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<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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<tr>
<td>F 164 ss=d 483.10(e), 483.75(4) PRIVACY AND CONFIDENTIALITY</td>
<td>All residents attending group meetings will have the right to personal privacy and confidentiality of his or her personal and clinical record. In-service will be held on 2/11/10 by Director of Nursing to all staff on residents' rights to personal privacy and confidentiality of his or her personal and clinical records, including but not limited to group meetings. All staff will be inserviced on 2/11/10 by Director of Nursing on recognizing &quot;no entrance&quot; sign on activity room door during residents' group meetings. This plan of correction will be monitored by the Administrator for compliance weekly x4 weeks then monthly and as needed. This plan of correction will be reviewed and followed in the monthly CQI meeting. The facility CQI committee is composed of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, Dietary Manager, Medical Director, and Pharmacy Consultant. The CQI committee will make recommendations and develop a plan of action if areas of non-compliance exist. The Activities Director will immediately implement any new plans of action recommended. The Administrator will monitor recommendations monthly to ensure the recommendations are being followed.</td>
<td>2-15-10</td>
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This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility staff failed to ensure the group meeting was not interrupted when Certified Nursing Assistant (CNA #1) interrupted the group meeting on two different occasions.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosed 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 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.

Administrator
**F 164**
Continued From page 1

The findings included:

During the group interview conducted in the activity room, on 1/25/10 at 10:30 AM, CNA #1 interrupted the group meeting at 10:35 AM, to enter the activity office. CNA #1 interrupted the group meeting again at 10:40 AM, when she left the office.

During the interview in the activity room on 1/27/10 at 9:00 AM, the Activity Director stated, "This [the activity office] is central supply where she [CNA #1] orders all supplies, gloves, syringes. Usually she [CNA #1] wouldn't have entered. The sign at the sign posting the group meeting in progress beginning at 10:30 AM was on the door."

**F 246**

All residents will have their call light within easy access when they are in their rooms and all residents will have their call lights answered in a timely manner. Residents #1, 11, 18, 12, 13, and 14 will have their call lights within easy access at all times when they are in their room. Residents #1, 6, 7, 11, and 15 will have their call lights answered in a timely manner.

The Director of Nursing will inservice all staff on 2/11/10 of the residents' right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, including but not limited to ensuring all residents' call lights are within easy access of the resident when they are in their rooms and that all residents have their call lights answered in a timely manner.
Continued From page 2 residents interviewed and during a statement obtained during a family interview.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 12/21/93, with diagnoses of Mental Retardation, Dementia with Behaviors and Convulsions.

Observations in Resident #1's room on 1/25/10 at 7:45 AM, revealed the call light was draped across the bed approximately 3 feet out of restrained Resident #1's reach.

2. Medical record review for Resident #11 documented an admission date of 8/9/09, with admission diagnoses including Diabetes, Presenile Delirium, Intracranial Hemorrhage and Decubitus Ulcers.

Observations in Resident #11's room on 1/25/10 at 10:49 AM, revealed the call light on the floor behind the bed, out of Resident #11's reach.

3. Medical record review for Resident #18 documented an admission date of 7/1/98 with admission diagnoses including Cerebrovascular Accident, Diabetes and Schizophrenia.

Observations in Resident #18's room on 1/26/10 at 3:42 PM, revealed the call light was on the right side rail. Resident #18 was unable to use the right arm to reach the call light.

4. Observations during the initial tour on 1/25/10 beginning at 5:45 AM, revealed the following:
   a. Room 103A - call light was laying on the top of the over bed light, out of RR #12's reach.

This plan of correction will be monitored by the Nurse Managers for compliance weekly x4 weeks then monthly and as needed. This plan of correction will be reviewed and followed in the monthly CQI meeting. The CQI Committee is composed of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, Dietary Manager, Medical Director, and Pharmacy Consultant. The CQI Committee will make recommendations and develop a plan of action if areas of noncompliance exist. The Director of Nursing will immediately begin to implement any new plan of action recommended. The Administrator will monitor new recommendations monthly to ensure recommendations are being followed.
F 246 Continued From page 3

b. Room 114 - call light was laying on the bedside table out of RR #14's reach.
c. Room 303 - call light was laying on the bedside table. RR #13 was lying in bed asleep with the call light approximately 3 feet out of RR #13's reach.

