The resident has the right, unless adjudged
incompetent or otherwise found to be
incapacitated under the laws of the State, to
participate in planning care and treatment or
changes in care and treatment.

A comprehensive care plan must be developed
within 7 days after the completion of the
comprehensive assessment; prepared by an
interdisciplinary team, that includes the attending
physician, a registered nurse with responsibility
for the resident, and other appropriate staff in
disciplines as determined by the resident's needs,
and, to the extent practicable, the participation of
the resident, the resident's family or the resident's
legal representative, and periodically reviewed
and revised by a team of qualified persons after
each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it
was determined the facility failed to revise the
resident care plan for emergency (ER) bleeding
for 1 of 17 (Resident #14) sampled residents.

The findings included:

Medical record review for Resident #14
documented an admission date of 11/15/07 with a
readmission date of 1/28/08 with diagnoses of End
Stage Renal Disease, Diabetes Mellitus, Bronchitis and Neuropathy in Diabetes. Review of
a physician's order dated 3/10 documented,

We are submitting this POC as
required by Federal Regulations. the submission of this POC is
not to be construed in any
way as an admission to the
accuracy of the citations nor
the finding of fact.

- Resident 14's care plan has been reviewed 3-19-10
and revised. The revision contains procedures
addressing emergency bleeding from the shunt.

Care plans for dialysis pts. w/ shunts
have been revised to address
emergency bleeding caused by shunts. MDS
nurse has received inservice by DON on the
development of care plans containing
procedures addressing emergency bleeding
causd by shunts.

Newly admitted dialysis pt.'s w/ shunts
will have care plans containing
procedures addressing
emergency bleeding caused by shunts, written on admission.

Present pt.'s care plans will
be monitored on 90 day intervals and
when a significant change occurs.
The DON / designee will monitor
newly admitted dialysis pt.'s w/
shunts along with present pts. receiving
first time orders for dialysis and
shunts, which will be monitored by the
QA Committee.
"...DIALYSIS EVERY Monday Wednesday AND Friday..." Review of the comprehensive care plan dated 3/2/10 had no documentation of a care plan to address emergency bleeding from Resident #14's shunt.

During an interview in the Minimum Data Set (MDS) office on 3/17/10 at 1:05 PM, the MDS nurse stated, "I need to add apply pressure [referring to shunt site] and call doctor. I'll take care of that [develop care plan for ER bleeding] now."

483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interviews, it was determined the facility failed to ensure staff administered medications per Percutaneous Endoscopic Gastrostomy (PEG) tube as evidenced by not checking residual and not dissolving crushed medications prior to administration of medications for 1 of 1 (Resident #4) sampled resident and 1 of 2 Random Residents (RR #2) residents observed with PEG tube.

The findings included:

- The two nurses identified deficient practices have been inserviced on the correct procedures of administering meds per peg tube by the DON. This inservice included a "skills check sheet" addressing peg tube med administration.

- Licensed nurses have been inserviced on correct peg tube med administration. This inservice also included information that all pts. w/ peg tubes have the potential to be affected by these same deficient practices.

- The RN Supervisors/designee, Pharmacy consultant, and the Nurse consultant will perform random medication passes checks to ensure that correct med pass procedures are being used along with a peg tube skill check list. All deficient practices will be corrected at the time of identification, and the nurse in question will receive one on one inservice on correct procedures.

- DON will monitor the random check results and will report results to the QA Committee.
1. Review of the facility's "ENTERAL TUBE MEDICATION ADMINISTRATION" policy documented, "...N. Prepare medications for administration... 2. Crush tablets and dissolve in (30ml) [milliliters] of warm water or other appropriate liquid... Dilute liquid medications with 10- [to] 30 ml of warm water or enteral formula if the liquid medication is hyperosmolar and compatible with enteral formulas... Check gastric contents for residual feeding..."

2. Observations in RR #2's room on 3/16/10 at 8:20 AM, revealed Nurse #2 administered RR #2's medications per PEG tube. Nurse #2 did not check gastric residual before administering the medications.

During an interview on the East hall on 3/17/10 at 11:20 AM, when asked about checking for gastric residual, Nurse #2 stated, "I usually do that. I was just nervous."

3. Observations in Resident #4's room on 3/16/10 at 8:50 AM, revealed Nurse #3 administered Resident #4's medications per PEG tube. Nurse #3 did not dissolve the crushed medications or dilute the liquid medications prior to administering the medications.

During an interview on the East hall on 3/17/10 at 11:25 AM, Nurse #3 stated, "I usually dissolve them [crushed medications]. I was nervous."

The identified cord was correctly placed by the DON at the time of the surveyor's discovery 3-19-10

All pts. have the potential to be affected by this deficient practice. Entire staff inserviced on Safety Hazards 3-18-10.

Safety Hazards will be checked during Daily Rounds by RN Supv./designee, and Maintenance staff members.

All deficient practices will be reported to the Safety Committee. Safety Committee actions, including corrective measures will be monitored by the QA Committee.
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adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to ensure 1 of 3 Random Residents (RR #3) environment remained free of an accident hazard.

The findings included:

Medical record review for RR #3 documented an admission date of 4/9/99 and an readmission date of 12/14/07 with diagnoses of Malnutrition Moderate Degree, Gastrostomy, Dysphagia, Oral Phase, Difficulty in Walking, Diabetes II Renal Uncontrolled, Mental Disorder, Renal Failure, Alzheimer's and Hyperlipidemia.

Observations of the breakfast tray delivery on the West hall in room 112 on 3/16/10 at 7:40 AM, revealed an enteral pump was positioned at the lower side of RR #1's bed. The pump was plugged in, with the cord running from the right side of the bed across to the plug in, at the sink, which is across the walkway at the foot of the bed. RR #3 was standing up at the foot of her bed, which was on the other side of the room. The cord of the pump was across the room between RR #3 and the door to the room. Certified Nursing Assistant (CNA #1) came in, set up RR #1's tray then stepped across the pump's cord that was approximately 2 feet from the floor to get a cloth for RR #1's face. CNA #1 stoppe over the cord again to get back to RR #1. RR #3
<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>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 4 would have to step over the cord to exit the room. The cord posed an accident hazard for RR #3.</td>
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During an interview in room 112 on 3/16/10 at 7:50 AM, when asked whether pump to be plugged in like that, the DON stated, "Would not expect pump to be plugged in across to the sink because it was a safety hazard and prevents the resident (RR #3) from coming out (of the room)."