

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

PRINTED: 11/03/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/20/2010
NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353		
(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 282	<p>Continued From page 20</p> <p>Observation of Resident #2 on 10/20/10 at 9:00 AM revealed the resident was in the bed with two (2) one half (1/2) side rails up and a bed alarm was noted.</p> <p>Interview with Certified Nursing Assistant (CNA) #11 who was emptying the trash in the resident's room, revealed she was not assigned to the resident; but was helping another CNA. She further stated, she was sometimes assigned to the resident and was familiar with the resident's care needs. Continued interview with CNA #11 revealed the resident did not have a bed motion detector.</p> <p>Observation of the resident on 10/20/10 at 9:20 AM with the Nurse Manager assigned to Resident #2, revealed there was a motion detector on the bedside table; however, the detector did not alarm with movement in front of the detector. The Nurse Manager checked the detector and stated it was on "chime" and was delayed in alarming. She stated the detector was set wrong and should have been set on "alarm" in order to alarm with motion in front of the detector. She further stated the nurses and CNAs were to check the function of the motion detectors every shift to ensure they were functioning properly.</p> <p>Interview on 10/20/10 at 9:30 AM with CNA #12, who was assigned to the resident, revealed the resident had a bed alarm; however, she was unaware of the resident having a motion detector. She stated she started her shift at 6:45 AM and was unaware she was assigned to the resident because she had been getting residents up for breakfast all morning. Continued interview revealed she did not check bed alarms at the beginning of the shift and was unaware there</p>	F 282	<p>Nursing was in- serviced 10/22/10 through 11/1/10 by the DON, QA Nurse, night shift nurse and weekend supervisor on checking alarms for placement and functioning, replacing one that is not functioning and following the care plan.</p> <p>Licensed nurses in-serviced on 11/1/10 by the DON and QA Nurse on the equipment check policy</p> <p>Unit managers educated on following the care plan and monitoring implementation on 11/1/10 by DNS and QA nurse.</p> <p>New equipment check policy.</p> <p>Personal alarms/motion detectors were added to the treatment records.</p> <p>The nurse will check these alarms every shift and document functioning. Any device noted not to be functioning will be replaced or repaired at that time.</p> <p>Department supervisors or designee has been assigned to assist with monitoring placement and functioning of alarms/motion detectors, equipment daily utilizing the QA audit tool. The QA audit tools will be reviewed during the daily meeting (Monday thru Friday) for compliance. The QA committee will review the current processes and modify as needed.</p>	

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F 282	Continued From page 21 were any motion detectors in the building. CNA #12 stated, when caring for the residents, she reviewed the Nurse Aide Care Plans, which were in a book at the nurse's station. Review of the Nursing Assistant Plan of Care with the CNA revealed there was an intervention for the bed motion detector.	F 282	10 random audits will be conducted monthly x3 then quarterly thereafter on care plan interventions by the DNS, QA Nurse or designee to ensure care plan interventions are implemented per care plan or physician order	11-2-10	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  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 which would not only maintain, but improve, the residents' abilities for one (1) of eight (8) sampled residents (Resident #2).  The findings include:  1. Review of Resident #2's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/10 revealed the facility assessed the resident as receiving restorative nursing for Active Range of Motion (AROM) and ambulation for the past seven (7) days.	F 318	F318 Resident #2's Therapy and restorative orders were clarified to meet the resident's needs on 10/21/10 by the physical therapist director.  Therapy Director on 10/22/10 reviewed residents that had been discharged in the past 30 days to ensure that the orders were written appropriately.  Therapy director was in-serviced on 10/21/10 by the Regional Therapy Director and the other therapists were in-serviced on 10/25/10 on the policy and procedure for writing discharge orders.		

