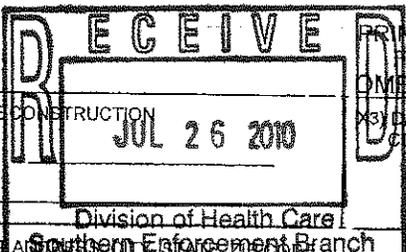


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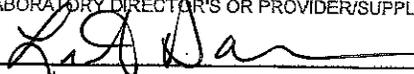
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ |
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| NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER | STREET ADDRESS 945 WEST RUSSELL STREET, PO BOX 300 ELKHORN CITY, KY 41522 |
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| (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 |
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| F 000 | INITIAL COMMENTS A standard health survey was conducted on June 27-30, 2010. Deficient practice was determined to exist with the highest scope and severity at an "F" level. An abbreviated standard survey (KY14920) was also conducted at this time. No deficient practice was identified related to the allegation and the allegation was unsubstantiated. | F 000 | <p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <p><u>Tag # F 157</u></p> <p>1. The physician was notified of resident # 26 refusing Megace. An order was obtained to discontinue Megace at that time.</p> <p>Please note that other interventions have been attempted for resident #26. Resident receives 6 small meals per day that is discontinued at this time with documented refusal. He has fortified oatmeal and orange juice with current diet of consistent carbohydrates, no added salt, and mechanical soft, with ground meats. Physician has made multiple medication changes in order to increase resident's appetite. Resident has refused each new intervention with noted</p> | |
| F 157 SS=D | 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 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. | F 157 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 07-23-10 |
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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 157 | <p>Continued From page 1</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 of a change in condition for one (1) of twenty-nine (29) sampled residents. The facility failed to notify the physician of resident #26's condition after the resident refused Megace fifty (50) times from June 1, 2010 through June 29, 2010.</p> <p>The findings include:</p> <p>A review of the medical record for resident #26 revealed the resident had been admitted to the facility on March 24, 2009, and had diagnoses to include Anorexia, Chronic Airway Obstruction, Chronic Pain, Anxiety, Depressive Disorder, Insomnia, Esophageal Reflux, Peptic Ulcer Disease, and Vitamin Deficiency. According to the weight record, the resident has had a weight loss of 13 pounds in the past 10 months. The resident weighed 126 pounds on August 30, 2009. The resident's weight on February 8, 2010, was 113 pounds. The physician ordered Megace 400 milligrams twice daily for weight loss on February 3, 2010, as a result of a recommendation from the Registered Dietitian. According to the weight record, on June 18, 2010, resident #13 weighed 113 pounds.</p> <p>An observation of medication administration for resident #26 was conducted on June 28, 2010, at</p> | F 157 | <p>documentation in Nutritional at Risk Meeting notes, Registered Dietician notes, dietary notes, social services notes, and nurses notes. Resident and family have been approached about an alternate source of nutrition (i.e. tube feeding), which was refused each time. The facility will continue to monitor resident's weights and notify physician and family of any change in condition of resident.</p> <p>2. A 100% audit of all active resident's MAR's and TAR's were reviewed to ensure no other resident's were refusing medications or treatments and that the physician was notified. New orders were obtained and put into place as identified.</p> <p>3. Charge nurses will utilize the 24-hour report to document any medication or treatment refusals. The Director of Nursing/Nursing Management Team will review the 24-hour reports Monday through Friday to ensure that the physician and legal representatives are notified of refusal of medications or treatments.</p> <p>The Director of Nursing/Assistant Director of Nursing inserviced all licensed nurses on July 16, 2010 regarding physician notification, notification of legal representatives, and documenting refusals on 24-hour shift reports. Licensed nurses</p> | |
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| F 157 | <p>Continued From page 2</p> <p>9:05 a.m. The nurse responsible for administering medications to resident #26 attempted to administer Megace 400 milligrams orally, at which time the resident refused after several attempts were made by the nurse to administer the medication.</p> <p>A review of the Medication Administration Record (MAR) for resident #26 revealed the resident has refused to take Megace 50 times from June 1, 2010 through June 29, 2010. A review of the nurse's notes revealed no documentation the physician of resident #26 had been notified the resident was not taking Megace as ordered by the physician.</p> <p>A review of the monthly reviews by the facility's Consultant Pharmacist did not reveal any recommendations regarding the Megace for resident #26.</p> <p>An interview was conducted on June 28, 2010, at 2:30 p.m., with the Licensed Practical Nurse (LPN) responsible for administering medications to resident #26 on June 28, 2010. The LPN stated he/she should have notified the physician when the resident refused to take the Megace as ordered. The LPN further stated it was the facility's policy to notify the physician if a resident refused any medication.</p> <p>A review of the facility's policy for Medication Administration dated October 2008 revealed the nurse was required to circle his/her initials on the MAR if a medication was not administered as ordered, and staff was also required to document the reason the medication was not administered on the MAR. The policy further stated the nurse was required to notify the physician of the</p> | F 157 | <p>will be inserviced on physician notification upon hire, annually, and as needed.</p> <p>4. The Director of Nursing/Nursing Management Team will perform weekly audits of all resident's MAR's and TAR's for refusal and physician notification weekly x 4 weeks, then monthly x 3 months.</p> <p>Review of notification to physician and legal representatives of medication/treatment refusals will continue in the Performance Improvement Committee Meetings until 95% threshold is met.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