5. During the group interview in the activity room on 1/25/10 at 10:30 AM, RRs #1, 6, 7, and 11 stated that the staff did not answer call lights timely, sometimes taking a "half hour or longer" to respond to the call lights.


During an interview in Resident #15's room on 1/27/10 at 8:55 AM, Resident #15 stated, "Seems like it takes 30 minutes [for the staff to respond to the call lights] but it may be 15 to 20 [minutes]. It seems longer probably when you have to go to the bathroom.

7. During a family interview in the conference room on 1/28/10 at 9:10 AM, a family member stated, "The problem [not answering call lights timely] is between supper and bedtime. One week ago, 210 room call light was on from 6:26 PM until 7:32 PM [time the light was answered] ... One time they put [On Call] on the toilet and came back [to assist the resident] 45 minutes later..."

F 250
SSD
483.15(g)(1) SOCIAL SERVICES

The facility must provide medically-related social
F 250 Continued From page 4

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 medical record review and interview, it was determined the facility failed to provide medically related social service interventions relating to behaviors for 2 of 17 Random Residents (RR #1 and 6).

The findings included:

1. Medical record review for RR #1 documented an admission date of 6/22/05 with diagnoses of Vertebral Fracture, Congestive Heart Failure, Diabetes, Peripheral Neuropathy, Anemia, Obesity, Tachycardia and Retention of Urine. Review of the Minimum Data Set (MDS) quarterly assessment form dated for 11/19/09 documented "B2. Memory a. Short-term memory OK-seems/appears to recall after 5 minutes... 1. Memory problem. b. Long-term memory OK-seems/appears to recall long past O. Memory OK... B4. COGNITIVE SKILLS FOR DAILY DECISION MAKING... 2. MODERATELY IMPAIRED- decisions poor, cues/supervision required..." Review of the 72-hour documentation sheet documented, "...Date & [and] time of incident 1/2/10 5 P [PM] Type of Incident Altercation c [with] Res. [Resident]. Narrative of Incident Res was slapped in face by another Resident..." Review of the Social Service progress note had no documentation or interventions related to the incident on 1/2/10.
F 250 Continued From page 5

During an interview in the conference room on 1/27/10 at 2:40 PM, the Social Worker stated, "Not reported [incident on 1/2/10] to me..." The Social Worker also confirmed that in the AM stand up meetings the nurse report sheet is read to them... "Just didn't know..."

2. Medical record review for RR #6 documented an admission date of 8/14/96 with current diagnoses of Explosive Disorder, Depression, Psychosis, Hypertension, Diabetes, Convulsions and Unsocial Aggression. Review of the MDS Medicare Preferred Perspective Payment (PPS) assessment form dated 12/3/09 documented, "B2. Memory a. Short-term memory OK-seems/appears to recall after 5 minutes... 1. Memory problem. b. Long-term memory OK-seems/appears to recall long past. 0. Memory OK... B4. COGNITIVE SKILLS FOR DECISION MAKING... 1. MODIFIED INDEPENDENCE-some difficulty in new situations only..." Review of the nurses notes dated 11/5/09 documented, "Resident in activity room with activity assistant...Activity assistant came to this nurse with a razor [razor] (disposable) that was in residents pouch on w/c wheelchair asked resident "what this?" [RR #6] stated, "someone gave me that so I could cut my throat." Razor disposed of in sharps and incident reported to SW [Social Worker]..."

Review of the 72-hour documentation sheet documented, "Date & time of Incident 1/2/10 5P Type of Incident Altercation c [with] resident... Narrative of incident Resident had altercation c another resident and slapped res in face..."

Review of the Social Services progress notes had no documentation or interventions related to the incident on 11/5/09 and 1/2/10.

F 278 483.20(g) - (j) RESIDENT ASSESSMENT

F 278
Resident #12's MDS has been reviewed and updated by the MDS Coordinator to reflect the resident's current PEG feeding status.

All residents will have an assessment that accurately reflects the resident's status and those assessments will be conducted or coordinated by a Registered Nurse along with the appropriate participation of health professionals. A Registered Nurse will sign and certify that the assessment is completed.

Each individual who completes a section of the assessment will sign and certify the accuracy of that portion of the assessment. The Director of Nursing inservices the Dietary Manager and MDS Coordinator on 1/28/10 regarding accurate coding on the MDS for residents receiving a PEG feeding. The Director of Nursing will audit the MDS of all residents receiving PEG feedings weekly x4 weeks then monthly to monitor compliance of accurate MDS coding.