*Continued on pg 23*

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F 318	<p>Continued From page 22</p> <p>Review of the Physician's Orders dated 10/10 revealed Orders for Restorative Nursing Program Level two (2) to the upper extremities, participate in exercise group and activities for five to seven days per week and Restorative Nursing Program Level three (3) for ambulation with rolling walker five (5) to seven (7) days a week.</p> <p>Further review of the Physician's Orders dated 09/16/10 revealed Orders for Physical Therapy to evaluate and treat four (4) times per week for four (4) weeks and to discontinue the restorative nursing program for the lower extremities.</p> <p>Review of the Daily Documentation for Restorative Nursing for 10/10 revealed the resident was to receive AROM to the bilateral upper extremities and lower extremities for fifteen (15) minutes, five (5) to seven (7) days per week. Further review of the Daily Documentation revealed the AROM to the bilateral upper and lower extremities was signed off as completed for the month of 10/10.</p> <p>Further review of the Daily Documentation for Restorative Nursing for 10/10 revealed the resident was to ambulate with the rolling walker to the bathroom five (5) to seven (7) days a week. Further review of the Daily Documentation revealed a "W" was documented for the minutes for 10/01/10 through 10/18/10 for ambulating the resident to the bathroom with a rolling walker.</p> <p>Interview on 10/19/10 at 2:00 PM with the restorative aide revealed Physical Therapy and Occupational therapy completed level I, the restorative aides completed level II, and the aides on the floor completed level III restorative</p>	F 318	<p>The nursing assistants were in-serviced on documenting the restorative programs and reporting refusals to the nurse. education initiated 10/22/10 and completed 11/1/10 by the QA Nurse, night shift nurse and weekend supervisor.</p> <p>Restorative nursing programs/ documentation added to the unit manager's task list for the unit managers to review weekly with any trends to be reviewed through the QA processes.</p> <p>Therapy Director to provide The QA committee with a list of residents that have been discharged from therapy weekly, then utilizing that list the restorative manager or designee will conduct weekly audits to ensure they have a copy of the discharge order and a restorative order as applicable upon discharge to ensure they are receiving the services as ordered. The audits will be reviewed during the daily (Monday thru Friday) QA meeting as completed.</p>	11-2-10
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F 318	<p>Continued From page 23</p> <p>activities. She further stated the resident attended the exercise program which was considered level II. Continued interview, revealed the resident was level III for ambulation to the bathroom and the aides on the floor were responsible to ensure it was done.</p> <p>Interview on 10/20/10 at 9:30 AM with CNA #12 who was assigned to the resident, revealed she did not ensure the resident received AROM and the resident was not ambulated to the bathroom. She indicated she was unaware the resident was to receive restorative nursing although she was completing the Daily Documentation Sheet for Restorative Nursing.</p> <p>Interview on 10/20/10 at 2:45 PM with CNA #11, who worked on Resident #2's unit revealed she was sometimes assigned to the resident; however, did not perform AROM or ambulate the resident because she was unaware the resident was to receive Restorative Nursing.</p> <p>Interview on 10/20/10 at 3:00 PM with CNA #13 revealed she was often assigned to the resident, and she ambulated the resident to the bathroom some days; however, the resident sometimes refused ambulation. Further interview, revealed if the resident refused she would document "W" for withheld on the Daily Documentation Sheet. She stated the resident often refused; however, she had not reported it to the nurse because the nurses were responsible for checking the sheets and should be aware if the resident was refusing. Further interview revealed she did not perform AROM for fifteen (15) minutes; however, felt the resident received AROM when getting dressed and when moving in bed.</p>	F 318		