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| F 157 | Continued From page 3 resident refusing medication. The policy also stated if the resident continued to refuse the medication, the nurse was required to contact the physician with each refusal. An interview was conducted on June 30, 2010, at 1030 a.m., with the physician of resident #26. The physician stated that he/she was not aware resident #26 had refused Megace 50 times since June 1, 2010. The physician further stated that had he/she been aware he/she would have discontinued the medication. | F 157 | | |
| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when | F 164 | <p align="center">Tag # F 164</p> <ol style="list-style-type: none"> The Director of Nursing immediately provided education to the nurse that provided the care to resident # 27 without providing privacy. All resident's having a gastrostomy tube have the potential to be affected. An audit has been conducted by the Nursing Management Team for all resident's with gastrostomy tubes to ensure that privacy is maintained during any provision of care. All licensed staff was inserviced on July 16, 2010 regarding providing privacy for resident's during any provision of care. All staff will be inserviced regarding privacy upon hire, annually, and as needed. The Director of Nursing/Nursing Management Team will observe licensed staff during medication passes for gastrostomy tube residents' to ensure that privacy has been provided weekly x 4 weeks then monthly x 3 months. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Date of Compliance – July 31, 2010. | |

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| F 164 | <p>Continued From page 4</p> <p>release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to afford personal privacy to one (1) of twenty-nine (29) residents during observation of a medication pass conducted on June 27, 2010. Privacy for resident #27 was not maintained while providing care/administering medications via the resident's gastrostomy tube.</p> <p>The findings include:</p> <p>Observation of medication pass on June 27, 2010, at 5:20 p.m., revealed Licensed Practical Nurse (LPN) #1 entered resident #27's room to provide care/administer medication via resident #27's gastrostomy tube. LPN #1 exposed resident #27's abdomen to administer medications via the resident's gastrostomy tube; however, LPN #1 failed to close the resident's door or pull the privacy curtain. Resident #16's roommate was present in the resident's room during the procedure.</p> <p>Interview on June 27, 2010, at 6:30 p.m., revealed LPN #1 was knowledgeable of the requirement to provide privacy for residents during any procedures. LPN #1 stated the LPN was just nervous and failed to provide privacy for the resident.</p> <p>Review of the facility's policy entitled "Feeding Tube-Instilling Medication" undated revealed staff</p> | F 164 | | |
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| F 164 | Continued From page 5 should ensure privacy to residents during any provision of care to a resident's gastrostomy tube. | F 164 | <p align="center">Tag # 252</p> <ol style="list-style-type: none"> 1. A 100% audit of all residents' rooms was conducted on 7/10/2010 by the Executive Director and Housekeeping Supervisor to identify source of urine odor. 2. The Executive Director and Housekeeping Supervisor completed a 100% audit of all residents' rooms to ensure that no other odors were noted. 3. An inservice was conducted on July 16, 2010 by the Director of Nursing/Assistant Director of Nursing with all staff in regards to urine odor control by flushing commodes after use, changing resident's after incontinent episodes, etc. 4. Facility rounds will be conducted by Executive Director, Housekeeping, or Nursing Management Team weekly x 4 weeks, then monthly x 3 months. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5. Date of Compliance July 31, 2010. | |
| F 252 SS=D | <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable, and homelike environment. Observations conducted during the survey from June 27-30, 2010, revealed a strong urine odor throughout the Rose Garden Unit/secured unit.</p> <p>The findings include: Observations during the initial tour of the Rose Garden Unit/secured unit on June 27, 2010, at 2:30 p.m., revealed a strong lingering odor of urine in the locked/secured unit.</p> <p>Interview on June 29, 2010, at 2:20 p.m., with a housekeeper assigned to the Rose Garden Unit revealed the housekeeper frequently had to flush the residents' commodes due to residents forgetting to flush the commodes. The housekeeper stated the commodes not being flushed when used caused some of the urine odor in the locked/secured unit. The housekeeper stated staff always notified the housekeeper when a resident urinated on the floor.</p> | F 252 | | |

