F 000 INITIAL COMMENTS

During the annual recertification survey conducted on October 19, 2010 through October 21, 2010, at St. Barnabas Nursing Home, no deficiencies were cited in relation to complaints #25053, #24075, #24888, #24494, #24107, #24085, #24402, related deficiencies were cited for complaints #24629, and #24616, under 42 CFR Part 482.13, Requirements for Long Term Care.

F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, facility policy review, and interview, the facility failed to complete a restraint assessment for two (#16, #8) of twenty-six residents reviewed.

The findings included:

Resident #16 was admitted to the facility on October 7, 2010, with diagnoses including Right Hip Fracture, Sepsis, Urinary Tract Infection, and Alzheimer's Disease.

Medical record review of a physician's order dated October 9, 2010, revealed "...Pt (patient) may use safety belt while up in w/c (wheelchair) for increased safety and awareness to ask for assist (assistance)."
**ST BARNABAS NURSING HOME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
950 SISKIN DRIVE
CHATTANOOGA, TN 37403

<table>
<thead>
<tr>
<th>F 221</th>
<th>Continued From page 1</th>
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<tbody>
<tr>
<td></td>
<td>Medical record review revealed no documentation a pre-restraint assessment had been completed prior to application of the safety belt.</td>
</tr>
<tr>
<td></td>
<td>Observation on October 20, 2010, at 3:20 p.m., revealed the resident propelself in a wheelchair, in the hallway, with a self-releasing soft safety belt in place.</td>
</tr>
<tr>
<td></td>
<td>Observation on October 20, 2010, at 3:40 p.m., with Minimum Data Set (MDS) Coordinator #1, revealed the resident seated in a wheelchair in the resident's room. Continued observation revealed MDS Coordinator #1 instructed the resident to remove the self-releasing soft safety belt. Continued observation revealed the resident could not remove the self-releasing soft safety belt.</td>
</tr>
<tr>
<td></td>
<td>Review of the facility's policy Restraints, Physical, General Guidelines for the Use of revealed &quot;...The resident must be physically and cognitively able to self-release devices such as Velcro lap trays or tables, seat belts with Velcro...If a resident cannot mentally and physically self-release, then the device is considered a restraint...The interdisciplinary restraints committee will review and monitor all residents with restraints. Attachments...Pre-restraining assessment...Quarterly restraint assessment...&quot;</td>
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<tr>
<td></td>
<td>Interview on October 20, 2010, at 3:45 p.m., with MDS Coordinator #1, in the hallway, confirmed resident #16's self-releasing soft safety belt was a restraint and a pre-restraining assessment had not been completed.</td>
</tr>
<tr>
<td></td>
<td>Resident #8 was admitted to the facility on September 17, 2008, with diagnoses including</td>
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**PROVIDER'S PLAN OF CORRECTION**

<table>
<thead>
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<th>F 221</th>
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| produced by Granstrom Communications Group will be viewed at new employee orientation by the Human Resource Director beginning 11/16/2010. The video will also be a part of inservice education provided by the DON/ADON or designee beginning 11/1/2010 and will be ongoing annually. This will include the evaluation of the individual's condition and circumstances, the potential risks and benefits of all options under consideration. In addition, a therapy screen will be performed by a PT and/or OT. It will be completed prior to the application of a restraint and recommendations will be given in regards to the least restrictive device and any other alternatives to the restraint to RN's and LPN's. Social Service Director or designee will educate the family and restraint consent will be obtained. All current residents and future residents with restraints will have a quarterly restraint elimination assessment from the initial date of the assessment starting 02/1/2011. This will be done by the falls IDT (DON, ADON, Therapy, Social Services, MDS nurses)

4. Visual audits to be performed beginning 11/1/2010 and written audit forms will be done weekly by the charge nurses/MDS nurses 11/8/2010. The completion of the assessments will be monitored by the MDS nurses/charge
ST BARNABAS NURSING HOME