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F 318	<p>Continued From page 24</p> <p>Interview on 10/20/10 at 1:45 PM with the Restorative Nurse revealed the resident was on level III for ambulation and the aides on the floor were to ambulate the resident to the bathroom. She stated the resident attended the level II exercise program and sometimes participated. She further stated the aides on the floor were to complete the AROM to the residents upper extremities. Continued interview revealed she was unable to tell if the resident was currently receiving Physical Therapy (PT) by record review; however, if PT were ordered for the resident, the lower extremity AROM would be discontinued by restorative. Further interview revealed she was to ensure the aides on the floor were completing the Restorative Nursing Program (RNP); however, she depended on the Nurse Managers to let her know when a resident was no longer getting the RNP due to refusal or decline. She stated she did not review the Daily Documentation for Restorative Nursing Sheets to ensure the RNP was being carried out, because it was the Nurse Managers responsibility.</p> <p>Interview on 10/20/10 at 1:50 PM with the Nurse Manager revealed she did not review the Dally Documentation for Restorative Nursing. She further stated she was unaware the intervention to ambulate the resident to the bathroom was being withheld and unaware the aides were not performing AROM. Continued interview revealed she was unsure if the resident was currently receiving Physical Therapy (PT) and could not tell by record review. She stated, if the resident were receiving PT, the Dally Documentation for Restorative Nursing Sheet should have been pulled out of the book and placed in the book with new interventions at the complellon of PT.</p>	F 318		

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**F 318** Continued From page 25  
Interview on 10/20/10 at 4:20 PM with the Director of Nursing, revealed the Restorative Nurse was to check the documentation to ensure the Daily Documentation for Restorative Nursing was being completed and was responsible for ensuring the restorative nursing was completed by the aides for the level II and level III programs.  
  
Interview on 10/20/10 at 2:10 PM with the Physical Therapy Assistant (PTA) revealed the Physical Therapist had recently been working with the resident; however, she was unsure if the resident was still receiving PT. The PTA found the Physical Therapy (PT) Daily Treatment Record which was in the the Physical Therapist's office and not in the resident's medical record. She stated the documentation revealed the resident had received PT from 09/19/10 through 10/06/10.  
  
Phone interview with the Physical Therapist on 10/20/10 at 3:20 PM; verified the resident had received PT from 09/19/10 through 10/06/10. He stated he had failed to complete the discharge summary to included the instructions for restorative nursing and failed to communicate with the restorative nurse. Further interview, revealed he should have written instructions for restorative nursing on the Physician's Orders to be signed by the Physician; however, the Physician's Order for restorative nursing did not get written due to it being a "crazy" month.

**F 318**

**F 323**  
**SS=D**  
**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**  
  
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to

**F 323** **F 323**  
  
Resident # 2's motion detector was repaired on 10/20/10 by the unit manager.

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F 323	<p>Continued From page 26 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review It was determined the facility failed to provide adequate supervision and monitoring to prevent accidents for two (2) of eleven (11) sampled residents (Residents #2 and #8). Resident #2 required a motion detector/alarm related to being a fall risk however, the detector was nonfunctional. Resident #8 had a history of falls, sustained falls from the bed to the floor, staff failed to ensure the resident's floor mat was in place.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of Resident #2's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Disease (CVA). Review of the Minimum Data Set (MDS) Assessment dated 08/26/10 revealed the facility assessed the resident as sustaining falls in the past thirty (30) days and thirty-one to one hundred eighty (31-180) days.</li> </ol> <p>Review of the Fall Risk Assessment dated 08/24/10 revealed the resident was at high risk for falls related to Intermittent confusion and had sustained falls in the past three (3) months. The resident was assessed as having a balance problem while walking and required the use of an assistive device for gait and balance Assessed to</p>	F 323	<p>Resident # 8's fall mat was added to the care plan on 10/21/10 by the nurse manager.</p> <p>Other residents with fall prevention equipment ordered were reviewed to ensure the equipment was functioning and in place, Rooms were checked for any other equipment not ordered. completed 10/20/10 by the unit managers and MDS coordinators.</p> <p>Residents with fall prevention equipment were reviewed and a safety checklist created by the QA Nurse and implemented 11/1/10</p> <p>All resident rooms and common areas were checked for safety hazards on 10/20/10 by the unit managers, MDS Coordinators , QA Nurse and DNS</p> <p>The interdisciplinary team was in-serviced by the Regional Nurse Consultant on 10/28/10 on the equipment check procedure and completing the equipment check QA tool.</p>	
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F 323

Continued From page 27  
received medication including anti-hypertensives and diuretics, and had a diagnosis of CVA.