This plan will be reviewed and followed in the monthly CQI meeting. The CQI committee is composed of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, Dietary Manager, Medical Director, and Pharmacy Consultant. The CQI committee will make recommendations to the Director of Nursing to develop a plan of action if areas of noncompliance.
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<td>F 278</td>
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<td>Medical record review for Resident #12 documented an admission date of 6/1/06 with diagnoses of Gastrointestinal Bleed, Gastric Ulcer, Cerebrovascular Accident, Hypertension and Dysphagia. A physician's order dated 1/7/10 documented Jevelity 1.2 at 380 milliliters (ml) per day. Review of a MDS with an assessment reference date (ARD) of 11/5/09 documented, &quot;...[section] K5. NUTRITIONAL APPROACHES... b. Feeding tube...no code...&quot; During an interview in the MDS office, Nurse #1 stated, &quot;...she [Resident #12] should have been coded as having a tube feeding...&quot;</td>
<td>F 278</td>
<td></td>
<td>are noted. The Director of Nursing will immediately begin to implement any new plans of action recommended. The Director of Nursing will monitor monthly any new recommendations to ensure the recommendations are being followed.</td>
<td>2-15-10</td>
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<td>F 280</td>
<td>SS=E</td>
<td>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.</td>
<td>F 280</td>
<td></td>
<td>Resident #1's care plan has been updated to reflect the current physician's order of &quot;diet: pureed with nectar thick liquids&quot;. Resident #2's care plan has been updated to reflect the impaction and a gout diet. Resident #12's care plan has been updated to reflect that the spouse has expired. Resident #13's care plan has been updated to reflect bilateral AKA, new approach, discontinuation of PO intake, and currently receiving PEG feeding. Resident #14's care plan has been updated to include interventions for emergency bleeding of dialysis shunt. A comprehensive care plan will be developed on all residents by the interdisciplinary team as determined by the resident's need and to the extent practicable and revised to reflect the resident's current status for changes in diet, constipation/impaction, living arrangement, change to PEG feeding, amputation, and/or care of emergency bleeding.</td>
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<td>F 280</td>
<td>Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure the comprehensive care plans were revised to reflect the resident's current status for changes in diets, constipation/impaction, living arrangement, change to feeding tube, amputation and/or care of emergency bleeding for 5 of 22 (Residents #1, 2, 12, 13 and 14) sampled residents. The findings included:</td>
<td>F 280</td>
<td>The MDS Coordinator, Care Plan Coordinator, Diet Manager, Social Service Director, and Restorative Nurse will be inserviced on 2/11/10 by the Director of Nursing on care plan review and revisions as it relates to diet changes, constipation/impaction, living arrangements, change to PEG feeding, amputation, and/or care of emergency bleeding. The Director of Nursing will audit random resident care plans weekly x4 weeks then monthly to monitor compliance with revisions. This plan will be reviewed and followed in the monthly CQI meeting. The CQI committee is composed of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, Dietary Manager, Medical Director, and Pharmacy Consultant. The CQI committee will make recommendations to the Director of Nursing to develop plans of action when areas of noncompliance are noted. The Director of Nursing will immediately begin to implement any new plans of action recommended. The Director of Nursing will monitor monthly new recommendations to ensure the recommendations are being followed.</td>
<td>2-15-10</td>
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| F 280 | Continued From page 9  
A 1/7/10 physician's order documented, "Gout diet order clarification: no tuna, no beef, no pork..." Review of the 10/9/09 nursing care plan did not document an update to the nursing care plan to reflect Resident #2's impaction or gout diet.  
During an interview in the Minimum Data Set (MDS) office on 1/27/10 at 1:55 PM, Nurse #1 confirmed the care plan had not been updated to reflect Resident #2 had an impaction or being placed on a gout diet.  
3. Medical record review for Resident #12 documented an admission date of 6/1/06 with diagnoses of Proteus Urinary Tract Infection (UTI), Gastrointestinal Bleed, Gastric Ulcer, Hypertension and Dysphagia. Review of the 1/19/10 nursing care plan documented, "Problem... Altered psychosocial well being... Approaches: MARRIED. RESIDES IN ROOM AS WITH HUSBAND..." The care plan was not revised to reflect Resident 12's spouse had died.  
