<table>
<thead>
<tr>
<th>Facility Name: Brookhaven Manor</th>
<th>Date: 9/21/13</th>
</tr>
</thead>
</table>

**P 000 INITIAL COMMENTS**

An annual reidentification survey and orientation investigation, 29CFR385, 29CFR386, 29CFR388, and 29CFR400, were completed by August 6, 2013. All deficiencies were cited during the annual reidentification investigation. 29CFR385 and 29CFR388. Citations were noted related to -

**P 241 RESPECT AND DIGNITY OF INDIVIDUALITY**

The facility must provide care for residents in a reasonable manner and in an environment that facilitates or enhances each resident's dignity and respect in full recognition of his or her individuality.

**P 241 REQUIREMENT**

Based on medical record reviews, observations, and interviews, the facility failed to ensure dignity for one resident (ID#40) in long-term care.

**P 241 THE FINDINGS INCLUDE:**

- Resident ID#40 was admitted to the facility on June 18, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Congestive Heart Failure, and Cerebral Vascular Disease.
- Medical record review of the Quarterly Minimum Data Set dated July 17, 2013, revealed the resident was cognitively intact, was totally dependent for bed care, personal hygiene, dressing, toileting, and eating.
- During the annual reidentification investigation, the facility failed to ensure dignity for resident ID#40 in a reasonable manner and in an environment that facilitated or enhanced each resident's dignity and respect in full recognition of his or her individuality.

**ADDITIONAL INFORMATION OR PROVIDER/CAREGIVER RESPONSE INFORMATION:**

For additional information or assistance with any issues, please contact the facility. If the resident or any other individual feels the issue has not been addressed, they can contact the Department of Health & Human Services, Office of Inspector General, 10th Floor, 3101 N. St. Louis Avenue, St. Louis, MO 63103, 1-800-728-3676. The facility is required to ensure dignity for residents in a reasonable manner and in an environment that facilitates or enhances each resident's dignity and respect in full recognition of his or her individuality.
**F 241**  Continued From page 1
bathing, and was always incontinent of bowel and bladder.

Observation on August 5, 2013, at 4:00 p.m., revealed the resident turned on the call light.
Continued observation revealed the call light was turned off at 4:03 p.m.

Interview on August 5, 2013, at 4:20 p.m., with the resident, in the resident’s room revealed the
resident had turned on the call light and requested to have a wet brief changed.
Continued interview revealed a staff member turned the call light off and said they would return.
Continued interview revealed the resident stated “don’t like I’ve...on myself, sometimes want 3 or 4
hours to be changed.”

Observation on August 5, 2013, at 4:38 p.m., revealed the resident turned on the call light.
Continued observation revealed Certified Nursing Assistant (CNA) #2 entered the resident’s room at
4:45 p.m. Continued observation with CNA #2 revealed the resident’s brief was saturated with urine.

Interview with the Director of Nursing on August 6, 2013, at 3:55 p.m., in the conference room
confirmed forty-five minutes was too long to wait for incontinence care to be provided.

**C/O #32091**

483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or
her interests, assessments, and plans of care;
**F 242** Continued From page 2

Interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident.

This **REQUIREMENT** is not met as evidenced by:

- Based on medical record review, review of the shower schedule, observation, and interview, the facility failed to provide showers for one resident (#31) of forty-two residents reviewed.

The findings included:

- Resident #31 was admitted to the facility on December 29, 2011, and readmitted to the facility on April 17, 2013, with diagnoses including Cerebrovascular Disease, Hemiplegia, Atrial Fibrillation, and Hypertension.

- Medical record review of the Quarterly Minimum Data Set dated May 19, 2013, revealed the resident had moderately impaired cognitive skills for daily decision making and was totally dependent for personal hygiene and bathing.

- Medical record review of the Nursing Weekly Summary dated July 31, 2013, revealed "...Alert (end) verbal able to make needs known..."

- Medical record review revealed no documentation when the resident received a shower.

- Review of the shower schedule revealed the resident was scheduled for showers on Monday, Wednesday, and Friday, on the 2:00 p.m. to 10:00 p.m. shift.

Resident #31 was given a shower the same day that Brookhaven was made aware of the resident's request.

