

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 08/19/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/05/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated/Partial Extended Survey investigating KY #00016751 and KY #00016806 was conducted 07/21/11 through 08/05/11.</p> <p>KY #00016751 was substantiated with deficiencies. KY #00016751 was substantiated with no deficiencies.</p> <p>Immediate Jeopardy was identified with deficiencies cited at F-441, F-490, and F-520 at a Scope and Severity (S/S) of a "K". The facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection. This was evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use and the facility's failure to ensure staff were knowledgeable related to the facility's policy regarding blood glucose monitor cleaning. The facility's failure to ensure staff properly disinfected the blood glucose monitors between resident use was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/28/11.</p> <p>An acceptable Allegation of compliance, related to the Immediate Jeopardy, was received on 08/02/11. On 08/04/11, the Immediate Jeopardy was verified to be removed on 08/02/11 as alleged.</p> <p>Deficiencies cited were CFR 483.10 Resident Rights F-157 at a Scope and Severity (S/S) of a "G", CFR 483.13 Resident Behavior and Facility Practice F-221 at a S/S of a "D", CFR 483.15 Quality of Life F-248 at a "F", CFR 483.20</p>	F 000	<p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE CITED DEFICIENCIES AS STATED IN THE 2567 INCLUDING ANY DETERMINATIONS OF SCOPE AND SEVERITY OF THE ALLEGED DEFICIENCIES. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567.</p> <p>The facility alleges compliance as of 9/20/11.</p> <div data-bbox="989 1212 1300 1398" style="border: 1px solid black; padding: 5px; text-align: center;"> <p><b>RECEIVED</b> <b>OCT 12 2011</b></p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>10/10/11</i>
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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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosable 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.

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F 000	Continued From page 1 Resident Assessment F-273 at a S/S of a "F", F-279 at a S/S of a "D", F-280 at a S/S of a "G", F-281 at a S/S of a "F", F-282 at a S/S of a "D", CFR 483.25 Quality of Care F-311 at a S/S of a "G", F-314 at a S/S of a "G", F-323 at a S/S of a "G", F-325 at a S/S of a "E", F-333 at a S/S of a "D", CFR 483.30 Nursing Services F-356 at a S/S of a "D", CFR 483.35 Dietary Services F-371 at a S/S of a "D", CFR 483.60 Pharmacy Services F-425 at a S/S of a "F", CFR 483.65 Infection Control F-441 at a S/S of a "K", CFR 483.75 Administration F-490 at a S/S of a "K", F-499 at a S/S of a "E", F-501 at a S/S of a "F", F-505 at a S/S of a "D", F-514 at a S/S of a "E", F-518 at a S/S of a "F", F-520 at a S/S of a "K". Substandard Quality of Care (SQC) was identified in the areas of CFR 483.15 Quality of Life F-248 at a "F". The highest Scope and Severity was a "K".	F 000		
F 157 SS=G	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 which results 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	F 157		

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F 157	<p>Continued From page 2 §483.12(a).</p> <p>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(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the Physician and/or responsible party of a change in condition, or need to alter treatment for five (5) of eighteen (18) sampled residents (Residents #14, #10, #11, #6 and #13).</p> <p>The facility failed to notify the Physician when Resident #14 self transferred and fell on 07/19/11, sustaining a cut above the left eye, a Left Hip Fracture and Left Wrist Fracture. Although the resident sustained a cut above the left eye which later required sutures and expressed pain of the left wrist, there was no documented evidence the Physician was notified of the fall and injury for two (2) hours after the fall.</p> <p>Resident #10 sustained a significant weight loss of six (6) pounds (5%) from the resident's weight prior to admission. Although the facility was</p>	F157	<p>The facility has policies and procedures to require prompt notification to the physician and the responsible party of a change in condition or a need to alter treatment.</p> <ol style="list-style-type: none"> <li>Resident #14's physician has been notified by nurse of status. Resident #10's physician has been notified by nurse of the weight loss and dietary recommendations. Resident #11's physician has been notified of the medication omission and revised orders were received. Resident #6's physician has been notified of skin condition and orders received for treatment. Resident #13 no longer resides at facility</li> <li>Full in-house audit for timely notifications to physicians and families was completed by Kathi Grimes, Nurse Consultant (NC) by 8/25/11 and follow-up was implemented as necessary.</li> <li>Nurses in-serviced on timeliness of physician and family notification by Kathi Grimes, NC, or Janet Manoogian, Director of Nursing (DON) on 8/4/11. All new orders will be reviewed at morning clinical meeting held Monday through Friday which is attended by the Interdisciplinary Team (IDT). ADON/DON will randomly check nurses progress notes for five (5) residents three times weekly for 4 weeks for notifications to physicians and families.</li> </ol>	9/20/11

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F 157	<p>Continued From page 3</p> <p>aware of the weight loss on 07/15/11, and dietary recommendations were made on 07/15/11 by the Dietician, there was no documented evidence the Physician was notified of the weight loss or dietary recommendations.</p> <p>Resident #11 had scheduled insulin to be administered daily at 9:00 PM; however, there was no documented evidence the Insulin was administered from 07/01/11 through 07/15/11. On 07/16/11, orders were received from the Physician to increase the 9:00 PM insulin daily. Staff transcribed the order without notifying the Physician that the Insulin had not been documented as administered for fifteen (15) days. Resident #6 developed a Stage II Pressure Sore on 07/22/11; however, there was no documented evidence the Physician was notified to obtain treatment orders until after surveyor interventions on 07/28/11.</p> <p>Resident #13 sustained falls on 07/13/11, 07/16/11, 07/17/11 and 07/25/11; however, there was no documented evidence the Physician was notified of the falls.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled "FALLS" (undated), revealed if a resident experienced a fall, the physician is to be notified. Interview on 08/05/11 at 4:20 PM, with Nurse Consultant #2 regarding the facility's fall policy revealed staff should be aware they are to notify the Physician of all falls.</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 07/12/11, with diagnoses which included Depression, Hypertension (HTN), Difficulty</p>	F 157	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented.</p> <p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p> <p>QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	

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F 157	<p>Continued From page 4</p> <p>Walking, Muscular Wasting and Disuse Atrophy, and Pneumonia.</p> <p>Review of the Nurse's Notes, dated 07/19/11, revealed the resident had self transferred to the bathroom and fell. At 1:00 PM, the nurse found the resident on the bathroom floor with a cut above the left eye. Although the resident fell, sustained a cut above the left eye, and later complained of pain to the left wrist, there was no documented evidence the Physician was notified of the fall and injury until two (2) hours later, at 3:00 PM. Further review of the 07/19/11 Nurse's Notes revealed the resident was sent to a local hospital at 4:00 PM due to mental status change and complaints of left wrist and left leg pain.</p> <p>Review of the facility's Incident Report about the fall, dated 07/19/11 and timed at 1:00 PM and Nurses' Notes review revealed Resident #14 fell in the bathroom and was found sitting up on the floor with her/his walker against the wall. The resident was injured with a cut above his/her left eye. Interview, on 07/27/11 at 3:30 PM, with Registered Nurse (RN) #6, revealed she entered Resident #14's room on 07/19/11 and found the resident on the bathroom floor with a cut above her/his left eye. She obtained vital signs and assessed the resident's extremities before transferring her/him to a chair. Continued interview revealed she did not notify the Physician immediately after the fall because there was not a change in the resident's condition except for the cut above the eye and the resident wasn't complaining of pain at that time. Further interview revealed the resident later did complain of pain to her/his left wrist; however, she again did not notify the Physician because she noted no</p>	F 157		

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F 157	<p>Continued From page 5 swelling to the wrist.</p> <p>The document also noted the physician was notified at 3:00 PM, two (2) hours after the fall occurred.</p> <p>Interview, on 07/27/11 at 4:07 PM, with RN #1 revealed the nurse observed Resident #14 at approximately 3:00 PM and he/she seemed confused, and complained of left wrist and left leg pain. She stated she sent the resident out to the hospital about 4:00 PM for x-rays, and concern there may be a brain injury. She stated the nurse should notify the physician right away after a fall.</p> <p>2. Review of the "Weight Policy", undated, revealed, if a resident had a weight loss of five (5) pounds or more and this had been verified by a re-weight and the nurse on duty, the facility was to notify the Physician, Power of Attorney, and Dietician. Further review revealed all recommendations would be implemented immediately.</p> <p>Review of the medical record revealed the facility admitted Resident #10, on 07/01/11 with diagnoses which included Dementia and Diabetes Mellitus. Review of the previous facility's Nutritional Disorders Note, dated 06/09/11 revealed the resident's intake had been 50-75% for most meals and the resident's current weight was one hundred and twenty (120) pounds which was down 3% over the last month, and down 1.5% over the last six (6) months.</p> <p>Interview with the Dietitian, on 08/02/11 at 12:40 PM, revealed she started requesting the resident's weight on 07/01/11, however record</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>review revealed no documented weight for Resident #10 until 07/15/11, despite the dietitian's request.</p> <p>Review of the facility's Weight Record revealed the first weight obtained at the facility on 07/15/11 was one hundred fourteen (114) pounds. Review of the Nutritional Disorders Note, dated 07/15/11, written by the Registered Dietician revealed the resident was known to the writer from the previous facility and was noted to have a marked decline in PO (by mouth) intake since the move to the new facility and was requiring more assistance. Further review revealed the resident's documented PO intake was 25 -50%.</p> <p>Review of the Dietician/Nutritional Recommendations made by the Dietitian on 07/15/11 revealed recommendations for laboratory data including a Pre-albumin, Complete Blood Count (CBC), and Renal Panel. Further recommendations included a Speech Therapy (ST) Screen, Occupational Therapy (OT) Screen, and to liberalize the diet to regular/discontinue the Consistent Carbohydrate Diet.</p> <p>Interview, on 08/02/11 at 12:40 PM, with the Dietitian revealed the facility did not obtain weights for the residents who were admitted from 07/01/11 to 07/15/11, although she had requested weights since 07/01/11. Further interview revealed she had the previous facility's weight for the resident because she worked at the resident's previous facility. She stated she noticed the weight loss on 07/15/11, after finally receiving the weight. She further stated she recommended the lab work, ST and OT screens, and liberalizing the</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>diet on 07/15/11. Continued Interview revealed she wrote recommendations on a form, and gave copies of the form to the unit nurses in order for them to notify the Physician of the recommendations. She stated her recommendations, dated 07/15/11, were not followed in reference to ordering the labs and liberalizing the diet and she made new recommendations on 08/02/11.</p> <p>Although the facility was aware of the significant weight loss of six (6) pounds (5%) from 06/09/11 to 07/15/11, there was no documented evidence the Physician was notified of the weight loss. Also, dietary recommendations were made on 07/15/11; however, there was no documented evidence the Physician was notified of the recommendations.</p> <p>Record review revealed Physician's Orders dated 07/19/11, for ST and OT to evaluate. However, there was no documented evidence of orders related to obtaining the laboratory data for a Pre-albumin level, CBC, Renal Panel, or for liberalizing the diet.</p> <p>Further review of the Weight Record revealed the next weight recorded on 07/28/11 was one hundred nineteen and a half (119.5) pounds with a reweight the same date of one hundred eighteen and one tenth of a pound (118.1) pounds. Observation of the resident being weighed on 08/02/11 revealed the resident's weight was one hundred seventeen (117) pounds.</p> <p>Review of the dietary recommendations, dated 08/02/11, revealed recommendations to obtain a Pre-albumin, Renal Panel, CBC, urine specimen,</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>discontinue the consistent carbohydrate diet, and assess the need for Lasix (diuretic medication) in light of weight loss.</p> <p>Further interview with the Dietitian, on 08/02/11 at 12:40 PM, revealed she did not usually write the Physician's Orders for her recommendations; however, she went ahead and wrote orders on 08/02/11 to ensure the Physician was notified.</p> <p>Review of the Physician's Orders, dated 08/02/11, revealed orders written by the Dietitian stating "recommend"; obtaining labs including a Pre-Albumin, CBC, BMP (Basic Metabolic Panel), liberalizing diet to regular, asking the Physician to assess Lasix (diuretic) dose, and notifying the Physician of a weight loss of 12% in the last six (6) months. Further review revealed a Physician's Order, dated 08/02/11, for Med Pass 2.0 (dietary supplement) 120 milliliters (ml's) twice a day.</p> <p>Interview, on 08/02/11 at 3:30 PM, with Licensed Practical Nurse (LPN) #5 revealed she was hired at the facility on 06/20/11, worked part time, and did not receive orientation to the process how dietary made recommendations. She stated she had faxed the dietary recommendations to the Physician on 07/15/11; however, there was no documented evidence the recommendations were faxed or that the Physician was notified of the recommendations. Continued interview revealed after a dietary recommendation was faxed, it was to be placed in a bin at the nurse's station for the nurse on the next shift to follow up, and ensure the Physician received the fax. She stated she worked part time and checked the bin in the mornings.</p>	F 157		

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F 157	Continued From page 9  Interview, on 08/04/11 at 1:00 PM, with the Attending Physician revealed he was the resident's Physician at the previous facility as well as this facility. He stated he was unaware of the resident's weight loss since the transfer to the facility until earlier this week. Further interview revealed he was unaware of the dietary recommendations dated 07/15/11 until 08/02/11.  3. Review of the "Physician Notification" Policy, undated, revealed good nursing judgement should determine when it was appropriate to contact the Physician.  Review of the medical record revealed the facility admitted Resident #11, on 07/01/11 with diagnoses which included Diabetes Mellitus.  Review of the Physician's Orders, dated 07/11 revealed orders for scheduled Lantus Insulln 100 Units/ML (milliliter), inject thirty-seven (37) Units subcutaneously (SQ) at 9:00 PM. Review of the Medication Administration Record (MAR), dated 07/11 revealed no documented evidence the medication had been administered from 07/01/11 through 07/15/11 (fifteen 15 days).  Record review revealed no documented evidence the Physician was notified that the Insulin was not administered per the Physician's Orders.  Review of the Physician's Orders, dated 07/16/11, revealed new orders to increase the Lantus Insulin to forty-one (41) Units at 9:00 PM.  Further review of the MAR revealed staff had discontinued the Lantus Insulin thirty seven (37)	F 157			

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NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
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F 157	<p>Continued From page 10</p> <p>Units for 9:00 PM and had transcribed the new order for the Lantus Insulin forty one (41) Units every day at night with an arrow pointing to 07/16/11 to start the medication.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 08/04/11 at 6:00 PM, revealed she had transcribed the order on 07/16/11 for the Lantus 41 Units and discontinued the Lantus 37 Units on the MAR. Further interview revealed she realized the MAR had not been signed off as the Lantus Insulin being administered at 9:00 PM from 07/01/11 through 07/15/11; however, she did not remember calling the Physician to notify him or questioning the nursing staff about the lack of documentation.</p> <p>Further interview, on 08/05/11 at 3:00 PM with LPN #4, revealed she notified the Physician on 08/04/11 that the Lantus Insulin 37 Units was not documented at 9:00 PM for 07/01/11 through 07/15/11, after surveyor intervention. She stated a Physician's Order was received at that time to decrease the 9:00 PM scheduled Lantus Insulin to 37 Units. She further stated she felt it was a significant mistake to fail to notify the Physician of the 9:00 PM Lantus Insulin not being documented as administered at the time she was transcribing the order for the increased dose of Insulin.</p> <p>Interview on 08/05/11 at 3:30 PM with the Attending Physician, revealed he was not notified of the lack of documentation on the MAR indicating the Lantus Insulin 37 Units was not administered 07/01/11 through 07/15/11 at the time he wrote the order to increase the Insulin on 07/16/11. He stated he thought the resident's blood sugar was higher than it should have been</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>and that was the reason for the Order for the increased dosage of Insulin on 07/16/11. Continued interview revealed it was a significant medication error to fail to administer the Insulin as ordered. He further stated, the resident could have had a reaction related to not receiving the Insulin as ordered, and then receiving an increased dose of 41 Units. Further interview revealed the nurse who transcribed the order for the increased dose of Insulin should have notified him regarding the lack of documentation on the MAR.</p> <p>4. Review of the policy titled "Notification" (no date) revealed the nurse was to notify the physician immediately for a change in condition, "such as the development of a stage II pressure sore".</p> <p>Review of the clinical record revealed the facility admitted Resident #6, from another facility, on 07/01/11 with diagnoses which included Alzheimer's Disease, Hypertension, and Lumbar Disc Disease with Chronic Back Pain.</p> <p>Review of the Physicians' Orders from the transferring facility, dated 06/30/11, revealed Resident #6 was to be transferred to the receiving facility with continuation of all orders. Continued review revealed the following order related to excoriation on the right buttock: "Cleanse with antimicrobial cleanser, apply Calmoseptine then Desenex"(Desenex is an antifungal skin cream).</p> <p>Review of the weekly skin assessment from the transferring facility, dated 06/30/11, revealed Resident #6 had a red area on the right buttock that did not blanch. The facility assessed the</p>	F 157		

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F 157	<p>Continued From page 12 area as a Stage I wound.</p> <p>Review of the Physician's Orders at the receiving facility for the month of July 2011 revealed the excoriated area on the right buttock was to be cleansed prior to the application of Calmoseptine, a barrier cream, and Micro-Guard Powder (Micro-Guard Powder is an antifungal).</p> <p>Review of the Admission MDS Assessment revealed Section M, related to pressure ulcers, was completed on 07/07/11. According to the assessment, Resident #6 was at risk for pressure ulcers but had no ulcers at a Stage I or higher.</p> <p>Review of the Skin Condition/Wound Progression note by LPN #2 dated 07/22/11, a Friday, revealed Resident #1 had an open lesion on the sacrum. The nurse classified the area as Stage II ulcer measuring 2.0 cm x 2.0 cm. Continued review revealed the nurse documented "wound was present on admission". Interview with LPN #5, on 08/05/11 at 4:45 PM, revealed she had done the skin assessment on 07/22/11, but had documented under LPN #2's name by accident.</p> <p>Observation of the skin assessment performed by LPN #5, on 07/28/11 at 2:45 PM, revealed an open area to the right buttock. The nurse classified the area as a Stage II wound and measured it at 3.0 cm x 1.5 cm. The nurse stated she was made aware of the area on the weekend. She further stated it was not open at that time. Continued interview revealed she instructed the aides to use Baza cream. LPN #5 stated she did not notify the physician, but left a note for the night shift to notify the Physician on Monday (07/25/11).</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>Review of the Nurse's Progress Notes revealed there was no evidence the Physician was notified of the newly identified open area on 07/22/11 or 07/25/11. Further review revealed no evidence the Physician was notified until orders were received for treatment on 07/28/11.</p> <p>5. Review of Resident #13's medical record revealed the facility admitted the resident on 06/03/11, with diagnoses which included unspecified Hypertension, Breast Cancer, and Coronary Artery Disease. The Minimum Data Set (MDS) Assessment, dated 06/10/11, revealed the facility assessed the resident as having a fall prior to being admitted. Further review revealed the facility assessed the resident as severely impaired, and as requiring extensive one person physical assistance with transferring, toilet use, and locomotion. Resident #13's care plan, dated 08/08/11 included interventions for forgetfulness and being at risk for falls. Included on the fall care plan were fall prevention alarms for both the chair and bed.</p> <p>Review of the facility's incident reports revealed the following fall incidents for Resident #13:</p> <p>The 07/13/11 Incident Report documented the resident fell trying to get to the bathroom. No injury was listed on the report. The Power of Attorney was notified, but there was no documented evidence the facility notified the Physician per the facility's policy. Interview with RN #1, on 07/27/11 at 6:00 PM, confirmed she did not mortify the Physician.</p> <p>The 07/16/11 Incident Report documented the</p>	F 157			

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F 157	Continued From page 14 resident was found on the floor in front of his/her wheelchair and the resident reported he/she had attempted to get clothing from the bottom drawer and his/her chair rolled backward. No injury was noted. The report notification section did not indicate the family or the Physician were notified. Interview with LPN #3, on 08/05/11 at 11:40 AM confirmed the Physician was not notified after the fall.  The 07/17/11 Incident Report documented the resident was found sitting on the floor beside his/her bed and stated he/she attempted to ambulate and leaned on his/her wheelchair but the wheels were not locked and the chair rolled away causing a loss of balance. Continued review revealed "No injury". There was no documented evidence the Physician was notified per the facility's policy. Interview with LPN #3, on 08/05/11 at 11:40 AM confirmed the Physician was not notified after the fall.  Review of the 07/25/11 Incident Report revealed the resident stated he/she was going to the recliner from the wheelchair and lost his/her balance. Continued review revealed there was no injury and no documented evidence the facility notified the Physician as required by the facility's policy. Interview with Registered Nurse (RN) #1, on 07/27/11 at 6:00 PM, revealed she did not contact the Physician after the fall.  Interview, on 08/05/11 at 11:40 AM, with LPN #3 revealed she had not been trained on the facility's "Falls Policy" and what was expected after a resident's fall.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		

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F 221	Continued From page 15  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 observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure a systematic process of evaluation and care planning prior to the use of restraints for one (1) of eighteen (18) sampled residents (Resident #7). The facility admitted Resident #7 and the resident used a positioning device that held the resident restrained in the wheelchair. Per facility policy, and regulatory guidelines, the facility failed to assess the resident related to the restraint, failed to explain the risks versus (vs.) benefits of the device, and failed to obtain written consent for the restraint.  The findings include:  Review of the facility's policy titled "Restraints/Pre-Restraining Assessment Tool" (undated) revealed residents were to be assessed prior to the use of a restraint. Continued review revealed the risks and benefits of the restraint device would be explained to the resident and informed consent was required prior to initiation of the device.  Review of the clinical record revealed the facility admitted Resident #7 on 07/01/11, with diagnoses which included Hypertension, Coronary Artery	F 221  F221	The facility utilizes restraints only to treat resident's medical symptoms and has a process to assess residents before utilization of a restraint, utilize the least restrictive restraint and obtain consents for use of the restraints.  1. Resident #7 was re-assessed by occupational therapy on 8/11/2011 for necessity of device and care plan updated by D.O. N. on 7/27/2011 and 8/11/2011 to reflect recommendations for seating and re-positioning. The care plan includes the interventions to meet the assessed needs of the resident.  2. A full house audit of orders and devices in place was completed by D.O.N. and Nurse Consultants on 8/26/11 and 9/2/11. Device assessments were completed by the D.O.N. and or nurse consultants based upon audit findings between 8/27/11 and 9/14/11. Care plans were updated as of 9/14/11 to assure that the care plan meets the assessed needs for each resident. Facility is currently restraint free.	9/20/11

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F 221	<p>Continued From page 16 Disease, Osteoporosis and Osteoarthritis.</p> <p>Observation, on 07/21/11 at 3:00 PM, revealed Resident #7 was sitting in a wheelchair. The resident was noted to have a soft trunk restraint in place. Two (2) long straps were noted crisscrossed behind the wheelchair and tied to the extension bars on either side, near the floor. Additional observations on 07/22/11 at 12:00 PM, 07/26/11 at 3:25 PM, and 07/27/11 at 12:15 PM revealed the restraint was in place as before.</p> <p>Review of the clinical record, including the Electronic Medical Record, revealed no documented evidence Resident #7 was evaluated for the restraint. Continued review revealed no evidence the risks vs. benefits had been explained to the resident and no signed consent form was completed, as per the facility's policy.</p> <p>Interview with Resident #7, on 07/21/11 at 3:00 PM, revealed the device was to assist the resident to sit up straight. Continued interview revealed the resident was unable to remove the device independently.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 07/22/11 at 12:10 PM, revealed the device worn by Resident #7 was used for positioning, but was a restraint because the resident could not remove it independently. She stated she was not aware of any special assessment requirements related to the use of a restraint. Continued interview revealed she had "vaguely" heard of a Risk vs. Benefit form, but did not know how or when it was used.</p> <p>Interview with the former Director of Nursing</p>	F 221	<p>3. Policy and procedure revised/updated for use of restrictive devices which includes assessment, and determination of whether the device is a restraint or an enabler. Devices determined to be a restraint will have risk verses benefits explained to resident, family/responsible party and consents for use obtained as of 9/14/2011. Nursing staff was re-inserviced regarding assessing for most appropriate type of device, risk/benefits policy to obtain consent for use with restraint use by D.O.N, and/or Nurse Consultant on 8/4/2011.</p> <p>All new orders for devices are being reviewed in the morning clinical meeting held Monday through Friday which is attended by the interdisciplinary team (IDT) and changes/modifications made as appropriate. In the event that a resident is assessed as potentially needing a restrictive device on a weekend, the staff is required to call the DON to review the assessment prior to implementing. Consents and evidence that risk verses benefits have been explained to authorized representatives prior to initiation of usage will be reviewed at this time as well.</p>	

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F 221	Continued From page 17 (DON), on 08/04/11 at 11:00 AM, revealed she was employed at the facility on 07/01/11 when Resident #7 was admitted. She stated she did not recall the resident had a restraint. Continued interview revealed the resident should have been assessed for the use of a restraining device. She further stated a Risk vs. Benefits form, a signed consent form and a Physician's Order were required. She added It was the admission nurse's responsibility to complete the process.  During interview, on 08/04/11 at 4:30 PM, Nurse Consultant #2 agreed the device was a restraint and the facility's policy should have been followed related to assessment, risk vs. benefit, and Informed consent.	F 221	Random audits of device usage and care plans for devices will be completed by D.O.N. / A.D.O.N. and/or Nurse Consultants on 5 residents three (3) times weekly for 4 weeks. If issues are noted, the auditor takes prompt action to address the identified concerns. Documentation of the random audits will be provided to the QA Committee for further review and recommendation.	
F 248 SS=F	<b>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</b>  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure an ongoing program of activities designed to meet the interests and well-being of each resident. The facility failed to ensure seven (7) of eighteen (18) sampled residents (Residents #1, #5, #6, #7, #10, #11 and #14) and six (6) unsampled residents (C, D, E, F, G and H) had their individual activity interests and special needs	F 248	4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected/re-educated and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.	

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F 248	<p>Continued From page 18</p> <p>met. The facility failed to ensure staff assigned to provide activities were provided the resources/materials for the activities. The facility failed to ensure the activities program was being monitored to ensure it was effective in meeting the residents' psychosocial well being. In addition, observations and complaints throughout the facility during the survey revealed a systemic failure to provide a varied program of activities that was well-communicated to the residents. Observations and interviews revealed activities were frequently cancelled or interrupted. In addition, the facility failed to ensure direct care nursing staff, who were assigned to provide activities, were qualified and trained to plan, coordinate and conduct consistent daily recreational offerings to the residents.</p> <p>The findings include:</p> <p>Interview with the Ombudsman, on 07/27/11 at 12:30 PM, revealed she had visited the facility a few days earlier and received a number of complaints from residents regarding the lack of activities. She reported the complaints included: residents weren't informed of activities; staff did not know where and when a scheduled activity, e.g. a movie, was to take place; activities were frequently cancelled without a reason given; and there wasn't enough variety.</p> <p>During a Group Interview on 08/04/11 at 2:15 PM, one (1) sampled resident and seven (7) unsampled residents agreed the facility was not meeting their needs related to activities. Resident #8 stated there were not enough activities, especially in the evening. He/she stated no one asked what the residents wanted related to activities. Unsampled residents D and</p>	F 248 F248	<p>The facility provides ongoing program activities programs designed to meet the interests, and geared to meet the physical, mental and psychosocial well-being of the residents.</p> <ol style="list-style-type: none"> <li>Residents #1, 5, 6, 7, 10, 11, 14, C, D, E, F, G and H have been interviewed and re-assessed by the Activity Director to determine their individual activity interests as 9/14/2011. Interviews were conducted by Activity Coordinator between 8/30/2011 and 9/14/2011. Care plans have been revised as necessary after interviews. Activity Director has obtained and made available appropriate activity materials for each household.</li> <li>Activity Director re-interviewed the remainder of facility residents to update activity preferences and assessments on 8/30/2011, 8/31/2011 and 9/1/2011. To address nursing staff not having enough time to do activities, facility hired one full time and one part time activity personnel as of 9/15/2011. The new activity personnel were trained by the Activity Coordinator upon hire. Staff will be encouraged to attend workshops as they become available.</li> </ol>	9/20/11
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F 248	<p>Continued From page 19</p> <p>G also voiced concerns that residents were not included in making activities decisions. Other concerns, agreed by all residents present, included the following: residents were not informed of the time and place of activities; frequent interruptions occurred when the CNAs had to leave to assist other residents with care needs; activities were frequently cancelled; and the residents did not feel the CNAs were qualified to conduct the activities.</p> <p>Observation, on 07/27/11 at 10:15 AM, revealed no Current Events activity was in progress on the C Hall, as scheduled on the Activities Calendar for July 2011.</p> <p>Interview with CNA #23, on 07/27/11 at 10:30 AM, revealed she did not conduct the Current Event activity that morning and did not know if anyone else had led the discussion. She stated "sometimes it gets done, sometimes it doesn't". Interview with CNA #16 on 07/27/11 at 10:35 AM revealed no Current Event activity had taken place that morning.</p> <p>Observation, on 07/27/11 at 10:30 AM, of the daily schedule posted on the B household, revealed "Current Events" was scheduled for 10:00 AM. Continued observation revealed there were no activities being conducted on the B household.</p> <p>Observation, on 07/27/11 at 2:30 PM, revealed a Trivia Game activity was posted as a scheduled activity for the B hall. However, the activity was not being conducted as scheduled. Interview, on 07/27/11 at 2:40 PM, with CNA #6 revealed the Trivia activity was not performed. The CNA</p>	F 248	<p>Residents polled on Activity preference and this is reflected in preference assessments. Residents are encouraged to verbalize activity requests and perception of activity availability in our monthly resident council meetings and care conferences. Activity calendar revised to reflect enhanced schedule and is posted in each resident's room as well as in the common area on each unit. New activity staff is scheduled to work expanded hours of 10 AM- 6 PM and on weekends. Evening activities were re-structured to include spa nights, movies and board games led by C.N.A. staff as of 9/15/2011. Activity Director inserviced nursing staff regarding their role with activities between 8/31/11 -9/7/2011.</p> <p>Activity Director and/or Administrator will audit activity participation, assessments with care plan revisions as needed 5 days a week for the next 4 weeks starting 9/6/11.</p> <p>Administrator is auditing activities, staffing and availability of supplies on a random basis with documentation of the auditing provided to the QA Committee.</p>		

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F 248	<p>Continued From page 20</p> <p>stated, to her knowledge, none of the residents on the hall were informed about the activity or that it was cancelled. She further stated she was not aware of the planned activity.</p> <p>Observation, on the C Unit on 08/02/11 at 10:30 AM, revealed there were no activities taking place on the unit. Interview with CNA #16 revealed the residents had no activities that morning. Review of the activities calendar revealed Current Events was on the schedule for 08/02/11. However, no time was given for the activity. Continued review revealed no times were noted for activities on the schedule for the entire month of August 2011.</p> <p>Interview with the Activity Director (AD), on 07/27/11 at 2:50 PM, revealed the facility's "Person Centered Care Approach" placed the responsibility for activities with the CNAs. All tracking of resident participation in activities was the CNAs' responsibility. He stated the CNAs did not have time to conduct activities along with all their other personal care responsibilities. The AD further stated the residents' activity needs, including 1:1 visits, were not being met.</p> <p>Subsequent interview with the AD, on 08/03/11 at 3:30 PM, revealed he was responsible for overseeing resident activities. He stated he had been going to the A, B, C skilled units the past two weeks to participate in board games with the residents. He further stated he had no activities staff for the skilled units and the aides were to lead and participate in the scheduled activities; however, the aides were unable to perform the activities due to being assigned too many duties. He realized the scheduled calendar of events was not being followed after reviewing the</p>	F 248	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p> <p>QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 8/30/11.</p> <p style="text-align: right;"><i>g</i> <i>na</i></p>	

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F 248	<p>Continued From page 21</p> <p>documentation for resident activities and interviewing the aides. Continued interview revealed he was assigned several responsibilities at the facility and was not allotted adequate time to perform his duties as Activities Director. Follow-up interview with the AD, on 08/03/11 at 3:55 PM, revealed the Certified Nursing Assistants (CNAs) were to record resident activities on the Resident Activity Record. He stated the CNAs were also suppose to be conducting and documenting 1:1 activities with the residents. He explained he was responsible for monitoring activities attended by the residents.</p> <p>Interview, on 07/27/11 at 10:30 AM with CNA #8, revealed the Activities Director and activities staff did not come to the A, B, or C units to do activities. She stated the CNAs were to lead and participate in the activities with the residents.</p> <p>Observation, on 08/02/11 at 10:20 AM, revealed the posted schedule of activities on the C household included "Current Events" at 10:00 AM. Continued observation revealed no activities were conducted. Interview with CNA #24 and CNA #1 at the time of observation revealed the activity had not taken place as scheduled.</p> <p>Review of the Activities Log Book revealed eleven (11) of nineteen (19) residents on the B Household did not participate in any activities on 08/01/11. Continued review revealed no activity participation for any resident on 08/02/11.</p> <p>Interview with CNA #8, on 08/02/11 at 10:55 AM, revealed the CNAs were responsible for conducting the Current Events activity every morning. She stated they were suppose to read</p>	F 248		
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F 248	<p>Continued From page 22</p> <p>the newspaper, but the facility never provided a newspaper in order to complete the activity. She further stated, "we don't have time for that, we are too busy". Continued interview revealed the CNAs were responsible for an afternoon activity each day at 2:00 PM. She stated the CNAs were to plan and carry out the activity, which usually consisted of bingo or a board game. During further interview the CNA stated the afternoon activity probably happened about twice a week. She stated less than five (5) residents participated in the afternoon games. CNA #8 further stated the CNAs kept the residents clean and dry; activities and cleaning the kitchen were lower priority.</p> <p>Interview, on 08/02/11 at 11:25 AM, with CNA #17 revealed the scheduled "Current Event" activity for Hall B did not occur that morning as planned. She stated she she did not read the current events from the newspaper. Additional interview with CNA #17, on 08/02/11 at 2:45 PM regarding documentation of activities, revealed the staff leading an activity was suppose to document which residents attended the activity. In addition, if the CNAs observed a resident participating in an activity such as visiting with family or watching television, the CNAs were to document it in the computer.</p> <p>1. Review of the clinical record revealed the facility admitted Resident #1 on 07/01/11, with diagnoses which included Alzheimer's Disease, Anxiety and Depression. In addition, the resident was status post Cardiovascular Accident (stroke) and was dependent for all care.</p> <p>Review of the Resident Activity Assessment,</p>	F 248			