Observations of Resident #12 on 1/26/10 at 2:20 PM, revealed Resident #12 did not have a roommate.  
During an interview in the MDS office on 1/27/10 at 2:15 PM, Nurse #1 stated, "...her husband has expired..."  
4. Medical record review for Resident #13 documented an admission date of 10/30/08 with diagnoses of Proteus UTI, Peripheral Vascular Disease, Bilateral Above the Knee Amputation (AKA), Dysphagia and late effects Hemiplegia. Review of the 10/7/09 nursing care plan documented, "Approaches: Ensure that resident..." |
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 280</td>
<td>Continued From page 10 has and wears properly-fitting non-skid soled shoes for ambulation... Goal: Resident will eat at least 50% [percent] of all meals served per day...&quot; Observations of Resident #13 on 1/25/10 at 9:05 AM, revealed Resident #13 lying in the bed with a tube feeding of Glucerna 1.2 infusing at 65 cubic centimeters (cc) and Resident #13 was noted to have bilateral AKA. During an interview in the MDS office on 1/27/10 at 2:00 PM, Nurse #1 stated that should have been taken off (referring to ambulation and meal consumption). 5. Medical record review for Resident #14 documented an admission date of 9/1/00 with diagnoses of Iron Deficiency Anemia, Chronic Kidney Disease, Hypertension, Diabetes, and Depressive Disorder. Review of the nursing care plan dated 12/17/09 did not include interventions for emergency bleeding. During an interview in the MDS office on 1/27/10 at 2:10 PM, Nurse #1 stated, &quot;...there should be an order for dialysis 3 days a week and there is no care plan for emergency bleeding.&quot; 483.25 QUALITY OF CARE 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.</td>
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<td>F 309</td>
<td>SS=D</td>
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<td>This REQUIREMENT is not met as evidenced</td>
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<td>F 309</td>
<td>Continued From page 11 by:</td>
<td>F 309</td>
<td>residents receiving dialysis will have a documented physician order in their clinical record. New nursing staff will receive inservice on following physician orders regarding head lice treatment and dialysis during orientation. Nurse Managers will audit clinical records of residents receiving head lice treatment and dialysis to ensure physician orders of such are being followed and documented orders are complete. Results of audits will be reported at the weekly Focus meeting. Focus meeting members consist of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Dietary Manager, Care Plan Coordinator, MDS Coordinator, and Pharmacy Consultant. This plan will be reviewed and followed in the monthly CQI committee meeting. The CQI committee is composed of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, Dietary Manager, Medical Director, and Pharmacy Consultant. The CQI committee will make recommendations to the Director of Nursing to develop a plan of action if areas of noncompliance are noted. The Director of Nursing will monitor monthly new recommendations to ensure recommendations are followed.</td>
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<td>Based on medical record review and interview, it was determined the facility failed to ensure physician's orders were followed for dialysis and failed to obtain orders for treatment of head lice for 2 of 22 (Residents #4 and 14) sampled residents and 1 of 16 Random Resident (RR #18). The findings included: 1. Medical record review for Resident #4 documented an admission date of 4/23/08 and readmission date of 1/25/08 with diagnoses of Paralysis Agitans, Alzheimer's Disease, Diabetes, Osteoarthritis, Hypertension, Anxiety and Esophageal Reflux. Review of a list of residents being assessed for head lice dated for 9/16/09 documented Resident #4 was treated for head lice. Review of Resident #4's physician's orders had no documented order for the treatment of head lice. During an interview in the Director of Nurses (DON) office on 1/27/10 at 11:45 AM, the Assistant Director of Nurses (ADON) stated, &quot;I can't find it [orders for treatment of head lice]...my nurse at that time had just taken boards and she verbally told me every one was done.&quot; 2. Medical record review for Resident #14 documented an admission date of 5/1/00 and readmission date of 10/14/08 with diagnoses of Anemia, Angiopathy, Diabetes, Hypertension, Chronic Kidney Disease, Myalgia, Myositis, Below Knee Amputation and Depressive Disorder. Review of the physician's orders dated 1/14/10 did not include orders for dialysis treatment.</td>
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F 309 Continued From page 12