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<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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</table>
| F 221             | Continued From page 2  
Diabetes, Alzheimer's Disease, and Senile Depressive Disorder.  
Medical record review of the Minimum Data Set dated September 24, 2010, revealed the resident had short/long term memory problems, with severely impaired cognitive skills for daily decision making.  
Medical record review of the careplan dated September 21, 2010, revealed, "...self-release soft belt while up w/c (wheelchair) to remind not to attempt rising (secondary to) lack safety awareness."  
Medical record review revealed no assessment for the continued use of the self-release soft belt.  
Observation on October 19, 2010, at 11:30 a.m., revealed the resident seated in the wheelchair with the self release soft belt in place.  
Interview on October 19, 2010, at 11:30 a.m., on the hall, with LPN #6 confirmed the resident was not able to self release the belt when asked.  
Interview on October 20, 2010, at 11:00 a.m., in the conference room, with the Director of Nursing, confirmed no restraint assessments had been done to determine the appropriateness of the restraint.  
F 226             | 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES | F 226 | 1) Although the injury occurring outside the facility was verbally investigated by the ADON by |
|                   |                                                                                                   |               | 12/3/10                                                                                         |
F 226  Continued From page 3
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, policy review, and interview, the facility failed to implement the abuse policy for one resident #9 with an injury of unknown origin of twenty-six residents reviewed.

The findings included:
Residents #9 was admitted to the facility on December 14, 2002, with diagnoses of Congestive Heart Failure, Cerebral Vascular Accident, and Hypertension.

Medical record review of the Nurse’s note dated December 4, 2009, (late entry for December 1, 2009) revealed "pt (patient) OOB (out of building) with family at 1400(2:00 p.m.)...Family brought pt back at 1445 (2:45 p.m.) daughter states (resident) is ‘complaining of L (left) hand pain so we brought (resident) back early’..."

Medical record review of the Nurse Practitioner note dated December 2, 2009, revealed "...L hand swollen (and) red..."

Medical record review of the X-Ray report of the left hand dated December 2, 2009, revealed "...Diffuse soft tissue swelling with no evidence for acute osseous changes..."

Medical record review revealed no investigations for the incident on December 1, 2009.
Review of the facility Abuse Prevention policy revealed "...All incidents are reviewed as to source of origin..."

Telephone interview with Licensed Practical Nurse (LPN) #2 on October 20, 2010, at 1:15 p.m., confirmed on December 1, 2009, the resident's daughter reported to LPN #2 the resident complained of pain in left hand. Continued interview revealed LPN #2 recalls the resident's left hand was examined and some redness was noted.

Interview with LPN #3 (on duty on December 2, 2009) on October 20, 2010, at 1:35 p.m., in the Director of Nursing Office, confirmed on December 2, 2009, some swelling was noted to the resident's left hand. Continued interview revealed LPN #3 received a call from the resident's daughter and after discussion with the daughter LPN #3 requested an X-ray.

Interview with the Director of Nursing on October 20, 2010, at 1:40 p.m. in the Director of Nursing office, confirmed on December 1, 2009, upon returning the resident to the facility, the resident's daughter reported to LPN #2 the resident had complained of left hand pain, on December 2, 2009; the x-ray revealed soft tissue swelling, and confirmed no investigation was completed to determine the origin of the injury.

c/o TN00024616
483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

1) When it was brought to our attention, a sanitary environment was re-established
ST BARNABAS NURSING HOME

F 253
Continued From page 5
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 observation and interview, the facility failed to maintain safety floor mats in clean condition for one (#5) of twenty-six residents reviewed.

The findings included:
Resident #5 was admitted to the facility on July 23, 2010, and readmitted on August 16, 2010, with diagnoses including Diabetes, Blindness, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with Left Hemiparesis, Diabetic Peripheral Neuropathy, Seizure Disorder, and Depressive Disorder.

Observation on October 19, 2010, at 12:20 p.m., and October 20, 2010, at 7:35 a.m., revealed the resident sitting on the side of the bed with the feet resting on a safety floor mat on the right side of the bed. Continued observation revealed a dressing was on the right foot, and the left foot was bare. Observation of the safety floor mat located on the left side of the bed revealed the floor mat was soiled with various shades and sizes of a black/gray stain.

Observation on October 21, 2010, at 9:05 a.m., with the Housekeeping Supervisor, in resident #5’s room, revealed the resident lying on the bed with bilateral safety floor mats in place, beside the bed. Interview with the Housekeeping

for Resident #5 as the mats were immediately taken and cleaned by Housekeeping staff on 10/21/2010.
2) Residents mats will be observed daily by the housekeeping staff and cleaned accordingly as of 10/21/2010
3) As of 10/21/2010, the facility will continue to provide a sanitary environment by daily monitoring and the continuation of a rotation of mat cleaning by housekeeping personnel. A new auditing tool with daily, weekly and monthly checks has been created and will be monitored by Housekeeping supervisor to ensure the cleanliness of every room mat. This will enable the Housekeeping supervisor to track the cleaning process. Dirty or soiled mats will be identified by the housekeeping staff prior to routine cleaning and will be taken out and cleaned immediately.
4) Random visual audits and written audits for cleanliness of the mats will be completed by the Housekeeping Supervisor beginning 11/1/2010 and reported to the Administrator and the Quality Improvement Team monthly for the November QI meeting. Such random audits will end on February 30, 2011 or whenever deemed necessary by the QI team.
<table>
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**Summary Statement of Deficiencies**

- 483.20(d)(3). 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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

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, observation, and interview, the facility failed to revise the care plan for one (#5) of twenty-six residents reviewed.