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F 248	<p>Continued From page 23</p> <p>dated 07/06/11, revealed the resident was not interviewable. Further review revealed no documented evidence the resident's family was included in identifying the resident's interests and there was no assessment for past interests completed.</p> <p>Review of the Activity Care Plan, dated 07/06/11, revealed interventions which included 1:1 visits, hand massages and visits by the therapy dog. Continued review revealed attendance and level of participation were to be documented as well.</p> <p>Review of the Resident Activity Record for July 2011 revealed Resident #1 received four 1:1 visits and one "other" visit during the month. Continued review revealed no documentation related to the nature of the visits or the resident's response.</p> <p>Observations on 07/21/11 at 5:10 PM, 07/22/11 at 9:30 PM and 1:30 PM, 07/26/11 at 3:30 PM and 4:40 PM, and 08/02/11 at 10:40 AM revealed Resident #1 was not engaged in any activity with staff or visitors.</p> <p>Interview with the AD on 08/03/11 at 3:35 PM revealed he had conducted "a couple" 1:1 visits and talked about the weather and current events.</p> <p>2. Review of the closed clinical record revealed Resident #5 was admitted by the facility, on 01/19/11 with diagnoses which included Osteoarthritis and Dementia. In addition, the resident was status post Cardiovascular Accident and required extensive assistance with all Activities of Daily Living (ADLs).</p>	F 248		

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F 248	<p>Continued From page 24</p> <p>Review of the Resident Activity Assessment, dated 06/07/11, revealed current activity interests included radio, reading, religious activities, movies, volunteer visits and talking with others. Continued review revealed the resident considered it very important to be able to go outside when the weather was good.</p> <p>Review of the activity care plan, dated 06/09/11, revealed interventions directed toward encouragement related to attendance and participation, and daily room visits. Continued review revealed the stated goal for Resident #5 was attendance at one activity outside the room at least once per week.</p> <p>Review of the Resident Activity Record revealed Resident #5 attended one Current Events discussion on 07/23/11 and refused a table game on 07/29/11. There was no documented evidence of any other activity involvement for the entire month and no record of a room visit. Continued review no documented evidence activity opportunities were offered and refused.</p> <p>Observations, on 07/21/11 at 3:00 PM, 3:55 PM, and 5:45 PM and on 07/22/11 at 9:00 AM and 1:00 PM revealed Resident #5 was not engaged in any activity with staff or visitors.</p> <p>Interview with the AD on 08/03/11 at 3:35 PM revealed Resident #5 "always refused" all activities. He stated he had not conducted a 1:1 visit with the resident during the month of July.</p> <p>3. Record review revealed the facility admitted Resident #8 on 07/01/11, with diagnoses which included Alzheimer's Disease and Lumbar Disc</p>	F 248			

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F 248	<p>Continued From page 25 Disease with Chronic Back Pain.</p> <p>Review of the Resident Activity Assessment, dated 07/09/11, revealed Resident #6's current interests included games, arts &amp; crafts, music, parties, radio and television, movies, conversation, religious activities and going outdoors.</p> <p>Review of the plan of care for activities, dated 07/09/11, revealed the following interventions: 1:1 visits; discuss recreational opportunities with resident and family; interview regarding interests; provide transportation; and monitor attendance.</p> <p>Review of the Resident Activity Record for July 2011 revealed no documented evidence of any activity offered, attended or refused.</p> <p>Observations, on 07/21/11 at 5:00 PM, 07/22/11 at 9:15 AM and 1:00 PM, 07/26/11 at 12:00 PM, 07/27/11 at 10:30 AM, 07/28/11 at 11:30 AM, 07/29/11 at 4:00 PM, 08/01/11 at 10:30 AM; and on 08/02/11 at 10:00 AM revealed Resident #6 was not engaged in any activity with staff or visitors.</p> <p>Interview with the AD, on 08/03/11 at 3:35 PM, revealed he did not know Resident #6 and did not recall the initial assessment.</p> <p>4. Review of the clinical record revealed the facility admitted Resident #7 on 07/01/11 with diagnoses which included Hypertension, Coronary Artery Disease, Osteoporosis and Osteoarthritis.</p> <p>Review of the Resident Activity Assessment,</p>	F 248		
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F 248	<p>Continued From page 26</p> <p>dated 07/05/11, revealed Resident #7's current interests included radio, going outdoors, and clergy visits. In addition, the resident considered it very important to have reading materials, follow the news and participate in religious services or practices.</p> <p>Review of the Activity Care Plan, dated 07/05/11, revealed interventions directed toward encouragement, arranging transport, documenting participation and visiting 1:1.</p> <p>Review of the Resident Activity Record for July 2011 revealed the only documented activity prior to 07/20/11 was one instance of watching television.</p> <p>Observations, on 07/26/11 at 3:25 PM and 4:40 PM, 07/27/11 at 10:25 AM, 10:50 AM, 12:30 PM and 2:00 PM, and 07/28/11 at 10:00 AM and 11:30 AM revealed Resident #7 was not engaged in any activity with staff or other residents.</p> <p>Interview with the AD, on 08/03/11 at 3:35 PM revealed he had visited Resident #7 a couple of times and read the Resident's mail. He stated Resident #7 had requested a Manhattan cocktail a few times, but this had not been provided yet.</p> <p>During the survey (07/21-08/05/11) Resident #7 was observed visiting with a member of clergy on one occasion. No other observations of the resident engaged in any activity were made.</p> <p>5. Review of the clinical record revealed the facility admitted Resident #14 on 07/12/11 with diagnoses which included Anxiety and Depression. The resident was transferred to the</p>	F 248		

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F 248	<p>Continued From page 27</p> <p>hospital on 07/19/11, due to a fall, and re-admitted on 07/25/11. The Minimum Data Set (MDS) Assessment, including activity preferences, had not been completed. Review of the resident's Interim Care Plan, dated 07/12/11, revealed no interventions related to activities. Review of the Resident Activity Record for July 2011 revealed no documented evidence Resident #14 had participated in any activities during the month of July 2011.</p> <p>Interview, on 08/03/11 at 3:55 PM, with the Activities Director (AD) revealed he had assessed Resident #14 for activity preferences on admission, and entered the data into the computer. Continued interview revealed Resident #14 did not have an individualized plan of care regarding activities. He stated it was a concern that Resident #14 had not attended any activities.</p> <p>6. Review of Resident #11's medical record revealed the facility admitted the resident to the C Unit on 07/01/11 with diagnoses which included Diabetes Mellitus, and Cerebral Vascular Accident. Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/26/11, revealed the facility assessed the resident as oriented.</p> <p>Review of the Resident Activity Assessment, dated 07/02/11, revealed the resident's current interest were games, sports, radio, reading, religious activities, wheeling outdoors, watching television, movies, talking, clergy visits, volunteer visits and resident visits.</p> <p>Review of the Resident Activity Record, dated</p>	F 248		

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F 248	<p>Continued From page 28</p> <p>07/11, revealed a friend visited and the resident participated in a table game on 07/28/11. There was no documented evidence of the resident participating in any other activities for 07/11.</p> <p>Interview, on 07/27/11 at 10:45 AM, with CNA #8 revealed she was assigned to Resident #11. She stated Resident #11 did not participate in activities and was only out of bed for physical therapy and lunch. She further stated he/she did not receive one (1) on one (1) activities in the room.</p> <p>Interview, on 07/27/11 at 3:45 PM, with Resident #11 revealed he/she did not participate in any activities in the facility. The resident stated he/she stayed in bed most of the time but did get up daily for Physical Therapy. Continued interview revealed the resident did not remember anyone offering any 1:1 activities in his/her room. Resident #11 stated he/she had played Wii Bowling at the previous facility and would like to play that again.</p> <p>Interview with the AD, on 08/03/11 at 3:30 PM, revealed he had visited Resident #11 twice 07/11; however, he had not documented the visits. He further stated the facility had Wii Bowling available, but he was unaware the resident wanted to play the game.</p> <p>9. Review of Resident #10's medical record revealed the facility admitted the Resident to the C Unit on 07/01/11, with diagnoses which included Dementia and Osteoarthritis. Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/26/11, revealed the facility assessed the resident as having</p>	F 248		

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F 248	<p>Continued From page 29</p> <p>severe impairment in cognitive skills for decision making.</p> <p>Review of the Resident Activity Assessment, dated 07/08/11, revealed the resident's current interests included cards, games, arts and crafts, music, social events, religious activities, going outdoors, television, movies, talking, clergy visits, and volunteer/resident visits.</p> <p>Review of the Resident Activity Record dated 07/11 revealed the resident participated in no activities 07/01 through 07/10/11. Further review revealed the resident attended only seven (7) activities for the remainder of the month of July.</p> <p>Interview, on 08/03/11 at 3:00 PM, with the Activities Director, revealed he would like to see Resident #10 participate in at least one (1) activity a day.</p> <p>Interview with Nurse Consultant #1, on 08/04/11 at 4:30 PM, revealed she had seen some activities taking place. She stated she had been more focused on clinical issues and had not yet addressed the activity problem.</p> <p>Interview with the Vice President of Operations (and Interim Administrator), on 08/05/11 at 5:20 PM, revealed he was aware there were concerns related to the Activities Program. He stated the issue was being examined. During continued interview, he explained facility Administration was interested in "Universal Workers", staff who performed a variety of duties, across disciplines. He acknowledged implementing such an approach was a "full culture change" and required a more systematic approach than had been</p>	F 248		

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NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 248	Continued From page 30 applied thus far. Although he felt there was enough staff, he stated staffing ratios and more staff education were two issues that needed further consideration.	F 248	The facility conducts comprehensive assessments to identify the residents needs within fourteen days of admission, and periodically in compliance with the requirements.  1. Comprehensive assessments were completed for residents #1, 2, 6, 7, 8, 10, 11, B, F, H, I, J, K, L, M, N, O, P, Q, R, S, and T by M.D.S., D.O.N., A.D.O.N and/or nurse consultants between 8/1/2011 and 9/14/2011. Care plans were updated as appropriate based upon assessments.  2. The remainder of facility resident's comprehensive assessments has been audited by M.D.S., D.O.N., A.D.O.N and/or Nurse Consultants on 8/23/2011. Revisions have been completed as appropriate. A monthly MDS calendar that indicates the assessment reference date for each resident is maintained by the MDS nurse. The MDS nurse reports status of MDS completion at the Monday through Friday Interdisciplinary Team (IDT) meeting to ensure timely completion.	9/20/11	
F 273 SS=F	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT  A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the comprehensive assessment was completed within fourteen (14) calendar days after admission. The facility admitted seven (7) sampled residents (Residents #1, #2, #6, #7, #8, #10 and #11) and fifteen (15) unsampled residents (Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T) on 07/01/11. Review of the Minimum Data Set (MDS) Assessments and interviews with administrative staff revealed none of these assessments were completed within fourteen (14) days of admission.  The findings include:  Review of the resident listing provided by Nurse Consultant #2 revealed twenty-two (22) highlighted names which represented residents	F 273			

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F 273	Continued From page 31 the facility accepted for admission from another facility on 07/01/11. Continued review revealed the list was made up of seven (7) sampled residents (#1, #2, #6, #7, #8, #10 and #11) and fifteen unsampled residents (B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T).  Review of MDS assessments for the sampled residents revealed no documented evidence the assessments were completed within fourteen (14) days of admission per facility policy and federal regulations.  Interview with the former Director of Nursing (DON), on 08/04/11 at 10:30 AM, revealed she was employed by the facility through 07/15/11. She stated the MDS nurse had resigned and left without completing the assessments on twenty-two (22) newly admitted residents.  Interview with Nurse Consultant #1, on 08/04/11 at 4:30 PM, revealed the MDS nurse had resigned soon after 07/01/11 (exact date not known). She stated the MDS assessments had been initiated but none had been completed when the MDS nurse left. Continued interview revealed the admission MDS assessments should have been completed within fourteen (14) days.	F 273	3. A new MDS Nurse was hired on 8/4/11. She was trained on facility policies and procedures, specifically assessments, CAAs, EMR documentation and Care plans on 8/4/2011 through 8/7/2011 by the Nurse Consultant. Nursing staff were provided with additional in-servicing on the comprehensive assessments including general observation, fall and skin risk, use of EMR, initial care plan by D.O.N. and/or Nurse Consultants between 8/4/11 and 8/16/11. D.O.N./A.D.O.N, M.D.S. and or Nurse Consultants will audit four (4) 14 day assessments each week for the next 4 weeks to check for completion.  4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The results of the auditing will be provided to the QA Committee for further review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	<p>Continued From page 32</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, intervention, and record review, it was determined the facility failed to develop a Comprehensive Plan of Care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment for one (1) of eighteen (18) sampled residents (Resident #10).</p> <p>The findings include:</p> <p>Review of Resident #10's medical record revealed the facility admitted the resident on 07/01/11 with diagnoses which included Dementia, Arthritis, and a history of falls.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment which was not completed until 07/26/11 (Refer to F-273) revealed the</p>	F 279  F273	<p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented.</p> <p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p>	

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F 279	Continued From page 33 facility assessed the resident as having severe impairment in cognitive skills for decision making, and as requiring extensive assistance with transfers, ambulation, dressing, and hygiene.  Review of the Care Area Assessment Summary (CAAS) dated 07/26/11 revealed the following areas triggered and there would be a Comprehensive Plan of Care related to these areas; oognitive loss, visual function, urinary incontinence, falls, and pressure. A Plan of Care was initiated on 07/08/11; however, there was no documented evidence these areas were addressed.  Interview on 07/27/11 at 5:30 PM with Nurse Consultant #1 who was serving in an administrative role due to the absence of the Director of Nursing (DON) since 07/14/11, revealed she had been at the facility since 07/18/11 and when she arrived she realized the Care Plans were incorrect. She further stated they were in the process of reviewing and revising the Care Plans. She stated the previous MDS nurse who had also completed the care plans, left the facility in mid July 2011 and a corporate nurse had been called in to work on the MDS's and Care Plans.	F279 F 279	The facility develops individualized care plans to address the assessed needs of the residents and modifies the care plan in a timely manner to assure that the interventions and measurable objectives address the ongoing and changing needs of the residents.  1. Resident #10's comprehensive care plan for cognitive loss, visual function, urinary incontinence, falls, and pressure which have been assessed as resident needs was completed on 08/01/2011 with revision on 9/18/2011 by M.D.S nurse.  2. An audit of CAAs and Care Plans of the other facility residents using the CAAs and Care Plan audit tool was completed on 9/19/2011 and care plans were revised as appropriate by M.D.S. nurse.  3. All licensed nursing staff were provided with additional inservicing on the comprehensive admission assessment and care planning process by D.O.N. and/or Nurse Consultants on 8/4/11. D.O.N., A.D.O.N. and/or Nurse Consultants will audit four (4) resident's 14 day assessments and the Care Plans each week for the next 4 weeks to check for completion.	9/20/11	
F 280 SS=G	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 or changes in care and treatment.  A comprehensive care plan must be developed	F 280			

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F 280	<p>Continued From page 34</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plans of Care were revised for two (2) of eighteen (18) sampled residents (Resident #13 and Resident #14).</p> <p>Resident #14 self transferred and fell on 07/19/11, sustaining a laceration requiring sutures above the left eye, a Hip Pinning Fracture Left Hip, and Left Radius and Ulna Fracture. A fall prevention alarm did not alert staff that the resident was up at the time of the fall. The resident's Plan of Care included bed and chair tab alarms to help prevent falls; however, interviews with staff revealed the resident was removing the tab alarms. The facility failed to revise the Plan of Care and implement new interventions prior to the fall. Also, upon re-admit to the facility after hospitalization for sutures above the left eye brow, a Hip Pinning Fracture Left Hip, and Left</p>	F279 F 280	4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The results of the auditing will be provided to the QA Committee for further review and recommendation. The facility administration's role in the monitoring is to track that the care plans are being developed and any identified corrective action is implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.	

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F 280	<p>Continued From page 35</p> <p>Radius and Ulna Fracture the facility failed to update the Plan of Care with additional interventions to prevent further falls.</p> <p>Resident #13 had multiple falls (on 07/13/11, 07/16/11, 07/17/11 and 07/25/11) and the Comprehensive Plan of Care was not revised and updated with information or interventions related to each of these fall incidents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "FALLS" (undated) revealed if the resident experiences a fall the resident's care plan is revised and updated with information related to the fall incident within 24 hours. Interview, on 08/05/11 at 4:20 PM with Registered Nurse (RN) #5 (Nurse Consultant #2), revealed after each fall staff should investigate the cause and the care plan should be revised with interventions to prevent the cause of the fall</p> <p>1. (Refer to F323) Record review revealed the facility admitted Resident #14 on 07/12/11, with diagnoses which included Depression, Hypertension (HTN), Difficulty Walking, Muscular Wasting and Disuse Atrophy, and Pneumonia. Record review revealed the facility initiated a Plan of Care, dated 07/12/11, which identified falls as a problem and had fall prevention interventions which included bed and chair alarms, call light within reach at all times; refer to therapies, frequent visual observations and toileting.</p> <p>Review of Resident #14's Treatment Administration Record (TAR) revealed each shift staff was to document they had checked to</p>	<p><del>F280</del> F280</p>	<p>Comprehensive care plans are developed in a timely manner and in compliance with the requirements and developed to meet the identified needs of the residents with modifications as dictated by the resident's changing needs:</p> <ol style="list-style-type: none"> <li>1. Resident #13 no longer resides at the facility. Resident #14's comprehensive care plan was revised 7/25/2011, 8/30/2011 and 9/12/2011, 9/14/2011, 9/19/2011 by D.O.N, staff nurses and M.D.S. for falls and it meets the resident's currently identified needs with measurable goals and specific interventions.</li> <li>2. An audit of care plans for the other residents of the facility was completed by D.O.N on 8/25/2011 and 8/26/2011 as documented on the care plan audit tool. Care plans were revised as appropriate as a result of this audit.</li> <li>3. CNA's and Nurses were provided additional in-servicing on 8/4/11 including the fall policy, prevention strategies and interventions by the D.O.N. and A.D.O.N. and/or Nurse Consultants. Additional in- servicing of nurses was provided on revising care plans at in-services held 8/22-8/24/11 by Theresa Martinez, Nurse Consultant.</li> </ol>	<p>9/20/11</p>	

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F 280	<p>Continued From page 36</p> <p>ensure alarms were in place. Further review of the TAR revealed there was no documentation on 07/18/11 by the nurses on day/evening/night to indicate alarm placement had been checked and by the day shift nurse on 07/19/11.</p> <p>Interview, on 07/28/11 at 11:50 AM and 2:50 PM, with Certified Nursing Assistant (CNA) #10 revealed she has provided care to the resident and the aides were responsible for checking to make sure residents' fall prevention alarms were in place. She further revealed Resident #14 would sometimes remove his/her alarms and get up by himself/herself. However, she had not informed the nurses the resident could take off the alarms. Interview, on 07/28/11 at 12:10 PM and at 3:15 PM, with CNA #17 revealed the resident would take off his/her alarms at times and she had observed Resident #14 up ambulating by himself/herself. However, she could not remember if she had notified the nurse regarding the resident's ability to take off the alarm. While the facility staff was knowledgeable of the resident's noncompliance history with the alarms, there was no evidence that the facility had revised the care plan to implement new interventions to prevent falls.</p> <p>Review of the facility's 07/19/11 Incident Report (incident time 1:00 PM) revealed Resident#14 fell in the bathroom and was found sitting up on the floor with her/his walker against the wall. Record review revealed the resident was later transferred to the hospital for evaluation of mental status change and pain to his/her left wrist and leg. Interview on 07/27/11 at 3:30 PM with Registered Nurse (RN) #6, revealed she entered Resident #14's room to administer medication and found</p>	F 280	<p>D.O.N. or designee will audit four (4) care plans each week for the next 4 weeks to check for completion with findings reported to QA committee.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The results of the auditing will be provided to the QA Committee for further review and recommendations.</p> <p>The facility administration's role in the monitoring is to track that the care plans are being developed and any identified corrective action is implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendation. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>		

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F 280	<p>Continued From page 37</p> <p>the resident on the bathroom floor with a cut above her/his left eye. RN #6 stated she did not hear an alarm sounding and could not remember if the resident had an alarm device on when she had found the resident: Interview, on 07/28/11 at 9:50 AM, with Certified Nursing Assistant (CNA) #6 revealed she had taken the resident to the toilet that morning before the fall and helped RN #6 with the resident after the fall. She stated she did not think the resident had alarms in place at that time or when she provided care earlier that day. Record review revealed the facility readmitted Resident #14 on 07/25/11 and the Physician's Order Form (same date) had diagnoses which included Hip Pinning Fracture Left Hip, Left Radius and Ulna Fracture, and Sutures above the left eyebrow as a result of the fall.</p> <p>There was no documented evidence the facility identified that either the alarm was not functioning, not in place or the resident may have removed the alarm. Review of the care plan after the incident revealed there was no documented evidence the facility had developed or implemented new interventions to prevent fall recurrence.</p> <p>Furthermore, interview with Nurse Consultant #1 on 07/27/11 at 5:30 PM, revealed the nurses could not access the care plans to refer to them or to revise them.</p> <p>2. (Refer to F323) Record review revealed the facility admitted Resident #13 on 06/03/11, with diagnoses which included unspecified Hypertension, Breast Cancer, and Coronary Artery Disease. Review of the care plan, dated</p>	F 280		
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F 280	<p>Continued From page 38</p> <p>06/08/11, revealed the resident was care planned for being at risk for falls due to fall history, incontinence, needing assistant with activities of daily living, and taking psychotropic medications. The fall care plan interventions included chair and bed fall prevention alarms, ambulate with 1-2 person assistance, encourage resident to ask for assistance, keep room free of clutter, and monitor side effects of medication. Review of the Minimum Data Set (MDS) Assessment, dated 06/10/11, revealed the resident had a fall prior to admission and was assessed as being cognitively impaired. Review of the Care Area Assessment Summary, dated 06/10/11, identified falls as a care area trigger. Review, of the 07/13/11, Incident Report (Incident time 10:00 AM) revealed Resident #13 fell trying to get to the bathroom. Further documentation noted the resident was not injured and did not have an alarm. There was no evidence the facility updated the resident's care plan with information/interventions after the fall on 07/13/11.</p> <p>Review, of the 07/16/11 Incident Report (Incident time 7:30 PM), revealed Resident #13 was found on the floor on 07/16/11 at 7:30 PM in front of his/her wheelchair. The report documented the resident stated when attempting to get clothing from the bottom drawer, his/her wheelchair rolled backward and he/she fell. The document noted there was no injury and the corrective measures listed included the resident was instructed to call for help if items were out of reach. There was no evidence the facility updated the resident's care plan with information/interventions after the fall on 07/16/11.</p> <p>Review of the 07/17/11 Incident Report (incident</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>		
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F 280	<p>Continued From page 39</p> <p>time 10:45 PM) revealed Resident #13 was found sitting on the floor beside his/her bed and reported he/she said they needed to use the restroom and when attempting to ambulate tried to lean onto his/her wheelchair, but the wheels were not locked and it rolled away causing a loss of balance. The document noted there was no injury and the corrective measures listed included instructing the resident to call when ambulation was needed and the morning shift may wish to call the physician to order a bed alarm. There was no evidence the facility updated the resident's care plan with information/interventions after the fall on 07/17/11.</p> <p>Review, of the 07/25/11 Incident Report (Incident time 7:30 PM), revealed Resident #13 stated he/she was going to the recliner from the wheelchair and lost his/her balance. The nurse noted that an alarm had been ordered. There was no documentation of injury. There was no evidence the facility updated the resident's care plan with information/interventions after the fall on 07/25/11.</p> <p>Interview, on 08/05/11 at 11:40 AM, with Licensed Practical Nurse (LPN#3), who completed the incident reports for Resident #13's falls on 07/16/11 and 07/17/11, revealed she had not been trained on the Facility's Falls Policy and what was expected after a resident's fall.</p> <p>Interview, on 08/03/11 at 5:05 PM with RN #3 (Nurse Consultant #1), revealed at this time she was one of the persons responsible for ensuring preventive interventions listed on incident reports were put in place. Further interview with RN #3 revealed, at this time, the care plans were not</p>	F 280		

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F 280 F 281 SS=F	<p>Continued From page 40 being updated, by staff, with interventions. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies it was determined the facility failed to ensure services provided by the facility met professional standards of quality for eight (8) of eighteen (18) sampled residents (#1, #2, #3, #6, #7, #8, #10 and #11) and fifteen (15) unsampled residents (B, F, H, I, J, K, L, M, N, O, P, Q, R, S, and T).</p> <p>The facility failed to ensure staff was trained and educated on the facility policy to complete an Admission Assessment which included Bowel and Bladder assessment, Braden Skin assessment, Fall assessment, and Elopement assessment. The facility admitted twenty-two (22) residents from another facility on 07/01/11. Record review revealed the facility failed to have a system in place to ensure Physician's Orders, including medications and ancillary services, were to be continued upon transfer to the facility resulting in discrepancies in medication orders occurring upon admission, which the facility failed to identify, resulting in residents failing to receive the care and services as ordered. The facility failed to administer medication at the proper dose for Resident #7 and #11. In addition, the facility failed to ensure ancillary orders related to obtaining laboratory tests, range of motion and</p>	<del>F2800</del> F 281	<p>Services are provided to meet the professional standards of care. The facility employs licensed nurses with experience and skills to provide services to the residents in addition to other qualified interdisciplinary team members.</p> <ol style="list-style-type: none"> <li>Residents are receiving services as ordered by the physician including medications, treatment orders, laboratory orders and ancillary orders. Resident # 1, 2, 6, 7, 8, 10, 11, B, F, H, I, J, K, L, M, N, O, P, Q, R, S, and T's admission assessments for Bowel and Bladder, Braden Scale, Fall and Elopement were completed by D.O.N., A.D.O. N, MDS Nurse and /or Nurse consultants by 9/14/2011.</li> </ol> <p>Resident #7 is receiving their medication in the proper dose as ordered and ancillary orders are being followed.</p> <p>Resident #11 insulin, weekly weights and lab testing are being provided as ordered by their physician.</p> <p>Resident #10 chair alarm is in place as ordered.</p> <p>Resident #3 is no longer at the facility.</p>	9/20/11
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F 281	<p>Continued From page 41</p> <p>restorative nursing, positioning and pressure sore prevention devices, and safety precautions were continued for the twenty-two (22) residents, as ordered, on admission by the facility.</p> <p>The facility failed to ensure Physician's orders were followed for Resident #11 related to the administration of Insulin, completing laboratory testing, and weekly weights and Resident #10 related to a chair alarm. Also, the facility failed to ensure medication was administered timely for Resident #3 who had medication orders to be given in the AM that were not administered until 1:50 PM.</p> <p>Interviews revealed Certified Nursing Assistants (CNAs) and record review revealed the facility failed to ensure reference guides for direct care were provided to alert staff of specific needs for individual residents' care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Nursing Department" (no date), "licensed nursing staff will complete the Admission Nursing Assessment within 24-48 hours of admission into the facility".</p> <p>Review of the undated facility's policy "Risk Assessments in the EMR (Electronic Medical Record)", resident assessments to be completed on admission include: Bowel and Bladder assessment, Braden Skin assessment, Fall assessment, and Elopement assessment.</p> <p>Review of the facility's policy title "Wound/Pressure Sore Policy/Procedure", revised on 12/22/09, revealed every resident was to have a full skin assessment, including measurements if indicated, documented every</p>	F 281	<p>2. All physician and ancillary orders have been clarified for lab tests, range of motion, restorative nursing, positioning, pressure sore prevention devices and safety precautions for residents of the facility by D.O.N. /A.D.O.N. and/or Nurse Consultants as of 9/14/11 as documented on the audit tool. This process occurred with several nurses and included review and clarification of the current physician orders for each resident. Orders were reviewed and compared with care plans, resident information direct care guides, medication administration records, treatment administration records, laboratory records, orders and sources of documentation for order implementation.</p> <p>3. The facility has a revised system in place to assure that physician' orders and ancillary orders continue at admission from any location including a transfer from another facility. Physician orders for medication and ancillary items for the residents listed were audited on 08/5-8/7/11 by a MedCare Pharmacy consultant and changes were made with physician authorization. As stated above in number 2, all physician and ancillary orders for the remainder of the residents have been clarified for lab tests, range of motion, restorative nursing, positioning, pressure sore prevention devices and safety precautions by D.O.N./ A.D.O.N., and /or Nurse Consultants.</p>	
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F 281	<p>Continued From page 42</p> <p>week. Review of the facility's policy "Weight Book Guidelines" revealed height and weight must be obtained within twenty-four (24) hours of admission.</p> <p>1. Review of Resident #10's medical record revealed the facility admitted the resident on 07/01/11 from another facility with diagnoses which included Dementia, Diabetes Mellitus, Urinary Incontinence, Recurrent Urinary Tract Infections, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed an order to transfer to the receiving facility with all current orders. Review of the Physician's Order Form for the month of July 2011 revealed medication orders were carried over from the previous facility; however the Ancillary Orders were not carried over.</p> <p>Review of the Ancillary Orders which were not carried over included; chair pad alarm when up, bed pad alarm when in bed, restorative ambulation days and evenings with a gait belt, Active Range of Motion (AROM) to upper and lower extremities each day and alternate upper extremities and lower extremities for fifteen (15) minutes for ten repetitions. (Refer to F-311, and F-323).</p> <p>There was no documented evidence the Physician's Orders were verified for this resident on admission on 07/01/11. As a result of the Ancillary Orders not being followed, Resident #10 did not receive ROM or ambulation, and had a decline in physical functioning. (Refer to F-311).</p>	F 281	<p>New revised <del>Direct Care Guides</del> to communicate care needed for a resident to the CNAs were completed and implemented by D.O.N./A.D.O.N. and/or Nurse Consultants on 08/10/11 and will be updated as needed.</p> <p>Audit has been completed on all residents for compliance of lab draws, medication orders, ancillary orders, restorative orders on 8/5/11, 8/6/11, 9/2/11, 9/6/11 and 9/14/11. Changes were made if needed and doctor was notified.</p> <p>Nurses were provided additional in-servicing 8/4/11 and 8/18/11 on fall policies, admission process to complete the assessment, direct care guides, following physician orders, doctor order processing, insulin orders, restorative program, medication pass, skin policy, skin assessment and weekly measurements, and lab process by D.O.N. and A.D.O.N. and/or Nurse Consultants. CNA's were provided additional in-servicing on 8/16/11 on Direct Care Guides by D.O.N, A.D.O.N. and/or Nurse Consultants.</p> <p>D.O.N and A.D.O.N. and/or Nurse Consultants are auditing new admissions each week for the next 4 weeks to check for completion of assessments.</p> <p>Additionally, medication pass audits are being performed once a week for one medication pass each week to assure medications are being delivered timely and as ordered. Documented audit findings will be reported to QA committee for additional review and recommendations.</p>		

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F 281	<p>Continued From page 43</p> <p>Further review of the Physician's Orders dated 07/25/11 revealed an order for dyson under the chair alarm and under the seat cushion and bed alarm.</p> <p>Observation of the resident on 07/26/11 at 4:00 PM revealed the resident was in a wheelchair with dyson in her/his room, and there was no chair alarm on the wheelchair.</p> <p>Interview, on 07/26/11 at 4:45 PM, with Certified Nursing Assistant (CNA)#21 revealed she was assigned to the resident and the resident did not have a chair alarm in place. When asked how she knew what safety devices to use for the resident, she stated the aides had no guide to refer to in providing care for the residents and they would ask the nurse if there was a question.</p> <p>Interview, on 07/26/11 at 6:00 PM, with Licensed Practical Nurse (LPN) #6 revealed the nurses verbally gave the CNA's report on any new concerns with the residents; however, there was no written guide for the CNA's to refer to when providing care such as a nurse aide care plan. She further stated she was unaware of the Physician's Order for the chair alarm.</p> <p>Further Interview, on 07/28/11 at 2:20 PM, with Nurse Consultant #1 revealed the Physician's Orders should have been followed related to the chair alarm.</p> <p>In addition, there was no documented evidence of a Nursing Admission Assessment, an Interim Care Plan, or a skin assessment was completed</p>	F 281	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented.</p> <p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>		