During an interview in the conference room on 1/27/10 at 2:10 PM, the Minimum Data Set (MDS) nurse stated, "Should have order for dialysis."

3. Medical record review for RR #16 documented an admission date of 9/17/09 with diagnoses of Osteoarthritis, Dehility, Osteoporosis, Idiopathic Scoliosis, Bronchitis, Anxiety, Anemia and Peripheral Vascular Disease. Documentation in RR #16's medical record documented that RR #16 had head lice on 9/16/09. Review of RR #16's physician's orders had no documented orders for the treatment of head lice.

During an interview in the DON's office on 1/27/10 at 11:45 AM, the ADON stated, "I can't find it [orders for treatment of head lice] ...my nurse at that time had just taken boards and she verbally told me every one was done."

F 323 SS=0

483.25(h) ACCIDENTS AND SUPERVISION

The facility must ensure that the resident environment remains as safe as possible and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it determined the facility failed to ensure appropriate monitoring to assure safety for 1 of 17 Random Resident (RR #15).

The findings included:

Random Resident #15 will be supervised by a staff member at all times when resident goes outside to the designated smoking area and when resident is not on the secured unit. All resident environments will remain "free of accident hazards as is possible and each resident will receive adequate supervision and assistance devices to prevent accidents. All staff members were interviewed by the Director of Nursing by 2/11/10 on ensuring all residents on the secured unit are supervised by a staff member at all times when the resident is in the designated smoking area and/or off of the secured unit. Staff Development Coordinator will interview all newly hired employees on ensuring all residents on the secured unit..."
F 323 Continued From page 13

Review of the facility's "POLICY AND PROCEDURE... SUBJECT SUPPLEMENT" Wandering Resident" documented "...2. Resident considered at risk will be assessed for the secure unit, if located in the facility or use of a wanderguard... 3. The Interdisciplinary Care Plan Team (IDCPT) will be responsible to develop a care plan to assure that the resident receives the appropriate monitoring to assure safety..."

Medical record review for RR #15 documented an admission date of 4/1/05 with diagnoses of Delusional Disorder, Convulsions, Esophageal Reflux, Depressive Disorder, Diabetes II, and Schizophrenia. The "Behavior Management Program" dated 8/3/09 documented "...Resident wanders almost daily beginning usually about 3:00 PM until dinner time..."

Observations on the 400 hall extension on 1/27/10 at 10:45 AM, revealed RR #15 wearing a smoking apron, walked down the 400 hall extension from the smoking area to the door of the secure unit and pushed the button to be let into the secure unit. There was no one with RR #15.

During an interview in the conference room, on 1/27/10 at 11:33 AM, the risk manager stated, "...A staff member is assigned to take her (RR #15) out. Someone from housekeeping is assigned during the day to take her out and in the evening a-CNA [Certified Nursing Assistant] ... (named RR #15) cannot leave the unit by herself..." The risk manager was asked if staff let RR #15 stroll back from outside by herself. The risk manager stated, "They [staff] are not
Continued From page 14
supposed to..."
F 441 483.66(a) INFECTION CONTROL

SS=D

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on policy review and observation, it was determined the facility failed to ensure infection control practices were used to prevent the spread of infection by not washing hands properly for 2 of 6 (Nurses #1 and 5) nurses observed administering medications.

The findings included:

1. Review of the facility’s handwashing policy documented, "PURPOSE To provide guidelines to employees for proper and appropriate handwashing that will aid in the prevention of transmission of nosocomial infections... 3. Dry hands thoroughly with paper towels and then turn off faucets with those towels..."

2. Medical record review for Random Resident #17 documented an admission date of 12/29/09 with diagnoses of Amputation of Below Knee, Peripheral Vascular Disease, Diabetes, Blind,

Resident #17 and 5 will receive their medications following the facility’s handwashing policy of drying hands thoroughly with paper towels and turning faucets off with those paper towels, as well as washing hands and changing gloves after touching items in the resident’s room. All residents receiving medications will receive care following facility policy on handwashing and hygiene to ensure infection control practices are used to prevent the spread of infection.

All staff will be instructed on facility policy of handwashing and hygiene by 2/11/10 by the Director of Nursing, Staff Development Coordinator will monitor compliance of nurse’s handwashing during medication administration by performing random audits that will include both verbal and visual demonstration weekly x 4 weeks then as needed with licensed nurses to ensure compliance.