Residents who are able will be interviewed to determine if they have been affected. Interviews completed by members of Interdisciplinary Team on 08/20/13 and 08/21/13. Audits of showers will be performed by DON or designee three (3) times per week for twelve (12) weeks. CNAs and Licensed nurses have been interviewed by RN, Risk Manager or before 08/23/13 regarding resident's right to make choices about frequency of showers. Upon review of the resident's choices regarding bathing will be noted and included on the CNA Kardex (care plans). These Kardexes will be updated routinely. Results of audits and interviews will be brought to the QA committee for review, DON or designee to ensure compliance.
<table>
<thead>
<tr>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction (Each correction action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 242</td>
<td>Continued From page 3 Observation and interview with the resident, on August 5, 2013, at 4:30 p.m., in the resident's room, revealed the resident stated does not get a shower, &quot;say they don't have enough time.&quot; Observation and interview with the resident on August 7, 2013, at 8:00 a.m. In the resident's room, revealed the resident stated, &quot;I don't get a shower once a week, don't like to stink, I get a bed bath at 8:00 or 9:00 at night, they tell me they don't have enough time.&quot; Continued interview with the resident revealed the resident was able to state the correct month, president, and year of birth. Interview on August 7, 2013, at 3:00 p.m., with the Director of Nursing, in the conference room, confirmed no documentation the resident received a shower three times a week.</td>
<td></td>
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<tr>
<td>F 246</td>
<td>C/O #32091</td>
<td>F 248</td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td>483.15(e)(1) Reasonable Accommodation of Needs/Prefereces</td>
<td>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to provide care in a reasonable time to</td>
<td></td>
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</tbody>
</table>
**F 246** Continued from page 4

*meat incontinent needs for one resident (#43) of forty-two residents reviewed.*

The findings included:

- Resident #43 was admitted to the facility on June 18, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Congestive Heart Failure, and Chronic Kidney Disease.

- Medical record review of the Quarterly Minimum Data Set dated July 17, 2013, revealed the resident was cognitively intact, and was totally dependent for dressing, personal hygiene, bathing, and was always incontinent of bowel and bladder.

- Review of the facility policy, Call Light, Use of, revealed "...answer all call lights promptly whether or not you are assigned to the resident..."

- Observation on August 5, 2013, at 4:00 p.m., revealed the resident turned on the call light. Continued observation revealed the call light was turned off at 4:03 p.m.

- Interview with the resident on August 8, 2013, at 4:20 p.m., in the resident’s room revealed the resident had turned on the call light and requested to have a wet blanket changed. Continued interview revealed a staff member turned the call light off and said they would return. Continued interview revealed the resident stated “don’t like I’ve...on myself, sometimes wait 3 or 4 hours to be changed.”

- Observation on August 5, 2013, at 4:38 p.m., revealed the resident turned on the call light.
**F 248**

Continued From page 5

Continued observation revealed CNA #2 entered the resident's room at 4:46 p.m. Continued observation with CNA #2 revealed the resident's brief was saturated with urine.

Interview with the Director of Nursing on August 5, 2013, at 3:56 p.m., in the conference room confirmed forty-five minutes was to long to wait for incontinence care to be provided.

C/O #32091

F 253

**483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES**

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

- Based on facility policy, observation, and interview, the facility failed to maintain a clean environment in two of four shower rooms observed.

- Review of facility policy, Shower Stalls, (no date) revealed "...shower stalls should be cleaned frequently to remove these fungi...wash walls and floor...inspect for appearance and odor..."

- Observation on August 5, 2013, at 9:20 a.m., of the 200 hall shower room revealed a black substance on the floor and the walls in the shower area. Continued observation revealed the metal door frame around the entry door to the...
Continued From page 5

shower area was rusted and had jagged edges.

Further observation at 8:45 a.m. of the 400 hall shower room revealed a black substance on the floor and the walls in the shower area. Continued observation revealed the metal door frame around the entry door to the shower area was rusted and had jagged edges.

Observation with the Director of Environmental Services on August 7, 2013, at 9:10 a.m., in the 400 hall shower room revealed a black substance on the floor and walls in the shower area.

Interview during the observation revealed "...showers are cleaned daily and a deep cleaning is done on Sunday..." Further interview confirmed "...it is mildew and has been there at least 2 days...don't think they have been cleaned...

Observation with the Director of Environmental Services on August 7, 2013, at 9:20 a.m., in the 200 hall shower room revealed a black substance on the floor and walls in the shower area.

Interview during the observation confirmed "...again that is mildew..."

Observation and interview with the Administrator on August 7, 2013, at 8:30 a.m., of the 200 and 400 hall shower room door frames confirmed the metal door frames were "broken and decayed" leaving rough edges on the bottom of the frames.