The findings included:

Resident #5 was admitted to the facility on July 12, 2010.
F 280
Continued From page 7
23, 2010, and readmitted on August 16, 2010, with diagnoses including Diabetes, Blindness, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with Left Hemiparesis, Diabetic Peripheral Neuropathy, Seizure Disorder, and Depressive Disorder.

Medical record review of a physician’s order dated August 19, 2010, revealed "...Pt (patient) is DNR (Do Not Resuscitate). Talked to spouse..."

Medical record review of the current Care Plan, reviewed on August 4, 2010, revealed "...CPR (Cardiopulmonary Resuscitation) Full Treatment...Will abide by resident and family’s wishes...Perform Cardiac Pulmonary Resuscitation (CPR)...Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated..."

Observation on October 19, 2010, at 10:15 a.m., revealed the resident lying on the bed receiving oxygen, with bilateral fall mats in place on the floor.

Interview on October 19, 2010, at 1:55 p.m., with Minimum Data Set Coordinator #1, in the nursing station, confirmed the current Care Plan was not revised to indicate the correct DNR status as ordered by the physician on August 19, 2010.

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced

F 281
1) Resident #16: An Interim Care Plan was placed on resident’s medical record immediately by the MDS nurse on 10/20/2010. Resident #23 was discharged from the facility on 12/23/2009.
2) As of 11/1/2010, Medical Records will continue to be
F 281 Continued From page 8

by:

Based on medical record review, observation, and interview, the facility failed to complete and Interim Care Plan for one (#16), and failed to follow physician's orders for one (#23) of twenty-six residents reviewed.

The findings included:

Resident #16 was admitted to the facility on October 7, 2010, with diagnoses including Right Hip Fracture, Sepsis, Urinary Tract Infection, and Alzheimer's Disease.

Medical record review of the Admission Evaluation and Interim Care Plan form dated October 7, 2010, revealed the portion of the form "...Screen for Fall Risk..." was not completed. Continued review of the Admission Evaluation and Interim Care Plan form revealed there was no Interim Care Plan completed for the resident.

Observation on October 20, 2010, at 3:20 p.m., revealed the resident propelling self in a wheelchair, in the hallway, with a self-releasing soft safety belt in place.

Interview on October 20, 2010, at 3:35 p.m., with the Minimum Data Set (MDS) Coordinator, at the nursing station, revealed the Interim Care Plan was to be documented on the Admission Evaluation and Interim Care Plan form dated October 7, 2010. Continued interview with MDS Coordinator #1 confirmed an Interim Care Plan was not completed for resident #16.

Resident #23 was admitted to the facility on December 4, 2009, with diagnoses including Asthma, Diabetes, Depression, and Knee

 reviewed in weekly medical records review meeting by MDS nurses, therapy OT, charge nurses and medical records clerk to identify new residents that are missing an interim care plan.

As of 11/1/2010, the team will also assess medical record for any physician orders that are not signed by a licensed nurse. Signed orders signify the acknowledgement of that order. 11/7/2010, The Charge nurses will assess the records for the completion of that order.

3) 11/1/2010, MDS nurses and the charge nurses will continue to do visual audits of medical records for the lack of Interim Care Plans weekly and charge nurses will do random (ten per week) visual and written audits. Charge nurses will assure that MD orders are being completed by checking the written orders, checking Medication Records and observing nurses completing the MD orders beginning 11/8/2010.

4) As of 11/16/2010 the MDS nurses and charge nurses will report findings to nursing management team (DON, ADON, Admission nurse, Charge Nurses, Wound Care Coordinator), ADON or designee and will be reported to the Administrator and the Quality Improvement Team monthly beginning in...
Continued From page 9
Replacement.

Medical record review of the Minimum Data Set dated December 23, 2009, revealed the resident had no problems with memory or decision making.

Medical record review revealed the resident was admitted to the facility on December 4, 2009, at 3:45 p.m.