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F 281	<p>Continued From page 44 upon admission.</p> <p>Also, there was no documented evidence of vital signs, or a weight obtained on the date of admission. As a result of weights not being obtained and monitored the resident sustained a significant weight loss of 5% from 06/09/11 through 07/15/11. (Refer to F-325).</p> <p>Continued record review, including the Electronic Medical Record (EMR), revealed no evidence any risk assessments were completed upon admission or afterward including Pressure Risk Assessments, Elopement Risk Assessments, and Bowel and Bladder Assessments.</p> <p>Also, there was no evidence a Falls Risk Assessment was completed until 07/22/11. Review of the Assessment revealed the resident scored a twenty-four (24), and a score over nine (9) would place the resident at risk for falls.</p> <p>2. Record review revealed the facility admitted Resident #11 on 07/01/11 with diagnoses which included Diabetes Mellitus, Cerebral Vascular Accident with hemiplegia, and a Gastric Feeding Tube.</p> <p>Review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed an order to transfer to the receiving facility with all current orders. Review of the Physician's Order Form for the month of July 2011 revealed medication orders were carried over from the previous facility; however there was a discrepancy in medication orders for Insulin and all ancillary orders were not carried over.</p> <p>Review of the Physician's Order Sheet from the</p>	F 281		
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F 281	<p>Continued From page 45</p> <p>transferring facility, dated 06/30/11, revealed orders for Novolog Insulin 100 Units/ML (milliliter), inject five (5) Units subcutaneously (SQ) at 6:00 AM, 12:00 PM, and 6:00 PM and Lantus Insulin 100 Units/ML, inject thirty-two (32) Units at 10:00 PM. However, review of the Physician's Order Form for the month of July 2011 revealed orders for Novolog Insulin 100 Units/ML, inject nine (9) Units at 6:00 AM, 12:00 PM, and 6:00 PM and Lantus Insulin 100 Units/ML, inject thirty-seven (37) Units at 9:00 PM.</p> <p>Review of the Ancillary Orders, dated 06/30/11, which were not carried over from the Physician's Orders Sheet from the transferring facility to the facility's Physician's Order Form for the month of July 2011 included; mechanical soft diet, half portions, Consistent Carbohydrate Mechanical Soft Diet, thin liquids, half portions diet and Tube Feeding orders for IsoSource 1.5 seventy (70) milliliters per hour for twelve (12) hours. (Refer to F-325)</p> <p>Further review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed orders to draw a Prothrombin Time (PT) and International Normalized Ratio (INR) on 07/14/11 which was not carried over to the facility's Physician's Order Form for the month of July 2011. Review of the resident's laboratory data revealed there was no documented evidence of a PT/INR obtained on 07/14/11.</p> <p>In addition, there was no documented evidence the Physician's Orders were verified for this resident on admission on 07/01/11.</p> <p>Interview, on 08/04/11 at 1:00 PM, with Resident</p>	F 281		

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F 281	<p>Continued From page 46</p> <p>#10's attending Physician and Resident #11's attending Physician's Associate, revealed the facility should have carried over the previous facility's Physician's Orders and he and the resident's Attending Physician assumed this was done. He further stated the PT/INR ordered to be obtained on 07/14/11 should have been drawn and it was a real concern when labs were not obtained as ordered, especially PT/INR. Also, he stated he had concerns related to the incorrect Insulin doses being administered and the Insulin orders from the previous facility should have been carried over to this facility's Physician's Orders for July 2011. He also stated any diet orders and tube feeding orders from the previous facility should have been on the July 2011 Physician's Orders for this facility.</p> <p>Interview, on 08/03/11 at 11:15 AM, with the Pharmacist, revealed the medication orders for the previous facility dated 06/30/11 and the July 2011 Physician's Orders for this facility should have been the same. He was unaware of why there was discrepancies in the Physician's Order Forms because the same pharmacy was contracted by both facilities. Continued interview revealed the previous facility may not have faxed all Physician's Orders to the pharmacy, which could account for the discrepancies. Continued interview revealed the Ancillary Orders were not on the Physician's Order Form for July 2011 because the previous facility printed their own monthly Physician's Order Form and Pharmacy did not have the Ancillary Orders in the system.</p> <p>Also, review of the Physician's Orders dated 07/11 revealed orders for Lantus Insulin 100 Units/ML (milliliter), Inject thirty-seven (37) Units</p>	F 281		

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F 281	<p>Continued From page 47</p> <p>subcutaneously (SQ) at 9:00 PM. However, review of the Medication Administration Record (MAR) dated 07/11 revealed the medication had not been documented as administered 07/01/11 through 07/15/11 at 9:00 PM.</p> <p>Review of the Physician's Orders dated 07/16/11 revealed orders to increase the Lantus insulin to forty-one (41) Units at 9:00 PM. Further review of the MAR revealed the Lantus Insulin 37 Units at 9:00 PM was discontinued and the new order for Lantus Insulin 41 Units every day at night was handwritten in with an arrow pointing to 07/16/11 as the start date.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 08/04/11 at 6:00 PM, revealed she transcribed the order on 07/16/11 for the Lantus 41 Units and discontinued the Lantus 37 Units on the MAR. Continued interview revealed she realized the MAR had not been signed off as the Lantus Insulin being administered at 9:00 PM for 07/01/11 through 07/15/11; however, she did not remember calling the Physician to notify him of the orders not being followed or questioning the nursing staff about the lack of documentation.</p> <p>Interview, on 08/05/11 at 3:30 PM, with the Attending Physician, revealed he should have been notified that the Lantus Insulin 37 Units was not administered 07/01/11 through 07/15/11 as ordered. He further stated it was a significant medication error to fail to administer the Insulin as ordered.</p> <p>Interview with LPN #5 on 08/05/11 at 2:00 PM, who was assigned to administer medication to Resident #11 on 07/01/11, 07/05/11, 07/09/11,</p>	F 281			

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F 281	<p>Continued From page 48</p> <p>07/10/11, and 07/14/11 revealed she did not remember administering Lantus 37 Units to Resident #11 at 9:00 PM. She further stated she signed the MAR to indicate it had been administered on the MAR, and if it was not signed out, it would not have been administered. Continued interview revealed it would be a significant medication error to not administer Insulin as ordered, because the resident could have an adverse effect.</p> <p>Interview, on 08/05/11 at 3:35 PM, with LPN #6 who was assigned to administer medication to Resident #11 on 07/06/11, 07/07/11, 07/08/11, 07/11/11, 07/12/11, 07/13/11, and 07/15/11, revealed she was administering Resident #11's 9:00 PM scheduled Lantus Insulin; however, was not signing it out because the other nurses were not signing it. Continued interview revealed she was new and had to question the other nurses on a lot of issues; however, had not questioned the nurses related to their reason for not signing out the medication.</p> <p>Further review revealed there was no documented evidence a Nursing Admission Assessment, an Interim Care Plan, or a skin assessment was completed on admission. Also, there was no documented evidence of vital signs, or a weight obtained on the date of admission.</p> <p>Review of the Physician's Orders dated 07/14/11 revealed orders for weekly weights.</p> <p>Review of the Dietary Weight Report revealed the first weight obtained at the facility was on 07/15/11 and the resident's weight was two hundred and five (205) pounds. The second</p>	F 281		

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F 281	<p>Continued From page 49</p> <p>weight was obtained on 07/28/11 and the resident's weight was two hundred and six (206) pounds. There was no evidence of an admission weight as per policy or weekly weights obtained as per Physician's Orders. See (F-325).</p> <p>Continued record review, including the Electronic Medical Record (EMR) revealed no evidence any risk assessments were completed on admission or afterward including Pressure Risk Assessments, Elopement Risk Assessments, and Bowel and Bladder Assessments.</p> <p>Further review, revealed the Fall Risk Assessment was not completed until 07/22/11. Review of the Fall Risk Assessment dated 07/22/11 revealed the resident was assigned a score of twenty-four (24), indicating a high risk for falls. According to assessment details, a score greater than nine (9) was considered high risk.</p> <p>Continued review revealed no documented evidence a skin assessment was completed until 07/08/11.</p> <p>3. Review of Resident #8's medical record revealed the facility admitted the resident on 07/01/11 with diagnoses which included Anxiety, Depression, and Diabetes Mellitus.</p> <p>Further review revealed there was no documented evidence a Nursing Admission Assessment or a skin assessment was completed on admission. Also, there was no documented evidence of vital signs, or a weight obtained on the date of admission</p> <p>Continued record review, including the Electronic</p>	F 281			

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F 281	<p>Continued From page 50</p> <p>Medical Record (EMR), revealed no evidence any risk assessments were completed on admission or afterward including Pressure Risk Assessments, Elopement Risk Assessments, and Bowel and Bladder Assessments.</p> <p>Review of the Falls Risk Assessment, revealed a completion date of 07/22/11 with a score of twenty-two (22) which placed the resident at high risk for falls.</p> <p>4. Observation revealed Registered Nurse (RN) #6, on 08/03/11 at 1:45 PM, was administering medications on the C Hall and had left the medicine cart. When the nurse came back to the medication cart, the surveyor asked if arrangements could be made for later in the day for the surveyor to observe a skin assessment on a few residents. The nurse stated she had one (1) more resident in which she needed to administer the 8:00 AM medications. She further stated she had been stopped for everything that morning and it was not unusual for her to be late with administration of medications.</p> <p>Further observation, on 08/03/11 at 1:50 PM, revealed RN #6 administered medications to Resident #3 which included Florastor two hundred and fifty (250) Milligrams (Mg's) (probiotic) which was due at 9:00 AM and was scheduled again at 9:00 PM, Fluorometholone 0.1% (one tenth percent) drops (steroid medication), one (1) drop in each eye which was scheduled at 9:00 AM for once a day, Hydrochlorothiazide twelve and a half (12.5) Mg's (anti-hypertensive medication ) which was scheduled for 8:00 AM for once a day, Mucinex ER six hundred (600) Mg's (expectorant to thin</p>	F 281		

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F 281	<p>Continued From page 51 and loosen secretions), two (2) tabs which was scheduled twice daily and was to be administered again at 5:00 PM per the Medication Administration Record (MAR), and Verapamil ER one hundred eighty (180) Mg's (anti-hypertensive medication) which was scheduled at 8:00 AM for once a day.</p> <p>Further interview with RN #6, on 08/03/11 at 4:00 PM, revealed she had been licensed as a nurse since 02/11 and had worked at the facility since 07/05/11. She stated on 08/02/11 and 08/03/11 she was "super late" with administration of the 8:00 AM medications because she was pulled here and there and she had twenty (20) residents on her medication pass. Continued interview revealed she usually completed administration of the 8:00 AM and 9:00 AM medications by 11:30 AM. She further stated she always gave her insulin on time, and if a resident was scheduled to receive the same medication at 8:00 AM and 2:00 PM, she would hold the 8:00 AM dose. Further interview revealed she knew the 8:00 AM medications were to be administered between 7:00 AM and 9:00 AM; however, the night shift nurses were always late giving report and she could not start the morning med pass until 8:00 AM. She further stated they needed another nurse on the C hall because she was responsible for performing treatments, obtaining vital signs, and completing assessments and documentation on the residents and it took her all day to pass medications. Further interview revealed she had spoken with the previous Administrative Nurses about her concerns and nothing was done.</p> <p>Interview, on 08/04/11 at 5:00 PM, with the Interim Director of Nursing (DON), and Nurse</p>	F 281		
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F 281	<p>Continued From page 52</p> <p>Consultant #1 and #2, revealed it was the facility's policy as well as a professional standard to ensure medications were administered one (1) hour before or one (1) hour after the scheduled time. Further interview revealed they were unaware there was a concern with medications administered late and they would adjust the medication times for the "Resident Centered Program".</p> <p>5. Review of the Clinical Record revealed the facility admitted Resident #1 from another facility on 07/01/11 with diagnoses which included Alzheimer's Disease, Anxiety and Depression. In addition, the resident was status post Cardiovascular Accident (Stroke) and was dependent for all care.</p> <p>Review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed an order for Resident #1 to transfer to the receiving facility with all current orders. Review of the Physician's Order form for the month of July 2011 revealed medication orders were carried over from the previous facility, but all ancillary orders were not. For instance, orders from the prior facility related to range of motion (ROM), pressure prevention devices and level of assistance required were not carried over at the new facility.</p> <p>Continued record review, including the Electronic Medical Record (EMR) revealed no documented evidence any risk assessments were completed on admission, including the Bowel and Bladder and Elopement Risk assessments.</p> <p>Further review of the Clinical Record revealed no</p>	F 281		
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F 281	<p>Continued From page 53</p> <p>documented evidence a formal skin assessment was completed prior to surveyor intervention on 07/27/11. (Refer to F 314)</p> <p>Review of the Fall Risk Assessment revealed the first assessment was completed on 07/23/11. Continued review revealed the resident was identified to be high risk for falls.</p> <p>Review of the "Resident's Weights" flow sheet revealed Resident #1 was not weighed on admission. The first documented weight was 07/15/11.</p> <p>6. Clinical Record review revealed the facility admitted Resident #2 from another facility, on 07/01/11, with diagnoses which included Alzheimer's Disease, Bradycardia, Hypertension and Dementia with Delusions.</p> <p>Review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed an order for Resident #2 to transfer to the receiving facility with all current orders. Review of the Physician's Order form for the month of July 2011 revealed medication orders were carried over from the previous facility, but all ancillary orders were not. For instance, no orders related to diet, positioning and pressure sore prevention devices, or range of motion were continued, as ordered, after admission to the facility.</p> <p>Review of the Medical Record, including the EMR, revealed no Admission Assessment was completed. Continued review revealed no documented evidence a Bowel and Bladder Assessment, Fall Risk Assessment, Elopement Assessment or Braden Skin Assessment were</p>	F 281		

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F 281	<p>Continued From page 54 completed on admission per facility policy.</p> <p>Review of the Resident's Weights flow sheet for the month of July 2011 revealed the first recorded weight for Resident #2 was on 07/15/11, two (2) weeks after admission to the facility.</p> <p>7. Review of the Clinical Record revealed Resident #6 was admitted by the facility on 07/01/11 with diagnoses which include Alzheimer's Dementia, Hypertension and Lumbar Disc Disease with Chronic Back Pain.</p> <p>Review of the Physician's Order Sheet from the transferring facility, dated 06/30/11, revealed Resident #6 was to transfer to the receiving facility with all current orders. Review of the Physician's Order form for the month of July 2011 revealed medication orders were carried over from the previous facility. However, all ancillary orders, including those related to diet, range of motion, and pressure sore prevention devices were not resumed upon admission to the facility.</p> <p>Review of the full Clinical Record, including the EMR, revealed no Admission Bowel and Bladder, Elopement Risk, Fall Risk, or Braden Skin Assessments were completed upon admission to the facility.</p> <p>Review of the Fall Risk Assessment revealed it was not completed until 07/22/11, three (3) weeks after admission to the facility. Review of the Skin condition/Wound Progression notes revealed the first full skin assessment was not completed until 07/22/11. Continued review revealed Resident #6 had a Stage II ulcer on the buttock. (Refer to F314).</p>	F 281		

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F 281	<p>Continued From page 55</p> <p>Review of the Resident's Weights flow sheet revealed the first documented weight was recorded on 07/15/11.</p> <p>8. Review of the facility's policy titled "Restraints/Pre-Restraining Assessment Tool" (not dated) revealed restraints were only to be used after assessment and explanation of risks vs. benefits for the device. In addition, the use of a restraining device required written consent of the resident or authorized representative.</p> <p>Clinical Record review revealed the facility admitted Resident #7 from another facility on 07/01/11 with diagnoses which included Hypertension; Osteoporosis and Osteoarthritis. In addition, the resident had two (2) pressure ulcers and an open surgical wound present on admission. Continued review revealed a diagnosis of chronic Methicillin-Resistant Staphylococcus Aureus (MRSA) at the surgical site.</p> <p>Review of the Physician's Order Sheet dated 06/30/11, from the previous facility, revealed Resident #6 was to transfer to the receiving facility with all current orders. Review of the Physician's Order form for the month of July 2011 revealed medication orders were carried over from the previous facility. However, medication orders for Baclofen (for pain) 10 milligrams (mg) twice daily and every six (6) hours as needed; to be given between scheduled doses, Ferrous Sulfate (Iron) 325 mg twice daily, Calcium 500 mg with Vitamin D 125 International units (IU) twice daily, and Nadolol (for high blood pressure) 5 mg once daily were not continued at the correct dose</p>	F 281		
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F 281	<p>Continued From page 56 after admitted by the facility. The medications were transcribed incorrectly and administered as follows: Baclofen 10 mg every six hours as needed (no regular scheduled doses); Ferrous Sulfate 325 mg once daily (twice daily was ordered); Calcium 500 mg and Vitamin D 200 IU once daily; and Nadolol 10 mg once daily.</p> <p>Continued review revealed ancillary orders, including orders related to active and passive range of motion, positioning and pressure relief devices, level of assistance and method of transfer were not carried over as ordered.</p> <p>Continued review of the Clinical Record, including the EMR, revealed no documented evidence an Admission Assessment, or assessments related to Bowel and Bladder, Falls Risk, Elopement Risk or Braden Skin had been completed on admission, per policy.</p> <p>Review of the Skin Condition Report dated 07/22/11 revealed no skin assessment or wound evaluation had been documented until three (3) weeks after admission, in spite of Resident #7's known pressure ulcers and history of MRSA at the surgical site. (Refer to F 314).</p> <p>Review of the Falls Risk Assessment revealed it was not completed until 07/22/11. Continued review revealed the Resident #7 scored twenty-six (26). Further review revealed, "a resident whose score is over nine (9) is at risk for falls.</p> <p>Review of the Resident's Weights flow sheet revealed Resident #7 was first weighed on 07/15/11, two (2) weeks after admitted by the</p>	F 281		

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F 281	<p>Continued From page 57 facility.</p> <p>Observations of Resident #6 revealed a torso positioning device was tied behind the wheelchair in a manner that prevented the resident from removing it, and was, therefore a restraint. Review of the Clinical Record revealed no documented evidence a restraint assessment was completed. Continued review revealed no evidence risks vs. benefits were explained; nor was a signed consent present, per facility policy. (Refer to F 222).</p> <p>Record reviews and interviews revealed Unsamped Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T were admitted by the facility on 07/01/11. There was no documented evidence any resident received the Admission Assessment per policy. In addition, the Unsamped Residents were not assessed for Falls Risk, Elopement Risk, or Bowel and Bladder function per policy. Also, no Braden Skin assessments were conducted on admission. Review of the Resident's Weights flow sheet for the month of July revealed the first recorded weight for all of the Unsamped residents was on 07/15/11 or later.</p> <p>Interview with LPN #8, on 08/02/11 at 5:00 PM, revealed she was working on 07/01/11 when twenty-two (22) residents were admitted by the facility. In addition, all residents from the old facility building were transferred to the facility on 07/01/11, with the exception of the private pay residents (exact number unknown), who were transferred on 06/30/11. Four (4) residents were placed on the A Hall and eighteen (18) were admitted to the C Hall. She stated she was one</p>	F 281			

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F 281	Continued From page 58 (1) of three (3) nurse performing admissions. She reported she helped settle the residents as they arrived, took vital signs and completed skin assessments. Continued interview revealed she did not enter the information into the computer, but kept notes on paper. She stated she gave her notes to the Assistant Director of Nursing (ADON) and the Minimum Data Set (MDS) nurse, neither of whom remain employed at the facility. She acknowledged she did not complete the Admission Assessment or other risk assessments as per the facility's policy. Nor did she obtain weights on the newly admitted residents. Further interview revealed she did not verify admitting physician orders. She stated she "was overwhelmed" and concentrated her time ensuring residents were fed and comfortable in their rooms. She further stated she was the only nurse working on the A Hall on 07/01/11, with responsibilities for their treatments and medications. When questioned further, she revealed she was pulled to the C Hall to admit five (5) or six (6) residents. LPN #8 outlined the nurse's responsibilities on admission to included the following: complete admission nursing assessment; obtain vital signs and weights; initiate the Interim Care Plan; perform risk assessments; complete head to toe skin assessment; verify immunization records and code status; and verify physician orders. She stated she had no direction from the Director of Nursing (DON) or ADON and reported the multiple admissions did not occur smoothly. On continued interview, the nurse revealed CNAs went room to room, trying to keep the resident clean, dry and turned and repositioned. She stated the CNAs had no care references regarding safety devices or other special	F 281			

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F 281	<p>Continued From page 59</p> <p>instructions for individualized care of the residents.</p> <p>Interview with LPN #4, on 08/03/11 at 4:30 PM, revealed she worked the day shift at the old facility building on 07/01/11 when eighteen (18) residents were moved to the new building on the same campus. She stated eight (8) private pay residents had been moved on 06/30/11. Continued interview revealed LPN #4 went to the new facility after all residents were transferred from the old building. She stated twenty-two (22) new residents were admitted by the facility on 07/01/11 as well. She further stated she went to the new building on the second shift, after all residents had been moved from the old building. Continued interview revealed she was not sure what duties, related to the admission process, had been completed. She also stated she did not verify any physician orders for the twenty-two (22) newly admitted residents and did not know if it had been done.</p> <p>Interview with the DON at the facility the residents were admitted from, on 08/04/11 at 2:05 PM, revealed she had been very involved with the planning and implementation of the scheduled transfer of twenty-two (22) residents to the new facility. She stated her Social Services staff was in contact with the DON at the receiving facility at least two (2) weeks prior to the move. She further stated she had assembled records for each resident which included, but was not limited to, the face sheet, physician's orders, information regarding wounds or pressure sores, and code status. Continued interview revealed she accompanied the residents to the new facility on 07/01/11. She stated her impression, on arrival at</p>	F 281			

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F 281	<p>Continued From page 60</p> <p>the facility was one of disorganization and "not enough help". She further stated no one greeted the new residents on arrival, rooms had not been assigned, and no staff was available to tell them where to go.</p> <p>Interview with the facility's previous DON, on 08/04/11 at 10:00 AM, revealed she was the DON at the facility up through 07/14/11. She further stated she felt the transition to the new facility building on 07/01/11 went smooth with the admission of twenty-two (22) residents from another facility and the transfer of the facility's residents from the old building to the new building. However, further interview revealed she was unaware the facility failed to complete Nursing Admission Assessments, and failed to call the Physicians to verify the Admission Physician's Orders on the twenty-two (22) newly admitted residents on 07/01/11. She stated the previous facility's Physician's Orders dated 06/30/11 were to be carried over to the 07/01/11 facility Admission Physician's Orders. She further stated she had resident rooms set up and the pertinent information in the residents' records from the previous facility including the Face Sheet, Diagnosis and Physician's Orders for the admission nurses to reference. Further interview revealed she was unaware vital signs, skin assessments, Interim Care Plans and Risk Assessments were not completed on the newly admitted residents. She stated weights did not need to be obtained because they were obtained in 06/11 by the previous facility.</p> <p>Continued interview revealed when asked how the staff knew what care was to be provided to the residents, she stated the Admitting Nurse</p>	F 281			

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F 281	<p>Continued From page 61</p> <p>should have referred to the Ancillary Physician's Orders from the previous facility and she knew the new residents did not require safety devices because she had been in touch with staff at the previous facility. Continued interview revealed she did not have extra staff come in to help with the transition on 07/01/11 because the staff had forty-eight (48) hours to admit residents and all shifts were to assist with the admission process. She stated, as the DON, she "assumed everything was being done per protocol".</p> <p>Interview, on 07/27/11 at 5:30 PM and 08/04/11 at 4:30 PM, with Nurse Consultant #1 revealed she started at the facility on 07/18/11 and was serving in an administrative role due to the absence of a DON at the facility since 07/14/11. She stated she was aware the Admission Assessment, skin assessments, Risk Assessments, and weights were not completed on admission for the twenty-two (22) residents admitted on 07/01/11. She further stated "we know pretty much everything related to the admission process was not done". Further interview revealed she had recognized right away, the Ancillary Physician's Orders had not been carried over from the previous facility's Physician's Orders dated 06/30/11, to the facility's July 2011 Admission Physician's Orders, and staff were in the process of reviewing Physician's Orders for discrepancies in comparing both sets of Orders. She further stated the aides had no resource to refer to in order to provide care to the residents and they were in the process of getting "Care Cards" completed for the aides.</p> <p>Interview, on 07/27/11 at 10:30 AM with CNA #8, who worked on Hall C where eighteen (18) of the</p>	F 281			

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F 281	<p>Continued From page 62</p> <p>newly admitted residents resided, revealed there was no guide for the CNA's to reference in order to provide care for the residents. She stated, "it would help if I had one". She further stated she felt uneasy because she was unsure of safety devices needed for the residents. Continued interview revealed the CNA's had asked the Administrative Nurse for a nurse aide care plan, and they were told the facility was working on it.</p> <p>Interview, on 08/02/11 at 11:15 AM, with CNA #22, who worked on Hall C, revealed the CNA's did not have care guides or any reference for the residents who were admitted on 07/01/11 from the previous facility in order to provide individualized care.</p> <p>Interview with the Vice President of Operations (and Interim Administrator), on 07/22/11 at 3:00 PM, revealed he knew there were serious problems at the facility. He stated the current corporate Administrative Team was working under the assumption no systems were in place, and was progressing system by system. Continued interview revealed he felt he had enough staff, but acknowledge many were newly hired and needed additional training.</p> <p>Subsequent interview with the Vice President of Operations, on 08/05/11 at 5:20 PM, revealed he had been at the facility since 06/26/11. He stated he originally came to assist with the transition from the old building to the new building. Continued interview revealed a large volume of complaints from family members soon after the</p>	F 281		

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F 281	Continued From page 63 transition let him know right away there were issues to be addressed. He stated he was aware no assessments had been completed on admission. He felt the former Administrative Team was not capable of making the transition to the larger facility and running it effectively.	F 281		
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the incident reports and review of the facility's policy, it was determined the facility failed to provide care in accordance with the resident's written comprehensive care plan for one (1) of eighteen (18) sampled residents (Resident #13). Resident #13 was assessed to be at risk for falls and care planned to have both chair and bed fall prevention alarms, but observation and interview revealed the facility failed to ensure the resident had such devices in place. Incident reports dated 07/13/11, 07/16/11, 07/17/11 and 07/25/11 reported resident falls.  The findings include:  Review of the facility's Falls policy (undated) revealed a Fall Assessment is supposed to be completed on admission to assess the resident for fall related factors. A plan of care will be developed addressing possible issues that may	F282 F 282	Residents are being provided care in accordance with the written individualized care plan.  1. Resident #13 no longer resides at the facility. 2. Residents with fall prevention devices have been assessed and care plans revised as necessary on 8/26/11 and 9/02/11 by D.O.N., A.D.O.N. and/or Nurse Consultants. 3. All nurses were provided an additional in-service on 8/4/11, on fall policy, prevention strategies and interventions by D.O.N., and/or Nurse Consultants. D.O.N., A.D.O.N. and/or Nurse Consultants will audit 5 residents with devices each week for the next 4 weeks to check that they are being used per doctor orders. Audits will also include reconciliation of the care plan to actual care being delivered with findings presented to the Quality Assurance Committee.	9/20/11

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F 282	<p>Continued From page 64</p> <p>be contributing to the risk for falls. Nursing staff may implement the use of bed/chair alarms. Precautions relating to the resident will also be placed on the nursing assistants care plan.</p> <p>Review of the facility's "Communication of resident care plans to direct care staff", dated 03/17/11 revealed that all direct care staff members will be informed regarding the individual residents plan of care. Procedures have been established to provide the information to staff members to maximize efforts in carrying out each plan of care effectively.</p> <p>1. Record review revealed the facility admitted Resident #13 on 06/03/11, with diagnoses which included unspecified Hypertension (HTN), Breast Cancer, and Coronary Artery Disease. The Minimum Data Set (MDS) dated 06/10/11, revealed the resident had a fall prior to admission, the Brief Interview for Mental Status (BIMS) Summary score identified the resident as being severely impaired, and the Activities of Daily Living (ADLS) section revealed the resident needed extensive assistance and one person physical assistance with transferring, toilet use and locomotion. The Care Area Assessment triggered for falls and the resident was care planned for falls due to history of falls, needing assistance with ADLS, and medications. The fall care plan included both chair and bed fall prevention alarms. Resident #13 was also care planned for forgetfulness.</p> <p>Review of the facility's incident reports revealed the following fall incidents for Resident #13:</p> <p>The 07/13/11 incident report documented the</p>	F 282	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented.</p> <p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	

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F 282	<p>Continued From page 65</p> <p>resident fell trying to get to the bathroom and the resident did not have an alarm. No injury was listed on the report.</p> <p>The 07/16/11 incident report documented the resident was found on the floor in front of his/her wheelchair and the resident reported when attempting to get clothing from the bottom drawer his/her chair rolled backward. No injury.</p> <p>The 07/17/11 incident report documented the resident was found sitting on the floor beside his/her bed. The resident stated he/she attempted to ambulate to the restroom and when trying to lean onto his/her wheelchair the wheels were not locked and the chair rolled away causing a loss of balance. No injury. The corrective measures documented included the nurse on the morning shift may wish to call the MD to order a bed alarm.</p> <p>The 07/25/11 incident report documented the resident stated he/she was going to the recliner from the wheelchair and lost his/her balance. The nurse documented on the report that an alarm had been ordered. There was no documentation of injury.</p> <p>Observations of Resident #13, on 07/28/11 at 8:50 AM, revealed the resident was in their wheelchair in the dining room with no fall alarm observed. On 07/28/11 at 10:40 AM, the resident was observed sitting in a straight stuffed chair in her/his room; however, there was no fall alarm attached to the resident. On 07/29/11 at 1:00 PM, the resident was observed in their room sitting in a straight stuffed chair and no fall alarm was present. Observation of the resident with CNA</p>	F 282		

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F 282	Continued From page 66 #17, on 07/28/11 at 10:40 AM, revealed the resident was seated in a straight.stuffed chair and the CNA verified no fall alarm was in place.  Interview, on 07/27/11 at 4:45 PM, with RN #8 about the resident's fall on 07/25/11 and if the resident was care planned for falls revealed RN #8 was not familiar with the care plan and after looking it up stated the care plan listed chair and bed alarms as an intervention for falls prevention. Further interview revealed the RN thought these interventions were in place but the resident takes them off. The RN sated she was told CNAs were responsible for checking if alarms are in place.  Interview, on 07/26/11 at 7:15 PM, with CNA #19, who had been working at the facillity for approximately three (3) weeks, revealed she had not looked at care plans to know the plan of care. She asked other CNAs about the residents. She stated she was not shown where the care plans were, but would like to look at the care plan.  Interview with RN #1, on 07/27/11 at 6:00 PM, about the 07/13/11 and 07/25/11 fall incidents for Resident #13, revealed the resident was very stubborn and tried to get up without help. She reported the resident did have a tag alarm at one time but would take the alarm off. Further interview revealed she did not know the resident was care planned for alarms. She stated she did not go by the care plan and was not famillar with what was on it, but uses the resident's Treatment Administration Record (TAR) for care Interventions which did not list the fall prevention alarms. RN #1 stated she did order an alarm after the fall on 07/25/11.	F 282			
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311			