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| F 252 | Continued From page 6 An interview conducted on June 29, 2010, at 2:30 p.m., with the Housekeeping Supervisor (HS) revealed the Rose Garden Unit definitely had a persistent urine odor. The HS stated some of the odor was caused by one male resident frequently urinating on the floor in the resident's bathroom. Further interview with the HS revealed that the resident's bathroom was cleaned at least three times a day and more often if needed. The HS stated staff had used several different cleaning agents and air fresheners, however, the urine odor remained. The HS stated the housekeeping staff performed deep cleaning of four rooms every day. The remaining rooms receive a general cleaning (dust, sweep, mop, clean bathroom) every day. The HS stated he/she made visual rounds each day to ensure staff performed the assigned cleaning assignment. | F 252 | | |
| 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 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | F 279 | <p align="center"><u>Tag # 279</u></p> <ol style="list-style-type: none"> Resident # 15's physician was notified to obtain an order for follow up CBC. New orders were obtained for CBC to be drawn monthly. Resident # 15's care plans were updated to reflect the anemia diagnosis and interventions for anemia. Please note that resident #15 had received labs with follow-up per physician orders. Resident was on Ferrous Sulfate 325 mg three times daily for the diagnosis of anemia. The Director of Nursing/Nursing Management Team will complete a 100% audit of all active resident's charts by July 31, 2010 to ensure that all diagnoses have been care planned with interventions for monitoring resident's signs/symptoms and lab values. The Regional Director of Clinical Services inserviced the Director of Nursing, MDS Coordinator, and MDS Assessment Nurse concerning the development of a comprehensive care plan upon admission and readmission to the facility. The Director of Nursing/Assistant Director of Nursing/MDS Coordinators inserviced all licensed staff on July 23, 2010 of the | |

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| F 279 | <p>Continued From page 7</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: Based on interview and record review, it was determined the facility failed to utilize the results of the comprehensive assessment to develop individual comprehensive plans of care for one (1) of twenty-nine (29) sampled residents. Resident #15 was readmitted to the facility with a new diagnosis of Iron Deficiency Anemia on December 21, 2009. However, there was no evidence the facility had developed a plan of care to address the resident's diagnosis of anemia. On June 9, 2010, resident #15 required a blood transfusion of three (3) packed red blood cells (PRBC) due to Hemoglobin (Hgb) of 6.7 gm/dL and Hematocrit (HCT) of 21.2%. (Refer to F505.)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the medical record revealed resident #15 was readmitted to the facility on December 21, 2009, with diagnoses of Chronic Renal Failure, Diabetes Mellitus, Atrial Fibrillation, Hypertension, and Iron Deficiency Anemia. <p>A review of the comprehensive readmission assessment conducted on January 4, 2010,</p> | F 279 | <p>importance of developing an interim care plan during the admission/readmission process. All licensed staff will be inserviced on developing interim care plans upon admission/readmission process upon hire, annually, and as needed.</p> <ol style="list-style-type: none"> 4. The Director of Nursing/Nursing Management Team will audit all admission and readmission charts weekly x 4 weeks then monthly x 3 months to ensure that implementation of care plans related to diagnosis, interventions, and labs are complete. <p>Any issued identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <ol style="list-style-type: none"> 5. Date of Compliance – July 31, 2010. | |
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| F 279 | <p>Continued From page 8</p> <p>revealed resident #15 was assessed to have a disease diagnosis of Anemia. However, a review of the comprehensive care plan for resident #15 revealed the facility failed to develop a plan of care to address the Anemia diagnosis and no interventions had been implemented to monitor the resident for signs/symptoms of anemia and to ensure lab reports were obtained/reported promptly.</p> <p>A review of the June 2010 physician's orders revealed resident #15 had orders to receive Ferrous Sulfate 325 mg three times a day for the diagnosis of Iron Deficiency Anemia. The physician's orders also included a Complete Blood Count (CBC) to be obtained yearly.</p> <p>Further review of the medical record revealed a CBC, Renal Panel, Serum Iron, and Ferritin level was obtained on June 7, 2010. A review of the lab test reports revealed the resident's Hgb level was 6.7 gm/dL (normal range is 14.0 gm/dL to 18.0 gm/dL), and the Hematocrit (HCT) was 21.2 percent (normal range is 42.0% to 52.0%). Additional lab test results obtained on June 7, 2010, revealed the Ferritin level was 19 (normal range is 24 to 336) and the Iron level was 10 mcg/dL (normal range is 35 mcg/dL to 150 mcg/dL).</p> <p>A review of the nurse's notes revealed resident #15's physician was notified of the abnormal lab test results on June 8, 2010, and orders were received to Type and Crossmatch resident #15 and to transfuse three units of Packed Red Blood Cells (PRBC).</p> <p>An interview conducted with the MDS Coordinator on June 30, 2010, at 2:05 p.m., revealed the MDS</p> | F 279 | | |
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| NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX #0 ELKHORN CITY, KY 41522 |