Medical record review of the Physician’s Admission Orders dated December 4, 2009, revealed the resident was to receive MS Contin (pain medication) 100 mg (milligrams), Lopressor (blood pressure medication) 12.5 mg, Levemir (form of insulin) 55 units, and Pepcid (Antacid) 20 mg, at 9:00 p.m. Continued review revealed the resident was to receive Coumadin (blood thinner) 1 mg at 6:00 p.m.

Medical record review of the Medication Administration Record dated December, 2009, revealed the resident did not receive any medications until 9:00 a.m., on December 5, 2009.

Interview with the Admission Nurse at 2:30 p.m., in the conference room, confirmed the resident did not receive the medications on December 4, 2009, as ordered by the Physician.

C/O # 24629 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

November and will continue for six months or more if deemed necessary by the QI team.

1) The nurse responsible for these weekly skin assessments displayed a noncompliance to the skin and wound care policy. After multiple inservices and verbal and written counseling
F 314 Continued From page 10

does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the facility policy, observation, and interview, the facility failed to perform weekly wound care assessments that resulted in a pressure ulcer not being identified resulting in harm to resident #3 of twenty-six residents reviewed.

The findings included:

Resident #3 was admitted to the facility on March 6, 2010, with diagnoses including Congestive Heart Failure, Hypertensive Heart Disease, Diabetes, Peripheral Vascular Disease, and Amputation of toe.

Medical record review of the Minimum Data Set dated March 19, 2010, revealed the resident had short/long term memory problems, moderately impaired cognitive skills for daily decision making, usually continent of bowel and bladder, and required extensive assistance for transfers and positioning.

Medical record review of the Braden Scale for Predicting Pressure Sore Risk dated March 6, 2010, revealed the form was blank.

Review of the facility policy, Skin and wound Care Program, revealed, "...The skin assessment must..."
<table>
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<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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| F 314 | Continued From page 11

be completed by a licensed nurse on every resident within two (2) hours of admission...A licensed nurse must complete this skin assessment weekly on all residents...

Medical record review of the careplan reviewed on May 26, 2010, and September 15, 2010, revealed, "...Turn and position resident every 2 hours as indicated by individual turning schedule posted in resident's room...ensure shower, shampoo, nail care and oral care per facility policy...weekly skin assessment...Dress in clothing comfortable for season and for therapy, ensure non skid footwear..."

Medical record review of the Quarterly Assessment documentation by the dietician, dated June 27, 2010, revealed, "Noted stage III L. (left) ankle...Alb (albumin) 2.7 (L) (low) Hgb (hemoglobin) 9.6 L (low) ...Added Arginina (protein supplement) 1 carton bid (twice a day) po (by mouth) x 21 d (days) for enhanced wound healing..."

Medical record review of the Resident/Wound Skin Assessment dated August 11, 2010, August 16, 2010, and August 25, 2010, revealed, "Tx (treatment) to LLE (left lower extremity)."

Medical record review of documentation by treatment nurse #1 on the physician's progress notes dated August 30, 2010, revealed, "Wound Care: PU (pressure ulcer) to (L) (left) ankle healing has stalled, wound bed is bulging from wound edges exposing muscle (and) tendon...new orders to send pt. (patient) to wound clinic for evaluation, cont. (continue) Iodosorb to aid in decreasing microbial load (and) remove exudate..."

4) 11/1/2010 Wound care coordinator and charge nurse will audit skin assessment completion weekly and report the findings to the Director of Nursing on a weekly basis. Weekly and monthly audits will continue to be completed by the Wound Care Coordinator and reported to the ADON to QI team beginning in November for one year or more if team deems necessary.
Continued From page 12

Medical record review of the Regional Wound Center Report dated September 7, 2010, revealed, "...The patient was noted to have a left lateral ankle wound that started in late May secondary to pressure...Patient was noted to have progressive ulceration of the wound with retained necrotic tissue and was sent to the Wound Care Center for evaluation...reviewing the nursing home records, the patient preferred to lie on...left side in a fetal position, but has been switched to the right side...Past Medical History: Positive for right transmetatarsal amputation secondary to peripheral vascular disease...Examination of the right lateral ankle shows ulceration measuring approximately 0.9 (centimeters) x (by) 0.8 (centimeters) with no drainage, with black eschar in this wound bed...attention was then turned to the right lateral ankle...The patient underwent a full-thickness skin debridement...the ulcer bed approximately 1 cm (centimeter) by 1 cm, down to yellow fibrous tissue underneath...this patient represents a very difficult patient to heal secondary to peripheral vascular disease and secondary to age and poor nutrition and dependent status of nonambulatory..."