F 279 483.20(d), 483.20(k)(1) DEVELOP

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.
Care plan for resident #145 has been corrected to include bowel and bladder incontinence.
All resident incontinent of bowel and bladder have potential to be affected.
All MDS's Incontinent by MDS Coordinator on 09/20/13.
All MDS's are affected.
All residents on need to care plan residents who are incontinent of bowel and bladder and care plan
needs to reflect needs of resident.
MDS Coordinator or designee to audit
all comprehensive assessment for twelve (12)
weeks of residents that are incontinent to ensure
that care plan reflect needs of resident correct as
needed.
Results of audits will be brought to the QA committee for review.

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
the facility failed to develop and revise a
Comprehensive Plan of Care for one resident
(#145) of forty-two residents reviewed.

The findings included:
Resident #145 was admitted to the facility on
February 12, 2011, with diagnosis including
Hypertension, Alzheimer's, Cerebrovascular Accidents, Dysphagia, and Osteoarthritis.

Review of the Minimum Data Set (MDS) dated
July 15, 2013, revealed "...Section H - Bladder
and Bowel...: Urinary Continence 3, Always
incontinent (no episodes of continent voiding)..."
| F 279 | Continued From page 6
Care Plan dated July 17, 2013, revealed
"...Problem onset July 17, 2013...Potential for
urinary tract infection...continent of
urine...Problem onset July 17, 2013, Potential for
skin breakdown...Continent of B&B (bowel and
bladder)..."

Interview with the MDS Coordinator on August 7,
2013, at 7:30 a.m., in the MDS Coordinator's
office confirmed the Comprehensive Care Plan
did not reflect the needs of the resident and had
not been revised.

| F 312 | 483.25(a)(3) ADL CARE PROVIDED FOR
DEPENDENT RESIDENTS
A resident who is unable to carry out activities of
daily living receives the necessary services to
maintain good nutrition, grooming, and personal
and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation,
and interview, the facility failed to provide
incontinence care timely for one resident (#160)
of forty-two residents reviewed.

The findings included:
Resident #160 was admitted to the facility on
January 24, 2011, and readmitted to the facility on
February 16, 2011, with diagnoses including
Hypertension, Congestive Heart Failure, and
Dysphagia.

Medical record review of the Quarterly Minimum

| F 279 | Resident #160 was provided with re-positioning and
incontinence care.
A body/skin audit has been performed by Treatment
nurse on 09/19/13 on all residents that require
total assistance with activities of daily living and
personal hygiene/care to ensure no other
residents have been affected.
CNAs and Licensed Nurses have been instructed
by RN, Risk Manager on or before 09/23/13
on importance of re-positioning and proper
incontinence care. Re-positioning audits will be
performed by DON or designee each day for
one (1) week, three (3) times per week for
three (3) weeks and weekly thereafter.
Results of audits will be brought to the QA committee
for review. DON or designee to ensure compliance.
**Brookhaven Manor**

**F 312**

Continued from page 9

Data Set dated July 22, 2013, revealed the resident had severe impairment in cognitive skills, was totally dependent for personal hygiene, bathing, and was always incontinent of bowel and bladder.

Observation on August 6, 2013, at 1:10 p.m., 1:45 p.m., and 4:30 p.m., revealed the resident seated in a gerichair in front of the nursing station.

Interview with Certified Nursing Assistant (CNA) #1 on August 6, 2013, at 4:30 p.m., at the nursing station confirmed resident #160 had not been repositioned or incontinence care provided since arriving on duty at 2:00 p.m. Continued interview with CNA #1 revealed CNA #1 stated "I've been busy, getting to (residents) now."

Observation with CNA #1, on August 6, 2013, at 4:35 p.m., revealed the resident had been incontinent of urine in the brief.

Interview with Licensed Practical Nurse (LPN) #4 on August 6, 2013, at 4:30 p.m., at the nursing station confirmed residents were to be repositioned and checked for incontinence every two hours.

C/O #32091

483.25(c) Treatment/SVCS to Prevent/Heal Pressure Sores

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
F 314

Pressure sores receive 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, facility policy review, and interview, the facility failed to timely obtain a dietary consultation, and to timely initiate and administer a vitamin as ordered for one resident (#168) of forty-two residents reviewed.

The findings included:

Resident #168 was admitted to the facility on July 18, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Fractured Neck of Femur, Bipolar Disorder, Osteoporosis, Hypertension, Convulsions, and Chronic Pain.

Medical record review of an Admission Nursing Note dated July 18, 2013, revealed "...open area to sacrum/coccyx..."