Review of the Incident/Accident Report dated 01/11/10 at 8:55 PM revealed the resident was found in the floor in the resident's room with a four (4) centimeter laceration to the back of the head. The environment/situational section of the Report revealed the resident was attempting to toilet and ambulating without needed assistance. Review of the Fall Investigation dated 01/11/10 at 8:55 PM revealed the resident sustained a head injury requiring emergency room evaluation. Review of the Nurse's Notes dated 1/11/10 at 9:15 PM revealed the ambulance arrived to transport the resident to the Hospital Emergency Room. Review of the Nurses Notes dated 01/11/10 at 11:20 PM revealed the emergency room called and the resident was returning to the facility with four (4) staples to the laceration at the back of the head.

Further review of the Fall Investigations revealed the resident sustained falls on 02/03/10 at 4:10 PM due to ambulating without needed assistance which resulted in a skin tear, and sustained a fall on 04/27/10 at 1:15 PM due to ambulating without needed assistance.

Review of the Fall Investigations and Referral for a Fall Therapy Forms revealed the resident sustained a fall on 05/29/10 at 4:25 PM while attempting to toilet and was in the bed prior to the fall, sustained a fall on 07/22/10 with no injuries and was in the bed prior to the fall, and sustained a fall on 08/09/10 at 4:30 AM while getting out of the bed due to attempting to toilet self, resulting in a skin tear and bruise.

F 323

Nurses were in-serviced by the DON and QA Nurse on 11/1/10 on the equipment check policy which includes checking placement and functioning as well as replacement if not functioning.

Nursing assistants were in-serviced on checking alarms for placement and functioning procedures by the QA Nurse, weekend supervisor and designated night shift nurse 10/22/10 through 11/1/10.

Environmental safety rounds will be conducted weekly by the QA Nurse or designees

Alarms/ motion detectors/fall prevention equipment will be audited by department supervisors or designee daily as assigned utilizing the safety device audit tool to ensure placement and functioning. The QA audit tools will be reviewed at the daily QA meeting (Monday thru Friday) for compliance. The QA committee will review the processes and modify as needed.

Environmental weekly safety round audits will be reviewed Monthly by the safety committee for any trends and recorded in our safety minutes.