Medical record review of the facility Skin/Wound Assessment for Pressure Ulcers dated September 7, 2010, revealed, "...Wound #2 (right outer ankle) stage III 0.9 (cm) (x) 0.8 (cm) (x) 0.2 yellow serous..."

Medical record review of documentation by the treatment nurse #1 on the physician's progress notes dated September 7, 2010, revealed, "...back from (named) wound care center. (L) (left) lateral ankle PU (pressure ulcer) 3.0 (cm) x
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<tbody>
<tr>
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<td>3.0 (cm) x 1.5 (cm) (with) serous drainage.</td>
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<tr>
<td></td>
<td>red/yellow wound bed (with) exposed tendon area was debrided at clinic... (R) (right) ankle lateral new open area. 0.9 x 0.8 x 0.2 serous drainage-yellow wound bed, will apply santyl drsg (dressing) (change) daily...</td>
</tr>
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<td></td>
<td>Medical record review of the wound care clinic physician's orders dated September 7, 2010, revealed, &quot;...Barrier periwound... (R) (right) lateral wound-santyl 4x4's roll gauze...&quot;</td>
</tr>
<tr>
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<td>Medical record review of the Quarterly Assessment dated September 19, 2010, revealed, &quot;...St. (stage) 3 (right) ankle improved to 1.0 (cm)x 1.0 x 0.1 (cm) (and) pink...&quot;</td>
</tr>
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<td>Medical record review of the Treatment Record for the month of September, 2010, revealed, &quot;...Cleasne PU (pressure ulcer) (R) (right) ankle NS (normal saline), pat dry, apply barrier cream to periwound, santyl to wound bed, 4x4 gauze conform wrap (change) daily...&quot; Continued review revealed no documentation the treatment was provided to the right ankle pressure ulcer on September 11, 12, 25, and 26, 2010.</td>
</tr>
<tr>
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<td>Observation on October 21, 2010, at 9:15 a.m., of the pressure ulcer on the right outer ankle, described by treatment nurse #1 as 3.0 cm x 2.0 cm unstageable with black eschar.</td>
</tr>
</tbody>
</table>
|       | Interview on October 21, 2010, at 9:30 a.m., at the nursing station, with the treatment nurse #1, confirmed... was not aware of the pressure ulcer on the right outer ankle until September 7, 2010, after the resident returned from the wound care center.
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| F 314         | Continued From page 14  
Interview on October 21, 2010, at 1:15 p.m., in the conference room, with treatment nurse #1, confirmed the treatment nurse did not remove the sock on the right foot when treatment was provided to the left ankle on August 30, 2010.  
Interview on October 21, 2010, at 1:30 p.m., with the Director of Nursing, in the conference room, confirmed there was no documentation the treatment was provided to the right ankle pressure ulcer on September 11, 12, 25, and 26, 2010. Further interview with the Director of Nursing confirmed there was no documentation the pressure ulcer on the right ankle had been identified prior to September 7, 2010.  
Interview on October 21, 2010, at 2:15 p.m., in the conference room, with Licensed Practical Nurse (LPN) #6, confirmed a skin assessment was done on August 25, 2010, but "did not see right ankle well", continued interview confirmed LPN #6 was unsure if...looked at the right ankle, may have "peeked" at it; LPN #6 stated the resident was resistant, and did not obtain help to complete the skin assessment. | F 314 |  |
| F 315         | 493.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | F 315 | F315  
1) For resident #16, Bladder training was initiated on 10/20/2010 and catheter removed. A bowel and bladder assessment will be completed for Resident #4, #11, #13, 11/1/2010, then bladder training will be initiated by the restorative nursing team accordingly. 11/1/2010, education for restorative CNA's will be given by the DON. Education on frequent toileting
F 315 Continued From page 15

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to initiate bladder training for one (#16), and failed to assess three (#4, #11, #15) for a bladder retraining program of twenty-six residents reviewed.

The findings included:

Resident #16 was admitted to the facility on October 7, 2010, with diagnoses including Right Hip Fracture, Sepsis, Urinary Tract Infection, and Alzheimer's Disease.

Medical record review of the Admission Evaluation and Interim Care Plan form dated October 7, 2010, revealed the resident had a urinary catheter upon admission to the facility.

Medical record review of a physician's note dated October 12, 2010, revealed "...Plan: D/C (discontinue) Foley (urinary catheter)..."