Medical record review of a Nursing Weekly Summary dated July 28, 2013, revealed "Res (resident) with Stg (Stage) 2 to coccyx..."

Medical record review of a Physician's Order dated July 28, 2013, revealed the resident was to receive Decubivite (vitamin) twice a day for thirty days...

Medical record review of the August 1-8, 2013, Medication Administration Record revealed no documentation the resident had received the Decubivite as ordered.
Continued From page 11

Medical record review revealed no documentation the Registered Dietician had evaluated the resident's nutritional needs until August 6, 2013.

Medical record review of a Registered Dietician's note dated August 6, 2013, revealed "...Debulvita ordered 7/29/13...Smoking negatively influences wound healing. Recommend Juven (protein supplement) BID (twice a day) until PU (pressure ulcer) healed."

Review of facility, Wound Care Protocols, revealed "...Stage II Characteristics; Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Treatment:...Initiate multivitamin until area is healed...Obtain dietary consult..."".

Observation with the Assistant Director of Nursing (ADON), on August 7, 2013, at 11:16 a.m., revealed Licensed Practical Nurse (LPN) #1 providing wound care to the resident. Continued observation revealed the dressing was removed from the coccyx revealing a wound described by the ADON as a Stage II pressure ulcer measuring 1.0 cm (centimeter) by 0.7cm.

Interview with the Director of Nursing (DON) on August 7, 2013, at 7:25 a.m., in the conference room, confirmed there was a delay in Initiating the Debulvita and the Physician's Order for Debulvita was not followed on August 1-6, 2013. Continued interview with the DON revealed the Registered Dietician was not notified of the resident's pressure until August 6, 2013, and confirmed there was a delay in obtaining a
F 314; Continued From page 12
consultation by the Registered Dietician.

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

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

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation, review of facility policy, observation, and interview, the facility failed to ensure interventions were in place related to falls for two resident’s (#1, #68) for forty-two residents reviewed.

The findings included:
Resident #1 was admitted to the facility on September 5, 2007, with diagnoses including Hypertension, Congestive Heart Failure, Atrial Fibrillation, Cerebral Vascular Accident with left sided paralysis, Diabetes and Anemia.

Medical record review of a significant change Minimum Data Set (MDS), dated May 13, 2013, revealed the resident scored a fourteen on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact and required extensive assistance with activities of daily living.

Medical record review of a fall assessment dated
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 323 | Continued From page 13
July 12, 2013, revealed the resident scored a fourteen on the assessment indicating the resident was at risk for a fall.

Medical record review of the Care Plan dated July 31, 2013, revealed "...potential for falls due to non-ambulatory status...supervision while toileting."

Medical record review of a Nurse's Note dated July 12, 2013, at 1:45 p.m., revealed the resident was found in the floor in the bathroom in the resident's room. Continued review revealed "...observed resident lying on the left side with...head and neck area at BR (bathroom) door...stated hit...head when...fell off the toilet..."
Continued review revealed "...no redness noted...skin w/d (warm and dry to touch)...was given scheduled MS Contin (medication for pain)."

Review of a witness statement report dated July 12, 2013, written by a Certified Nurse Assistant (CNA) #4 revealed "...looked resident to toilet after supper and...told me to give...emergency light and give...privacy...a short time later...was on my way to check on resident since light had not come on...heard resident calling for help...on reaching the room resident was in the floor in front of the toilet..."

Review of a facility investigation dated July 12, 2013, revealed "...residents observed lying on left side in floor of restroom...residents had been assisted to toilet by staff...residents reports dropping the call light cord and being unable to retrieve it..."

Review of facility policy, Falls and Falls Risk,
Managing, with a revision date of December 2007 revealed "...staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling."

Observation on August 6, 2013, at 2:30 p.m., in the resident's bathroom, revealed a call light cord with a red extension cord applied to the call light cord.

Observation on August 6, 2013, at 4:30 p.m., in the hallway outside of the resident's room revealed the resident sitting in the wheelchair and a splint to the left upper extremity due to paralysis to the left side.

Observation on August 7, 2013, at 7:50 a.m., in the resident's room revealed the resident in the room and the Hospice Nursing Assistant assisting the resident with bathing.

Telephone interview with CNA #4 on August 15, 2013, at 10:35 a.m., revealed "...wanted to go to the bathroom during supper tray pass...took the resident to the bathroom...states the resident told me you can come back, it's going to be awhile...gave... the call light... it was a short cord... I left the room... came back in about ten minutes later and heard resident yelling...had fallen in the floor... dropped the call light and could not reach it..."