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F 311 SS=G	<p>Continued From page 67 <b>IMPROVE/MAINTAIN ADLS</b></p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure an effective program was in place to provide maintenance and restorative programs that would not only maintain, but improve, the residents' abilities for three (3) of eighteen (18) sampled residents (Resident #10, #6, and #7) and ten (10) unsampled residents (Unsampled Resident T, J, K, L, M, N, O, P, Q, and R).</p> <p>Interview with the Administrator, the Interim Director of Nursing, and Nurse Consultant #1 and #2, revealed twenty-two (22) residents were admitted from another facility on 07/01/11. Continued interview revealed the systems which were in place prior to 07/01/11 had failed, including the restorative nursing program.</p> <p>Resident #10 was receiving restorative ambulation and was able to ambulate fifteen (15) feet to one hundred (100) feet, and was receiving Active Range of Motion (AROM) to the upper and lower extremities in 06/11 prior to admission to the facility on 07/01/11. However, there was no documented evidence the resident received restorative ambulation and range of motion (ROM) after admission to the facility on 07/01/11. Resident #10 sustained a decline in functional ability as evidenced by decreased ROM in the left</p>	F 311	<p>The facility provides appropriate treatment and services to assist residents to maintain or improve their abilities including through maintenance and restorative programs.</p> <p>1. Resident #10 was evaluated by Occupational therapy on 8/24/11 and Physical therapy on 8/04/11 and is now on a revised Restorative nursing program as of 9/10/11.</p> <p>Resident # 6 was re-evaluated by Restorative nursing on 9/01/11 and 9/16/11 by Restorative Nurse Consultant and programming was revised.</p> <p>Resident #7 was re-evaluated by D.O.N. on 9/2/11. Restorative nursing and programming was revised.</p> <p>Resident # T was re-evaluated by Restorative Nurse Consultant on 9/15/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # J was re-evaluated by Restorative Nurse Consultant on 9/13/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # K was re-evaluated by Restorative Nurse Consultant on 9/11/11 and 9/15/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # L was re-evaluated by Restorative Nurse Consultant on 9/16/11 and programming and care planning was revised based upon the resident needs.</p>	9/20/11
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F-311	<p>Continued From page 68 knee and the inability to ambulate.</p> <p>Resident #6 was to receive passive range of motion (PROM) to all extremities for ten (10) minutes, three (3) times per day, seven (7) days per week. However, there was no documented evidence the ROM was performed.</p> <p>Resident #7 was to receive PROM to the neck for five (5) minutes every day; AROM to the extremities, ten (10) to fifteen (15) repetitions, daily Monday through Friday; and PROM to bilateral knees, ten (10) repetitions, twice daily Monday through Friday. However, there was no documented evidence the range of motion was performed.</p> <p>Unsampled Resident T was to receive AROM, alternating upper and lower extremities, fifteen (15) minutes daily; PROM to the left ankle, ten (10) repetitions daily; and ambulate seventy-five (75) feet or more daily. However, there was no documented evidence the range of motion and ambulation was performed.</p> <p>In addition, Unsampled Residents J, K, L, M, N, O, P, Q, and R revealed each were to receive PROM, AROM and/or ambulation. However, there was no documented evidence the ROM and/or ambulation was performed.</p> <p>The findings include:</p> <p>Review of the facility's policy "Restorative Nursing Policy", undated, revealed all residents admitted would be screened for their physical, mental and psychosocial abilities. Further review revealed if the resident was not placed in a skilled therapy</p>	F 311	<p>Resident # M was re-evaluated by Restorative Nurse Consultant on 9/13/11 and programming and care planning was revised based upon the resident needs. Resident # N No longer resides at the facility.</p> <p>Resident # O was re-evaluated by Restorative Nurse Consultant on 9/01/11 and 9/11/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # P was re-evaluated by Restorative Nurse Consultant on 9/10/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # Q was re-evaluated by Restorative Nurse Consultant on 9/15/11 and programming and care planning was revised based upon the resident needs.</p> <p>Resident # R was re-evaluated by Restorative Nurse Consultant on 9/16/11 and programming and care planning was revised based upon the resident needs.</p> <p>Residents on restorative nursing programs are having the programs consistently delivered as ordered and planned. Periodic reviews of the program occur and are documented in the restorative nursing notes including progress towards goals and any modifications to the programs as needed by the changing needs of the individual residents.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>		
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F 311	<p>Continued From page 69</p> <p>program and appeared to require assistance with range of motion (ROM) to prevent further contractures, ambulation to prevent a further decline in mobility or assistance in other areas, the resident would be evaluated and placed into a restorative program appropriate to meet their needs. The policy further stated, it would be the admitting nurse's responsibility to notify the appropriate disciplines for referrals to restorative.</p> <p>1. Review of the clinical record revealed the facility admitted Resident #10 on 07/01/11 with diagnoses which included Dementia and Arthritis.</p> <p>Review of the Physician's Order Sheet, from the previous facility, dated 06/30/11, revealed Resident #10 was to receive restorative ambulation seven (7) days a week, days and evening, with instructions to document the number of feet and use a gait belt and walker. Continued Further review revealed orders for (AROM) to upper and lower extremities each day in the evening with instructions to alternate upper and lower extremities for fifteen (15) minutes for ten (10) repetitions. The orders further stated, transfer to receiving facility with continuation of all current orders.</p> <p>Review of the Restorative Service Delivery Record from the previous facility dated 06/11 revealed the resident was receiving AROM to all extremities for fifteen (15) repetitions to the upper and lower extremities in the evenings through 06/30/11. Further review revealed the resident received ambulation fifteen (15) days in 06/11, with the amount of feet ambulated ranging from fifteen (15) feet to one hundred (100) feet. Interview, on 08/02/11 at 2:00 PM, with the</p>	F 311	<p>2. An audit of other facility residents for restorative programming was completed by D.O.N. on 9/2/11 and 9/14/11 to determine appropriate needs and programs have been initiated and/or reviewed and modified based on assessments. Documentation of the program implementation or modification is located in the medical record and /or Electronic Medical Record (EMR).</p> <p>3. Licensed nurses and CNA's were re-inserviced 8/18/11 on assessment of residents who would be appropriate for various restorative programs by D.O.N., and/or Nurse Consultants. The facility offers a variety of restorative programming based upon resident assessment needs, such as, dining, ambulation, transfer, bowel/bladder retraining, Range of Motion, both passive and active and ADL retraining. Re-implementation of the restorative programming occurred as each resident's assessment was completed and their needs identified between 9/1/11 and 9/19/11. Re-assessments were completed by D.O.N. and/or Restorative Nurse Consultants. Restorative screening is being completed upon admission, quarterly, annually and with significant change in status. D.O.N., A.D.O.N. and/or Nurse Consultants will audit 4 restorative programs each week for the next 4 weeks with results presented to QA committee for review and recommendation.</p>		

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F 311	<p>Continued From page 70</p> <p>Restorative Registered Nurse (RN) from the previous facility, revealed the staff was ambulating the resident prior to discharge.</p> <p>Further review of the Clinical Record revealed the facility, upon admission of the resident, initiated their own Physician's Order Form. Review of the July 2011 Admission Physician's Orders, dated 07/11, revealed medications had been carried over from the previous facility. However, continued review revealed none of the ancillary orders, including the ordered restorative ambulation and ROM, had been carried over from the previous orders and initiated at the facility.</p> <p>Interview, on 08/02/11 at 5:00 PM, with Licensed Practical Nurse (LPN) #8 revealed there were twenty-two (22) residents who were admitted from another facility on 07/01/11. She stated she had admitted Resident #10 and five (5) other residents on 07/01/11. Continued interview revealed the previous facility's Physician's Orders were in the chart as well as the facility's Physician's Orders; however, she did not compare the two (2) sets of orders to ensure the orders continued from the previous facility nor did she call the physician to verify orders.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 07/26/11 revealed the facility had assessed the resident as having severe impairment in cognitive skills for daily decision making. Further review revealed the facility had assessed the resident as requiring extensive assistance with transfers and ambulation and as having no limits in ROM.</p>	F 311	<p>4. The I.D.T. team will review MD orders and therapy recommendations each morning (Monday through Friday) during clinical meeting to assure prompt implementation of orders and identification of issues for follow-up. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>		

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F 311	<p>Continued From page 71</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 07/28/11 revealed the resident required extensive assist of one staff for ambulating, was unsteady, and had balance issues. Further review revealed the residents diagnosis of Dementia was severe and limited her/his balance and mobility awareness of the need to move and change positions. Further review revealed there was no Comprehensive Plan of Care to review related to areas triggered from the Admission MDS.</p> <p>Observation of a skin assessment, on 07/27/11 at 11:45 AM, revealed two (2) staff stood the resident up from the chair with difficulty due to the resident not fully bearing weight. The staff was observed holding the resident under the arms to assist the resident to stand.</p> <p>Interview, on 07/27/11 at 10:30 AM, with Certified Nursing Assistant (CNA) #8, who was assigned to Resident #10, revealed she had been at the facility for three weeks and had received one (1) day in the classroom for orientation and one (1) day working on the floor with another CNA. She stated there was no reference guide for the CNA's to use related to how to provide specific care for the residents and she was unaware of any residents receiving restorative nursing. Continued interview revealed if the CNA's had a question related to a resident's care, they were to ask a nurse or another CNA. She further stated the aides did not provide range of motion or ambulation for Resident #10. She stated the resident was transferred with two staff members and a gait belt.</p> <p>Interview, on 07/27/11 at 3:00 PM, with CNA #20,</p>	F 311		

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F 311	<p>Continued From page 72</p> <p>who was assigned to Resident #10, revealed she was hired on 07/16/11. She stated she received a day of classroom orientation and worked with another aide the first week. She stated there was no nurse aide care plan to refer to and she had to remember all the care the resident was to receive. She further stated the resident was transferred with two assist and a gait belt. She stated there was no restorative program at the facility and she did not perform range of motion on the residents.</p> <p>Interview, on 07/27/11 at 4:25 PM, with Licensed Practical Nurse (LPN) #4, who was consistently assigned to the resident, revealed there was no reference for the aides to use to provide care and the aides had to ask questions if needed related to care provided. She further stated the aides and nurses did not provide range of motion and there was no restorative nursing program in place.</p> <p>Interview, on 08/05/11 at 2:15 PM, with Physical Therapist (PT) #1 and the Occupational Therapist/Director of Therapy revealed they had evaluated the resident after surveyor questioning on 08/02/11. They stated the resident had decreased range of motion in the left knee and decreased strength in the legs. Further interview revealed the resident was unable to ambulate and would benefit from physical therapy. Further interview revealed they were aware there would be approximately twenty-two (22) residents moved on 07/01/11 from another nursing home and they had gone to the other facility before the move to obtain a list of residents who were in PT at the time of transfer, however did not get a list of residents who were receiving restorative</p>	F 311		

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F 311	<p>Continued From page 73</p> <p>nursing. Further interview revealed prior to 07/01/11, there were restorative aides, however now the CNA's on the floor were expected to do restorative. Further interview revealed when the residents were discharged from PT, the CNA's received instruction related to the restorative program needed and the DON received a copy of the Restorative Form stating the instructions for the residents restorative program. Further interview revealed the resident had received Speech Therapy and Occupational Therapy at the facility since admission; however, had not received Physical Therapy</p> <p>Further interview on 08/05/11 at 4:30 PM with Physical Therapist #2 revealed as far as she knew, they had screened all residents who were admitted on 07/01/11 the first week of admission. She further stated, they planned to perform physical therapy on those residents who were previously receiving restorative nursing prior to admission until the restorative nursing program was in place. The surveyor asked for documented evidence Resident #10 was screened on admission; however, the information was not provided.</p> <p>Review of the Physical Therapy Evaluation, with an onset date of 08/03/11, revealed the resident recently moved to this facility from another nursing home and had a documented decline in physical abilities in the restorative record indicating the need for a physical therapy evaluation. Further review revealed the resident would benefit from skilled physical therapy intervention to address functional deficits and reach maximum functional independence. The goals included; sit to stand with minimum assist,</p>	F 311		
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F 311	<p>Continued From page 74</p> <p>ambulate five (5) feet with rolling walker, improved range of motion in the left knee, and develop and instruct patient/caregiver restorative program.</p> <p>Interview, on 08/04/11 at 1:00 PM, with the Attending Physician revealed all the orders from the previous facility were to have been carried over on 07/01/11 when the residents were admitted to the facility. He stated he was unaware the resident was not receiving restorative nursing and unaware there was a decline in her physical functioning. Further interview revealed he was not notified on 07/01/11 when the resident was admitted to verify the Physician's Orders.</p> <p>2. Record review revealed the facility admitted Resident #6 on 07/01/11 with diagnoses which included Alzheimer's Dementia and Lumbar Disc Disease with Chronic Back Pain. Continued review revealed the resident was admitted from another facility with Physician's Orders to continued current orders.</p> <p>Review of the Physician's Order Sheet from the previous facility, dated 06/30/11, revealed the following order: Transfer to receiving facility with continuation of all current orders. Continued review revealed Resident #6 had an order to receive passive range of motion to all extremities for ten (10) minutes, three (3) times per day, seven (7) days per week.</p> <p>Further review of the Clinical Record revealed the facility, upon admission of the resident, initiated their own Physician's Orders Form. Review of</p>	F 311		

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F 311	<p>Continued From page 75</p> <p>the July 2011 orders revealed medications had been carried over from the previous facility. However, continued review revealed none of the ancillary orders, including the order for range of motion, had been initiated at the new facility.</p> <p>Record review revealed no evidence Resident #6 had received restorative services since admission to the facility.</p> <p>3. Record review revealed the facility admitted Resident #7 on 07/01/11 with diagnoses which included Osteoarthritis, Osteoporosis, and Chronic Wounds. Continued review revealed the resident arrived from another facility with orders, including the following: Transfer to receiving facility with all current orders; Passive range of motion to neck for five (5) minutes every day; Active range of motion to extremities, ten (10) to fifteen (15) repetitions, daily Monday through Friday; and Passive range of motion to bilateral knees, ten (10) repetitions, twice daily Monday through Friday.</p> <p>Review of the Physician's Orders for July 2011 revealed the medication orders from the previous facility had been carried forward. However, ancillary orders, including the orders related to range of motion, were not continued after transfer.</p> <p>Record review revealed no documented evidence Resident #7 had received the ROM as ordered since admission to the facility.</p> <p>4. Review of the Physicians Order Sheet dated 06/30/11 for Unsampled Resident T revealed orders included the following: Transfer to</p>	F 311		

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F 311	<p>Continued From page 76</p> <p>receiving facility with all current orders; Active range of motion, alternating upper and lower extremities, fifteen (15) minutes daily; Passive range of motion to left ankle, ten (10) repetitions daily; and ambulate seventy-five (75) feet or more daily.</p> <p>Review of the active Physician's Orders for the month of July 2011 revealed medication orders were carried forward after the transfer, but ancillary orders, including those regarding range of motion and ambulation, were not.</p> <p>Continued review of transfer orders, dated 06/30/11, for Unsampled Residents J, K, L, M, N, O, P, Q, and R revealed each had an order to transfer to the receiving facility with current orders. Continued review revealed orders for passive range of motion, active range of motion and/or ambulation were included.</p> <p>Review of the July 2011 Physician's Orders, initiated after transfer, revealed medication orders were continued. However, no ancillary orders, including the for range of motion and ambulation orders were carried over.</p> <p>Interview, on 08/04/11 at 4:30 PM, with the Interim DON, Nurse Consultant #1 and #2, revealed they were not sure if the Physicians were called to verify Physician's Orders on 07/01/11 when the twenty-two (22) residents were admitted from another facility. Further interview revealed they had noted the ancillary orders including restorative nursing from the previous facility's Physician's Orders dated 06/30/11 were not carried over to the facility Admission Physician's Orders on 07/01/11, and they were in</p>	F 311		
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F 311	Continued From page 77 the process of comparing the orders. Continued interview revealed they had began to investigate the restorative program and were aware there was no range of motion or restorative nursing documented or being provided.  Interview, on 08/05/11 at 5:20 PM, with the Interim Administrator revealed the residents from the old facility building and twenty-two (22) residents from another facility were moved into the new facility building on 07/01/11. He stated the previous DON did not return after 07/15/11, and the previous Assistant DON had left shortly afterward. He stated he brought in consultant nurses after noting there were system problems. Continued interview revealed the systems which were in place prior to 07/01/11 were to continue after the move to the new building; however, with the increase in resident census, new building, new staff and inadequate training, and lack of direction from the Administrative Nurses, the systems were not being utilized. He stated he was aware there were problems with the residents not receiving restorative nursing.	F 311			
F 314 SS=G	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 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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F 314	<p>Continued From page 78</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure residents who entered the facility without pressure did not develop a pressure sore and residents who developed a pressure sore received necessary care and treatment for three (3) of eighteen (18) sampled residents (Residents #6, #7, and #1). The facility failed to ensure a system was in place to ensure their skin assessments were completed on admission and weekly per policy. In addition, there was no evidence the resident's records were monitored for completeness and accuracy related to skin assessments and wound progression. Also, the facility failed to ensure physicians were notified immediately of new pressure areas, treatments were initiated timely, and treatments were administered accurately according to the orders. The facility also failed to ensure appropriate infection control procedures were practiced during wound care.</p> <p>The facility failed to ensure Resident #6, who was admitted on 07/01/11 with a Stage I pressure ulcer, had a skin assessment on admission and weekly per policy. In addition, the facility failed to ensure treatment orders for the Stage I ulcer were followed. The first documented skin assessment was three (3) weeks after admission, on 07/22/11. The Stage I had progressed to a Stage II ulcer. Record review revealed the facility failed to notify the physician to obtain new treatment orders was for six (6) days, and on 07/28/11, observation of the skin assessment by the surveyor revealed the area was larger.</p>	F 314  F314	<p>The facility assures that residents admitted without pressure ulcers do not develop ulcers unless they are clinically unavoidable and the facility provides appropriate, consistent and necessary treatment for pressure ulcers to promote healing, prevent infection and to prevent new sores from developing.</p> <p>1. On 7/28/11, Nurse Consultant along with a staff nurse assessed resident #6 skin status. Based upon that assessment the MD was notified by the staff nurse and new skin treatment orders were received and implemented. LPN #4 was provided with re-education on 7/28/11 regarding appropriate use of the Electronic Medical Record (EMR), correct wound measurement technique, importance of timely MD notification for new orders, initial findings and with changes in wound condition, timely documentation of skin assessments, promptly signing off of treatments as completed, following MD orders, obtaining all treatment supplies and notifying nursing administration if unable to locate supplies, contact precautions and proper treatment procedures including contact precautions, hand washing with glove changes.</p>	9/20/11	

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F 314	<p>Continued From page 79</p> <p>The facility failed to ensure Resident #7, who was admitted with three (3) open areas, had a skin assessment on admission or weekly per policy. In addition, dressing changes were not performed as ordered and infection control procedures during the dressing change did not meet facility policy.</p> <p>The facility failed to ensure Resident #1 had a skin assessment on admission and weekly per policy. The first documented skin assessment revealed a Stage II pressure area. Observation and interview revealed treatment to the area was not administered as ordered.</p> <p>In addition, the facility failed to ensure skin assessments were completed on admission and weekly, per facility policy, for twenty-two (22) residents admitted by the facility on 07/01/11 (Sampled Residents #1, #2, #6, #7, #8, #10 and #11; and, Unsampled Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy titled Types of Isolation and PPE (Personal Protective Equipment) Required (no date), contact isolation requires healthcare personnel to "wear a gown and gloves for all interactions that may involve contact with the patient".</li> </ol> <p>Review of the policy titled Skin Care: Pressure Sore Prevention, dated February 2007, revealed "the Braden Scale tool, a systematic, validated risk assessment tool, will be completed within 24 hours of admission by the admitting nurse and reviewed by the Director of Nursing."</p>	F 314	<p>On 7/28/11, Nurse Consultant along with a staff nurse assessed resident #7 skin status. Based upon that assessment the MD was notified by the staff nurse and new skin treatment orders were received and implemented.</p> <p>On 7/28/11, Nurse Consultant along with a staff nurse assessed resident #1 skin status. Based upon that assessment the MD was notified by the staff nurse and new skin treatment orders were received and implemented.</p> <p>Weekly skin assessments have been completed by Nursing staff for Residents #8, 10, 11, B, F, H, I, J, K, L, M, N, O, P, Q, R, S, and T. Treatments are being provided per doctor orders, infection control procedures are being followed and physicians notified appropriately. Skin assessments are part of the admission process.</p> <ol style="list-style-type: none"> <li>2. All other residents of the facility were audited 8/1/11 by two facility staff nurses with follow-up auditing completed by A.D.O.N. on 8/29/11 to further review skin assessments and treatment orders. Treatment orders and care plans were updated as needed.</li> </ol>	

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F 314	<p>Continued From page 80</p> <p>Review of the policy titled Skin Care: Wound/Pressure Sore Assessment/Documentation, dated February 2007, revealed wound documentation must include size, color of tissue, stage of the wound, drainage, odor and other pertinent information.</p> <p>Review of the policy titled Wound/Pressure Sore Policy/Procedure, dated 12/22/09, revealed every resident was to have a weekly skin assessment performed and documented.</p> <p>1. Record review revealed the facility admitted Resident #6, on 07/01/11, from another facility with diagnoses which included Alzheimer's Disease, Hypertension, and Lumbar Disc Disease with Chronic Back Pain.</p> <p>Review of the Physicians' Orders from the transferring facility, dated 08/30/11, revealed Resident #6 was to be transferred to the receiving facility with continuation of all orders. Continued review revealed the following order related to excoriation on the right buttock: "Cleanse with antimicrobial cleanser, apply Calmoseptine then Desenex". (Desenex is an antifungal skin cream.)</p> <p>Review of the Physician's Orders at the receiving facility for the month of July 2011, initiated on admission, revealed the excoriated area on the right buttock was to be cleansed prior to the application of Calmoseptine, a barrier cream, and Micro-Guard Powder. (Micro-Guard Powder is an antifungal.) Review of the Treatment Administration Record (TAR) for the month of July 2011 revealed no documented evidence the</p>	F 314	<p>3. The D.O.N. is responsible for the wound care program and has developed protocols for wound care and preventive measures. Skin sweeps are being done every week by licensed nurse staff to identify new skin issues and monitor wound healing progress or lack of progress along with physician notification for revised orders as necessary. Licensed nurses and CNA's were re-in-serviced 8/4/11 and 8/18/11 on the skin policy, wound protocols, infection control program and skin/wound prevention revised protocols and policies were introduced by D.O.N and/or A.D.O.N. and/or Nurse Consultants. D.O.N, A.D.O.N., and/or Nurse Consultants will audit 6 skin sheets per week and 2 treatment observations which includes monitoring for appropriate use of infection control practices specifically use of personal protective equipment each week for the next 4 weeks with results presented to QA committee.</p>		

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F 314	<p>Continued From page 81</p> <p>treatment was administered during the month. Interview with Licensed Practical Nurse (LPN) #5 on 07/28/11 at 2:45 PM revealed she could not explain why the treatment was administered as ordered. She stated "we just used the Baza" (a moisture barrier cream).</p> <p>Review of the weekly skin assessment from the transferring facility, dated 06/30/11, revealed Resident #6 had a red area on the right buttock that did not blanch. The area was classified as a Stage 1 wound with no measurements documented.</p> <p>Review of the Admission MDS Assessment revealed Section M, related to pressure ulcers, was completed on 07/07/11. Continued review revealed the resident was assessed to be at risk for pressure ulcers but had no ulcers at a Stage 1 or higher.</p> <p>Continued review of the clinical record, including the Electronic Medical Record (EMR), revealed no documented evidence a skin assessment was completed on admission. Review of the Nurses' Progress Notes revealed LPN #4 made a late entry on 07/21/11 in reference to a skin assessment completed on 07/07/11. The nurse documented "no new skin issues noted". No clarification or description of the resident's actual skin condition was given.</p> <p>Interview with LPN #4 on 08/03/11 at 4:30 PM revealed every admission should include completion of a head-to-toe skin assessment, per facility policy. During continued interview, she explained the phrase "no new skin issues noted" meant no new areas were identified. She further</p>	F 314	<p>4. D.O.N, A.D.O.N., and/or Nurse. Consultants will monitor TAR's 2 times weekly for four (4) weeks to ensure treatments are being provided as ordered. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>		

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F 314	<p>Continued From page 82</p> <p>stated it could mean a previously identified area remained, or no areas were present. The nurse acknowledged the comment did not give a clear picture of the actual skin condition.</p> <p>Review of the Skin Condition/Wound Progression note by LPN #2, dated 07/22/11, revealed Resident #1 had an open lesion on the sacrum. The area was classified as Stage II and measured 2.0 cm x 2.0 cm. Continued review revealed the nurse documented "wound was present on admission". Interview with LPN #5 on 08/05/11 at 4:45 PM revealed she had actually done the skin assessment on 07/22/11 but had documented under LPN #2's name.</p> <p>Review of the Nurses' Progress Notes revealed no evidence the physician was notified of the newly identified open area on 07/22/11. Review of the Physicians' Orders revealed no orders were received for treatment of the new area until 07/28/11, after surveyor intervention.</p> <p>Observation of the skin assessment with LPN #5, on 07/28/11 at 2:45 PM, revealed an open area to the right buttock. LPN #5 classified the area as a Stage II wound and measured it at 3.0 cm x 1.5 cm. When questioned, the nurse stated she had been made aware of the area on the weekend. She stated it was not open at that time (although her documentation on 07/22/11, a Friday, revealed it was open). She further stated she instructed the aides to use Baza cream. Continued interview revealed LPN #5 did not notify the physician.</p> <p>2. Record review revealed the facility admitted Resident #7 on 07/01/11, with diagnoses which</p>	F 314			

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F 314	<p>Continued From page 83</p> <p>Included Osteoarthritis, Osteoporosis, Hypertension, and Methicillin-Resistant Staphylococcus Aureus (MRSA).</p> <p>Review of the Wound Report completed 06/28/11, prior to the transfer, revealed Resident #7 had a Stage II pressure area to the left outer foot, 4.0 centimeters (cm) long x 2.8 cm wide by 0.8 cm deep. Review of the Wound Report, dated 06/29/11, revealed the resident had a Stage IV pressure sore on the left buttock (or ischium). The wound was measured at 6.0 cm x 7.1 cm x 4.2 cm. In addition, review of the Weekly Skin/Wound Assessment, dated 06/29/11, revealed a surgical incision was present on the right hip.</p> <p>Review of the Physicians' Order Sheet from the transferring facility, dated 06/30/11, revealed the resident had multiple pressure sores and treatment orders were to be continued at the receiving facility.</p> <p>Review of the Physician's Orders for the month of July 2011 revealed the resident was admitted with wound treatment orders carried over from the previous facility. The orders included: cleanse left Ischium open area with Dakin's Solution, then apply Polysporin Powder along with Santyl once daily and as needed (PRN); apply Double Antibiotic Ointment to open area on outer left foot twice daily until healed; and apply dry gauze dressing to surgical incision daily.</p> <p>Record review revealed no documented evidence the facility conducted a skin assessment upon admission, per policy, to record the size and condition of the wounds.</p>	F 314			

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F 314	<p>Continued From page 84</p> <p>Review of the Skin Condition Report-Unhealed Daily Wound Assessment, for the period 07/01 to 08/02/11 revealed the only recorded skin/wound assessment was on 07/22/11, three (3) weeks after the resident was admitted to the facility.</p> <p>Observation, on 07/26/11 at 4:00 PM, revealed a STOP sign on the door to Resident #7's room. Interview with Certified Nursing Assistant (CNA) #20 on, 07/26/11 at 4:15 PM, revealed the sign was to alert staff to isolation precautions for Resident #7. The aide stated the resident "has wounds". Further interview revealed gloves and gowns were to be worn when caring for the resident. Continued observation revealed a cart in the resident's bathroom contained gloves and gowns.</p> <p>Interview with LPN #4, on 07/26/11 at 4:15 PM, revealed Resident #7 was in contact isolation for MRSA in a wound. She stated the wound was draining and she became concerned when she learned the resident had a history of MRSA. Continued interview revealed she became aware of the resident's history "a day or two after admission" and placed the resident on Contact Isolation precautions at that time.</p> <p>Observation of the dressing change conducted by LPN #4, on 07/27/11, at 10:50 AM revealed the presence of three (3) open areas.</p> <p>Observation revealed unhealed surgical incision at the right hip was open at both ends. Both areas were draining, serous drainage at the bottom, and thick tan secretions at the top were observed. LPN #4 did not wear a gown</p>	F 314		

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F 314	<p>Continued From page 85</p> <p>throughout the procedure, in spite of the contact precautions instituted per facility policy. In addition, CNA #23 failed to wear a gown while assisting with turning and positioning the resident for the wound care.</p> <p>Observation of the Stage IV ulcer on the left buttock revealed no dressing was in place prior to the procedure. Continued observation revealed the nurse packed the wound with dry gauze, contrary to the treatment orders.</p> <p>Continued observation revealed after application of the dressing, and prior to removing her gloves, the nurse picked up the trash can and carried it to the other side of the bed. Further observation revealed she performed the dressing change to the left foot without changing gloves or practicing hand hygiene.</p> <p>Interview with LPN #4, on 07/27/11 at 11:00 AM, revealed the resident did remain under contact isolation for the history of MRSA in the right hip wound. She stated gloves and a gown should have been worn if there was a chance of contact with wound drainage. She acknowledged the hip wound was draining heavily and stated she and the aide should have worn a gown. Continued interview revealed the nurse knew she should have washed her hands and applied new gloves between wound sites. Upon further interview regarding the Stage IV ulcer, LPN #4 stated she did not know why there was not a dressing in place prior to the procedure. She further stated "it must have fell off". When questioned about her choice of dressings, she stated the order for Santyl, used for debridement, was only to be used PRN (as needed) and she did not feel</p>	F 314			

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F 314	<p>Continued From page 86 debridement was indicated.</p> <p>Interview with NC #2 on 08/04/11 at 5:50 PM revealed the contact isolation procedure for Resident #7 indicated staff should have worn gowns during the dressing change to the draining wounds.</p> <p>Interview with the Wound Care Center consultant, an Advanced Registered Nurse Practitioner (ARNP), on 08/03/11 at 3:30 PM, revealed she was familiar with Resident #7. The ARNP stated contact isolation precautions were appropriate for the resident.</p> <p>Review of the Physician's Order dated 07/29/11 revealed a new order to monitor the Stage I pressure ulcer on the bunion area of the right foot. Continued review revealed new treatment orders were received on 08/02/11 at 3:00 PM, prior to the observed skin assessment, related to the now open area on the right great toe and the new area on the right hip.</p> <p>Observation of the skin assessment by Nurse Consultant #2, on 08/02/11 at 5:05 PM, revealed two (2) additional open areas had developed since the previous observed dressing changes. A new "shearing" area, measuring 0.2 cm x 0.2 cm was noted on the left hip. In addition, a "superficial Stage II" area was observed over a bunion at the base of the right great toe.</p> <p>Interview with Nurse Consultant (NC) #1 and NC #2, on 08/04/11 at 4:30 PM, revealed they began duties at the facility on 07/18/11 and 07/29/11, respectively. They stated they were aware skin assessments had not been done on admission.</p>	F 314		

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F 314	<p>Continued From page 87</p> <p>Continued interview revealed the expectation was skin assessments would be completed on admission and weekly for every resident.</p> <p>3. Review of the clinical record revealed the facility admitted Resident #1 on 07/01/11, with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Continued review revealed the resident was status post Cardiovascular Accident (Stroke) and was immobile and dependent for all care.</p> <p>Review of the Weekly Skin Assessment, dated 06/22/11, (done at the facility the resident was admitted from), revealed Resident #1 had no abnormal skin conditions.</p> <p>Review of the Nutrition Progress Note, dated 07/04/11, revealed the dietician documented Resident #1 had "no skin issues according to nursing staff".</p> <p>Review of the Admission Minimum Data Set (MDS) assessment revealed section M, related to pressure ulcers, was completed on 07/05/11. Continued review revealed Resident #1 was at risk for pressure ulcers but did not have any pressure ulcers at the time of the assessment.</p> <p>Review of the Nursing Progress Note dated 07/05/11 revealed Licensed Practical Nurse (LPN) #5 documented, "weekly skin assessment done no new issues".</p> <p>Review of the Care Plan, dated 07/13/11, revealed Resident #1 was at risk for developing a pressure ulcer. Interventions were directed to preventing skin breakdown, and recognizing and</p>	F 314		

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F 314	<p>Continued From page 88 reporting new abnormal areas.</p> <p>Review of the nurse's Progress Note, dated 07/23/11, revealed LPN #4, during a skin assessment, identified an open area on the right buttock measuring 5.6 centimeters (cm) by 3.8 cm that was "currently being treated". Continued review revealed no other description or staging of the wound was documented. Continued review of the clinical record revealed no evidence a skin assessment was completed between 07/05/11 and 07/23/11 as per facility policy.</p> <p>Observation of the skin assessment performed by LPN #4 on 07/27/11 at 3:30 PM revealed an open area to the right buttock measuring 6.4 cm by 3.0 cm. Interview at that time revealed the nurse was not sure if the area was present on admission to the facility. Continued interview revealed the area was being treated with Baza cream, as ordered by the physician. Further observation revealed there did not appear to be any treatment present to the wound. The nurse stated the cream had not been applied that day because she hadn't got to it yet.</p> <p>Interview with Nurse Consultant #1, on 08/04/11 at 4:30 PM revealed the facility admitted twenty-two (22) residents on 07/01/11. She stated she was contracted by the facility on 07/18/11 and recognized right away that admission procedures, including skin assessments, were not completed on any of the twenty-two (22) residents.</p> <p>6. Record review revealed the facility admitted Unsampled Resident B on 07/01/11, with diagnoses which included dementia with behavior</p>	F 314			

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F 314	<p>Continued From page 89</p> <p>disturbances, Diabetes Mellitus, Coronary Artery Disease with stent, Chronic Heart Failure, Cerebrovascular Accident, Peripheral Artery Disease, Dyslipidemia, Gastroparesis, Colon Cancer, Gastrointestinal Bleeding and history of Deep Vein Thrombosis.</p> <p>Review of the resident's admitting Physician Orders revealed an order for Desenex powder to excoriation to abdominal folds as needed three (3) times a day. Continued review revealed an order for Remedy Skin Repair every day to be applied to feet. An order for Lidex cream to be applied to affected area two (2) to three (3) times daily until rash is cleared was also noted. In addition, an order for Remedy Skin Repair cream to be applied to the lower extremities every day related to dry skin was noted.</p>	F 314		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 323		