11-2-10

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F 323	<p>Continued From page 28</p> <p>Continued review of the Fall Investigations and Referral for a Fall Therapy Forms revealed the resident sustained a fall on 09/09/10 at 3:30 PM resulting in a skin tear, due to ambulating without needed help, and was in the bed prior to the fall. Review of the Nurse's Notes dated 09/09/10 at 3:15 PM, and 10:35 PM and 09/12/10 at 04:30 AM, revealed the resident sustained a bruise to the right arm, a bruise under the left eye and a hematoma to the left cheek related to the fall on 09/09/10.</p> <p>Further review of the Fall Investigations revealed the resident sustained a fall on 10/14/10 at 7:15 AM with no injury, while attempting to slide down in the wheelchair.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 06/01/10 revealed the resident had poor safety awareness and attempted to transfer unassisted from the wheelchair to the bed and out of the bed. Further review of the RAPS stated the resident and a motion detector to the bed to alert staff of attempted transfers.</p> <p>Review of the Comprehensive Plan of Care dated 08/31/10 revealed the resident had a history of falls related to decreased mobility, decreased cognition, and bowel and bladder incontinence. The interventions included a bed motion detector.</p> <p>Review of the Physician's Orders dated 10/10 revealed Orders for a bed motion detector to the bed, and to check placement and function every shift.</p> <p>Observation of Resident #2 on 10/20/10 at 9:00 AM revealed she/he was in the bed with two (2)</p>	F 323		
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F 323	<p>Continued From page 29</p> <p>one half (1/2) side rails up and a bed alarm in place. Interview with Certified Nursing Assistant (CNA) #11 who was emptying the trash on the resident's side of the room, revealed she was not assigned to the resident; however, was often assigned to the resident and familiar with the resident's care needs. She stated she was assisting the CNA who was assigned to the resident. Continued interview with CNA #11 revealed the resident did not have a bed motion detector.</p> <p>Observation of the resident on 10/20/10 at 9:20 AM with the Nurse Manager assigned to the resident revealed the motion detector was on the bedside table; however, the detector did not alarm with movement in front of the detector. The Nurse Manager checked the detector and verified it was on "chime" and was delayed in alarming. She stated the motion detector was set wrong and should have been set on "alarm" in order to alarm with motion in front of the detector. Continued interview revealed the nurses and CNAs were to check the function of the motion detectors every shift to ensure they were functioning properly.</p> <p>Interview on 10/20/10 at 9:30 AM with CNA #12 who was assigned to the resident, revealed there was a bed alarm on the resident's bed; however, the resident did not have a motion detector that she was aware. Continued interview revealed she started her shift at 8:45 AM and was not aware she was assigned to the resident because she had been getting residents up for breakfast all morning. She further stated, she did not check bed alarms at the beginning of the shift and was not aware there were any motion detectors in the building. Continued interview revealed she</p>	F 323		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WINDSOR CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>125 STERLING WAY MOUNT STERLING, KY 40353</b>
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F 323	<p>Continued From page 30</p> <p>reviewed the Nurse Aide Care Plans which were in a book at the nurse's station when caring for the residents. Review of the Nursing Assistant Plan of Care with CNA #12 revealed an intervention for the bed motion detector.</p> <p>Although the resident sustained eight (8) falls since 01/11/10, with seven (7) of the falls resulting from the resident attempting to self transfer or ambulating without needed assistance, there was no evidence staff ensured the bed motion detector was in place and working properly.</p> <p>2. Review of Resident #8's medical record revealed diagnoses which included Dementia, and Osteoporosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/21/10 revealed the facility assessed the resident as being severely impaired in cognitive skills and as requiring extensive to total assistance with transfers and ambulation.</p> <p>Review of the Fall Risk Assessment dated 10/05/10 revealed the resident was at high risk for falls related to intermittent confusion, falls in the past three (3) months, had a gait/balance problem, received narcotic and psychotropic medications, and had a diagnosis of Osteoarthritis.</p> <p>Review of the Incident/Accident Report dated 07/28/10 at 6:20 PM revealed the resident was in the bed when the nurse was working with the resident's roommate and the nurse heard the resident hit the floor, resulting in swelling and an abrasion over the right eye and bruising to the right shoulder. Review of the Hospital Emergency Department Record dated 07/28/10 revealed the resident sustained a Contusion to</p>	F 323		

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F 323	<p>Continued From page 31 the Head and Shoulder.</p> <p>Review of the Fall Investigation dated 10/11/10 and the Nurse's Notes dated 10/11/10 at 2:30 PM revealed the resident rolled out of the bed and on to the floor landing on a floor mat. The resident sustained a scratch to the forehead and a bruise to the left shoulder.</p> <p>Review of the Comprehensive Plan of Care dated 05/20/09 revealed the resident was at risk for injury due to falls related to a history of dizziness, a history of attempting to self transfer, was non-ambulatory, unsteady on her/his feet, received pain medications and psychotropic medications, incontinence of bowel and bladder, and had a History of Falls. Further review of the Plan of Care revealed the fall interventions did not include a fall mat</p> <p>Observation of Resident #8 on 10/19/10 at 11:25 AM, 1:30 PM, 1:50 PM, and 2:15 PM revealed the resident was in the bed. Fall interventions were noted including a perimeter mattress, a pressure alarm, bolster pillows on either side of the resident, and the bed in low position. There was a folded up mat standing upright against a wall.</p> <p>Further observation of the resident on 10/19/10 at 3:00 PM revealed the resident was in the bed with the mat on the floor on the left side of the bed.</p> <p>Interview on 10/20/10 at 10:15 AM with Certified Nursing Assistant (CNA) #10 revealed she was assigned to the resident on 10/19/10 during the day shift. She stated someone else had assisted the resident back to bed and she did not realize the mat was not on the floor until she did rounds shortly before 3:00 PM. Review of the Nursing</p>	F 323		

