

2. Inservice on relevant topics will be conducted monthly/22 times a year at a minimum of the facility for CNAs and nurses.

3. An inservice log will be maintained and a record of attendance by the staffing coordinator.

4. Findings will be reviewed by DNS weekly and reported to the monthly CQI meeting.

5. The Administrator will monitor through monthly CQI process and review POC as indicated by trends and findings. | 7/22/11 |
<table>
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  a. CNA #3 had 10 hours.
  b. CNA #3 with a hire date of 4/19/05 had 9 hours.

During an interview in the Administrator's office on 7/13/11 at 9:55 AM, the Administrator confirmed that these were all of the in-service hours for these CNAs. The Administrator stated, "...they [CNAs] just do not come in for the in-services..."