Medical record review of a physician's order dated October 12, 2010, revealed "initiate bladder training to D/C Foley catheter when completed training..."

Medical record review revealed no documentation the bladder training had been initiated.

Observation on October 21, 2010, at 7:45 a.m., revealed the resident sitting in a wheelchair, in the resident's room, with a urinary catheter draining yellow urine into a drainage bag.

Interview on October 21, 2010, at 8:00 a.m., with
 Continued From page 17

dated September 27, 2010, revealed the resident had short and long term memory problems, was moderately impaired with cognitive skills for daily decision making, and was incontinent of bowel and bladder.

Medical record review revealed no documentation a bladder assessment had been completed to develop an individualized bladder retraining program.

Interview on October 20, 2010, at 3:00 p.m., with the Director of Nursing, in the conference room, confirmed the resident had not been assessed for a bladder retraining program.

Resident #15 was admitted to the facility on August 19, 2009, with diagnoses including Hypertension and Rheumatoid Arthritis.

Medical record review of the Minimum Data Set dated August 26, 2010, revealed the resident had short and long term memory problems, was moderately impaired with cognitive skills for daily decision making, and was frequently incontinent of bowel and incontinent bladder.

Medical record review revealed no documentation a bladder assessment had been completed to develop an individualized bladder retraining program.

Interview on October 20, 2010, at 4:15 p.m., with the Director of Nursing, in the conference room, confirmed the resident had not been assessed for a bladder retraining program.

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

1) A fall’s investigation and new interventions have been done.

12/3/10
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the Assistant Director of Nursing, in the nursing station, confirmed the bladder training had not been initiated.

Interview on October 21, 2010, at 8:35 a.m., with the Director of Nursing, in the conference room, confirmed there was no medical justification for the resident to require a urinary catheter.

Resident #4 was admitted to the facility on August 20, 2009, with diagnoses including Debility, Advanced Alzheimer's Disease, Depression, and Atrial Fibrillation.

Medical record review of the Minimum Data Set dated August 24, 2010, revealed the resident had short and long term memory problems, was moderately impaired with cognitive skills for daily decision making, and was frequently incontinent of bowel and bladder.

Medical record review revealed no documentation a bladder assessment had been completed to develop an individualized bladder retraining program.

Interview on October 20, 2010, at 3:00 p.m., with the Director of Nursing, in the conference room, confirmed the resident had not been assessed for a bladder retraining program.

Resident #11 was re-admitted to the facility on June 17, 2010, with diagnoses including Hypothyroidism, Alzheimer's Disease, Diabetes Mellitus Type 2, and Urinary Incontinence.

Medical record review of the Minimum Data Set
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<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
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| F 323 | Continued From page 18 | 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, observation, and interview, the facility failed to investigate and implement new interventions after a fall for one resident (#9) and failed to ensure a restraint was applied correctly for one resident (#8) of twenty-six residents reviewed. The findings included: Resident #9 was admitted to the facility on December 14, 2002, with diagnoses of Congestive Heart Failure, Cerebral Vascular Accident, and Hypertension. Medical record review of the care plan updated on October 22, 2009, revealed the resident had a history of falls and the facility had implemented pressure pad bed alarm at night with padded mats on the floor to each side of the bed. Medical record review of the Nurse's note dated December 4, 2009, (late entry for December 1, 2009) revealed "...CNA's called Nurse to room pt (patient) states 'I slipped out of my w/c (wheelchair)...I didn't hurt anything..." Medical record review revealed no investigation | F 323 | determined for resident #9 by the Fall's IDT (DON, ADON, Social Services, Therapy Director, MDS nurses) by 11/1/2010. Restraints were properly re-applied for Resident #8 per the ADON with assistance from the therapy Director on 10/20/10. 2) Effective 11/1/2010: Any resident experiencing a fall observed or not observed will be assessed for reasons for the fall. Planning and implementation of new interventions will occur through the falls IDT (DON, ADON, Social Services, MDS nurses). 11/1/2010 Residents that are at high risk for falls will be identified through a falls risk assessment and incident reporting ongoing. 3) Beginning 11/1/2010, each fall will be investigated by DON or designee and a therapy screen will be initiated for new interventions as appropriate. Evaluation that new interventions have taken place will occur through visual checks from DON, ADON, MDS nurses, therapy department or designee. Falls will be tracked three times per week by the Fall IDT (Interdisciplinary Team which includes DON/ADON, Therapy Director, Social Services, and MDS nurses). Falls will be tracked by the Fall IDT on the new tool "Falls Tracking Assessment" form. Inservicing for restraint application was done 10/20/2010 by the...
F 323 Continued From page 19
was completed or new interventions implemented after the fall.