Staff Development Coordinator will report findings at weekly Focus meetings and monthly CQI meetings. The Focus meeting members consist of the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, and Dietary Manager.
**NAME OF PROVIDER OR SUPPLIER:**

Martin Health Care

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

150 MT PELIA RD
MARTIN, TN 38237

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** | **PREFIX TAG** | **DESCRIPTION** |
---|---|---|
F 441 | | Continued From page 15 Neuropathy, Congestive Heart Failure and Hypercholesterolemia. Observations in Random Resident (RR) #17's room on 1/25/10 at 6:00 AM, revealed Nurse #1 washed her hands after gathering supplies for an accouchec. After Nurse #1 washed her hands, she turned the faucet off with her bare hands. 3. Medical record review for Resident #5 documented an admission date of 7/11/08 and a readmission date of 10/23/08 with diagnoses of Dementia, Hypertension, Syncope and Collapse, Anorexia, Gastrostomy and Depressive Disorder. Observations in Resident #5's room on 1/25/10 at 9:45 AM, revealed Nurse #5 washed her hands, rolled the head of Resident #5's bed up manually and then put on gloves. With the same gloved hands Nurse #5 checked placement of Resident #5's Percutaneous Endoscopic Gastrostomy tube.

**F 514** | **SS=D** | **CLINICAL RECORDS**

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
Continued From page 16

Based on medical record review and interview, it was determined the facility failed to ensure clinical records were complete and accurately documented for 2 of 22 (Residents #2 and 4) sampled residents and 1 of 17 Random Residents (RR #16).

The findings included:


During an interview in the conference room on 1/26/10 at 11:40 AM, the Assistant Director of Nursing stated, "...they [bms] should be documented on the MARs..."

2. Medical record review for Resident #4 documented an admission date of 4/23/08 and readmission date of 11/25/09 with diagnoses of Paralysis Agitans, Alzheimer's Disease, Osteoarthritis, Diabetes, Esophageal Reflux, Hypertension and Anxiety. Review of Resident #2's clinical record/MAR now has bowel movements documented each shift. Physician was notified and aware of head lice treatment on resident #4 and 16. All nurses were informed by the Director of Nursing on 2/11/10 on ensuring clinical records are complete and physician orders are accurately documented. All residents will have bowel movements accurately documented on clinical records/MAR every shift. All residents requiring head lice treatment will have an accurate physician's order in their clinical record.

New nursing staff will receive in-service on ensuring clinical records are accurate and complete.

Nurse Managers will perform a random audit of resident clinical records to ensure accurate documentation of resident bowel movements weekly x 4 weeks and as needed. Nurse Managers will audit clinical records of residents receiving head lice treatment to ensure accurate documentation of physician orders. Results of audits will be reported at the weekly Focus meeting. Focus meeting members include the Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, MDS Coordinator, Care Plan Coordinator, Staff Development Coordinator, Environmental Director, Administrator, and Dietary Manager. This plan will be reviewed and followed in the facility's monthly CQI committee meeting. CQI committee members consist of the Director of Nursing.
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documentation in the medical record dated 9/16/09 revealed Resident #4 was treated for head lice. Review of the physician’s orders revealed there was no documented order for the treatment of head lice.

During an interview in the Director of Nurse's (DON) office on 1/27/10 at 11:45 AM, the Assistant Director of Nurses (ADON) stated, “I can’t find it [order for treatment of head lice]...my nurse at that time had just taken boards and she verbally told me every one was done.”

3. Medical record review for RR #16 documented an admission date of 9/17/03 with diagnoses of Osteoarthritis, Dehility, Osteoporosis, Idiopathic Scoliosis, Bronchitis, Anxiety, Anemia and Peripheral Vascular Disease. Review of documentation in RR #16’s medical record revealed RR #16 was treated for head lice on 9/16/09. Review of the physician’s orders revealed there was no documented order for the treatment of head lice.

During an interview in the DON’s office on 1/27/10 at 11:45 AM, the ADON stated, “I can’t find it [order for treatment of head lice] ...my nurse at that time had just taken boards and she verbally told me every one was done.”

F 514 Assistant Director of Nursing, Activities
Director, Social Services Director, 
MDS Coordinator, Care Plan 
Coordinator, Staff Development 
Coordinator, Environmental Director, 
Administrator, Dietary Manager, 
Medical Director, and Pharmacy 
Consultant 
The CQI committee will make recommendations to the Director of Nursing to develop a plan of action if areas of noncompliance are noted. The Director of Nursing will monitor monthly new recommendations to ensure recommendations are followed.