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F 323	<p>Continued From page 90</p> <p>by: Based on observation, interview, record review, and review of the facility's policies it was determined the facility failed to ensure each resident received adequate supervision and monitoring to prevent accidents for three (3) of eighteen (18) sampled residents (Resident #14, #13 and #10). The facility failed to ensure staff was knowledgeable and trained regarding the facility's Fall's Policy and Risk Assessment Policy. The facility failed to ensure these policies were implemented.</p> <p>Resident #14 self transferred without staff assistance and fell on 07/19/11, sustaining a cut above the left eye (required sutures), a Hip Pinning Fracture Left Hip and Left Radius and Ulna Fracture. The facility failed to ensure systems for checking assistive devices were implemented. The facility failed to notify the physician at the time of the incident. The facility's investigation of the incident failed to identify that staff failed to communicate their knowledge that Resident #14 was able to remove alarming devices and would attempt to rise and ambulate without assistance. This failure prevented the facility from revising the care plan interventions to prevent falls.</p> <p>Resident #13 had multiple falls; however, the facility failed to evaluate and analyze the causative factors and implement interventions to prevent falls. In addition, the facility failed to ensure the Physician and responsible parties were notified of the falls as per facility policy.</p> <p>The facility failed to complete the Falls Risk Assessment timely, per the facility policy for</p>	F 323  F323	<p>The facility ensures 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. The facility has developed an accident prevention program with the involvement of the entire facility staff to focus on prevention of accidents including falls.</p> <p>1. Resident #14 was last assessed for fall risk on 8/18/11 and assistive devices are in place as ordered by the physician. Nursing staff are checking and documenting the device placement appropriately and care plan has been revised. Resident #13 is no longer residing at the facility. Resident #10 was assessed on 7/22/11 and 9/26/11 for fall risk and a fall care plan is in place. Resident #11 was assessed for fall risk on 8/18/11 and a fall care plan is in place. Resident #7 was assessed for fall risk on 7/22/11 and a fall care plan is in place. Resident #1 was assessed for fall risk on 7/23/11 and a fall care plan is in place. Resident #6 was assessed for fall risk on 7/22/11 and a fall care plan is in place. Resident #8 was assessed for fall risk on 7/22/11 and 9/18/11 and a fall care plan is in place.</p>	9/20/11
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F 323	<p>Continued From page 91</p> <p>Resident #10. Additionally, while the facility identified the resident at high risk for falls, the facility failed to develop a care plan to address the risk and failed to follow physician orders related to a chair alarm.</p> <p>Additionally, the facility failed to conduct assessments for sixteen (16) residents who were admitted on 07/01/11 for falls risk as per facility policy (Residents #1, #6, #7, #8, #10, #11 and Unsampld Residents B, F, H, I, J, K, M, O, P, Q, R, and T). This failure to assess for fall risk of each resident resulted in the facility's failure to develop and implement safety measures through the care planning process in order to ensure an environment as free of accidental hazards as is possible for the residents.</p> <p>In addition, the facility failed to ensure a safe environment as evidenced by observation of the electrical room, soiled utility rooms and laundry room with unlocked doors or doors which were propped open, leaving access to harmful chemicals and electrical equipment.</p> <p>The findings include:</p> <p>Review of the facility's Falls policy, undated, revealed a Fall Assessment was to be completed on admission to assess the resident for fall related factors, a Plan of Care would be developed to address issues that could contribute to the risk for falls, and precautions related to the resident would be placed on the Nursing Assistant's Care Plans. Further review revealed the Physician and family should be notified after a fall, the resident's Care Plan should be revised and updated with information related to the fall</p>	F 323	<p>Resident # O, and S, were assessed for fall risk on 7/22/11 and a fall care plan is in place.</p> <p>Resident # I, K, M, P, Q, R, and T were assessed for fall risk on 7/23/11 and a fall care plan is in place.</p> <p>Resident #L was assessed for fall risk on 8/18/11 and a fall care plan is in place.</p> <p>Resident #N no longer resides at the facility.</p> <p>Resident #B was assessed for fall risk on 7/23/11 and 9/14/11 and a fall care plan is in place.</p> <p>Resident #F was assessed for fall risk on 7/23/11 and 9/18/11 and a fall care plan is in place.</p> <p>Resident #H was assessed for fall risk on 7/23/11 and 9/19/11 and a fall care plan is in place.</p> <p>Resident #J was assessed for fall risk on 7/22/11 and a fall care plan is in place.</p> <p>Electrical room, soiled utility rooms, and laundry room doors were closed and locked immediately and no residents were affected by the unlocked or propped doors. Automatic closers and automatic locks are in place on the doors. These doors are monitored to make sure they are closed, locked and not propped open during environmental rounds we are conducting (3) three times per week for the next four weeks.</p>		

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F 323	<p>Continued From page 92</p> <p>Incident within 24 hours, and a Post Fall Assessment was to be completed by the designated personnel completing the follow up/investigation. Telephone Interview, on 08/04/11 at 10:45 AM, with the previous DON, who worked at the facility until 07/15/11, revealed residents were to be assessed for fall risks on admission. She stated, if the admission nurse determined a fall alarm device would be appropriate, the nurse was to call the Physician and request an order. Further interview revealed the nurse would be expected to transcribe the monitoring of the alarms on the TAR which would include checking both the placement and function each shift. She further stated the nurses were to check each shift to ensure the alarms were in place and functional, and to sign the TAR to indicate this was done. She stated the nurses were trained on this process.</p> <p>Review of the policy titled Risk Assessments in the Electronic Medical Record (EMR), undated, revealed the fall risk assessment was to be completed upon admission by the charge nurse.</p> <p>Interview, on 08/05/11 at 4:20 PM, with Nurse Consultant #2 regarding the facility's fall policy, revealed staff should be aware they were to notify the Physician and the responsible party after each fall. She further stated, staff should investigate the cause of each fall and revise the Plan of Care with interventions to prevent further falls.</p> <p>1. Record review revealed the facility admitted Resident #14 on 07/12/11 with diagnoses which included Depression, Hypertension (HTN), Difficulty Walking, Muscular Wasting and Disuse</p>	F 323	<p>2. Remainder of facility residents have been assessed for fall risk and care plans are in place as appropriate.</p> <p>3. The D.O.N., A.D.O.N. and/or Nurse Consultants have completed audits and assessments for all residents for fall risk. All assessments were completed by 9/19/11 and interventions and care plans have been initiated by the D.O.N., A.D.O.N. and/or Nurse Consultants. Licensed nurses and CNA's were provided an additional in-service on 8/4/11, 8/16/11, and 8/18/11 on the accident prevention and fall policy, prevention strategies and interventions along with fall risk assessment completion, care planning, locking and no propping of doors by D.O.N., A.D.O.N. and/or Nurse Consultants. D.O.N, A.D.O.N. and/or Nurse Consultant will audit (3) three incidents/accidents per week to see if nurses are following the fall policy and 5 device orders each week for the next 4 weeks.</p>		

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F 323	<p>Continued From page 93</p> <p>Atrophy, and Pneumonia. Interview, on 08/04/11 at 1:20 PM, with RN #4 revealed she had admitted Resident #14 on 07/12/11 to the facility. She stated the resident was identified to be a fall risk on admission because he/she recently had Pneumonia and appeared to be weak. She further stated the previous Director of Nursing (DON) had also informed her the resident had a history of falls. Continued interview revealed she called the Physician on admission and obtained an order for fall prevention alarms for the bed and chair; however, record review revealed there was no documented evidence of a Physician's Orders for the bed and chair alarm or the facility completed a Falls Risk Assessment on admission. She further revealed she documented on the Treatment Administration Record (TAR) to check placement each shift. She stated, she informed the CNAs the resident would need assistance with transfers, but did not know if it was included on the care plan.</p> <p>Review of the resident's Plan of Care, dated 07/12/11, identified the facility developed a fall's prevention care plan detailing the following interventions: alarm to bed and chair, call light within reach, refer to therapies, frequent visual observation and toileting.</p> <p>Review of Resident #14's Treatment Administration Record (TAR) revealed the facility staff was to check to ensure alarms were in place each shift. TAR review revealed there was no documentation by the nurses on days/evenings/nights to indicate the alarm placement had been checked on 07/18/11 and by the day shift nurse on 07/19/11 for Resident #14.</p>	F 323	<p>D.O.N. /A.D.O.N. will audit new admission charts for completion of risk assessments and care plans at the morning I.D.T. meeting Monday through Friday. I.D.T. will review falls as part of daily clinical meeting, Monday through Friday to further determine root cause analysis and necessity to revise care interventions further in an effort to prevent additional falls.</p> <p>The policy for fall has been reviewed and revised to ensure compliance.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	

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F 323	<p>Continued From page 94</p> <p>Review of the Nurse's Notes and the facility's Incident Report, dated 07/19/11, revealed at 1:00 PM the nurse found Resident #14 sitting up on the floor in the bathroom after falling with her/his walker against the wall. The resident was assessed to have a cut above the left eye.</p> <p>Interview, on 07/27/11 at 3:30 PM, with Registered Nurse (RN) #6 revealed she entered Resident #14's room on 07/19/11 to administer medication and found the resident on the bathroom floor with a cut above her/his left eye. She further stated she obtained vital signs and assessed the resident's extremities before transferring her/him to a chair. RN #6 stated she did not hear any alarm when she found the resident on the floor and could not remember if the resident had an alarm device on. She stated she had not checked for alarm placement during her shift because she was told the Certified Nursing Assistants (CNAs) were responsible for checking placement and documenting this in the TAR. Continued interview revealed she did not notify the Physician immediately after the fall because she did not note any change in the resident's condition, except for the cut above the eye.</p> <p>Interview, on 07/28/11 at 9:50 AM, with Certified Nursing Assistant (CNA) #6 revealed she took care of Resident #14 on 07/19/11. She stated, after being notified of the fall by RN #6, she helped assist the resident to the chair. She stated she did not think the resident had alarms in place at that time or when she provided care earlier that day. She had taken the resident to the toilet that morning. Further interview revealed she was not very familiar with the resident because she did not usually work on that hall. She further stated it</p>	F 323			

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F 323	<p>Continued From page 95 was the CNA's responsibility to check alarm placement.</p> <p>Continued interview with RN #6 revealed the resident later complained of pain to her/his left wrist; however, she again did not notify the Physician because there was no swelling to the wrist noted.</p> <p>Interview, on 07/27/11 at 4:07 PM, with RN #1 revealed she observed Resident #14 at about 3:00 PM and said he/she seemed confused, complained about his/her left wrist hurting, and complained of leg pain. She stated she sent the resident out to the hospital about 4:00 PM because of concerns about a possible brain injury and complaints of wrist and leg pain. Further interview revealed she did not know why the day shift nurse had not already sent the resident out to the emergency room. She stated, after a fall the nurses were to notify the Physician right away. Further review of the Nurse's Notes and the incident report, dated 07/19/11, the facility notified the Physician at 3:00 PM (2 hours after the fall with injury) and transferred Resident #14 to a local hospital at 4:00 PM per ambulance due to mental status change and complaints of left wrist and left leg pain.</p> <p>Review of the Physician's Order Form, dated 07/25/11, revealed Resident #14 was re-admitted to the facility on 07/25/11 with diagnoses which included Sutures (above the right eye brow), Hip Pinning Fracture Left Hip, and Fracture of the Left Radius and Ulna as a result of the fall.</p> <p>There was no documented evidence that the facility had identified through their investigation</p>	F 323		

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F 323	<p>Continued From page 98</p> <p>whether the alarm was alarming, malfunctioning at the time of the fall, or had been removed by the resident. However, interview on 07/28/11 at 11:50 AM and 2:50 PM, with CNA #10 assigned to the resident's unit, revealed Resident #14 was capable of taking off his/her alarms and would sometimes remove them and get up by himself/herself; however, she had not informed the nurses the resident could take off the alarms. Interview, on 07/28/11 at 12:10 PM and at 3:15 PM, with CNA #17 revealed the resident would take off his/her alarms at times and she had observed Resident #14 up ambulating by himself/herself. She stated she would remind the resident he/she needed to use the call light and the resident would say he/she could get up by himself/herself. However, she could not remember if she had notified the nurse of the resident taking off the alarm. However continued interview with RN#6 revealed she was not aware that Resident #14 was removing his/her alarms.</p> <p>While staff interviews revealed that several staff was aware of Resident #14's ability to remove the alarm used to alert staff to provide assistance with ambulation to prevent fall, there was no documented evidence on the care plan that the facility had revised the care plan to reflect new interventions to address the resident's ability to remove the alarm. Furthermore interview, on 08/04/11 at 1:20 PM, with RN #4 revealed she did not detail on the TAR that staff was to check the functioning of the alarms because she assumed the staff would check to ensure the alarm was functioning when placement was checked. Further interview revealed she should have included to check function of the alarms on the TAR.</p>	F 323			

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F 323	<p>Continued From page 97</p> <p>Further interview with RN #6 revealed the nurse had not reviewed or been trained on the facility's Falls Policy nor was she aware of the residents Care Plan on fall precautions.</p> <p>Interview, on 07/27/11 at 5:30 PM, with Nurse Consultant #1, who was hired on 07/18/11 and was working in an administrative role, revealed when she came to the facility the Care Plans were not accessible to the nurses and the nurses still could not access the Care Plans to refer to them or revise them.</p> <p>2. Record review revealed the facility admitted Resident #13 on 06/03/11 with diagnoses which included unspecified Hypertension (HTN), and Coronary Artery Disease. Review of the Comprehensive Plan of Care, dated 06/08/11, revealed the facility identified the resident was at risk for falls related to a history of falls, incontinence, needing assistance with Activities of Daily Living (ADL's), and receiving psychotropic medications. The interventions included both chair and bed fall prevention alarms. Review of the Minimum Data Set (MDS) Assessment, dated 06/10/11, revealed the facility assessed the resident as having severe impairment in cognitive status for daily decision making, and required extensive assistance with transferring, toilet use, and locomotion. Further review revealed the facility assessed the resident as having a fall prior to admission. A Care Area Assessment Summary was requested; however, only the trigger sheet was provided which revealed the resident triggered for falls.</p> <p>Review of the Incident Report, dated 07/13/11</p>	F 323		

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F 323	<p>Continued From page 98</p> <p>and incident time 10:00 AM, revealed the resident fell while trying to get to the bathroom and did not have an alarm in place. The Power of Attorney was notified; however, there was no documented evidence detailing that the facility notified the Physician. No injury was identified on the Report. There was no documented evidence the facility had revised the Plan of Care with new interventions to prevent further falls.</p> <p>Review of the Incident Report, dated 07/16/11 and incident time 7:30 PM, revealed the resident was found on the floor in front of their wheelchair. According to the Report the resident fell when attempting to get clothing from the bottom drawer when his/her chair rolled backward. The corrective measures documented on the incident report revealed the resident was instructed to call for help if items were out of reach. Review of the report notification section revealed there was no documented evidence that the facility notified the family or Physician of the incident. Further review revealed the Incident Report did not indicate if the alarm was in place and/or alarming at the time of the fall. The report indicated there was no injury. Furthermore, there was no documented evidence the Plan of Care was revised with new interventions to prevent further falls after this incident.</p> <p>Review of the Incident Report, dated 07/17/11 and incident time 10:45 PM, revealed the resident was found sitting on the floor beside his/her bed. According to the Report the resident stated he/she attempted to ambulate to the restroom and when trying to lean onto his/her wheelchair the wheels were not locked and the chair rolled away causing a loss of balance. The corrective</p>	F 323			

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F 323	<p>Continued From page 99</p> <p>measures documented included instructing the resident to call when ambulation was needed. The report stated there was no injury and the nurse on the morning shift may wish to call the MD to order a bed alarm. There was no documented evidence the Plan of Care was revised with interventions to prevent further falls after this incident and no documented evidence the facility notified the Physician of the fall.</p> <p>The Incident Report, dated 07/25/11 and incident time 7:30 PM, documented the resident was found on the floor next to the recliner and stated she/he was transferring to the recliner from the wheelchair and lost her/his balance. The nurse documented on the Report, an alarm had been ordered. Continued review, revealed there was no injury and the Power of Attorney was notified. However, there was no documented evidence the facility notified the Physician. Additionally, there was no documented evidence the Plan of Care was revised with new interventions to prevent further fall recurrence after the incident.</p> <p>Observations of Resident #13, on 07/28/11 at 8:50 AM, revealed the resident was in their wheelchair in the dining room with no fall alarm observed. On 07/28/11 at 10:40 AM, the resident was observed sitting in a straight stuffed chair in her/his room; however, there was no fall alarm attached to the resident. On 07/29/11 at 1:00 PM the resident was observed in their room sitting in a straight stuffed chair and no fall alarm was present. Observation of the resident with CNA #17, on 07/28/11 at 10:40 AM, revealed the resident was seated in a straight stuffed chair and the CNA verified no fall alarm was in place.</p>	F 323		

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F 323	<p>Continued From page 100</p> <p>Interview with RN #1 on 07/27/11 at 6:00 PM who was assigned to the resident on the dates of the falls on 07/13/11 and 07/25/11, revealed the resident was very stubborn and tried to get up without help. She reported the resident did have a tab alarm at one time; however, would take the alarm off. Further interview revealed she did not know if the resident was care planned for alarms because she did not review the Care Plans and she was not familiar with this residents fall interventions. She stated she used the resident's Treatment Administration Record (TAR) as a reference to provide care. RN #1 further stated she ordered an alarm after the fall on 07/25/11; however, there was no documented evidence of a Physician's Order for an alarm. Further interview revealed she did not contact the Physician after the falls on 07/13/11 and 07/25/11 because they did not have to contact the Physician if the resident was not injured.</p> <p>Interview, on 08/05/11 at 11:40 AM, with LPN #3, who completed incident reports for Resident #13's falls on 07/16/11 and 07/17/11, revealed she had not been trained on the facility's Falls Policy and what was expected after a resident's fall. Further interview revealed she did not notify anyone regarding the falls and was told she only was supposed to notify the Physician or a family member if they observe an injury with a fall. She did not talk to any supervisor about the fall because she thought they would be aware of the fall through reporting the incident in the computer system.</p> <p>Interview with Nurse Consultant #1, on 07/28/11 at 10:15 AM, regarding the determination of fall prevention interventions after fall events revealed</p>	F 323		
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F 323	<p>Continued From page 101</p> <p>she got together with the nurses involved to come up with interventions to try to prevent further falls. When asked about what interventions were identified after Resident #13's fall on 07/25/11, she revealed there should be orders for an alarm and the resident should have an alarm put in place.</p> <p>Further interview, on 08/03/11 at 5:05 PM, with Nurse Consultant #1 regarding who was responsible for monitoring the follow-up interventions for incidents, revealed she was one of the persons responsible for ensuring follow-up interventions listed on incident reports were performed. When questioned about the fall prevention alarm for Resident #13, which was identified as an intervention after the 07/25/11 fall, she stated it should have been in place; however, after she had talked to staff they informed her the resident refused to use an alarm. Further interview revealed she had not spoken to the resident regarding the alarms. Further interview revealed she had verbally told staff to check on the resident more frequently, every hour, but did not remember what staff she spoke to and she had not followed up to see if this was being done. She also stated they did not have care plans in place for staff to update.</p> <p>3. Review of Resident #11's medical record revealed the facility admitted the resident on 07/01/11 with diagnoses of Cerebral Vascular Accident (CVA) with Hemiplegia. The facility was unable to provide documented evidence that they had completed a Falls Risk Assessment or an Admission Plan of Care. Review of the Admission Minimum Data Set (MDS) Assessment, which was not completed until</p>	F 323		

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F 323	<p>Continued From page 102</p> <p>07/26/11 (Refer to F-273), revealed the facility assessed the resident as oriented, and as requiring extensive assistance with transfers and ambulation in the room.</p> <p>Review of the Care Area Assessment Summary (CAAS), dated 07/26/11, revealed indicators of fall risk for this resident included impaired balance, pain, incontinence, Hemiplegia, and Arthritis. Further review revealed the resident was nonambulatory, a hooyer lift was used for transfers, and the resident received Ativan (anti-anxiety medication), Lexapro (anti-depressant medication), and Ambien (Hypnotic medication) which placed the resident at a higher risk for falls. Further review revealed the CAAS triggered for falls.</p> <p>Review of the Comprehensive Plan of Care, dated 07/26/11, revealed the risk for falls was not an identified concern and no interventions were in place for the prevention of falls. Observation, on 07/27/11 at 12:00 PM, revealed Resident #11 was up in their wheelchair with a chair alarm in place. Further observation revealed the resident's bed had a bed alarm. However record review of the Plan of Care on 07/27/11 revealed no evidence the facility had developed a plan at that time.</p> <p>Record review revealed the facility had developed and implemented a Plan of Care to address falls on 08/01/11 which revealed the resident was at risk for falls due to impaired mobility and poor safety awareness related to cognitive deficit. The interventions included a chair and bed alarm, and staff to assist with transfers; however, there was no specific Intervention for transfer technique.</p>	F 323		

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F 323	Continued From page 103  4. Review of Resident #10's medical record revealed the resident was admitted on 07/01/11 with diagnoses which included Dementia, Arthritis, and a history of falls. Record review revealed no documented evidence the facility had completed a Falls Assessment or Falls Risk Assessment upon admission or had developed and implemented an Admission Plan of Care. Review of the Comprehensive Care Plan revealed it was initiated on 07/08/11 with new problems and interventions added on 07/14/11 and 07/15/11. Continued review revealed the risk for falls was not an identified concern and no interventions were placed for the prevention of falls.  Review of the Fall Risk Assessment, dated 07/22/11, revealed the resident was assigned a score of twenty-four (24), indicating a high risk for falls. According to assessment details, a score greater than nine (9) was considered high risk.  Review of the Physician's Orders, dated 07/25/11, revealed an order for placement of dysem under the chair alarm and under the seat cushion and a bed alarm (written by the Interim Director of Nursing (DON)).  Review of the Admission Minimum Data Set (MDS) Assessment which was not completed until 07/26/11 (Refer to F-273) revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making, and as requiring extensive assistance with transfers and ambulation. Review of the Care Area Assessment Summary (CAAS), dated 07/26/11, revealed indicators of fall risk for this	F 323		

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F 323	<p>Continued From page 104</p> <p>resident included impaired balance during transfers, diuretics, incontinence, visual impairment, Arthritis, and cognitive impairment. Further review revealed the CAAS triggered for falls.</p> <p>Observation of Resident #10, on 07/26/11 at 4:00 PM, revealed the resident was in a wheelchair in her/his room. The wheelchair had a Dycem seat mat (non slip material) to help keep the resident from slipping out of the seat; however, there was no chair alarm on the wheelchair.</p> <p>Interview, on 07/26/11 at 4:45 PM, with Certified Nursing Assistant #21, who was assigned to Resident #10, revealed she verified the resident did not have a chair alarm in place. She further stated the aides had no guide to refer to in providing care for the residents.</p> <p>Interview, on 07/26/11 at 6:00 PM, with Licensed Practical Nurse (LPN) #6 revealed the nurses verbally gave the aides report on any new issues with the residents; however, there was no written reference for aides to refer to when providing care such as a nurse aide care plan. She stated she tried to do rounds every hour or so to make sure the beds were in low position, and call bells were in reach as well as check for safety devices, although she had no list of safety devices in which to refer. She stated the resident probably needed a chair alarm because the resident leaned forward. She further stated she was unaware of the Physician's Order for the chair alarm.</p> <p>Further observation of the resident, on 07/27/11 at 10:30 AM, revealed the resident was in a</p>	F 323		

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F 323	<p>Continued From page 105</p> <p>recliner with her/his feet elevated and no alarm was on the chair.</p> <p>Interview, on 07/27/11 at 5:30 PM, with Nurse Consultant #1 revealed if the Falls Risk Assessment and Interim Care Plan were not provided, the facility did not complete them. She further stated the facility was still in the process of ensuring Care Plans were up to date and revised as needed.</p> <p>Further interview, on 07/28/11 at 2:20 PM, with Nurse Consultant #1 revealed the Physician's Orders should have been followed related to the chair alarm. She further stated the chair alarm was only for the wheelchair and the order may need to be clarified.</p> <p>5. Review of the Clinical Record revealed the facility admitted Resident #7 on 07/01/11 from another facility with diagnoses which included Osteoporosis, Osteoarthritis, Anemia and Hypertension. Review of the Comprehensive Care Plan revealed it was initiated on 07/05/11 with new problems and interventions added on 07/07/11, 07/11/11, and 07/18/11; however, risk for falls was not an identified concern and no interventions were placed for the prevention of falls. Continued review, including review of the Electronic Medical Record (EMR), revealed a fall risk assessment was not completed until 07/22/11. Review of the Fall Risk Assessment, dated 07/22/11, revealed the resident was assigned a score of twenty-six (26), indicating a high risk for falls. According to assessment details, a score greater than nine (9) was considered high risk. Review of the Comprehensive Care Plan revealed new</p>	F 323		

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F 323	<p>Continued From page 106</p> <p>interventions had been added on 07/27/11; however, there was no risk for falls care plan developed and no interventions were implemented for the prevention of falls.</p> <p>6. Record review of Resident #1 revealed the facility admitted the resident on 07/01/11. Record review revealed no documented evidence the residents were assessed upon admission to determine their risk for falls. Review of the 07/23/11 Fall Risk Assessments for Resident #1 revealed the facility assessed the resident as at high risk for falls.</p> <p>7. Record review revealed the facility admitted Resident #6 on 07/01/11. Record review revealed no documented evidence the residents were assessed upon admission to determine their risk for falls. Review of the 07/22/11 Fall Risk Assessments for Resident #6 revealed the facility assessed the resident as at high risk for falls.</p> <p>8. Record review revealed the facility admitted Resident #8 on 07/01/11. Record review revealed no documented evidence the residents were assessed upon admission to determine their risk for falls. Review of the 07/22/11 Fall Risk Assessments for Resident #8 revealed the facility assessed the resident as at high risk for falls.</p> <p>9. Unsamped Residents B, F, H, I, J, K, M, O, P, Q, R, and T revealed the facility admitted the residents on 07/01/11. Record review revealed no documented evidence the residents were assessed upon admission. Review of the Fall Risk Assessments for Unsamped Residents B</p>	F 323		

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F 323	<p>Continued From page 107</p> <p>(on 07/23/11), F (on 07/23/11), H (on 07/23/11), I (on 07/23/11), J (on 07/22/11), K (on 07/23/11), M (on 07/23/11), O (on 07/22/11), P (on 07/23/11), Q (on 07/23/11), R (on 07/23/11) and T (on 07/23/11) revealed all were assessed as high risk for falls. Record review revealed the facility could provide no documented evidence that a falls risk assessment had been completed for Unsampled Residents L, N, and S.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 07/22/11 at 10:30 AM, revealed she had been working on 07/01/11 when twenty-two (22) residents were admitted from another facility. She stated it was hard to know where to start when so many residents began arriving. Continued interview revealed she went room to room, took vital signs and looked at the residents' skin for problems. She further stated she wrote her findings on a piece of paper and gave it to the Assistant Director of Nursing (ADON) at the end of the shift. LPN #8 reported she did not know what the ADON did with the information. Further interview revealed the ADON was no longer employed at the facility.</p> <p>Telephone interview with the former Director of Nursing (DON), on 08/04/11 at 11:00 AM, revealed she was not aware the assessments were not done on admission. She stated she assumed everything was done per protocol. She further stated she did not monitor the admission documentation for completeness. Continued interview revealed she had no explanation for why assessments weren't done per policy or why she did not know there was a problem.</p> <p>Interview with Nurse Consultant #1, on 08/04/11 at 4:30 PM, revealed she was aware fall risk</p>	F 323		

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F 323	<p>Continued From page 108</p> <p>assessments required during the admission process had not been done. She stated it was impossible to understand why proper procedures had not been followed since she was not brought into the facility until 07/18/11.</p> <p>7. Observation, on 07/26/11 at 11:40 PM, revealed the Storage Utility Room on "B" Hall was unlocked. Observation of the room revealed the following products: plastic bottle labeled Blue Bowl Cleaner, and plastic bottle of Virex 256 (disinfectant).</p> <p>Observation, on 07/26/11 at 11:55 AM, revealed the Soiled Utility Closet on Hall "A" was unlocked. Further observation revealed the room contained the following products: plastic bottle of Virex 256, and bottle of Blue Bowl Cleaner.</p> <p>Review of the Blue Bowl Cleaner Material Safety Data Sheet (MSDS) hazards identification section revealed: Skin/Eye - severe burns, Ingestion - harmful or fatal, and Inhaled - Harmful Corrosive Fumes. Review of the Virex 256 MSDS hazards identification section revealed: Eye contact - moderately irritating, Ingestion - Irritating.</p> <p>interview with CNA #16, on 07/26/11 at 12:10 PM, revealed she was taught to lock the soiled utility room; however, we do not have a key. I think the nurses have a key.</p> <p>Interview with CNA #1, on 07/26/11 at 12:15 PM, revealed the Soiled Utility Closet on Hall "A" was not locked because they don't have keys for all staff. Further interview revealed residents could get into the closet when it is unlocked.</p>	F 323		

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F 323	<p>Continued From page 109</p> <p>Observation, on 07/26/11 at 11:55 AM, revealed the door to electrical room (IDF #1) was unlocked. This room was just outside of the entrance to 'C' household, in the central hallway. Observation revealed IDF #1 contained the electrical junction/power panels for the facility. It was further observed that a loop of Local Area Networks (LAN) cable had been looped over the door knob and shaped in a way that extended past the door. The LAN cable prevented the door from closing and automatically locking. A key was necessary to access the lock on IDF #1's door.</p> <p>Interview with Nurse Consultant #1, on 07/26/11 at 3:40 PM, revealed the door to IDF #1 should be locked at all times to prevent residents from unauthorized access.</p> <p>Further observation, on 07/26/11 at 12:00 PM, revealed the residents' family laundry room (123 D), had no lock on the door. 123 D was located in the central hallway near the entrance to 'C' household. Room 123 D contained two (2) clothes washing machines, and two (2) clothes dryers. Two (2), one (1) gallon plastic containers of liquid bleach, three (3) one (1) gallon plastic containers of liquid soap, and a one (1) gallon plastic container of 'Gain' brand liquid laundry detergent were observed within the sink cabinet.</p> <p>Review of Liquid Bleach MSDS sheet health hazards revealed: Eye contact - may cause severe but temporary eye injury, and Ingestion - Nausea and vomiting. Review of Gain Liquid Laundry detergent MSDS sheet health hazards revealed: Ingestion - may result in gastrointestinal irritation with nausea, vomiting,</p>	F 323			

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F 323	Continued From page 110 and/or diarrhea.	F 323		
F 325 SS=E	<p>Interview with Nurse Consultant #1, on 07/26/11 at 3:40 PM, revealed all hazardous materials were to be securely stored. She stated, the reason room 123 D was not a secured room (lockable) was unknown.</p> <p>483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of facility policy it was determined the facility failed to ensure policy and procedures were implemented to obtain and monitor residents' weights and to monitor residents' food consumption to ensure residents maintained acceptable parameters of nutritional status for six (6) of eighteen (18) sampled residents (Residents #10, #11, #7, #8, #1 and #6) and fifteen (15) unsampled residents, Unsampled Residents (B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T).</p> <p>The findings include:</p>	F 325		

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F 325	<p>Continued From page 111</p> <p>Review of the facility's policy titled "Weight Book Guidelines", revealed height and weight must be obtained within twenty-four (24) hours of admission. Further review revealed weekly weights were to be recorded every Thursday.</p> <p>Review of the facility "Weight Policy", revealed all new admissions would be placed on weekly weights until their weight was stable and this would be the responsibility of the nurse on duty at the time of the new admission. Further review revealed if a resident had a weight loss of five pounds or more and this had been verified by a re-weight and the nurse on duty, the facility was to notify the attending Physician; Power of Attorney, and Dietician. Review of the policy revealed all recommendations would be implemented immediately.</p> <p>1. Review of Resident #10's medical record revealed the facility admitted the resident from another facility on 07/01/11 with diagnoses which included Dementia and Diabetes Mellitus.</p> <p>Review of the medical record revealed prior to admission; the resident's intake had been fifty to seventy-five percent (50-75%) most meals and the resident weighed one hundred twenty (120) pounds in June 2011. Further review revealed there was no documented evidence of an admission weight.</p> <p>Interview, on 08/02/11 at 5:00 PM, with Licensed Practical Nurse (LPN) #8 revealed there were twenty-two (22) residents who were admitted from another facility on 07/01/11 and she had admitted Resident #10 as well as five (5) other</p>	F325F 325	<p>The facility, based on a resident's comprehensive assessment, ensures that a resident maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible and receives a therapeutic diet when there is a nutritional problem.</p> <p>1. Resident #10's weight records were obtained 8/22/11 by the Diet tech and physician ordered labs were obtained on 7/19/11 and again 8/5/11, 8/9/11 and again 8/16/11, 8/23/11, 9/6/11, 9/16/11. Care plan has been reviewed and revised by the Diet tech on 8/30/2011, 9/15/2011 and 9/19/2011. . Residents #10, 11, 7, 8, 1, 6, B, F, H, I, J, K, L, M, N, O, P, Q, R, and T weight records were obtained 8/22/11 along with meal consumption being obtained by the C.N.A.'s and recorded in the EMR. (Electronic Medical Record) being monitored weekly and care plans reviewed and revised on 8/30/11, 9/15/11 and 9/19/11 by the Diet Tech or Dietician as needed.</p>	9/20/11