Interview with the Director of Nursing (DCN) on August 7, 2013, at 9:56 a.m., in the DCN office revealed "...would not have left the resident in the bathroom by herself..." Continued interview confirmed the CNA did leave the resident in the bathroom unattended, the call light cord was to
continued from page 15

short for the resident, the resident was at risk for fall, and the facility had failed to ensure a safe environment for the resident.

resident #63 was admitted to the facility on March 8, 2013, with diagnoses including pelvic fracture, congestive heart failure, osteoporosis, dysphagia, chronic obstructive pulmonary disease, and esophageal gastro reflux.

Review of the quarterly Minimum Data Set (MDS), dated June 3, 2013, revealed the resident scored a three on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired and required extensive assistance with activities of daily living.

Medical record review of a Nurse’s Note dated August 2, 2013, at 11:00 a.m., revealed "...summons to room, resident sitting in floor beside the bed...alarms sounding...w/o (wheel chair) to the side behind the resident...one wheel locked..."

Medical record review of a Physician’s Order dated August 5, 2013, 10:20 a.m., revealed "...anti-rollback bar to w/o..."

Medical record review of the Care Plan dated August 5, 2013, revealed "...anti-rollback bar to w/o..."

Observation on August 6, 2013, at 5:22 p.m., in the hallway outside of the resident’s room revealed the resident in the wheelchair with no anti-rollback bar on the wheelchair.

Interview with the Assistant Director of Nursing (ADON) on August 8, 2013, at 5:25 p.m., in the...
<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Tag</th>
<th>Providers Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued from page 16, resident's room confirmed the anti-rollback bar was not in place on the resident's wheelchair.</td>
<td>F 323</td>
<td>The tray tested on 300 wing was a test tray.</td>
</tr>
<tr>
<td>F 364</td>
<td>SS=D NUTRITIVE VALUE/APPEARANCE, PALATABLE/PREF TEMP</td>
<td>F 364</td>
<td>Residents interviewed by members of the Interdisciplinary Team on or before 08/30/13 on food quality andtemp.</td>
</tr>
<tr>
<td></td>
<td>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance and food that is palatable, attractive, and at the proper temperature.</td>
<td></td>
<td>Dietary Manager to perform test tray audits three (3) times a week for twelve (12) weeks. Dietary Manager to ensure compliance.</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was maintained at appropriate temperatures on one of four hallways.</td>
<td></td>
<td>CDM to inform all Dietary staff on or before 08/30/13 on proper plate temperatures. All audits will be brought to QA committee for three (3) months for review.</td>
</tr>
<tr>
<td>F 411</td>
<td>SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN S/NFS</td>
<td>F 411</td>
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Observation on August 7, 2013, revealed the food cart arrived on the 300 hallway at 8:40 a.m. Continued observation revealed the last food tray was delivered to the residents on the hallway at 9:15 a.m.

Interview with resident #168 on August 6, 2013, at 8:06 a.m., in the resident's room revealed the eggs were always not warm enough at breakfast.

Observation and interview with the Dietary Manager on August 7, 2013, at 9:15 a.m., on the 300 hallway revealed the last tray was removed from the cart and confirmed the eggs and food items were not warm enough.
F 411
Continued From page 17

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may change a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to obtain a dental consult for one resident (#218) of forty-two residents reviewed.

The findings included:

Resident #218 was admitted to the facility on April 30, 2013, with diagnoses including Pneumonia, Chronic Airway Obstruction, Multiple Organ Failure with Septic, Marfan Syndrome, Spinal Stenosis, Thoracic Aortic Aneurysm, Osteoarthritis, Ventral Hernia, Anxiety, Alcohol Abuse, and Degenerative Disc Disease.

Medical record review of the admission Minimum Data Set (MDS) dated May 7, 2013, revealed the resident had likely cavity or broken natural teeth.

