**F 000 INITIAL COMMENTS**

On December 7, 2010 the annual recertification survey and investigation of complaint #26815 was completed. No deficiencies were cited related to the complaint.

**F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)**

A facility must immediately inform the resident; consult with the resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident resulting in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

**F 000 PROVIDER'S PLAN OF CORRECTION**

This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

1) Residents # 5's Physician and responsible party was notified on 9/13/10 by the Assistant Director of Nursing. No adverse outcome noted.

2) Residents have the potential to be affected by the citation. No residents were identified to be affected by this.

3) An in-service on “Abuse Prevention and Event Management Policy and Procedure” for reporting events to the Physician and the responsible party, documentation requirements of notification and use of notification checklist was conducted by the Administrator and Director of Nursing for licensed nursing and certified nursing assistants on 12-5-10 and completed on 12-9-10. Licensed nurse assigned to the resident will complete the notification checklist prior to leaving shift.

The Director of Nursing implemented a notification checklist on 12-09-10 that will be completed on all events starting 12-14-10.
This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to timely notify the attending physician and responsible party of a fall for one resident (#5) of sixteen residents reviewed.

The findings included:

Resident #5 was originally admitted to the facility on November 30, 2004, and readmitted on September 22, 2010, with diagnoses including Cardiovascular Accident (Stroke), Renal Failure, Hemangioma, Congestive Heart Failure, Hypertension, Anemia, Anorexia, and Chronic Airway Obstruction.

Medical record review of the facility investigative report and nurses notes revealed the resident experienced a fall without injury on September 10, 2010, at 4:20 p.m.; continued review revealed the resident's physician and responsible party were not notified of the fall until September 13, 2010.

Observation on December 5, 2010, at 12:40 p.m., in the dining room, revealed the resident sitting in a wheelchair eating lunch and talking with another resident at the table.

Interview with the Assistant Director of Nursing (ADON), and Director of Nursing (DON) in the DON's Office on December 7, 2010, at 2:50 a.m., confirmed the facility failed to notify the attending physician and responsible party of the resident's fall occurring on September 10, 2010, until September 13, 2010, (three days later).
1) Resident #4 immediately had a dental assessment performed and documented by the Director of Nursing on 12/5/10. Results of the assessment were reported to the POA by the Social Service Director on 12/5/10 and to the physician by the Assistant Director of Nursing on 12/5/10. No adverse outcome noted.

2) All residents had dental assessments performed on 12/5/10 by the Director of Nursing, Assistant Director of Nursing and the Minimum Data Set Nurse.

3. An in-service was conducted by the Director of Nursing and/or Registered Nurse Supervisor for licensed nurses. How to perform dental assessments and documentation requirements, and certification for assistant to report problems with teeth or dentures to the nurse for follow-up assessment to be done and documented on 12-5-10 and completed on 12-9-10.

4) The Director of Nursing and/or Registered Nurse Supervisor will verify accuracy of all dental assessments weekly times 4 weeks then monthly times 3 months and/or 100% compliance. Results of audits will be reviewed at the Quality Assurance meeting. Members of the Quality Assurance Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Dietary Manager, Minimum Data Set RN, Medical Records, and Rehab Manager.
Continued From page 3

three missing upper teeth (#1, #2, #16).

Continued review of a Dental Assessment dated October 1, 2010, revealed the assessment of the upper teeth section to be blank.

Observation of the resident’s upper front teeth on December 5, 2010, at 2:00 p.m., in the resident’s room, revealed tooth #10 (upper front lateral incisor) was broken at the gum line.

Interview with the Licensed Practical Nurse (LPN) #1 on December 5, 2010, at 2:50 p.m., in the Director of Nursing’s (DON) office confirmed LPN #1 failed to complete the October 1, 2010, quarterly dental assessment of the resident’s upper teeth.

Interview with the Minimum Data Set (MDS) Coordinator on December 5, 2010, at 3:10 p.m., in the Director of Nursing’s (DON) office confirmed the MDS Coordinator completed the quarterly dental assessments dated July 15, 2010, and October 6, 2010, and did not recall a missing lateral incisor (#10 - upper front lateral).

Telephone interview with the resident’s dentist on December 6, 2010, at 10:00 a.m., confirmed the resident’s lateral incisor - tooth #10 (upper front lateral) was broken at the gum line upon the initial visit with the resident on April 28, 2010.

Continued interview with the dentist confirmed the tooth did not need extracting, "...unless the tooth was symptomatic (causing pain) it did not need to be extracted; tooth extraction in geriatric residents can have adverse side effects or be detrimental to the resident..."