Telephone interview with Licensed Practical Nurse (LPN) #2 (on duty December 1, 2009) on October 20, 2010 at 1:15 p.m., confirmed on December 1, 2009, the resident slid out of the wheelchair and no injury was noted. Continued interview revealed LPN #2 was unsure if the above occurrence were reported.

Interview with the Director of Nursing on October 20, 2010, at 1:40 p.m. in the Director of Nursing office, confirmed on December 1, 2009, the resident slid out of wheelchair and no investigation was completed or new interventions implemented after the fall on December 1, 2009.

c/o TN00024616

Resident #8 was admitted to the facility on September 17, 2008, with diagnoses including Diabetes, Alzheimer’s Disease, and Senile Depressive Disorder.

Medical record review of the Minimum Data Set dated September 24, 2010, revealed the resident had short/long term memory problems, with severely impaired cognitive skills for daily decision making.

Medical record review of the careplan dated September 21, 2010, revealed, "...self-release soft belt while using wheelchair to remind not to attempt rising (second to) lack safety awareness..."

Medical record review of the physician’s...
ST BARNABAS NURSING HOME

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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<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 323</td>
<td>Continued From page 20 Recapitulation orders dated October 1, 2010, through October 31, 2010, revealed, &quot;...10/23/08-continue self release belt...&quot; Medical record review of the manufacturer's instructions for the self release soft belt revealed, &quot;...The Patient-Release Soft Belts are intended to act as &quot;gentle reminders&quot; for patients to ask for assistance when leaving the wheelchair...They are designed to be easily opened and removed by most patients...place the belt at the patient's waist and bring the straps directly behind the patient. Thread the straps through the space between the space between the wheelchair seat and backrest...&quot; Observation on October 19, 2010, at 11:30 a.m., revealed the resident seated in the wheelchair with the self release soft belt in place with the left strap wrapped around the outer lower leg of the wheelchair and looped over the right kickspur and the right strap between the leg of the wheelchair and backrest of the wheelchair and looped over the left kickspur. Interview on October 19, 2010, at 11:30 a.m., on the hall, with LPN #6 confirmed the resident was not able to self release the belt when asked and confirmed the self release soft belt was applied incorrectly.</td>
<td>F 323</td>
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<tr>
<td>F 328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</td>
<td>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;</td>
<td>F 328</td>
<td>1. F328 toenails were examined for Resident #5 immediately. It was found on 10/25/2010 by the podiatrist that resident's nails were gangrenous. Resident is a Hospice patient and is at the end of life with comfort measures only. Trimming of the nails were not safe for this</td>
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<td>Continued From page 21</td>
<td>F 328</td>
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<td></td>
<td></td>
<td>Tracheostomy care;</td>
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<td>Tracheal suctioning;</td>
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<td>Respiratory care;</td>
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<td>Foot care; and Prostheses.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, policy review, observation, and interview, the facility failed to obtain podiatry services for one (#5) of twenty-six residents reviewed.</td>
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<td>The findings included:</td>
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<td>Resident #5 was admitted to the facility on July 23, 2010, and readmitted on August 16, 2010, with diagnoses including Diabetes, Blindness, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with Left Hemiparesis, Diabetic Peripheral Neuropathy, Seizure Disorder, and Depressive Disorder.</td>
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<td>Medical record review of the Minimum Data Set (MDS) dated July 28, 2010, revealed the resident required extensive assistance with personal hygiene and bathing.</td>
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<td>Medical record review of a physician's progress note dated July 26, 2010, revealed &quot;...toenail(s) need trimming...&quot;</td>
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<td>Observation on October 19, 2010, at 10:15 a.m., revealed the resident lying on the bed with the feet exposed. Observation revealed a dressing covered the right foot, and the toenails of the left foot were long.</td>
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Observation and interview on October 19, 2010, at 2:05 p.m., with MDS Coordinator #2 revealed the resident lying on the bed, and the great toenail on the left foot was described as extending approximately 1/4 inch past the fat pad of the toe, the third and fourth toenails on the left foot described as extending approximately 1/2 inch beyond the fat pads of the toes. Continued interview with MDS Coordinator #2 confirmed the toenails were in need of trimming.

Review of the facility's policy Fingernails/Toenails, Care of revealed "...do not trim the nails of diabetic residents or residents with circulatory impairments..."