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F 323	Continued From page 32 Assistant Plan of Care dated 10/10 revealed there was no fall intervention noted for the use of a fall mat.  Interview on 10/20/10 at 3:00 PM with MDS Coordinator #1 revealed the nurse who initiated the fall mat should have revised the Plan of Care to include the fall mat. She stated she revised the Care Plans during Quarterly and Comprehensive MDS review. She further stated, she reviewed the resident records, and observed the residents for any fall interventions when revising a Plan of Care. Further review, revealed she was unsure why the fall mat was not on the Care Plan.  Interview on 10/20/10 at 4:10 PM and 4:20 PM with the Director of Nursing (DON) revealed falls were reviewed weekly in the Fall Meeting and the Plans of Care were reviewed and updated during the meeting for new falls. The DON was unsure why the fall mat was not on the Care Plan.  Further interview with the DON on 10/20/10 at 4:20 PM revealed she had just called and spoken with the nurse who assessed the resident after the resident sustained the fall on 07/28/10. She stated the nurse had initiated the fall mat; however, had failed to revise the Plan of Care and communicate the intervention to nursing.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (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	F 325	F 325  Resident # 1's care plan was updated to include current approaches and the facility ensured that the resident was receiving the ensure per MD orders.		

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F 325	<p>Continued From page 33</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</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 acceptable perimeters of nutritional status were monitored for one (1) of eleven (11) sampled residents (Resident #1). Resident #1 experienced a greater than 5% weight loss in less than one month, with no evidence the facility implemented physician order related to providing the resident Ensure supplement, an intervention for the weight loss. Resident #1 lost thirteen (13) pounds from October 8 to October 20, 2010, a seven and three tenths percent (7.3%) weight loss.</p> <p>The findings include:</p> <p>Review of Resident #1's medical records revealed upon re-admission to the facility on October 8, 2010 Resident #1 weighed one hundred seventy-six (176) pounds.</p> <p>Review of the Dietary Recommendations, dated October 11, 2010, revealed a recommendation for Ensure supplement three (3) times daily for weight loss. Physician's orders, dated October 12, 2010, revealed an order for the Ensure three times daily.</p> <p>Further review of the weight record for Resident #1 revealed a weight of 170 pounds on October 15, 2010. A physician communication form was</p>	F 325	<p>Completed 10/19/10 by the nurse manager</p> <p>Other charts were reviewed to ensure that resident with orders for supplements were receiving them per MD orders. Audit completed by the unit managers and the QA Nurse 10/22/10 through 11/1/10.</p> <p>The dietician reviewed residents receiving supplements on 10/26/10 through 10/28/10. Supplements were reviewed to ensure that they were ordered and if still required in order to switch over to our new supplement policy.</p> <p>The six months weight variance report was reviewed by the DON and QA nurse on 10/11/10 to determine if any other residents had significant avoidable weight loss for one, three and/or 6 months, no others identified.</p> <p>The interdisciplinary nursing team was in-serviced by the Regional Nurse Consultant on 10/28/10 on the new supplement policy.</p> <p>Nurses were in-serviced by the DON and QA Nurse on 11/1/10 on the new</p>	

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F 325 Continued From page 34  
completed and faxed to Resident #1's physician stating, "Resident has had approximately twenty (20) pound weight loss since acute illness and low back pain; current weight is 170 pounds". Orders were obtained for Megace ES (appetite stimulant) 625 milligrams (mg) every day from Resident #1's physician. Resident #1's weighed one hundred and sixty-three (163) pounds on October 20, 2010, a total weight loss of thirteen (13) pounds since readmission from the hospital on October 8, 2010.