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F 325	<p>Continued From page 112</p> <p>residents that day. She stated she did not obtain weights for the residents she admitted on 07/01/11 because it was overwhelming.</p> <p>Review of the facility Weight Record revealed the first weight obtained on Resident #10, was on 07/15/11 and was recorded as one hundred-fourteen (114) pounds. This was a significant weight loss of six (6) pounds (5%) from the resident's weight prior to admission. However, there was no evidence the resident's physician had been notified of this weight loss.</p> <p>Review of the Nutritional Disorders Note, dated 07/15/11, written by the Registered Dietitian revealed the resident was known to the writer from the previous facility and was noted to have a marked decline in PO (by mouth) intake since the move to the new facility and required more assistance than usual. Further review revealed the resident's PO intake was twenty-five to fifty percent (25-50%) per documentation.</p> <p>Review of the Dietician/Nutritional Recommendations made by the Dietitian on 07/15/11, revealed recommendations for a Pre-albumin, Complete Blood Count (CBC), Renal Panel, Speech Therapy (ST) Screen, Occupational Therapy (OT) Screen, and liberalize diet to regular/discontinue the Consistent Carbohydrate Diet. Review of the Physician's Orders, dated 07/19/11, revealed Physician's Orders for ST and OT to evaluate and treat. However, there was no documented evidence of orders related to obtaining a Pre-albumin level, a CBC, Renal Panel or liberalizing the diet and no documented evidence the Physician was notified of the recommendations to obtain orders.</p>	F 325	<p>2. Remaining residents have been assessed by dietician and/or Diet tech for weight variations and care plans updated as appropriate on 8/30/11, 9/15/2011 and 9/19/2011.</p> <p>3. The facility is obtaining a weekly weight on new admissions X(4) weeks and then the dietician determines if weekly weight are still necessary. An admission check list has been developed by the D.O.N. to include admission weight to be reviewed by the I.D.T. (Interdisciplinary Team) during the morning meeting to assure compliance. The policy for admissions was reviewed and revised. Nurses and CNA's were in-serviced 8/4/11, 8/16/11, and 8/18/11, 8/24/11 on meal service, hydration program, lab processing, doctor notification, admission policy, recording meal intake and weekly weights by D.O.N./A.D.O.N. and/or Nurse Consultant. Dietician and/or diet tech will audit weekly weights for the next 4 weeks. Diet tech, is monitoring staff for (2) two meals/day, 5 days each week for 4 weeks to see proper hydration and nutrition is followed. The audit findings will be submitted to the Quality Assurance Committee (QA).</p>	

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F 325	<p>Continued From page 113</p> <p>Review of the resident's Plan of Care, dated 07/15/11, completed by the Dietitian, revealed the resident was at high nutritional risk related to weight loss, decline in PO (by mouth) intake, need for therapeutic diet, and diagnosis of Diabetes Mellitus with a goal stating the resident would maintain a weight of one hundred fourteen (114) pounds. The interventions included monitoring intake of meals and recording percentages, weekly weights, and notifying the Physician of any significant changes.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 07/26/11 revealed the facility assessed the resident as having short and long term memory problems and as having severe impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring one person to assist the resident with eating and as having a weight loss of five (5) percent (5%) in the last month or loss of ten percent (10%) or more in the last six (6) months.</p> <p>Review of the Care Area Assessment Summary, dated 07/26/11, revealed the resident had functional problems which affected the ability to eat including Arthritis, vision problems, the need for a special diet, and the inability to perform Activities of Daily Living (ADL's) without significant physical assistance. Further review revealed the resident was at high nutritional risk related to weight loss over six (6) months and the resident's intake had declined requiring the resident to require more assistance with meals.</p> <p>Interview, on 07/28/11 at 10:15 AM, with the</p>	F 325	<p>4. To assure compliance with weekly weights and insure care plans have been updated along with physician notification, nurses were inserviced on the revised weight loss policy and protocol by the D.O.N./A.D.O.N. and/or Nurse Consultant on 8/18/11 and 8/24/11. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	

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F 325	<p>Continued From page 114</p> <p>Dietary Technician revealed she was to ensure the weights were obtained and performed calculations to identify weight losses. She further stated the Certified Nursing Assistants (CNA's) obtained the weights, the nurses entered the weights in the computer, and she received the handwritten weights from the weight book to review. Continued interview revealed there were twenty-two (22) residents moved from another facility on 07/01/11 and those residents weights were not obtained on admission including Resident #10. She stated the weekly weights may not have been done.</p> <p>Interview, on 08/02/11, at 12:40 PM with the Dietitian revealed the facility did not obtain weights for the residents who were admitted on 07/01/11 until 07/15/11, although she had requested weights since 07/01/11. Further interview revealed she had the previous facility's weight for Resident #10 because she worked at the resident's previous facility. She stated she had noticed the weight loss, on 07/15/11, after finally receiving the weights. She stated she recommended the lab work, ST and OT screens, and liberalizing the diet. Further interview revealed she wrote recommendations on a form, and gave copies to the unit nurses in order for them to notify the Physician of the recommendations and obtain the recommended orders. She stated her recommendations, dated 07/15/11, were not followed in reference to ordering the labs and liberalizing the diet. She further stated she made new recommendations on 08/02/11.</p> <p>Review of the new recommendations dated 08/02/11 revealed recommendations to obtain a</p>	F 325		

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F 325	<p>Continued From page 115</p> <p>Pre-albumin, Renal Panel, CBC, urine specimen, discontinue the consistent carbohydrate diet, and assess the need for Lasix (diuretic medication) in light of weight loss.</p> <p>Review of the Physician's Orders dated 08/02/11 revealed orders written by the Dietitian which stated "recommend"; obtaining labs including a Pre-Albumin, CBC, BMP(Basic Metabolic Panel), liberalizing diet to Regular, asking the Physician to assess Lasix dose, and notifying the Physician of a weight loss of 12% in the last six (6) months. Further review revealed a Physician's Order dated 08/02/11 for Med Pass 2.0 (dietary supplement) 120 milliliters twice a day.</p> <p>Interview, on 08/02/11 at 3:30 PM, with Licensed Practical Nurse (LPN) #5 revealed she had faxed the dietary recommendations to the Physician on 07/15/11; however, there was no documented evidence the recommendations were faxed or that the Physician had been notified of the recommendations.</p> <p>Review Resident #10's Meals &amp; Weight Record for July 2011 revealed there were several meals which were not recorded for intake including 07/02/11 at supper, 07/04/11 at breakfast and lunch, 07/05/11 at supper, 07/06/11 at lunch, 07/09/11 and 07/10/11 at breakfast and lunch, 07/12/11 at supper, 07/15/11 at lunch, 07/18/11 and 07/19/11 at lunch, 07/21/11 at supper, 07/22/11 at lunch, 07/29/11 at breakfast and lunch, and 07/31/11 at supper. Further review revealed on the days all three (3) meals were recorded, the average meal intake for the twenty-four hours was 41% to 75%.</p>	F 325			

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F 325	<p>Continued From page 116</p> <p>Continued interview with the Dietitian on 08/02/11 at 12:40 PM revealed she could get a general idea of the meal consumption from the Meals and Weight Record; however, had noted there were several meals for all the residents in which there was no documentation of meal intake and she had concerns.</p> <p>Interview, on 07/27/11 at 4:25 PM, with Licensed Practical Nurse (LPN) #4 who was consistently assigned to the resident, revealed the Nurses did not review the Meals and Weight Record and the aides were to let the Nurses know if there was a decrease in food intake. She stated if poor intake was reported by the aides, the Nurses were to call the Physician. She further stated Resident #10 had poor intake sporadically; however she was unaware of the weight loss.</p> <p>Interview on 08/04/11, at 4:50 PM, with Certified Nursing Assistant (CNA) # 21, who was assigned to the resident, revealed she was to verbally report to the nurses if a resident was not eating well and document the resident's consumption in the kiosk (computer). She stated the kiosk would show the residents consumption for a week at a time; however, she did not consistently review the intakes.</p> <p>Interview with the Attending Physician, on 08/04/11 at 1:00 PM, revealed he was unaware of the resident's weight loss since the transfer to the facility until recently. He further stated he was unaware of the dietary recommendations dated 07/15/11 until 08/02/11.</p> <p>Interview, on 08/04/11 at 10:00 AM, with the previous Director of Nursing (DON) who worked</p>	F 325		

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F 325	<p>Continued From page 117</p> <p>at the facility until 07/15/11, revealed she would not have expected the nurses to obtain admission weights because the residents would have June 2011 weights from the previous facility. Continued interview revealed the CNA's were to input the meal consumption in the computer and the Nurses were to monitor the intake if there was a problem with residents not eating; however, the Nurses did not need to monitor the residents' intake on a daily basis.</p> <p>Interview, on 08/04/11 at 4:30 PM, with Nurse Consultant #1, Nurse Consultant #2 and the Interim DON, revealed they became aware of Resident #10's significant weight loss on 08/03/11 and recognized there was a problem related to timely notification to the Physician of weight loss and dietary recommendations not being followed. Further interview revealed the Dietitian would be writing recommendations on the Physician's Orders with the chart flagged for the nurse to follow up with notification to the Physician.</p> <p>2. Record review revealed the facility admitted Resident #11 on 07/01/11 with diagnoses which included Diabetes Mellitus, Cerebral Vascular Accident, and a Gastric Feeding Tube.</p> <p>Review of the resident's Plan of Care dated 07/07/11 revealed the resident required tube feeding due to a history of Dysphagia which impeded adequate PO (by mouth) intake, and was at high nutritional risk. The goals included maintaining weight and increasing PO Intake to at least 75% of meals. The interventions included monitoring the percentage of PO intake each meal daily and weekly weights. Review of the Physician's Orders dated 07/14/11 revealed</p>	F 325		

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F 325	<p>Continued From page 118 orders for weekly weights.</p> <p>Review of the Meals &amp; Weight Record for 07/11 revealed meal percentages were not consistently recorded for intake including 07/01/11 at lunch, 07/02/11 at supper, 07/04/11 at breakfast and lunch, 07/05/11 at supper, 07/06/11 at lunch, 07/09/11 and 07/10/11 at breakfast and lunch, 07/12/11 at supper, 07/15/11 at lunch, 07/18/11 and 07/19/11 at lunch, 07/21/11 at supper, 07/22/11 at lunch, and 07/26/11 at supper. Further review revealed on the days all three meals were recorded the average meal intake for the twenty-four hours was 33% to 75%.</p> <p>Review of the Dietary Weight Report revealed the first weight obtained at the facility was on 07/15/11 for 205 pounds, and the second weight was obtained on 07/28/11 at 206 pounds. There was no evidence of an admission weight or weekly weights obtained.</p> <p>Interview, on 08/02/11 at 5:00 PM, with Licensed Practical Nurse (LPN) #8 revealed she had admitted Resident #11 and did not obtain a weight on admission due to multiple residents being admitted at the same time.</p> <p>3. Review of the clinical record revealed the facility admitted Resident #7 from another facility, on 07/01/11, with diagnoses which included Gastroesophageal Reflux Disease, Dyslipidemia, Coronary Artery Disease and Chronic Pressure Ulcers.</p> <p>Review of the Comprehensive Care Plan, dated 07/07/11, revealed the facility identified Resident #7 resident as being a high nutritional risk.</p>	F 325		

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>		
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F 325	<p>Continued From page 119</p> <p>Continued review revealed interventions for monitoring meal intake and weekly weight trending.</p> <p>Review of the Weight Record for the period 07/01/-08/05/11 revealed Resident #7 was first weighed on 07/15/11, two (2) weeks after admission. Continued review revealed the next recorded weight was two (2) weeks later, on 08/01/11.</p> <p>Review of the Meals &amp; Weight Record for the period between 07/01/11 and 08/05/11 revealed no intakes were recorded for twenty-five (25) meals during the month. Only six (6) snacks were documented during the same period.</p> <p>4. Review of the clinical record revealed the facility admitted Resident #1 on 07/01/11 with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Continued review revealed the resident was status post Cardiovascular Accident and dependent on staff for all care.</p> <p>Review of the Comprehensive Care Plan revealed the resident was assessed to be high nutritional risk related to Dysphagia, with a history of poor intake and weight loss. Interventions included "monitor intake of meals and record percentages."</p> <p>Review of the Meals &amp; Weight Record for 07/01-08/05/11 revealed no documentation of meal intake for twenty-four (24) meals during the period. Continued review revealed the only documented weight for Resident #1 was on 07/15/11. There was no evidence weekly weights</p>	F 325			

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F 325	<p>Continued From page 120 were being obtained.</p> <p>5. Review of the clinical record revealed the facility admitted Resident #6 on 07/01/11 with diagnoses which included Alzheimer's Disease and Hyperlipidemia.</p> <p>Review of the Comprehensive Care Plan revealed the resident was assessed as high nutritional risk. Interventions included instructions to monitor percentage intake each meal.</p> <p>Record review revealed no evidence Resident #6 was weighed by the facility upon admission as per facility protocol. Further review revealed Resident #6 was not weighed until 07/15/11, two (2) weeks after admission.</p> <p>Review of the Meals &amp; Weight Record revealed no documentation of thirty-three (33) meals between 07/01/11 and 08/04/11. Continued review revealed only five (5) snacks were recorded during the same period.</p> <p>4. Record review revealed the facility admitted Unsampld Resident B on 07/01/11 with diagnoses with Dementia and Diabetes Mellitus.</p> <p>There was no documented evidence the facility weighed the resident on admission as per facility policy, as evidenced by the first weight obtained on 07/15/11, fourteen (14) days after admission.</p> <p>Review of the resident's "Meals and Weight" documentation revealed of the twenty-five documented days from 07/02/11 through 08/04/11, sixteen (16) of the seventy-five (75) meals had no documented intake. Continued</p>	F 325		

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F 325	<p>Continued From page 121</p> <p>review revealed nine (9) days between 07/02/11 and 08/04/11 had no documented intake for any meals; 07/05/11, 07/09/11, 07/14/11, 07/16/11, 07/17/11, 07/18/11, 07/21/11, 07/23/11 and 07/24/11.</p> <p>5. Record review revealed the facility admitted Resident #8 on 07/01/11. There was no documented evidence of an admission weight or weekly weights as per facility admission policy and procedure. Resident #8's first recorded weight was entered 07/15/11.</p> <p>Review of Resident #8's Meal and Weight Record for 07/11 revealed twenty-one (21) of ninety-six (96) meals were not documented. In addition, thirty-one (31) of thirty-two (32) AM snacks were not documented, thirty-one (31) of thirty-two (32) PM snacks were not documented, and thirty-one (31) of thirty-two (32) night (HS) snacks were not documented.</p> <p>6. Record review revealed the facility admitted Unsampled Resident F on 07/01/11. There was no documented evidence of an admission weight or weekly weights. The first recorded weight was entered 07/15/11.</p> <p>Review of Unsampled Resident F's Meal and Weight Record revealed twenty-five (25) of ninety-six (96) meals were not documented. In addition, thirty-one (31) of thirty-two (32) AM snacks were not documented, thirty-one (31) of thirty-two (32) PM snacks were not documented, and thirty-one (31) of thirty-two (32) HS snacks were not documented.</p> <p>7. Record review revealed the facility admitted</p>	F 325		
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F 325	<p>Continued From page 122</p> <p>Unsampled Resident H on 07/01/11. There was no documented evidence of an admission weight or weekly weights. The first recorded weight was entered on 07/15/11.</p> <p>Review of Unsampled Resident H's Meal and Weight Record revealed twenty-eight (28) of ninety-six (96) meals were not documented. In addition, thirty-two (32) of thirty-two (32) AM snacks were not documented, twenty-seven (27) of thirty-two (32) PM snacks were not documented, and thirty-two (32) of thirty-two (32) HS snacks were not documented.</p> <p>8. Record review revealed the facility admitted Unsampled Residents I, J, K, L, M, N, O, P, Q, R, S and T on 07/01/11. Review of the Meal and Weight Records for these residents revealed no documented evidence of meal intake for twenty-four (24) meals or more between 07/01/11 and 08/05/11. In addition, the facility failed to weigh these residents on admission as per facility policy. Further record review revealed the facility failed to obtain a weight for the unsampled residents prior to 07/15/11, two (2) weeks after admission. Unsampled Resident R was not weighed until 07/28/11, four (4) weeks after admission.</p> <p>Interview, on 08/04/11 at 4:30 PM, with Nurse Consultant #1, Nurse Consultant #2 and the Interim DON, revealed they were aware the weights were not completed for the residents who were admitted 07/01/11. Further interview revealed they were aware there was an issue with the meal intakes not being documented and a recent in-service had been completed with staff related to documenting meal intakes. Continued</p>	F 325			

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F 325	Continued From page 123 interview revealed there were no committees in place to evaluate the residents' nutritional status. However, they would be instituting an interdisciplinary team meeting which would meet every week to discuss weights. Further interview revealed the Dietitian was now tracking weights and would inform the Nurses and Nurse Management of significant weight changes.	F 325		
F 333 SS=D	<b>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</b>  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the residents were free of significant medication errors for two (2) of eighteen (18) sampled residents (Residents #11 and #7).  Resident #11 had Physician's Orders dated 07/11 for Lantus 100 Units/ML (milliliter), inject thirty-seven (37) Units subcutaneously (SQ) at 9:00 PM. Review of the Medication Administration Record (MAR) dated 07/11 revealed the medication had not been documented as administered 07/01/11 through 07/15/11. On 07/16/11 new Physician's Orders were obtained to increase the Lantus Insulin to forty-one (41) Units at 9:00 PM. However, when staff transcribed the new order for the Lantus 41 Units, and discontinued the order for the Lantus 37 Units on the MAR, there was no documented evidence the Physician was notified.	F 333		

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F 333	<p>Continued From page 124</p> <p>Resident #6 was transferred to the facility with medication orders including Baclofen, Ferrous Sulfate, Calcium with Vitamin D and Nadalol. When the facility admitted the resident on 07/01/11, the facility failed to transcribe the orders correctly and Resident #6 received the wrong dose of all four (4) medications until 07/22/11 when the discrepancy was identified by the survey team.</p> <p>The findings include:</p> <p>Review of Resident #11's medical record revealed the facility admitted the resident on 07/01/11 with diagnoses which included Diabetes Mellitus.</p> <p>Review of the Physician's Orders dated 07/01/11 revealed orders for Lantus Insulin 100 Units/ML (milliliter), Inject thirty-seven (37) Units subcutaneously (SQ) at 9:00 PM. Review of the Medication Administration Record (MAR) dated 07/11 revealed the medication had not been documented as administered from 07/01/11 through 07/15/11.</p> <p>Review of the Physician's Orders dated 07/16/11 revealed orders to increase the Lantus Insulin to forty-one (41) Units at 9:00 PM.</p> <p>Further review of the MAR revealed the Lantus Insulin 37 Units for 9:00 PM was discontinued and the new order for Lantus Insulin 41 Units every day at night was handwritten in with an arrow pointing to 07/16/11 to start the medication.</p> <p>Interview, on 08/04/11 at 6:00 PM, with Licensed Practical Nurse (LPN) #4, revealed she had</p>	F 333  F333	<p>The facility ensures that residents are free of significant medication errors.</p> <p>1. Resident #11's physician was notified by the surveyor of the medication omission at the time of the survey and revised orders were received by a staff nurse on 8/4/2011. No adverse effects were noted from the omission. Resident #7 medication order has been clarified with physician and he is receiving correct dosage of medication with no adverse effects noted. Resident #6 was incorrectly identified. The listed medication orders are for Resident #7. D. O. N. clarified resident orders with his physician on 8/4/2011.</p>	9/20/11
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F 333	<p>Continued From page 125.</p> <p>transcribed the order on 07/16/11 for the Lantus 41 Units and discontinued the Lantus 37 Units on the MAR. She stated, she realized the MAR had not been signed off as the Lantus Insulin being administered at 9:00 PM for 07/01/11 through 07/15/11; however, did not remember calling the Physician to notify him or questioning the nursing staff about the lack of documentation.</p> <p>Further interview, on 08/05/11 at 3:00 PM, with LPN #4 revealed the Physician was notified on 08/04/11 that the Lantus Insulin 37 Units was not documented at 9:00 PM for 07/01/11 through 07/15/11 after surveyor intervention. She further stated a Physician's Order was received at that time to decrease the 9:00 PM scheduled Lantus Insulin to 37 Units. Continued interview revealed she felt it was a significant mistake to fail to notify the Physician of the 9:00 PM Lantus Insulin not being documented as administered at the time she was transcribing the order for the increased dose of Insulin.</p> <p>Interview, on 08/05/11 at 3:30 PM, with the Attending Physician, revealed he was not notified of the lack of documentation on the MAR indicating the Lantus Insulin 37 Units was not administered from 07/01/11 through 07/15/11 at the time he wrote the order. He stated he thought the resident's blood sugar was higher than it should have been and that was the reason for the Order for the increased dosage of Insulin on 07/16/11. He further stated it was a significant medication error to fail to administer the Insulin as ordered. Further interview revealed the resident could have had a reaction related to not receiving the Insulin as ordered, and then receiving an increased dose of 41 Units.</p>	F 333	<ol style="list-style-type: none"> <li>2. A pharmacy audit of physician orders for all residents was completed on 8/5-8/7/11 by a MedCare Pharmacy consultant to determine if additional clarification of orders was indicated. Physicians were notified with clarifications needed and new orders received as appropriate.</li> <li>3. See Element #2 above. Audit compared MD orders with MAR's. Nurses were re-inserviced 8/4/11, and 8/18/11 on the admission process, medication administration, doctor order processing, and physician notification by D.O.N., A.D.O.N. and/or nurse consultants as well as pharmacy consultant. Med Pass Observations will be done by the D.O.N., A.D.O.N. and/or Pharmacy consultant on a quarterly basis. Pharmacy consultant is conducting med pass observation audits for licensed nurses with findings reported to D.O.N., D.O.N., A.D.O.N. and/or nurse consultants who will audit 5 resident medication administration records (MAR's) each week for the next 4 weeks to assure medication administration and med pass timeliness.</li> </ol>	

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F 333	<p>Continued From page 126</p> <p>Continued interview revealed the nurse who transcribed the order for the increased dose of Insulin should have contacted him regarding the lack of documentation on the MAR.</p> <p>Interview, on 08/05/11 at 2:00 PM, with LPN #5, who was assigned to administer medication to Resident #11 on 07/01/11, 07/05/11, 07/09/11, 07/10/11, and 07/14/11 revealed she did not remember administering Lantus 37 Units to Resident #11 at 9:00 PM, even though she signed off the medication as being administered. Further interview revealed she was hired at the facility on 06/20/11 and had been a nurse for three (3) years. She further stated pharmacy had observed her on medication pass for competency at another facility; however, she had never been observed on medication pass at this facility. She stated she received orientation at the facility which included following a medication nurse on the medication cart. Continued interview revealed it would be a significant medication error to not administer Insulin as ordered, because the resident could have an adverse effect.</p> <p>Interview, on 08/05/11 at 3:35 PM, with LPN #6, who was assigned to administer medication to Resident #11 on 07/06/11, 07/07/11, 07/08/11, 07/11/11, 07/12/11, 07/13/11, and 07/15/11, revealed she had been licensed as a nurse since 02/11 and was hired at the facility on 06/20/11. She stated she had received orientation to administering medication by watching a video and by following another nurse on the medication cart; however, she had never been observed for competency while passing medications. She stated if she was withholding a medication, she would document her initials and circle the initials</p>	F 333	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected, and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented.</p> <p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	
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F 333	<p>Continued From page 127</p> <p>as well as write a reason for holding the medication on the back of the MAR. Further interview revealed she was administering Resident #11's 9:00 PM scheduled Lantus Insulin; however, was not signing it on the MAR because the other nurses were not signing it. She stated she was new and had to question the other nurses on a lot of issues; however, had not questioned the nurses related to their reason for not signing out the medication.</p> <p>Interview, on 08/03/11 at 11:15 AM, with the Pharmacist revealed he tried to watch medication pass with each nurse at least once a year, and the last time he watched a nurse on medication pass was in 02/11 or 03/11. Further interview, on 08/05/11 at 6:00 PM, revealed it was a significant medication error to not administer Insulin because if Insulin was not administered as ordered, the resident's blood sugar would not be under control.</p> <p>2. Record review revealed the facility admitted Resident #7 on 07/01/11, from another facility with diagnoses which included Coronary Artery Disease, Hypertension and Anemia.</p> <p>Review of the Physicians Order Sheet, dated 08/30/11 from the previous facility, revealed Resident #7 was to be transferred to the receiving facility with continuation of all orders, including the following medication order: Nadalol (for high blood pressure) 5 mg once daily. Review of the admission Physician's Orders for July 2011 revealed the medication was resumed on admission by the facility as follows: Nadalol 10 mg once daily.</p>	F 333		

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F 333	<p>Continued From page 128</p> <p>Review of the MAR for the entire month of July 2011 revealed the drug was administered according to the incorrect dose initiated by the facility upon admission. Review of the Physician's Orders and the MAR for August 2011 revealed the order had been verified by the Physician, only after surveyor intervention.</p> <p>Upon comparative review of the transfer orders and the admission order with the Pharmacist on 08/02/11, he confirmed order discrepancy.</p> <p>Interview with the Pharmacist, on 08/02/11 at 2:50 PM, revealed the facility Pharmacy also served the prior facility. He stated the medications from the previous facility were already in the Pharmacy's computer system when the residents were admitted by the facility. He reported the facility requested new orders be printed for Resident #7 on 07/01/11, the date of admission. Continued interview revealed the medication orders should have been the same when printed and he could not explain what had happened. He stated he had no knowledge of the error prior to being notified by the survey team. On further interview, the Pharmacist acknowledged the doubled dose of Nadalol, given for high blood pressure, could be considered a significant error. Subsequent interview with the Pharmacist, on 08/05/11 at 6:00 PM, revealed it was the Pharmacy's responsibility to ensure admission medication orders were correct. He stated he visited the facility on 07/13/11 to conduct the monthly Medication Regimen Review (MRR). He further stated he did not identify the discrepancy in medication orders during the review.</p>	F 333		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD VILLA HILLS, KY 41017</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 356	<p>Continued From page 129</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to post the nurse staffing data requirements in a prominent place readily accessible to residents and visitors.</p>	F 356  F356	<p>The facility posts daily nurse staffing date in a clear and readable format in a prominent place and maintains the data as required by State law.</p> <ol style="list-style-type: none"> <li>1. The facility is posting daily nurse staffing data.</li> <li>2. No residents were affected by this practice.</li> <li>3. Human Resource Director and the nurses have been inserviced by D.O.N./ A.D.O.N. and/or nurse consultants on the requirement to post nurse staffing on 08/04/11. D.O.N , A.D.O.N and/or nurse consultants will audit the nurse staff posting 5 times each week for the next 4 weeks.</li> <li>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.</li> </ol>	9/20/11

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>
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F 356	<p>Continued From page 130</p> <p>The findings include:</p> <p>Observation during tour of the facility, on 08/03/11 at 9:00 AM, revealed there was no posting of a Nurse staffing data sheet in a prominent place readily accessible to residents and visitors.</p> <p>Interview, on 08/03/11 at 9:40 AM, with the facility's Interim Director of Nursing (DON) revealed she was not aware of the facility posting the nursing staffing data information in a public place. She said the facility's Human Resource Manager may be more familiar with this requirement.</p> <p>Interview, on 08/03/11 at 9:50 AM, with the facility's Human Resources Manager revealed she did not know that posting this information was requirement and that the nursing staffing data was not being posted at all.</p> <p>Interview, on 08/03/11 at 11:50 AM, with RN #3 (Nurse Consultant #1) revealed the nurse staffing data was currently not being posted.</p>	F 356	<p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	
F 371 SS=D	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371		

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NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 131  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare and distribute food under sanitary conditions. Observation of the 08/04/11 lunch time meal service revealed improper wearing of hair nets.  The findings include:  Observation, on 08/04/11 at 12:15 PM, revealed SRNA #15's hair net did not properly cover her hair. There was hair which was uncovered protruding from the bottom of the back of the hair net. SRNA #15 was observed to stand near the residents' serving line and was observed to walk into the kitchenette with exposed hair. Interview with SRNA #15, on 08/04/11 at 12:52 PM, revealed her hair net should have fully covered her hair because her hair could fall out and into resident's food.  Observation, on 08/04/11 at 12:35 PM, revealed SRNA #6's hair net did not fully cover hair while she was plating resident's food during the lunch time meal service. Interview with SRNA #6, on 08/04/11 at 12:50 PM, revealed her hair net should have fully covered her hair in order to keep hair from falling into resident's food.  Interview with the Diet Technician, on 08/04/11 at 2:55 PM, revealed hair nets should be completely covering hair while serving and if walking near food.	F371 F 371	The facility maintains that it stores, prepares, distributes and serves food under sanitary conditions. 1. No residents were affected by this practice. 2. No residents were affected by this practice. 3. Facility is wearing hair nets appropriately. Staff has been in-serviced by Dietician or Diet Tech on properly wearing hairnets on 8/4/11. 4. Diet tech, is monitoring staff for proper use of hair nets 2 meals/day, 5 days each week for the next 4 weeks. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.	9/20/11
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	<p>Continued From page 132</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide pharmaceutical services, including procedures to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident. The facility failed to verify the admission orders with the transfer orders when the facility admitted twenty-two (22) residents from another facility, on 07/01/11. As a result of the facility's failure, two (2) of eighteen (18) sampled residents (#7 and #11), received inaccurate dosing of medications, that were determined to be significant medication errors.</p>	F 425  F425	<p>The facility maintains that it provides pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biological) to meet the needs of each resident.</p> <ol style="list-style-type: none"> <li>1. Resident #11's physician has been notified of the medication omission by staff nurse on 7/28/2011 and revised orders were received. No adverse effects were noted. Resident #7 medication order has been clarified by D.O.N. on 8/4/2011 with physician and he is receiving correct dosage of medication. No adverse effects were noted.</li> <li>2. A pharmacy audit of all physician orders was completed on 8/5-8/7/11 by a MedCare Pharmacy consultant to determine if additional clarification of orders was indicated. Physicians were notified with clarifications needed and new orders received as appropriate.</li> </ol>	9/20/11

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>	
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F 425	<p>Continued From page 133</p> <p>Resident #7's admission medication orders included Baclofen, Ferrous Sulfate, Calcium with Vitamin D, and Nadalol. The medications were carried over from the previous facility with inaccurate dosing instructions.</p> <p>Resident #11 had admission medication orders, including Lantus Insulin, thirty-seven (37) units to be given every night. However, the transfer orders from the previous facility included Lantus Insulin, thirty-two (32) units to be given every night.</p> <p>The findings include:</p> <p>1. Review of the Clinical Record revealed the facility admitted Resident #7 on 07/01/11 with diagnoses which included Coronary Artery Disease, Hypertension and Anemia.</p> <p>Review of the Physician's Order Sheet dated 06/30/11 revealed Resident #7 was to be transferred to the facility with continuation of all orders, including the following medication orders: Baclofen 10 milligrams (mg) twice daily and every six hours as needed (to be given between scheduled doses); Ferrous Sulfate (iron) 325 mg twice daily; Calcium 500 mg with Vitamin D 125 international units (IU) twice daily; and Nadalol (for high blood pressure) 5 mg once daily. Review of the admission Physician's Orders for July 2011 revealed the medications were resumed on admission by the facility, on 07/01/11, as follows: Baclofen 10 mg every eight hours as needed; Ferrous Sulfate 325 mg once daily; Calcium 500 mg with Vitamin D 200 IU once daily; and Nadalol 10 mg once daily.</p>	F 425	<p>3. See Element #2 above. All Nurses were re-inserviced 8/4/11 and 8/18/11, on the admission process, medication administration, doctor order processing, and physician notification by D.O.N. and/or Nurse Consultant as well as Pharmacy consultant. Pharmacy consultant is conducting med pass observation audits for licensed nurses with findings reported to D.O.N. D.O.N., A.D.O. N and/or Nurse Consultant will audit (5) five resident medication administration records (MAR's) each week for the next (4) four weeks to assure medication administration and med pass timeliness.</p> <p>4. Audits included comparison with the MD orders. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 425	<p>Continued From page 134</p> <p>Review of the Medication Administration Record (MAR) for the month of July revealed the medications were administered according to the incorrect doses initiated by the facility upon admission.</p> <p>Upon comparative review of the transfer orders and the admission orders, with the Pharmacist on 08/02/11, he confirmed the errors had occurred.</p> <p>2. Review of Resident #11's medical record revealed the facility admitted the resident, from another facility, on 07/01/11 with diagnoses which included Diabetes Mellitus.</p> <p>Review of the the transfer orders dated 08/30/11 revealed Resident #11 was to transfer to the receiving facility with continuation of all current orders. The medication orders included Lantus Insulin 100 Units/ML (milliliter), inject thirty-two (32) units subcutaneously (SQ) every evening.</p> <p>Review of the admission Physician's Orders dated 07/01/11 revealed the order for Lantus Insulin 100 Units/ML (milliliter), inject thirty-seven (37) Units subcutaneously (SQ) at 9:00 PM.</p> <p>Review of the MAR for July 2011 revealed the order was printed at the wrong dose of thirty-seven (37) units. However, there was no documented evidence the Lantus Insulin was ever given. (Refer to F 333)</p> <p>Interview with the Pharmacist, on 08/02/11 at 2:50 PM, revealed the facility Pharmacy also served the prior facility. He stated the medications from the previous facility were already in the Pharmacy's computer system when the residents</p>	F 425			

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F 425 Continued From page 135  
were admitted by the facility. He further stated the facility requested new orders be printed for all twenty-two (22) residents on 07/01/11, the date of admission. Continued interview revealed the medication orders should have been the same when printed and he could not explain what had happened. He stated he had no knowledge of the errors prior to being notified by the survey team. On further interview, the Pharmacist acknowledged the doubled dose of Nadalol, given for high blood pressure, could be considered a significant error. During follow-up interview with the Pharmacist, on 08/03/11 at 11:15 AM, he confirmed the Lantus Insulin error. He stated improper administration of insulin could be serious, as it would affect the resident's blood sugar levels.