Interview on October 19, 2010, at 2:15 p.m., with the Director of Nursing, in the nursing station, revealed a podiatrist would be required to trim the toenails due to the resident's diagnosis of Diabetes.

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to obtain laboratory results as ordered by the physician for one resident (#11) of twenty-six residents reviewed.

The findings included:
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<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 502</td>
<td>Continued From page 23</td>
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Resident #11 was re-admitted to the facility on June 17, 2010, with diagnoses including Hypothyroidism, Alzheimer’s Disease, Diabetes Mellitus Type 2, and Urinary Incontinence.

Medical record review of a physician’s order dated August 26, 2010, revealed, "...Vit D (Vitamin D) 50,000 I Units (International Units - a form of measurement) 3 x (times) week x 30 days...Check Vit D level on 9/29/10..."

Medical record review of a physician’s order dated August 30, 2010, revealed, "...Start Levothyroxine 25 mcg (micrograms)...TSH (thyroid-stimulating hormone level - a blood test used to detect problems affecting the thyroid gland) in 3 and 6 weeks..."

Medical record review revealed no documentation the lab specimens had been obtained as ordered on August 25, 2010, or August 30, 2010 as ordered.

Interview with the Assistant Director of Nursing (ADON), on October 21, 2010, at 7:55 a.m., at the Second Floor Nursing Station, confirmed the facility failed to obtain the lab specimens as ordered on August 25, and August 30, 2010.

F 514

1) For Resident #5 an order clarification for SS1 was obtained 10/20/2010 by the Hospice Nurse.

2) Beginning 11/01/2010, all resident’s medical records will be reviewed weekly by MDS RN's and Charge RN's for accuracy and systematic organization.
F 514  Continued From page 24

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 maintain an accurate clinical record for one (#5) of twenty-six residents reviewed.

Resident #5 was admitted to the facility on July 23, 2010, and readmitted on August 16, 2010, with diagnoses including Diabetes, Blindness, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with Left Hemiparesis, Diabetic Peripheral Neuropathy, Seizure Disorder, and Depressive Disorder.

Medical record review of a physician’s order dated September 14, 2010, revealed "...SSI (sliding scale insulin) level 1 coverage..."

Medical record review of the physician’s recaptulation orders dated October 2010, revealed the resident was to receive level 2 sliding scale insulin protocol for blood glucose.

Medical record review of the Sliding Scale Diabetic Monitoring Log dated September 2010, revealed the following scale for level 1 coverage of blood glucose: 60-110=0 units of insulin; 111-150=2 units of insulin; 151-200=2 units of insulin; 201-250=4 units of insulin; 251-300=4

F 514  
3)  Beginning 10/20/2010, Visual audits to be completed by the charge nurses. Inaccurate findings of the chart review will be taken to each individual nurse and a medication error form will be completed. This will be reported to the DON and ADON by the charge nurses weekly. Continuing education and inservicing will be given to all Medication administration licensed nurses by the charge nurses on an individual basis. Progressive disciplinary action will be given by the DON or designee for continual noncompliance issues. Inservice and accurate clinical documentation is being given by the Omnicare Pharmacist on 11/4/2010 and ongoing.

11/09/2010, results of accuracy of clinical records will be reported by the charge nurses at the weekly nursing management team (DON, ADON, Charge nurses, Wound Care Coordinator, Admission Nurse).

4)  ADON will report audits to the QI team starting in November for 6 months or more if deemed necessary by the team.
F 514 Continued From page 25

units of insulin; 301-350=6 units of insulin; 351-400=6 units of insulin; and >400=8 units of insulin and notify provider.

Medical record review of the Sliding Scale Diabetic Monitoring Log dated September 2010, revealed the following scale for level 2 coverage of blood glucose: 60-110=0 units of insulin; 111-150=2 units of insulin; 151-200=4 units of insulin; 201-250=4 units of insulin; 251-300=6 units of insulin; 301-350=8 units of insulin; 351-400=8 units of insulin; and > (greater than) 400=10 units and notify provider.

Medical record review of resident #5's September 15-30, 2010, and the October 1-18, 2010, Sliding Scale Diabetic Monitoring Log revealed the resident received the sliding scale insulin with level 1 coverage.

Interview on October 20, 2010, at 9:10 a.m., with the Assistant Director of Nursing, at the nursing station, confirmed the October 2010, physician's recapitulation orders indicated the resident was to receive sliding scale insulin by the level 2 insulin protocol was not accurate.