Observations on October 19, 2010 revealed Resident #1 did not receive the Ensure supplement at the 10:00 AM snack. Interview with Resident #1's family, on October 19, 2010 at 11:30 AM, revealed staff did not provide the Ensure supplement, as ordered, but had provided ginger ale as a snack for Resident #1.

An interview with the Registered Dietician (RD) on October 19, 2010, at 4:00 PM, revealed Resident #1 returned from the hospital on October 8, 2010. The RD stated Ensure was recommended for Resident #1 to receive three (3) times between meals, to be given as a snack at 10:00 AM, 2:00 PM, and 8:00 PM.

An interview with the Assistant Dietary Manager on October 19, 2010 at 3:50 PM revealed the tray cards for Resident #1 noted the Ensure supplement on the cards, however the tray line staff differed from the staff who sent the resident snacks to the floor.

An interview with CNA #6 on October 19, 2010 at 4:00 PM revealed snacks were passed at 10:00 AM, 2:00 PM, and a snack was passed on the second shift at 8:00 PM. CNA #6 was

F 325 supplement policy Nurses educated on monitoring weights and comparing discharge weights to the re-admit weight and address accordingly by the QA Nurse, weekend supervisor and designated night shift nurse 10/22/10 through 11/1/10.

Supplements have been added to the medication record for nursing to provide and document amount taken, the DON, QA Nurse or designee will audit the medication records weekly x4 then twice monthly and then monthly thereafter to ensure compliance with the system change. Audits will be reviewed through the QA processes and modified as needed.

*continued on pg 36*

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F 325	<p>Continued From page 35</p> <p>responsible for distributing snacks and supplements to residents during her shift. The CNA was unaware Resident #1 was to receive, physician ordered, Ensure three times daily.</p> <p>An interview with Kitchen employees #1, and #2, on October 20, 2010, at 10:20 AM until 10:30 AM, revealed kitchen staff prepare the snacks on separate trays with the resident's name date, and time the supplement was due on a sticker, and affixed to the side of the supplement. Kitchen employees #1, and #2 were unaware Resident #1 had physician ordered Ensure supplements three times daily prior until October 20, 2010. The kitchen employees stated the Ensure snacks were set aside for Resident #1 starting on October 20, 2010, when they became aware of the physician's order.</p> <p>An interview with the LPN Unit Manager (UM) on October 19, 2010 at 2:00 PM revealed Resident #1 returned from the hospital on October 8, 2010 with a weight of 176 pounds. The UM stated the dietician was notified that Resident #1 had lost weight during the acute hospital admission, on October 11, 2010. According to the UM the RD made dietary recommendation, and physician's orders were received for Ensure supplement between meals. The UM stated on October 15, 2010 Resident #1's weight was 170 pounds, a six (6) pound weight loss since Resident #1 returned from the hospital and the UM notified the physician. According to the UM, Resident #1's physician prescribed Megace ES 625 mg every day. According to the UM if a resident sustains a weight loss the Dietitian should be notified, and thought the dietitian should have received a referral when Resident #1 was re-admitted to the facility October 8, 2010.</p>	F 325	<p>The resident's weights will be reviewed during the daily (Monday thru Friday) QA meeting by the QA committee after the weights are obtained per the MD orders. Any discrepancies will be referred to the dietician. Residents re-admitted to the facility following an acute care stay will have their charts reviewed by the QA committee the next business day following re-admit to ensure any weight loss has been addressed and referred to the dietician as needed.</p>	11-2-10
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11-2-10