F 425

F 441  
SS=K 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -

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F 441	<p>Continued From page 136</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Centers for Disease Control and Prevention (CDC) guidelines, manufacturers instructions, and the facility's policy and procedure, it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to</p>	F 441 F441	<p>The facility maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and helps to prevent the development and transmission of disease and infection.</p> <ol style="list-style-type: none"> <li>Resident #10,11,16, E,U,V,A,W,B Blood glucose monitoring device is being sanitized between use per facility protocol, manufacture recommendations and CDC guidelines when used. No adverse effects have been noted with these residents. Resident #7 no longer needs contact precautions. Staff is following appropriate standard precautions with dressing changes. Resident #3 no longer resides at the facility.</li> <li>No other residents have been determined to be affected from this practice as evidenced by lab results obtained at the time of survey for all residents utilizing the glucometers.</li> <li>Nursing staff in-serviced by D.O.N., A.D.O.N. and/or Nurse Consultant on infection control policy, wound care guidelines, and hand washing on 8/4/11, 8/16/11, and 8/18/11. D.O.N., A.D.O.N. and/or Nurse Consultant will audit infection control procedures such as hand washing and proper wound protocols during normal rounds 3 times weekly for the next 4 weeks. Diet Tech, is monitoring staff for hand washing (2) two meals/day, 5 days each week for 4 weeks with results presented to D.O.N.</li> </ol>	9/20/11
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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>
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F 441	<p>Continued From page 137</p> <p>help prevent the development and transmission of infection for two (2) of eighteen sampled (Resident #10 and #11) residents and two (2) Unsampled Residents (Unsampled A and B). The facility failure to ensure staff properly disinfected shared blood glucose monitors after each use. The facility failure to ensure staff were knowledgeable related to the facility's policy regarding blood glucose monitor cleaning.</p> <p>On 07/28/11, facility staff failed to disinfect the blood glucose monitor according to manufacturer's recommendations and CDC guidelines between testing the blood sugar levels of Residents #10 and #11. In addition, facility staff was observed using a blood glucose monitor to test Unsampled Resident A and Unsampled Resident B's blood sugar levels without disinfecting the device between each use. The facility identified nine (9) residents who required blood glucose monitoring and for which this failure had a likelihood to affect which included (3) of eighteen (18) sampled residents (Resident #10, #11 and #16) and six (6) unsampled residents (Unsampled Resident E, U, V, A, W and B).</p> <p>The facility failed to ensure proper infection control procedures were followed related to dressing changes for Resident #7. Facility staff failed to adhere to standards of practice and facility policy related to isolation precautions for Resident #7 who had a wound infection with contact isolation in place.</p> <p>In addition, Resident #3 had a diagnosis of Clostridium Difficile Toxin Positive and was being treated for the infection with antibiotics. The</p>	F 441	<p>Glucose sanitation audits will be completed by D.O.N./A.D.O.N. and/or Nurse Consultant (2) two times weekly X 4 weeks. Infection control policies and procedures related to the infection control program have been reviewed and/or revised and presented for review with the QA committee during the QA meetings. Staff have been re-inserviced on the Infection Control policies and procedures by D.O.N./A.D.O.N. and/or nurse consultant on 8/4/2011, 8/16/2011 and 9/7/2011.</p> <p>4. The facility is monitoring infection control technique for dressing changes and isolation precautions as stated in Element #3.</p> <p>If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations</p>	

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NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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F 441	<p>Continued From page 138</p> <p>facility failed to display signage on the resident's door and failed to adhere to its policy related to contact precautions.</p> <p>Also, improper hand hygiene was observed during the noon meal service on 08/04/11.</p> <p>The facility's failure to ensure proper infection control practices were followed to disinfect multi-use blood glucose monitors, placed residents in the facility at risk for serious harm, injury, impairment or death. Immediate Jeopardy was identified on 07/28/11 and the facility was notified on 07/29/11.</p> <p>Observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable Allegation of Compliance (AOC). However, non compliance continued to exist at an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the facility established and maintained an effective infection control program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the Centers for Disease Control and Prevention guidelines revealed if blood glucose meters were shared, the device should be cleaned and disinfected after every use. Review of the facility policy, "New Policy Update for Cleaning our Glucometer", undated, revealed the glucometer should be cleaned after every resident with an EPA (Environmental Protection Agency) approved disinfectant that meets the 1:10 bleach solution. Review of the blood</li> </ol>	F 441		

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F 441	<p>Continued From page 139</p> <p>glucose monitor manufacturer's instructions revealed the blood glucose monitor should be disinfected with a 1:10 dilution of 0.5 %-0.6% sodium hypochlorite solution after each use.</p> <p>Observation, on 07/28/11 at 4:15 PM revealed Registered Nurse (RN) #1 entered Unsampld Resident A's room on Unit B with a caddy that contained a blood glucose monitor, alcohol preps, lancets, cotton balls, and test strips. RN #1 was observed testing the blood sugar for Unsampld Resident A. After she completed the blood sugar testing, she entered Unsampld Resident B's room and completed a blood sugar test with the same monitor. Observation revealed she did not clean the monitor between Unsampld Resident A's test and Unsampld Resident B's test.</p> <p>Interview with RN #1 on 07/28/11 at 4:28 PM revealed she cleaned the monitor at the end of the shift with alcohol wipes. She further stated she had received no training by the facility related to cleaning the monitor and was unaware of the manufacturer's guidelines or the facility's policy and procedure.</p> <p>Observation on 07/28/11 at 4:15 PM, revealed Licensed Practical Nurse (LPN) #5 entered Resident #10's room, on Unit C, with a caddy that contained a blood glucose monitor, alcohol preps, lancets, cotton balls, and test strips. LPN #5 was observed testing the blood sugar for Resident #10. After she completed the blood sugar testing, she failed to clean the blood glucose monitor and entered Resident #11's room. She placed the blood glucose monitor on the resident's bedside table, and proceeded to insert a test strip into the monitor. However, the Nurse did not proceed</p>	F 441			

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F 441	<p>Continued From page 140 with testing the resident's blood sugar due to surveyor intervention.</p> <p>Interview with LPN #5 on 07/28/11 at 4:20 PM revealed she was hired by the facility 08/11. She stated she had received no training at the facility related to cleaning the glucometers after each use, and was unaware of the need to clean the glucometers. Continued interview revealed the nurse was unfamiliar with the manufacturer's guidelines and facility's policy related to disinfecting blood glucose monitors after each use.</p> <p>Observation of the caddies on the B and C Units, immediately after interviews with RN #1 and LPN #5, revealed the caddies provided by the facility for blood glucose monitoring contained no disinfectant wipes with a 1:10 bleach solution per CDC guidelines, manufacturer's guidelines, and facility policy.</p> <p>Interview, on 07/28/11 at 5:30 PM, with Nurse Consultant #1, who was serving in an administrative role related to the absence of a Director of Nursing (DON) since 07/14/11, revealed it was the facility's policy to clean the monitors between each resident use. She further stated she was unaware that staff was not cleaning the glucose monitors after each use. Continued interview revealed there was no system in place to monitor staff related to ensure the blood glucose monitors were disinfected between resident use. Further interview, on 07/28/11 at 6:00 PM, revealed she had checked the recent in-service records and found no documented evidence of training related to disinfecting the blood glucose monitors between</p>	F 441		

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F 441	<p>Continued From page 141 residents, per facility policy.</p> <p>2. Review of the policy titled Types of Isolation and PPE (Personal Protective Equipment) Required (no date) revealed contact isolation requires healthcare personnel to "wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment".</p> <p>Review of the clinical record revealed the facility admitted Resident #7 on 07/01/11, with diagnoses which included Status post Right Hip Surgery with a history of Methicillin-Resistant Staphylococcus Aureus (MRSA) at the surgical site.</p> <p>Observation on 07/26/11 at 4:00 PM, revealed a "STOP" sign on the door to Resident #7's room. Interview with Certified Nursing Assistant (CNA) #20 on 07/26/11 at 4:15 PM, revealed the sign was to remind staff of isolation precautions for Resident #7. CNA #20 stated the resident "has wounds" and explained staff were to wear gloves and gowns when caring for the resident. Further observation revealed a cart in the resident's bathroom contained gloves and gowns.</p> <p>During interview on 07/26/11 at 4:15 PM, LPN #4 revealed Resident #7 was in contact isolation for MRSA in a wound. She stated the wound was draining and the resident had a history of MRSA at the site. She explained contact isolation precautions included the wearing of gloves and a gown if there was a chance of coming in contact with wound drainage.</p> <p>Review of laboratory results dated 09/09/10</p>	F 441		

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F 441	<p>Continued From page 142</p> <p>revealed a wound culture, site not specified, was positive for MRSA. Review of the physician's Progress note dated 06/12/11, prior to transfer to the facility, revealed "Chronic MRSA Right hip".</p> <p>Review of the Wound Care Progress Note, dated 08/03/11, also revealed Resident #7 had chronic MRSA of the right hip. Review of the Comprehensive Care Plan regarding skin integrity, dated 07/27/11, revealed no interventions were in place for Resident #7 related to the MRSA or the need for contact isolation precautions.</p> <p>Review of the Wound Report dated 06/28/11, prior to admission, revealed Resident #7 had a Stage II pressure sore on the left outer foot, 4.0 centimeters (cm) long x 2.8 cm wide by 0.8 cm deep. Review of the Wound Report, dated 06/29/11, revealed the resident had a Stage IV pressure sore on the left buttock (or ischium). The wound was measured at 6.0 cm x 7.1 cm x 4.2 cm. Review of the Weekly Skin/Wound Assessment, dated 06/29/11, revealed an unhealed surgical incision present on the right hip.</p> <p>Review of the Physician's Orders for the month of July 2011 revealed orders were in place for dressing changes to the three (3) open wounds.</p> <p>Review of the Skin Condition Report, dated 07/22/11, revealed a copious (very large) amount of drainage was noted at each of the wound sites.</p> <p>During observation of the dressing changes with LPN #4 on 07/27/11 at 10:50 AM revealed the following:</p>	F 441			

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F 441	<p>Continued From page 143</p> <p>The unhealed surgical incision at the right hip was draining at both ends. LPN #4 did not wear a gown throughout the procedure, in spite of the contact precautions and the history of MRSA at the site. In addition, CNA #23 did not wear a gown while assisting with turning and positioning the resident for the wound care although gowns were available in the isolation cart in the resident's bathroom.</p> <p>Observation of the Stage IV ulcer on the left buttock revealed no dressing was in place prior to the procedure. The absence of a dressing could allow any drainage to contaminate bed linens, seat of the wheelchair and sling of the mechanical lift used to transfer the resident. In addition, the resident had no barrier against bacteria entering the wound.</p> <p>Continued observation revealed, after application of the dressing to the left buttock, the nurse picked up the trash can and carried it to the other side of the bed. The nurse proceeded to perform the dressing change to the left foot without changing her gloves or practicing hand hygiene.</p> <p>Interview with LPN #4, on 07/27/11 at 11:00 AM, revealed the resident did remain under contact isolation for the history of MRSA in the right hip wound. She acknowledged the hip wound was draining heavily and stated she and CNA #23 should have worn a gown and gloves per facility policy. Continued interview revealed she should have washed her hands and applied new gloves between wound sites.</p> <p>Interview with the Wound Care Center consultant,</p>	F 441		

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F 441	<p>Continued From page 144</p> <p>an Advanced Registered Nurse Practitioner (ARNP), on 08//03/11 at 3:30 PM revealed she was familiar with Resident #7 and consulted regarding the wounds on an as needed basis when requested. She stated Resident #7's wounds were chronic, as well as the MRSA at the surgical site. When questioned further, the ARNP stated contact isolation precautions were appropriate for the resident.</p> <p>Interview with Nurse Consultant #2 on 08/04/11 at 5:50 PM revealed Resident #7's contact isolation status indicated staff should have worn gowns during the dressing change to the draining wounds.</p> <p>3. Observation during meal service, on 08/04/11 at 12:25 PM, revealed CNA #16 assisted with seating residents at tables by pushing wheelchairs around. CNA #16 was then observed to deliver three (3) bowls of soup to three (3) different residents without changing her gloves or washing her hands between resident contact or prior to food contact. It was noted she held the bowls in such a way that her gloved fingers made contact with the soup.</p> <p>Observation on 08/04/11 at 12:40 PM revealed CNA #16 assisted a resident to replace his/her nasal cannula into their nose and was then noted to serve three (3) more residents their lunch time meal without changing her gloves and washing her hands.</p> <p>Interview with CNA #16 on 08/04/11 at 12:54 PM revealed she should have washed her hands after each resident contact before another resident contact and before handling residents'</p>	F 441		

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F 441	<p>Continued From page 145 food.</p> <p>Interview with the Dietary Technician on 08/04/11 at 2:55 PM revealed hands should be washed and gloves changed between tasks if anything except food is touched.</p> <p>4. Review of the facility's Infection Control Policy (no date) revealed staff were to implement isolation precautions as needed for specific infections. Review of the "Types of Isolation and PPE (personal protective equipment) required" (no date) revealed "Healthcare personnel caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment". Continued review revealed Clostridium Difficile was an example of pathogens requiring contact isolation precautions.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident from a local hospital on 07/20/11 with diagnoses which included Abdominal Pain, Colitis, Fever, Hypertension (HTN), and Chronic Obstructive Pulmonary Disease (COPD). Review of the hospital record revealed a stool culture report dated 07/16/11, indicated Resident #3 was Clostridium Difficile (C-diff) Toxin Positive. Review of the admitting physician's Progress Note dated 07/18/11 revealed a diagnosis of C-diff. Review of the admission orders dated 07/20/11, revealed an order for Vancomycin 250 mg/5 ml oral solution by mouth four (4) times a day. Review of the initial care plan, dated 07/20/11, revealed identified problems included Clostridium difficile.</p>	F 441		

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F 441	<p>Continued From page 146</p> <p>Observation on 07/21/11 at 1:45 PM, revealed no signage displayed on the door to Resident #3's room indicating contact precautions were in effect, per facility policy and procedure, and no PPE was available outside or inside the resident's room. Continued observation, on 07/21/11, between the hours of 1:45 PM and 2:15 PM revealed staff and visitors entered and exited Resident #3's room.</p> <p>Interview with LPN #3 on 07/21/11 at 5:10 PM revealed that per facility policy related to infection control, a sign should have been posted outside the resident's room. In addition, a cart containing PPE should have been placed at the entrance to the room or just inside the entrance. She agreed there was no sign or PPE in place.</p> <p>Interview with the Interim Director of Nursing on 07/21/11 at 5:42 PM revealed she was aware Resident #3 was positive for C-diff when admitted on 07/20/11. She stated gowns were not available at the time of the interview. Continued interview revealed she had informed staff to pass the isolation instructions along to the night shift and she would work on obtaining proper PPE first thing in the morning (07/22/11).</p> <p>Interview on 07/28/11 at 5:30 PM with Nurse Consultant #1 revealed she had been at the facility since 07/18/11 and was temporarily in charge of infection control. She stated there had been no infection control program in place since the previous DON, and Assistant DON left the facility mid July 2011. She further stated she was unaware of what infection control program was in place prior to her arrival at the facility. Further interview revealed the infections were not being</p>	F 441			

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F 441	<p>Continued From page 147</p> <p>tracked and trended at that time; however, the nurses were to indicate resident infections on the twenty-four (24) Hour Report and she was conferring with the nurse about the residents' infections and what follow up was needed related to the infection.</p> <p>The facility provided an Acceptable Credible Allegation of Compliance (AOC) on 08/01/11 that alleged removal of the IJ effective 08/02/11, based on the following;</p> <ol style="list-style-type: none"> <li>1) Nurse Consultant #1 verified the manufacturer's recommendation for sanitizing the Easy Maz L blood glucose monitoring device between resident use, and verified the wipes used at the facility had the proper chemicals to disinfect the device.</li> <li>2) The licensed staff identified as not correctly cleaning the monitors were interviewed to investigate the cause of not following nursing standards of practice related to cleaning the blood glucose monitors and in-services on proper cleaning of the monitors.</li> <li>3) All licensed staff were re-educated by Nurse Consultant #1, Nurse Consultant #2, and Licensed Practical Nurse (LPN) #8 on sanitizing the blood glucose monitor and would be performing a return demonstration prior to working.</li> <li>4) Labs were drawn on the nine (9) residents who received finger stick blood sugars at the facility to check for infectious disease on 07/29/11.</li> </ol>	F 441			

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F 441	<p>Continued From page 14B</p> <p>5) The above actions were discussed at the Quality Assurance Meeting on 07/29/11 and the Medical Director was in agreement with the actions taken and future plans.</p> <p>On 08/04/11, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 08/02/11 based on the following:</p> <p>Observation on 08/04/11 at 4:10 PM revealed Registered Nurse (RN) #1 cleaned the blood glucose monitor with Sani-Wipes before and after performing the fingerstick blood sugar on each resident, as per facility policy.</p> <p>Interview on 08/04/11 at 4:15 PM, with RN #1 revealed she had two (2) inservices related to cleaning the glucometer and it was discussed how to disinfect the monitors and what products to use for disinfecting the monitors. She further stated the monitors were to be cleaned before and after use with the Sani Wipes. She further stated the entire monitor was to be wiped off with the Sani Wipes and the monitor was to air dry for two (2) minutes.</p> <p>Observation, on 08/04/11 at 4:15 PM, with LPN #2 revealed she cleaned the blood glucose monitor with Sani-Wipes before and after performing the fingerstick blood sugar on each resident, as per facility policy.</p> <p>Interview, on 08/04/11 at 4:20 PM, revealed LPN #2 had been educated on the facility's policy related to the proper cleaning of the monitors with Sani Wipes before and after use.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>	
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F 441	<p>Continued From page 149</p> <p>Observation, on 08/04/11 at 4:15 PM, revealed Licensed Practical Nurse (LPN) #10 cleaned the blood glucose monitor with Sani-Wipes before and after performing the fingerstick blood sugar on each resident, as per facility policy.</p> <p>Interview, on 08/04/11 at 4:15 PM, revealed LPN #10 had received a mandatory inservice, prior to 08/02/11, related to disinfecting the blood glucose monitor. She stated she been checked off three (3) times by the Administrative Nurses.</p> <p>Observation, on 08/05/11 at 11:30 AM, revealed RN #4 cleaned the blood glucose monitor with Sani-Wipes before and after performing the fingerstick blood sugar on each resident, as per facility policy.</p> <p>Interview, on 08/05/11 at 11:35 AM, revealed RN #4 was aware of the policy and had been educated on the proper cleaning of the monitor before and after each use with Sani-Wipes.</p> <p>Review of the residents' records revealed all the insulin dependent diabetic residents were tested for the Human Immunodeficiency Virus Antigen/Antibody (HIV AG/AB) and Hepatitis B Surface Antigen (HEP BS AG). Laboratory tests to check for HIV or Hepatitis B infections, were completed for all residents with Diabetes Mellitus who received blood glucose monitoring, on 07/29/11.</p> <p>Interview with Nurse Consultant #2, on 08/04/11 at 3:40 PM, revealed all licensed staff received in-services and had performed competency on the cleaning of the blood glucose monitors prior to 08/02/11. Record review of the Nursing</p>	F 441		

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F 441	Continued From page 150 Roster, the blood glucose monitoring in-services, and competencies revealed all licensed nurses had received the training and had demonstrated competency on the cleaning of the monitors, before 08/02/11.	F 441			
F 490 SS=K	The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC). <b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 observation, interview, record review and review of Centers for Disease Control and Prevention (CDC) guidelines, manufacturers instructions, and the facility's policy and procedure, it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection. This was evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use. The facility failed to ensure staff were knowledgeable related to the facility's policy regarding blood glucose monitor cleaning between resident use.	F 490			

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F 490	<p>Continued From page 151</p> <p>The failure to ensure staff were knowledgeable of the proper procedure to clean blood glucose monitors affected two (2) of eighteen (18) sampled residents and two (2) unsampled residents. Observation on 07/28/11 revealed facility staff failed to disinfect the blood glucose monitor according to manufacturer's recommendations, CDC guidelines, and facility policy, between testing the blood sugar levels of Residents #10 and #11. Additionally, facility staff was observed using a blood glucose monitor to test Unsampled Resident A and Unsampled Resident B's blood sugar levels without disinfecting the device between each use. The facility identified nine (9) residents who required the use of a blood glucose monitor for testing blood sugar for which this failure had a likelihood to affect.</p> <p>In addition, the facility failed to ensure proper infection control procedures were adhered to related to dressing changes for Resident #7, who had a wound infection for which he/she was in contact isolation.</p> <p>In addition, Resident #3 had a diagnosis of Clostridium Difficile (C-diff) Toxin Positive and was receiving antibiotics for the infection. However, the facility failed to display signage on the resident's door and failed to follow its policy related to contact precautions.</p> <p>Also, improper infection control related to hand hygiene was observed during the noon meal service on 08/04/11.</p> <p>The failure of the facility to ensure proper infection control practices were adhered to,</p>	F4900 F-490	<p>The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.</p> <p>1. Resident #10,11,16, E,U,V,A,W,B Blood glucose monitoring device is being sanitized between uses as visualized by the D.O.N., A.D.O.N. and/or Nurse Consultant during glucose sanitation audits No adverse effects have been noted with these residents. Resident #7 no longer needs contact precautions. Staff is following appropriate standard precautions with dressing changes. Resident #3 no longer resides at the facility. Administration is reviewing completed monitors weekly along with information presented during the QA meetings to ensure facility policies and procedures are being followed.</p> <p>2. No other residents have been determined to be affected from this practice as evidenced by lab results obtained at the time of survey for all residents utilizing the glucometers. No other residents in the facility had a diagnosis of C-diff.</p>	9/20/11

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F 490	<p>Continued From page 152</p> <p>placed residents in the facility at risk for serious harm, injury, impairment or death. Immediate Jeopardy was identified on 07/28/11.</p> <p>Observations, staff interviews, and in-service record reviews were completed to verify removal of Immediate Jeopardy as alleged in the acceptable Allegation of Compliance (AOC). The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm, for all residents with a diagnosis of Diabetes Mellitus who received blood glucose monitoring. This was in order for the facility to implement monitoring and a surveillance program.</p> <p>In addition, based on observation, interview, and record review, it was determined the facility's Administration failed to ensure the facility provided a program of activities designed to meet, in accordance with the Comprehensive Assessment, the interest and physical, mental, and psychosocial well-being of the residents. Substandard Quality of Care (SQC) was identified at CFR 483.15 Quality of Life F-248.</p> <p>The Substandard Quality of Care deficient practice included a system failure in which residents were not offered activities according to their interest per the Comprehensive Assessments and the Activities Assessments. The facility failed to ensure activities were performed as scheduled, failed to ensure there was sufficient staff to perform the activities, and failed to ensure sufficient training for staff, who were designated to perform the activities.</p> <p>Additionally, based on interview and record</p>	F 490	<p>3. Facility was following appropriate infection control by 8/2/2011 as noted in the citation. Facility is doing activities as stated previously in F248 which also states the plan of correction for activities. Facility is following proper admission procedures, nutritional programs and taking weekly weights when appropriate per facility policy and stated in F325 plan of correction. Previous Administration, Executive Director (ED) and Director of Nursing (DON) resigned. A new DON was hired on 8/8/11. The facility is actively recruiting a new Executive Director. The Corporate VicePresident/Operations and current ED, is monitoring the facility progress. The facility has hired a new MDS nurse on 8/4/11 and is actively recruiting an Assistant Director of Nursing. Nursing staff in-serviced by D.O.N., A.D.O.N and/or Nurse Consultants on infection control policy, wound care guidelines, and hand washing on 8/4/11, 8/16/11, and 8/18/11. D.O.N., A.D.O.N and/or Nurse Consultants will audit infection control procedures such as hand washing and proper wound protocols during normal rounds (3) three times weekly for the next 4 weeks. Diet tech, is monitoring staff for hand washing (2) two meals/day, 5 days each week for 4 weeks with results presented to D.O.N.</p>	

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F 490	<p>Continued From page 153</p> <p>review, it was determined the facility failed to ensure adequate assessment and monitoring to ensure residents maintained acceptable parameters of nutritional status for six (6) of eighteen (18) sampled residents (Resident #10, #11, #7 #8, #1 and #6) and fifteen (15) unsampled residents, Unsampled Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T). Resident #10 had a significant weight loss of six (6) pounds (5%) from 06/09/11 to 07/15/11. However, the facility failed to notify the Physician of the weight loss and failed to notify the Physician of the Dietician's recommendations which were written 07/15/11. In addition, the facility failed to obtain admission weights per the facility's policy for residents who were admitted on 07/01/11 including Residents #1, #6, #7, #8 #11 and Unsampled Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T. Also, there was no documented evidence of meal intakes being documented, tracked, or monitored consistently.</p> <p>The findings include:</p> <p>1. Based on observation, interview, and record review (of Centers for Disease Control and Prevention (CDC) guidelines, manufacturer's instructions, and the facility's policy and procedure,) it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection as evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use and failed to ensure staff was knowledgeable related to the facility's policy regarding blood glucose monitor cleaning. This affected two (2) sampled residents</p>	F 490	<p>Glucose sanitation audits will be completed by D.O.N., A.D.O.N and/or Nurse Consultants (2) times weekly X 4 weeks.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. Administration is reviewing completed monitors weekly along with information presented during the QA meetings to ensure facility policies and procedures are being followed.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations. QA meetings have taken place on 8/1/11, 8/14/11, 8/31/11 and 9/30/11.</p>	

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F 490	<p>Continued From page 154</p> <p>(Resident #10 and #11) and two (2) unsampled residents. On 07/28/11, facility staff was observed using a blood glucose monitor to test Residents #10 and #11's blood sugar levels without disinfecting the device between each use. Also, on 07/28/11 facility staff was observed using a blood glucose monitor to test Unsampled Resident A's and Unsampled Resident B's blood sugar levels without disinfecting the device between each use. The facility identified nine (9) residents, who require blood glucose monitoring for which this failure has a likelihood to effect. Additionally, staff failed to implement proper infection control technique related to a dressing change for Resident # 7 who was in contact isolation, failed to ensure proper signage was in place and isolation precautions were adhered to for Resident #3 related to the diagnosis of C. Difficile Toxin A, and failed to ensure proper hand hygiene was followed at meal service.</p> <p>2. Review of the Infection Control Policy and Infection Control Reports for the facility, revealed any infection report was sent to the front office to alert other departments of any precautions needed regarding infections. Copies were also to be sent to the Director of Nursing (DON)/Assistant DON for review and follow up. Further review revealed isolation precautions were to be implemented as needed for specific infections, i.e., contact, droplet, and provide staff with appropriate personal protective equipment. "The Director of Nursing has ultimate responsibility for review of completed infection control reports and assessing infection trends or patterns within the facility. Each charge nurse had responsibility for recognizing the signs and symptoms of infection and completing the</p>	F 490			

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F 490	<p>Continued From page 155</p> <p>Infection Report. Physician, family and staff should always be aware of infection and their role in management, prevention of spread and precautions which should be taken. The DON reviews all infection reports monthly and reports to the Safety Committee any trends or patterns. The Safety Committee recommends further services or other education to prevent and/or control infections disease in the facility".</p> <p>Interview was conducted, on 07/28/11 at 5:30 PM and on 08/03/11 at 4:30 PM, with Nurse Consultant #1, who started at the facility on 07/18/11 and was serving in an administrative role due to absence of a DON at the facility since 07/14/11. She stated there was no infection control program in place after the DON left on 07/14/11, and the Assistant DON left on 07/15/11. Further interview revealed the new infection control program was in the process of being implemented. She further stated the glucose monitors should be cleaned between each resident use with bleach wipes as per the facility's policy and the Centers for Disease Control (CDC) guidelines. Continued interview revealed she was unaware staff was not cleaning the glucose monitors after each use with bleach wipes and there was no system in place to monitor staff related to ensuring the cleaning of the blood glucose monitors between resident use. Further interview on 07/28/11 at 6:00 PM, revealed she had reviewed the recent in-services and there was no documented evidence of training related to cleaning the blood glucose monitors per facility policy. Continued interview revealed the facility was not tracking and trending infections when she arrived on 07/18/11.</p>	F 490		

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F 490	<p>Continued From page 156</p> <p>Interview, on 08/05/11 at 5:20 PM, with the Administrator revealed the previous Administrator resigned 07/15/11 and the previous DON left 07/15/11. He stated he had been in the building since 06/28/11 and identified fairly quickly there were clinical issues after talking with staff and receiving complaints from families. He further stated he brought in Nurse Consultant #1 and other corporate staff after identifying system problems in the facility including infection control.</p> <p>3. Based on observation, interview, and record review, it was determined the facility failed to ensure an ongoing program of activities designed to meet the individual interests of each resident. Record review and interviews with staff, residents, and the Ombudsman revealed residents' individual activity interests and special needs were not met. In addition, observations and complaints from residents and staff revealed a systemic failure to provide a varied program of activities that was well-communicated to the residents. Record review and interview revealed activities were frequently cancelled or interrupted due to the floor staff having to provide resident care as well as implement the activity program. In addition, record review and interviews revealed no evidence the staff assigned to conduct resident activities had received training to plan, coordinate and conduct consistent daily recreational offerings.</p> <p>Interview, on 08/03/11 at 3:00 PM, with the Activities Director revealed there was no activities staff and the Certified Nursing Assistants (CNAs) were to lead the scheduled activities. However, further interview revealed the CNAs were unable to perform the activities due to</p>	F 490		
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F 490	<p>Continued From page 157</p> <p>being assigned to many duties including housekeeping duties and dietary duties. The Activities Director stated he realized the scheduled calender of activitiles were not being completed after reviewing the documentation for resident activitiles and interviewing the CNAs. Continued interview revealed he was to oversee the activities on the units; however, was assigned several responsibilities at the facility which did not allot him the time needed to perform his duties as Activities Director.</p> <p>Interview with the Vice President of Operations (Interim Administrator), on 08/05/11 at 5:20 PM, revealed he was aware of concerns related to the Activities Programs and the facility was looking at the issue, but had not yet implemented an action plan. During continued interview, he explained facility Administration was interested in "Universal Workers", staff who performed a variety of duties, across disciplines. Further interview revealed implementing such an approach was a "full culture change" and required a more systematic approach than had been applied thus far. He stated he felt there was enough staff; however, stated staffing ratios and more staff education were two issues that needed further consideration.</p> <p>4. Interview, on 08/04/11 at 4:30 PM, with Nurse Consultant #1, Nurse Consultant #2 and the Interim DON, revealed they were aware the weights were not completed for the twenty-two (22) residents who were admitted 07/01/11. Continued interview revealed they were aware there was an issue with the meal intakes not being documented and a recent in-service had been completed with staff related to documenting</p>	F 490		

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F 490	Continued From page 158 meal intakes. Further interview revealed they became aware of Resident #10's weight loss on 08/03/11, and as of that date there were no committees in place to evaluate the residents' nutritional status. However, they were in the process of instituting an interdisciplinary team meeting which would meet every week to discuss weights. Continued interview revealed the Dietitian was now tracking weights and would inform the Nurses and Nurse Management of significant weight changes. Further interview revealed they were aware there was a problem related to dietary recommendations not being followed, and the Dietitian would be writing recommendations on the Physician's Orders with the chart flagged for the nurse to follow up with notification to the Physician. Continued interview revealed the facility failed to have a system in place to assess, plan, implement and monitor residents for nutritional status.	F 490  F499	The facility employs professionals necessary to carry out the provisions for professional staff in accordance with applicable State laws. 1. No residents were affected by this citation.  2. No other residents of facility were affected by this citation.  3. LPN's #4, and #8 licenses were re-verified by Human Resources on 8/4/2011. Registered Dietitian's license and credentials have been verified. CNA #6 license was re-verified by Human Resources on 8/4/2011. Facility is checking licenses according to state laws. D.O.N.re- inserviced Human Resource Director (HR) on how to verify licenses by 8/4/11. In house audit of employee files has been completed by Human Resources Director to ensure licenses are up to date as of 8/4/2011. D.O.N., A.D.O.N and/or Nurse Consultants will audit (2) two new employee files each week for the next 4 weeks.	9/20/11
F 499 SS=E	<b>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS</b>  The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.  Professional staff must be licensed, certified, or registered in accordance with applicable State laws.  This REQUIREMENT is not met as evidenced by: Based on interview employee file review it was determined the facility failed to ensure all licensed staff had active licenses when the licenses were not verified annually after the expiration/renewal	F 499		

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F 499	Continued From page 159 date for four (4) of fourteen (14) employee files reviewed.  The findings included:  Review of Licensed Practical Nurse (LPN) #4's employee file revealed the last license verification revealed LPN #4's license expired 10/31/09.  Review of LPN #8's employee file revealed the last license verification revealed LPN #8's license expired 10/31/09.  Review of Certified Nursing Assistant (CNA) # 6's employee file revealed the last license verification revealed CNA #8's license expired 03/18/11.  Review of the Registered Dietitian's (RD) employee file revealed no verification of RD credentials or state licensure.  Interview with the Human Resource Manager, on 08/01/11 at 3:15 PM, revealed she did not check the RD's licenses because she was not aware they required licenses. Continued interview, on 08/04/11 at 10:30 AM, revealed she could not find any current verifications of licensure for LPN #4, #8 or CNA #6.	F 499	4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.		
F 501 SS=F	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.	F 501			