Medical record review of the Nutritional Evaluation dated May 9, 2013, revealed..., Due to tooth loss not able to eat carrots sticks."
<table>
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<tr>
<th>F 411</th>
<th>Continued From page 18</th>
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<tbody>
<tr>
<td></td>
<td>Medical record review of the Care Plan reviewed on August 1, 2013, revealed &quot;...Resident has potential for weight change...Dental consult as needed...&quot;</td>
</tr>
<tr>
<td></td>
<td>Medical record review revealed no documentation a dental consult had been obtained.</td>
</tr>
<tr>
<td></td>
<td>Observation on August 5, 2013, at 11:20 a.m., revealed the resident lying on the bed. Interview with the resident during the observation revealed the resident had chewing and eating problems due to no upper teeth and only seven teeth on the bottom.</td>
</tr>
<tr>
<td></td>
<td>Interview with Registered Nurse (RN) #1 on August 6, 2013, at 2:00 p.m., in the MDS office confirmed the resident had not received a dental consult.</td>
</tr>
</tbody>
</table>

| F 431  | Multi-use vial on #2 med cart on 400 hall was removed and discarded. |
| SS=0   | Residants with insulin orders were checked by Unit Manager on 08/02/13 for expiration date and proper storage. |
|        | Licensed staff were involved by RN, Risk Manager on or before 08/23/13 on facility policy for med storage and labeling. |
|        | DON or designer will check all insulin vials for correct storage, expiration data, and labeling for three (3) weeks for twelve (12) weeks. DON to ensure compliance. Audits will be discussed in QA meeting for any trends and follow up as needed. |
### F 431 Continued From page 19

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 1970 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 review of facility policy, observation, and interview, the facility failed to label and store medications correctly on one of seven medication carts.

The findings included:

Review of facility policy, Medication Storage in the Facility, revealed "...Medications and biological are stored safely, securely, and properly...Procedures...C. All medications are stored in the box, bag or other container with the pharmacy label...M. Outdated, contaminated...are immediately removed from stock...R. Insulin storage after opening: Insulin is to be dated when opened..."

**Observation with Registered Nurse (RN) #2 on**
Continued from page 20.

August 6, 2013 at 2:10 p.m., of in medication cart #2 on the 400 hall revealed one multi-dose vial of Humalog 100 u/ml (units per milliliters) in a plastic bag with an open date written as July 8, 2013, and an expiration date of August 4, 2013. Further observation revealed one opened multi-dose vial of Lantus 100 u/ml without a resident's name, the date opened, or the date of expiration. The vial was not in a plastic bag.

Interview with RN #2 on August 6, 2013, during the observation confirmed the medications were not stored correctly.

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to accurately document the discharge date and failed to maintain a complete medication administration record for one resident (#229) of forty-two residents reviewed.

F 514

Resident #228 Face sheet has been corrected to accurately reflect the resident's discharge date. Medical Records Director completed an audit of 100% of face sheets for discharged residents going back three (3) months to ensure no other residents have been affected on 08/22/13. Medication administration sheets have also been audited by Medical Records Director to ensure proper documentation of insulin administration. Audits will be performed on resident face sheets by DON or designee three (3) times a week for twelve (12) weeks to ensure information on face sheets is accurate.

Licensure staff has been informed by Risk Manager on 08/20/13 on facility policy on medication administration and documentation. Audits of medication administration record will be performed three (3) times per week for twelve (12) weeks.

Results of audits will be brought to the QA committee for review. DON, Administrator, or designee to ensure compliance.
The findings included:

Resident #228 was admitted to the facility on December 19, 2012, with diagnoses including Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Anemia, and Congestive Heart Failure.

Medical record review of the Face Sheet for resident #228 revealed the resident was discharged from the facility on December 28, 2012. Continued review of a Nurse's Note dated December 29, 2012, revealed the resident was to be sent to the local hospital for evaluation and treatment.

Interview with the Director of Nursing on August 6, 2013, at 3:00 p.m., in the admission's office confirmed the date on the Face Sheet was incorrect and the resident was discharged from the facility on December 29, 2012.

Medical record review of resident #228's July 2012 Physician's Orders revealed Lantus insulin (long lasting insulin) to be administered every night.

Medical record review of the Medication Administration Record (MAR) for July 2012 revealed on July 7, 2012, the lantus insulin was not documented as being administered.

Interview by telephone with Licensed Practical Nurse (LPN) #1 (nurse on duty on July 7, 2012) on August 7, 2013, at 10:00 a.m., revealed LPN #1 had failed to document on the MAR the insulin being administered. Continued interview with LPN #1 confirmed the insulin was given on July 7.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F514</td>
<td>Continued from page 22 2012. Interview with the Director of Nursing (DON) on August 7, 2013, at 12:50 p.m., in the DON's office confirmed the documentation on the MAR for July 2012 was not complete.</td>
<td><strong>F514</strong></td>
<td>Cross-referenced to the appropriate deficiency</td>
</tr>
</tbody>
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C/O #31665