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F 325	Continued From page 36	F 325		
F 406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Physical Therapy was provided as required by the Comprehensive Plan of Care for one (1) of eight (8) sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Review of Resident #2's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/10 revealed the facility assessed the resident as requiring extensive assistance with transfers and ambulation.</p>	F 406	<p>F 406</p> <p>Resident #2's therapy and restorative order was clarified to meet the residents current needs on 10/21/10 by the physical therapist director.</p> <p>Therapy Director on 10/22/10 reviewed residents that had been discharged from therapy in the past 30 days to ensure that the order was written appropriately.</p> <p>Therapy Director was in-serviced on 10/21/10 by the Regional Rehab Director and the other therapists were in-serviced by the Therapy Director on 10/25/10 on the policy and procedure for writing discharge orders.</p> <p><i>Continued on pg 38</i></p>	

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F 406	<p>Continued From page 37</p> <p>Review of the Physician's Orders dated 09/16/10 revealed Orders for Physical Therapy to evaluate and treat four (4) times per week for four (4) weeks and to discontinue the restorative nursing program for the lower extremities.</p> <p>Review of the Comprehensive Plan of Care dated 09/16/10 revealed the resident had a problem with weakness, decreased mobility skills, decreased gait ability, and hip pain. The interventions included Physical Therapy four (4) times per week for four (4) weeks.</p> <p>Interview on 10/20/10 at 1:45 PM with the Restorative Nurse revealed the resident was receiving restorative nursing. She stated the aides on the floor were to ambulate the resident to the bathroom and perform Active Range of Motion (AROM) to the resident's upper extremities. She further stated the resident also attended the exercise program and sometimes participated. Continued interview revealed she was unable to tell if the resident was currently receiving Physical Therapy (PT) by record review. She stated if the resident were receiving PT at that time, the AROM to the lower extremities would be held by restorative nursing.</p> <p>Interview on 10/20/10 at 1:50 PM with the Nurse Manager, revealed she was unsure if the resident was currently receiving Physical Therapy (PT) and could not tell by record review. She stated there was a recent Physician's Order for PT on 09/16/10; however, there was no PT information in the record.</p> <p>Interview on 10/20/10 at 2:10 PM with the Physical Therapy Assistant (PTA) revealed the Physical Therapist had recently been working with</p>	F 406	<p>Therapy Director to provide the QA committee with a list of residents discharged from therapy weekly, then utilizing the list the restorative manager or designee will conduct a weekly audit to ensure they have a copy of the discharge order and a restorative order as applicable upon discharge. The audits will be reviewed during the daily (Monday thru Friday) QA meeting. The QA committee will review the processes and modify if needed.</p>	11-2-10	

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F 406	<p>Continued From page 38</p> <p>the resident; however, she was unsure if the resident was still receiving PT. The PTA found the Physical Therapy (PT) Daily Treatment Records which were in the Physical Therapist's office, and stated the documentation revealed the resident had received PT from 09/19/10 through 10/06/10. However, the PTA stated she could not find a discharge summary and did not know if the resident was supposed to be discharged to a restorative nursing program.</p> <p>Phone interview with the Physical Therapist on 10/20/10 at 3:20 PM, verified the resident had received PT from 09/19/10 through 10/06/10. Continued interview with the PT revealed he had failed to complete the discharge summary to include the instructions for restorative nursing and failed to communicate with the restorative nurse. He further stated he should have written a Physician's Order to discontinue the resident from PT with instructions for restorative nursing to be signed by the Physician. Continued interview revealed there was a weekly meeting to discuss whether residents attending PT needed to be discharged to restorative nursing. He stated the Administrator, the Director of Nursing, the Unit Mangers, and the Quality Assurance Nurse attended the meetings. He further stated the resident had been discussed in the meeting recently; however, the Physician's Order to discharge the resident from PT and the Physician's Order for restorative nursing did not get written due to it being a "crazy" month.</p>	F 406		
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