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F 501	<p>Continued From page 160</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview it was determined the facility failed to ensure the Medical Director was in collaboration with facility leadership in implementing and evaluating policies and procedures that reflect current standards of practice. Specifically, the facility failed to involve the Medical Director in the planning process for the physical transfer of thirty (30) residents from the old building to the new building on 06/30/11 and 07/01/11, and the admission of twenty-two (22) residents from another facility on 07/01/11.</p> <p>The findings include:</p> <p>Interview with Nurse Consultant (NC) #1 on 07/22/11 at 1:30 PM revealed the facility accepted twenty-two (22) new admissions from another facility on 07/01/11. She stated the Administrative Team in place on 07/01/11, including the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) had all resigned on 07/15/11. Continued interview revealed she had been contracted as a nurse consultant beginning 07/18/11. She further stated it was evident facility systems, especially related to the admission process, had failed.</p> <p>Interview with the Vice President of Operations (VPO), on 07/22/11 at 3:00 PM revealed he had been working with the facility for a few months, during the planning of the transition to the new building. He stated he was now serving as Interim Administrator pending the hiring of a new Administrator. He stated he had acquired the services of NC #1 on 07/18/11, after identifying</p>	<p>IF501</p> <p>F501</p>	<p>The Medical Director (MD) is responsible for implementation of resident care polices and coordination of medical care in the facility.</p> <ol style="list-style-type: none"> <li>1. Janet Manoogian, Director of Nursing (D.O.N.) will work with the current Medical Director while awaiting a new MD to coordinate medical care in the facility.</li> <li>2. D.O.N. and Medical Director meet weekly to collaborate regarding any new facility processes.</li> <li>3 Meeting between Medical Director and Executive Director took place on 9/19/11 regarding policy reviews, regulatory compliance, QA meetings, issues with other doctors and the Medical Director's duty to assist in correction issues and major changes in the facility.</li> <li>4. The current Medical Director is Dr. Michael Cholera. DON and Executive Director are monitoring Medical Director practice until new Director is hired</li> </ol>	<p>9/20/11</p>
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F 501	<p>Continued From page 161</p> <p>the problems since 07/01/11. He stated they were progressing system by system, working under the assumption that no effective systems were in place.</p> <p>Interview with the Medical Director (MD) on 08/02/11 at 11:30 AM revealed he knew about the plan to admit the twenty-two (22) residents on 07/01/11 but had not been consulted or involved in the transition in any way. He stated he had not been made aware of the problems after 07/01/11 including: the failure to obtain labs timely, the failure to initiate ancillary orders, such as range of motion; the failure to complete admission assessments; the failure to perform skin assessments and falls risk assessment, and the failure to utilize appropriate safety and pressure prevention devices. Continued interview revealed he had not been made aware of the lack of an ongoing infection control system until after the survey team identified Immediate Jeopardy on 07/29/11, related to the failure to disinfect blood glucose monitoring devices between resident use. He stated the facility should have considered infection control issues prior to admitting twenty-two (22) residents on 07/01/11. During continued interview the MD explained it would have been important to consider the residents' diagnoses and plan cohorting if necessary. He stated, "I'm approachable but I can't force them to ask my input". He further stated he would have appreciated being included in planning for the transition.</p> <p>Subsequent interview with the VPO on 08/05/11 at 5:20 PM revealed the role of the Medical Director included oversight, coordination with the Director of Nursing, and participation in the</p>	F 501			

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F 501  F 505 SS=D	<p>Continued From page 162</p> <p>Quality Improvement process. He stated he did not recall what degree of inclusion or involvement the MD had during the transition.</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to promptly notify the Physician of the findings of laboratory data for one (1) of eighteen (18) sampled residents, (Residents #11). The facility received results on a Prothrombin Time (PT) and International Normalized Ratio(INR) PT/INR for Resident #11 on 07/19/11; however, there was no documented evidence the Physician was notified of the results until 07/28/11 after surveyor intervention.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review revealed the facility admitted Resident #11 on 07/01/11 with diagnoses which included Diabetes Mellitus, Cerebrovascular Disease, and Anemia.</li> </ol> <p>Review of the resident's laboratory data revealed the resident had a Prothrombin Time/International Normalized Ratio drawn on 07/19/11 and resulted the same day. The PT was 31.6 High with a reference range of (9.3-12.4) and the INR was 2.80 High with a reference range of (0.87-1.14). However, there was no documented evidence the laboratory measurement results were faxed or</p>	F 501  R5005  F505	<p>The facility promptly notifies the attending physician of lab results.</p> <ol style="list-style-type: none"> <li>Resident #11 physician was notified of lab result on 7/28/11 by a staff nurse with no adverse reactions noted.</li> <li>Audit of remaining residents was performed and completed by D.O.N., A.D.O.N. and/or nurse consultants by 8/24/11 with no adverse reactions noted. All resident's lab results were reviewed for notification to physician by a staff nurse and D.O.N. and/or nurse consultant on 8/15/11, 8/23/11, 8/25/11 and 9/2/11 9/6/11.</li> <li>All nurses were in-serviced on proper notification of lab results, nursing standard of practice related to physician notification and follow-up with lab results by D.O.N. and/ Nurse Consultants on 8/4/11 and 8/18/11. DON, ADON and/or Nurse Consultant will audit (6) labs weekly for the next 4 weeks for availability and notification.</li> </ol>	9/20/11

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F 505	Continued From page 163 called to the Physician.  Interview, on 07/28/11 at 11:20 AM, with Licensed Practical Nurse (LPN) #5, who was assigned to the resident, revealed she was unsure if the Physician was notified of the results. She stated she faxed the lab results to the Physician on 07/19/11 when she received the lab results and again on 07/23/11; however, there was no documented evidence of the fax being sent. Further interview revealed she was hired in 06/11 and had no training related to labs. She stated, normally if she could not reach the Physician per phone, she would fax the lab results and leave the lab results in a bin at the nurses station for the next shift to attempt contact with the Physician.  Interview with Nursing Consultant #1, on 08/04/11 at 4:30 PM, revealed Physician should be notified of laboratory results as soon as they are received by the facility from the Lab. She further stated the old facility building had a Coumadin (anticoagulant medication) tracking system; however, apparently the system was not in place at this time. Further interview revealed there was no policies regarding laboratory data.	F 505	4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  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	F 514			

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F 514	<p>Continued From page 164</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed to ensure accurate clinical records were maintained for six (6) of eighteen (18) sampled residents (Residents #1, #6, #7, #8, #13, and #14), and fifteen (15) Unsampled Residents (B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T). This was evidenced by the facility's failure to accurately document meal consumption and/or bowel movement records.</p> <p>The findings include:</p> <p>Review of the facility's "Bowel and Bladder Management Policy and Procedure" (undated) revealed the following procedures were to be performed. Certified Nursing Assistants (CNAs) were to complete the bowel record and report concerns or changes to the nurse. The nurses were to review bowel records. If a resident had no bowel movement in three consecutive days the nurse was to administer laxatives as directed by the physician.</p> <p>1. Review of the Clinical Record revealed the facility admitted Resident #8 on 07/01/11 with diagnoses which included Depression, Hypertension, Diabetes and Edema. Review of</p>	F 514  F514	<p>The facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.</p> <p>1. Resident #8 bowel movements and meal consumption are being monitored and recorded daily. Resident F bowel movements and meal consumption are being monitored and recorded daily. Resident H bowel movements and meal consumption are being monitored and recorded daily. Resident #I bowel movements and meal consumption are being monitored and recorded daily. Resident #6 bowel movements and meal consumption are being monitored and recorded daily. Resident #7 bowel movements and meal consumption are being monitored and recorded daily. Resident #I bowel movements and meal consumption are being monitored and recorded daily. Resident #J bowel movements and meal consumption are being monitored and recorded daily.</p>	9/20/11
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F 514	<p>Continued From page 165</p> <p>the Bowel Movement Summary for July 2011 revealed the resident had no documented bowel movement between 07/19 and 07/24/11 (six days), or between 07/26 and 07/30/11 (five days). Review of the Meals and Weights record for 07/01 through 08/05/11 twenty-one (21) of ninety-six (96) meals were not documented. Thirty-one (31) of thirty-two (32) morning snacks were not documented. Thirty-one (31) of thirty-two (32) afternoon snacks were not documented, and thirty-one (31) of thirty-two (32) before bed snacks were not documented.</p> <p>2. Review of the Bowel Movement Summary for July 2011 revealed Unsampled Resident F had no bowel movement recorded from 07/07 through 07/13/11 (seven days), 07/15 to 07/18/11 (four days), or 07/30/11 through 08/05/11 (seven days). Review of the Meals and Weights record for 07/01/ through 08/05/11 revealed twenty-five (25) of ninety-six (96) meals were not documented. Thirty-one (31) of thirty-two (32) morning snacks were not documented. Thirty-one (31) of thirty-two (32) afternoon snacks were not documented, and thirty-one (31) of thirty-two (32) before bed snacks were not documented.</p> <p>3. Review of the Bowel Movement Summary for July 2011 revealed Unsampled Resident H had no recorded bowel movements for a period of five (5) days, from 07/16 through 07/20/11. Review of the Meals and Weights record for 07/01 through 08/05/11 revealed twenty-eight (28) of ninety-six (96) meals were not documented. Thirty-two (32) of thirty-two (32) morning snacks were not documented. Twenty-seven (27) of thirty-two (32) afternoon snacks were not documented, and thirty-two (32) of thirty-two (32) before bed snacks</p>	F 514	<p>Resident #K bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #L bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #M bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #N bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #O bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #P bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #Q bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #R bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #S bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #T bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #13 no longer resides in the facility.</p> <p>Resident #14 bowel movements and meal consumption are being monitored and recorded daily.</p> <p>Resident #B bowel movements and meal consumption are being monitored and recorded daily.</p>	

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F 514	<p>Continued From page 166 were not documented.</p> <p>4. Review of the Clinical Record revealed the facility admitted Resident #1 on 07/01/11 with diagnoses which included Alzheimer's Disease, Dysphasia, Anxiety and Depression. Review of the Bowel Movement Summary for 07/07 through 08/05/11 revealed no documented bowel movement from 07/07 through 0710/11 (four days), 07/17 through 07/22/11 (six days), 07/24 through 07/27/11 (four days) or 07/31 through 08/05/11 (six days). Review of Meals and Weights record for 07/01 through 08/05/11 revealed twenty-four (24) of ninety-six (96) meals were not documented.</p> <p>5. Clinical Record review revealed the facility admitted Resident #6 on 07/01/11 with diagnoses which included Alzheimer's Disease. Review of the Bowel Movement Summary for 07/07 through 08/05/11 revealed no bowel movement was record from the five (5) day period between 07/11 and 07/15/11. Review of the Meals and Weights record for 07/01 through 08/05/11 revealed thirty-three meals were not documented.</p> <p>6. Review of the Clinical Record revealed the facility admitted Resident #7 on 07/01/11 with diagnoses which included Hypertension and Anemia. Review of the Bowel Movement Summary for 07/07 through 08/05/11 revealed no documented bowel movement from 07/26 through 07/30/11, a period of five days. Review of the Meals and Weights record for 07/01 through 08/05/11 revealed twenty-five meals were not documented.</p> <p>7. Review of the Bowel Movement Summary for</p>	F 514	<p>Resident #7 bowel movements and meal consumption are being monitored and recorded daily. The C.N.A. team leader is responsible for assuring that documentation for bowel movements and meal consumption is being completed daily.</p> <p>2. Remaining residents of the facility are having meal intakes and Bowel movements recorded daily by the C.N.A.'s</p> <p>3. Nurses and Certified Nursing Assistants (CNAs) were in-serviced on proper documentation of meals and bowel movements by D.O.N., A.D.O.N. and/or nurse consultants on 8/4/11, 8/16/11, and 8/18/11. D.O.N., A.D.O.N. and nurse consultants will audit 5 meal intakes and 4 bowel movements each week for the next 4 weeks. C.N.A. team leader is responsible to assure daily documentation is in place.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented and systems and policies are implemented.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/05/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADONNA MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2344 AMSTERDAM ROAD</b> <b>VILLA HILLS, KY 41017</b>
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F 514	<p>Continued From page 167</p> <p>July 2011 revealed Unsamped Resident I had no bowel movement record for the fourteen (14) day period from 07/13 through 07/26/11. Review of the Meals and Weights record for the month of July revealed twenty-eight meals were not documented.</p> <p>8. Review of the Bowel Movement Summary for July 2011 revealed Unsamped Resident J had no documented bowel movement between 07/16 and 07/21/11 (six days), 07/24 through 07/27/11, and 07/31/ through 08/05/11. Review of the Meals and Weights for 07/01 through 08/05/11 revealed twenty-four meals had not been documented.</p> <p>9. Review of the Bowel Movement Summary for July 2011 revealed Unsamped Resident K had no documented bowel movement from 07/11 through 07/17/11 (seven days) and 07/19 through 08/05/11 (eighteen days). Review of the Meals and Weights record revealed twenty-six meals were not documented in July 2011.</p> <p>10. Review of the Bowel Movement Summary for Unsamped Resident L revealed no documented bowel movement between 07/09 and 07/14/11 (six days) and 07/16 through 08/05/11 (twenty days). Review of the Meals and Weights record revealed no documented consumption for twenty-eight meals in July 2011.</p> <p>11. Review of the Bowel Movement Summary for Unsamped Resident M revealed no bowel movement was recorded between 07/17 through 07/20/11 (four days). Review of the Meals and Weights record revealed no documented consumption for twenty-five meals in July 2011.</p>	F 514	<p>Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p> <p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p>	
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F 514	<p>Continued From page 168</p> <p>12. Review of the Bowel Movement Summary for Unsampld Resident N revealed no bowel movement was documented between 07/17 and 07/23/11 (seven days) and 07/25 through 08/05/11 (twelve days). Review of the Meals and Weights record for July 2011 revealed twenty-five meals were not documented.</p> <p>13. Review of the Bowel Movement Summary for Unsampld Resident O revealed no documented bowel movement for the period from 07/10 through 07/20/11 (eleven days) and from 07/28 through 08/03/11 (seven days). Review of the Meals and Weights record revealed twenty-five meals were not documented in July 2011.</p> <p>14. Review of the Bowel Movement Summary for Unsampld Resident P revealed no documented bowel movement from 07/08 through 07/14/11 (seven days) and from 07/26 through 07/29/11 (four days). Review of the Meals and Weights Record revealed twenty-five meals were not documented during the month of July.</p> <p>15. Review of the Bowel Movement Summary for Unsampld Resident Q revealed no bowel movement was recorded between 07/15 and 07/18/11 (four days) or between 07/25 and 07/29/11 (five days). Review of the Meals and Weights record for the month of July 2011 revealed twenty-eight meals were not documented.</p> <p>16. Review of the Bowel Movement Summary for Unsampld Resident R revealed no bowel movements were record from 07/16 through 07/19/11 (four days). Review of the Meals and</p>	F 514		

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F 514	<p>Continued From page 169.</p> <p>Weights record revealed twenty-seven meals were not documented in July 2011.</p> <p>17. Review of the Bowel Movement Summary for Unsampled Resident S revealed no documented bowel movement from 07/11 through 07/14/11 (four days). Review of the Meals and Weights record revealed twenty-six meals were not documented in July 2011.</p> <p>18. Review of the Bowel Movement Summary for Unsampled Resident T revealed no bowel movement was recorded from 07/15 and 07/18/11 (four days) or from 07/26 through 08/02/11.</p> <p>19. Record review revealed the facility admitted Resident #13 to the facility on 07/01/11 with diagnoses which included unspecified Hypertension (HTN), Breast Cancer, and Coronary Artery Disease. The Minimum Data Set (MDS) dated 06/10/11 revealed the resident was at risk for constipation and had as a care plan intervention to monitor BM and record. Review of the Bowel Movement Summary - Last 30 Days (06/27/11 - 07/26/11) for Resident #13 revealed on bowel movements were recorded from 07/04/11 - 07/21/11.</p> <p>20. Record review revealed the facility admitted Resident #14 on 07/12/11 with diagnoses which included Depression, Hypertension (HTN), Difficulty Walking, Muscular Wasting and Disuse Atrophy, and Pneumonia. Review of the Bowel Movement Summary - Last 30 Days (06/27/11 - 07/26/11) revealed no bowel movements were recorded for Resident #14 from 07/12/11 - 07/19/11. Further review of the resident's record</p>	F 514		
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F 514	<p>Continued From page 170</p> <p>revealed the residents daily meal consumption was not recorded for each meal. There was no meal consumption recorded for the dinner meals on 07/13/11 and 07/19/11. No meal consumption was recorded from 07/14/11 - 07/18/11.</p> <p>21. Record review revealed the facility admitted Unsampled Resident B on 07/01/11 with diagnoses which included Dementia, Diabetes Mellitus, and Chronic Heart Failure.</p> <p>Review of the resident's "Meals and Weight" documentation revealed of the twenty-five documented days from 07/02/11 through 08/04/11 revealed sixteen (16) of the seventy-five (75) meals had no documented intake. Continued review of the resident's "Meals and Weight" documentation revealed nine (9) days between 07/02/11 and 08/04/11 had no documented intake for any meals; 07/05/11, 07/09/11, 07/14/11, 07/16/11, 07/17/11, 07/18/11, 07/21/11, 07/23/11 and 07/24/11.</p> <p>Review of the resident's bowel records revealed Unsampled Resident B had no documented bowel movement from; 07/13/11 through 07/19/11, 07/21/11 through 07/24/11 and 07/28/11 through 07/29/11 with no documented interventions during these time frames.</p> <p>Interview on 07/26/11 at 7:00 PM with CNA #7 who was working on hall "B" regarding the recording of resident bowel movements revealed the CNAs are supposed to record them in the computer system each shift. The CNAs have to have a special badge that allows access to the system, but she does not know if all CNAs have access or have been trained on the system.</p>	F 514			

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F 514	<p>Continued From page 171</p> <p>Further interview revealed CNAs do have a sheet available to them that will allow them to record resident meal consumption, fluid consumption, and bowel movements. They give this to someone who has access to the computer and they are supposed to input the information into the system.</p> <p>Interview on 07/26/11 at 7:15 PM with CNA #19 revealed she does not have access to the computer system to record bowel movements. She records resident meal consumption, fluid consumption, and bowel movements on a sheet and then gives the sheet to someone who has access to the system and expects them to enter the information.</p> <p>Interview on 07/26/11 at 6:30 PM with Nurse Consultant #1 regarding the Bowel Movement Summary - Last 30 Days (06/27/11 - 07/26/11) for Resident #13, no bowel movements recorded from 07/04/11 - 07/21/11. Further interview revealed, at this time the facility does not have a system in place to monitor bowel movements. The resident bowel movements are supposed to be documented daily in the Kiosk (computer system apparatus) but not everyone had access or knew how to document. RN #3 revealed the former DON and ADON (both left the facility on 07/15/11) had been responsible for monitoring the bowel movement data being recorded.</p> <p>Interview with CNA #12, on 07/27/11 at 11:00 AM, revealed the aides were supposed to enter bowel movements and meal consumption into the Kiosk (computer) at the end of each shift. She stated the aides on hall "B" took turns entering residents' meal consumption and bowel movements into the</p>	F 514			

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F 514	<p>Continued From page 172</p> <p>computer. She explained if it was not her turn to document in the computer, she made notes on a piece of paper and gave them to the aide who was to enter that information in the Kiosk at the end of the shift or whenever they had time.</p> <p>Interview, on 07/27/11 at 4:25 PM with Licensed Practical Nurse (LPN) #4, revealed the Nurses did not review the Meals Record and the aides were to let the Nurses know if there was a decrease in food intake. She stated if poor intake was reported by the aides, the Nurses were to call the Physician.</p> <p>Interview on 08/02/11 at 12:15 PM with CNA #17 revealed the CNAs are responsible for recording bowel movements into the computer system. The Nurses then review a report showing who had bowel movements. After being shown the Bowel Movement Summary for Resident #13 that had no bowel movements recorded from 07/04/11 - 07/21/11, she stated it indicated either the CNAs did not enter the information or the computer system did not record the data that was entered.</p> <p>Interview on 08/02/11 at 12:20 PM with RN #6 revealed CNAs are supposed to track the resident's bowel movements and document that information. They will let the Nurses know if there is a problem or the residents may inform them. Further interview revealed she does not see the bowel movement report.</p> <p>Interview with the Dietitian, on 08/02/11 at 12:40 PM, revealed she could get a general idea of the meal consumption from the Meals and Weight Record; however, she had noted there were several meals for all the residents in which there</p>	F 514		
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F 514	Continued From page 173 was no documentation of meal intake and she had concerns about it.  Interview, on 08/04/11 at 10:00 AM, with the previous Director of Nursing (DON) who worked at the facility until 07/15/11, revealed the CNA's were to input the meal consumption in the computer and the Nurses were to monitor the intake if there was a problem with residents not eating; however, she stated the nurses did not need to monitor the residents' intake on a daily basis.	F 514		
F 518 SS=F	<b>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</b>  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.  This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy review it was determined the facility failed to ensure employees were trained in emergency procedures when they begin work in the facility. Two (2) of five (5) employees interviewed were new and reported they had not been provided any training on what to do in an emergency. In addition, four (4) of five (5) employees interviewed were not familiar with where the fire extinguishers were located. The facility moved residents and direct care staff into a new building on 06/30/11 and 07/01/11.  The findings include:	F 518		

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F 518	<p>Continued From page 174</p> <p>The facility has an overall Disaster and Evacuation Plan (Revised June 2011) and included in this plan was the Fire/Tornado Policy which stated all staff will know the locations of all fire extinguishers and fire alarms. Review of the fire alarm diagram, included with the plan, did not identify the location of the fire alarms.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, regarding emergency preparedness, on 08/03/11 at 2:20 PM, revealed she had been hired the first week of June 2011. The CNA revealed the facility did not provide any training on what to do in an emergency. Further interview revealed she had no idea where the fire extinguishers were located and was not sure where the fire alarms were located but thought they maybe at the end of the hallways.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, regarding emergency preparedness, on 08/03/11 at 1:50 PM, revealed she had been hired in June 2011. The LPN revealed the facility did not provide any training on what to do in an emergency. Further interview revealed she did not know where the fire extinguishers were located, or what the facility's elopement plan intalled.</p> <p>Interview with LPN #2, regarding emergency preparedness, on 08/03/11 at 3:45 PM, revealed she thought the fire extinguishers were in the hallways but did not know which hallways.</p> <p>Interview with the Activity Director, regarding emergency preparedness, on 08/03/11 at 4:05 PM, revealed he knew there were fire</p>	F 518 F518	<p>The facility trains all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff and carry out unannounced staff drills using those procedures.</p> <ol style="list-style-type: none"> <li>1. No residents were affected by this citation.</li> <li>2. No residents were affected by this citation.</li> <li>3. All current employees were re-trained by the Facilities Director on emergency procedures, location of fire extinguishers and alarms on 9/2/11, 9/9/11 and 9/19/11. New employees will be trained by Facilities Director during orientation on emergency procedures. The Facilities Director will hold fire drills each month and quarterly perform other drills such as evacuation and tornado watches to further the training of staff on emergency procedures. Completion of emergency drills will be monitored by the Executive Director for compliance.</li> </ol>	9/20/11

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F 518	<p>Continued From page 175</p> <p>extinguishers in the kitchen but did not know where the rest of them were located. He stated he was not sure where the fire alarms were located.</p> <p>Interview on, 08/03/11 at 3:20 PM, with the Human Resources Manager revealed all new employees were given the Disaster and Evacuation Plan which included the Fire/Tornado Policy to take home and read. She provided a document showing CNA #2 and LPN #1 had initial that they had reviewed the Safety and Security section of the Employee Training and Orientation Outline. Further interview revealed she thought the Director of Activities, who was kind of the Safety Officer, reviewed these policies with the new employees. She also stated when they moved to the new building the Administrator held an inservice with the Managers and presented them with the Fire Alarm Diagram and showed them how to read the alarm panel which showed the location of where the alarm was sounding. However, continued interview revealed she did not think the facility staff had received education from the Managers</p> <p>Interview, on 08/03/11 at 4:05 PM, with the Activity Director who revealed he was responsible for reviewing the Fire/Tornado Policy with new employees when they were in the old building and also showed them the location of the fire extinguishers and alarms. Further interview revealed he had not done this since they moved into the new building. He did not know if anyone else took on this responsibility for new employees. To his knowledge no one had educated to the location of the fire extinguishers and alarms.</p>	F 518	<p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed as noted below for any revisions or adjustments.</p> <p>The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy. The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p>		

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F 518	Continued From page 176  Additional interview, on 08/04/11 at 12:45 PM, with the Human Resources Manager revealed the department heads were to show the employees where the fire extinguishers and smoke alarms were located in their respective areas. She stated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were supposed to educate the nursing staff.  Interview, on 08/05/11 at 4:20 PM, with Nurse Consultant #2 revealed as apart of the general orientation, Human Resources provided training on fire and evacuation procedures. Further interview revealed the Human Resources person was responsible for showing new staff where the fire alarms and fire extinguishers were located in the building. She stated the DON and ADON were responsible for showing the nursing employees where they were located in their areas.	F 518			
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520			

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F 520	<p>Continued From page 177</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to identify quality issues with the potential for negatively affecting the residents.</p> <p>The facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection. This was evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use and failure to ensure staff were knowledgeable related to the facility's policy regarding blood glucose monitor cleaning. This was also evidenced by the staff failing to adhere to proper infection control technique during dressing changes, failing to ensure proper hand hygiene at meal service, and failing to follow the policy related to isolation precautions for a resident with a known infectious disease.</p> <p>The facility's failure to ensure proper infection control practices were followed, placed residents</p>	F 520  F520	<p>The facility maintains a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility and at least 3 other members of the facility's staff.</p> <p>See responses regarding individual residents from all previously written FTags.</p> <ol style="list-style-type: none"> <li>1. See responses for all remaining facility residents as previously written in the above Ftags.</li> <li>2. The facility has been following a Quality Assurance process which includes quarterly meetings, monitoring issues and developing plans to correct. Infection control procedures are being followed. Facility has re-established an infection control program. Facility is doing activities as stated previously in F248. Facility is following proper admission procedures, nutritional programs and taking weekly weights per protocol and as stated in F325 plan of correction.</li> </ol>	9/20/11
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/05/2011
NAME OF PROVIDER OR SUPPLIER  MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
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F 520	<p>Continued From page 178</p> <p>in the facility at risk for serious harm, injury, impairment or death. Immediate Jeopardy was identified on 07/28/11 and was removed on 08/02/11, after an acceptable credible Allegation of Compliance (AoC) was received and further observations, in-service record reviews, and staff interviews were conducted to verify removal of the Jeopardy.</p> <p>In addition, there was a system failure related to the facility's failure to provide a program of activities designed to meet, in accordance with the Comprehensive Assessment, the interest and physical, mental, and psychosocial well-being of each resident. Substandard Quality of Care (SQC) was identified at CFR 483.15 Quality of Life F-248.</p> <p>Also, based on interview and record review, it was determined the facility had a system failure related to ensuring admission weights and weekly weights were obtained and monitored, meal consumption was monitored, and Registered Dietician recommendations were implemented in order to ensure residents maintained acceptable parameters of nutritional status for six (6) of eighteen (18) sampled residents (Resident #10, #11, #7 #8, #1, and #6) and fifteen (15) unsampled residents, Unsampled Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T). The facility failed to notify the Physician and follow dietary recommendations which were written on 07/15/11 when the facility became aware that Resident #10 had a significant weight loss of six (6) pounds (5%) from 06/09/11 to 07/15/11. Additionally, the facility failed to obtain admission weights per the facility's policy for residents who were admitted on 07/01/11 including Resident #1,</p>	F 520	<p>The facility has developed a C.Q.I. monitoring schedule for the year 2011 to insure that systems are effective and correction has been achieved.</p> <p>3. New Administration ED and D.O.N. will be in-serviced by the Vice President of Operations (VPO) on the Quality Assurance (QA) policy. VPO will monitor quarterly that QA is complete.</p> <p>4. If problems are identified during the monitoring process immediate corrective action will be taken, staff involved will be redirected and the procedure/system will be reviewed for any revisions or adjustments. The facility administration's role in the monitoring is to track that the monitors are being completed and any identified corrective action are implemented. Review and/or revision of policies will be indicated by the administrator sign off on the policy.</p>		

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F 520	<p>Continued From page 179</p> <p>#6, #7, #8 #11, and Unsampled Residents B, F, H, I, J, K, L, M, N, O, P, Q, R, S and T. In addition, there was no documented evidence of meal intakes being documented consistently.</p> <p>The findings include:</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to have an effective system to ensure blood glucose monitors were disinfected between resident use as per policy. On 07/28/11 facility staff was observed using a blood glucose monitor to test Resident #10's and Resident #11's blood sugar levels without disinfecting the monitor between each use. In addition, on 07/28/11 facility staff was observed using a blood glucose monitor to test Unstamped Resident A's and Unstamped Resident B's blood sugar levels without disinfecting the monitor between each use.</p> <p>Additionally, the facility failed to ensure proper infection control procedures were adhered to related to dressing changes for Resident #7 who had a wound infection for which he/she was in contact isolation.</p> <p>Also, Resident #3 had a diagnosis of C. difficile Toxin Positive and was receiving with antibiotics for the infection. However, the facility failed to display signage on the resident's door and failed to follow its policy related to contact precautions.</p> <p>In addition, improper infection control related to hand hygiene was observed during the noon meal service on 08/04/11.</p> <p>Interview with Nurse Consultant #1, on 07/18/11</p>	F 520	<p>The QA committee is made up of at least the following members, Administrator, Director of nursing, Medical Director, MDS Nurse and Assistant Director of nursing. Findings of audits will be reported to QA monthly for review and recommendations.</p>		

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F 520	<p>Continued From page 180</p> <p>at 5:30 PM, 07/28/11 at 6:00 PM, and 08/03/11 at 4:30 PM revealed she started at the facility on 07/18/11, and noted there was no infection control program in place after the previous Director of Nursing (DON) and Assistant Director of Nursing (ADON) left on 07/13/11. She stated there was no system in place to monitor staff related to ensuring the cleaning of the blood glucose monitors between resident use. Further interview revealed she had reviewed the recent in-services and there was no documented evidence of training related to cleaning the blood glucose monitors per facility policy. Continued interview revealed the facility had not been tracking and trending infections when she arrived on 07/18/11; however, she was starting to track infections from the information on the the twenty-four (24) hour report.</p> <p>2. Based on observation, interview, and record review, it was determined the facility failed to have an effective system to ensure residents were offered activities according to their interest per the Comprehensive Assessment and the Activities Assessments. Also, observation and interviews from residents and staff revealed a systemic failure to provide a variety of activities which was communicated to residents. In addition, observations and interviews revealed activities were interrupted or cancelled as a result of floor staff having to coordinate and conduct daily recreational offerings, as well as provide resident care.</p> <p>Interview, on 08/03/11 at 3:00 PM, with the Activities Director revealed the Certified Nursing Assistants (CNAs) were to lead and participate in the scheduled activities. However, the CNAs</p>	F 520		
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F 520	<p>Continued From page 181</p> <p>were unable to always perform the activities due to being assigned to many duties including housekeeping duties and dietary duties. He stated the scheduled calender of activity events were not being completed after reviewing the documentation for resident activities and interviewing the CNAs. Continued interview revealed he was assigned several responsibilities at the facility which did not allot him the time needed to perform his duties as Activities Director.</p> <p>Interview, on 08/04/11 at 10:30 PM, with Nurse Consultant #1, who was serving in an administrative role, and Nurse Consultant #2, revealed they had a QA Meeting on 07/29/11 which was the first meeting since she had started on 07/18/11. She further stated the Medical Director attended and made suggestions to assist with getting into compliance with issues identified. She further stated the committee intended to educate staff on immediate needs and get audits in place. Continued interview revealed the facility did not currently have a process in place to ensure weekly interdisciplinary meetings were held related to infection control, activities, and other issues identified. However, they would be in the process of getting that implemented.</p> <p>Interview, on 08/05/11 at 5:20 PM, with the Vice President of Operations (and Interim Administrator) revealed he had been in the building since 06/26/11. Continued interview revealed the previous Administrator resigned 07/15/11 and the previous DON left 07/15/11. He stated the systems which were in place in the old facility building were not being implemented since</p>	F 520		

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F 520	<p>Continued From page 182</p> <p>the move to the new facility building on 07/01/11 which included infection control. He stated, after noting concerns with clinical issues, he brought in Nurse Consultant #1 and other corporate staff. Further interview revealed he was aware of concerns related to the Activities Program and the facility was examining the issue. He stated the facility Administration was interested in "Universal Workers", staff who performed a variety of duties, across disciplines. Continued interview revealed implementing such an approach was a "full culture change" and required a more systematic approach than had been applied thus far. He stated he felt there was enough staff; however, he stated staffing ratios and more staff education were two issues that needed further consideration.</p> <p>4. Interview, on 08/04/11 at 4:30 PM, with Nurse Consultant #1, Nurse Consultant #2 and the Interim DON, revealed the facility was aware the weights were not completed for the residents who were admitted 07/01/11, and was aware there was an issue with the meal intakes not being consistently documented. Continued interview revealed a recent in-service had been completed with staff related to documenting meal intakes. Further interview revealed they became aware of Resident #10's weight loss on 08/03/11, and as of that date there were no committees in place to evaluate the residents' nutritional status. Continued interview revealed they were in the process of instituting an interdisciplinary team meeting which would meet every week to discuss weights. Also, interview revealed the Dietitian was now tracking weights and would inform the Nurses and Nurse Management of significant weight changes. Continued interview revealed</p>	F 520		

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F 520	Continued From page 183 they were aware there was a problem related to dietary recommendations not being followed, and the Dietitian would be writing recommendations on the Physician's Orders with the chart flagged for the nurse to follow up with notification to the Physician.	F 520			