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| F 279 | Continued From page 9 Coordinator reviewed the physician's orders daily to identify new diagnoses and medications. The MDS Coordinator stated a care plan should have been developed to address resident #15's diagnosis of Anemia to include interventions for monitoring the resident for signs/symptoms and lab test results. | F 279 | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided and care was delivered in accordance with professional standards of quality for five (5) of twenty-nine (29) sampled residents (residents #9, #26, #27, #28, and #29). Staff failed to verify placement of resident #27's gastrostomy tube prior to the administration of medication via the gastrostomy tube (G-tube), as required per facility policy. Staff also failed to administer resident #9's medication (Renvela) with meals as ordered by the physician. Additionally, staff failed to maintain aseptic technique during administration of medications to residents #26, #28, and #29. The findings include: 1. A review of the facility's Medication Administration procedure for feeding tubes directed staff to verify a resident's G-tube placement, prior to any medication administration, by instilling 20 cc of air into the tube while auscultating the abdomen with a stethoscope to | F 281 | Tag # F 281 1. Resident # 9's physician was notified that Renvela was given before mealtime and not with meal. New orders received to administer with food, does not have to be given with meals. No adverse effect was identified 72 hours after medication was administered. Lab values were within normal range. LPN was aware that Renvela is to be administered with food. Resident #9's care plan was updated to reflect change in Renvela from being administered at mealtime to be given with food. Resident # 26 was not adversely affected by LPN pouring liquid medication back into bottle. Pharmacy was notified to replace medication at the facilities expense. LPN was aware that medication should not be poured back into the medication bottle. Resident # 27 was not adversely affected by LPN #1 not instilling 20ml of air prior to medication administration. LPN #1 had aspirated stomach content before administering medications. LPN was aware of the facility policy. Resident #28's physician was notified related to coenzyme and Vitamin E being sticky and hard to squeeze from capsule. New orders | |

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| F 281 | <p>Continued From page 10</p> <p>validate air movement in the stomach.</p> <p>Observation on June 27, 2010, at 5:20 p.m., revealed resident #27 was scheduled to receive four medications via the resident's gastrostomy tube (G-tube). Licensed Practical Nurse #1 (LPN) was observed to use a syringe and aspirate a small amount of beige liquid. LPN #1 then proceeded to administer the resident's prescribed medication via the G-tube. LPN #1 failed to use air to check the placement of the G-tube as required per the facility policy.</p> <p>An interview was conducted on June 27, 2010, at 6:30 p.m., with LPN #1, who had administered resident #27's G-tube medications. LPN #1 stated the LPN was aware of the facility's policy of checking placement of a resident's G-tube and the LPN should have instilled air into the G-tube prior to any medication administration, and listened with the stethoscope for proper air movement. LPN #1 stated the LPN was just nervous and failed to check placement of resident #27's G-tube prior to the medication administration.</p> <p>2. Observation on June 27, 2010, at 4:55 p.m., revealed LPN #2 prepared and administered seven oral medications for resident #9. Resident #9 received Renvela 800 milligrams, three tablets at 4:55 p.m. (Renvela is a phosphate binder and is indicated in patients with Chronic Kidney Disease that require dialysis. Renvela is used to reduce blood levels of phosphorus of renal dialysis patients). Review of the physician's orders revealed the medication Renvela was to be administered with meals. Further observation revealed resident #9's supper tray was delivered and set up at 6:05 p.m., one hour and ten</p> | F 281 | <p>were received on June 28, 2010.</p> <p>Resident # 28 was not adversely affected by LPN handling Vitamin E with bare hands to extract medication from capsule or LPN leaving liquid in the capsule. Resident # 28 was not adversely affected by LPN laying spoon on overbed table and replacing spoon into cup with water and medications to continue medication administration.</p> <p>Resident #29 was not adversely affected by LPN picking up Vitamin C from resident's bed and placing into the resident's mouth while not wearing gloves. LPN was aware that the Vitamin C should have been discarded and replaced. LPN was also aware that gloves should have been worn prior to handling medication.</p> <p>2. All residents have the potential to be affected. The Director of Nursing/Nursing Management Team/Unit Manager immediately began performing one on one medication pass observations, education of licensed staff to ensure oral and g-tube medication administration is performed per facility policy and procedures. Medication pass observation for all staff was completed on July 23, 2010.</p> | |
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| F 281 | <p>Continued From page 11 minutes after taking the Renvela.</p> <p>Interview with LPN #2 on June 27, 2010, at 6:20 p.m., revealed LPN #2 was knowledgeable that Renvela was given to residents with renal failure; however, LPN #2 stated the LPN did not know the action of the medication or the purpose of administering the medication with meals. The LPN stated the medication was given with the other medications because it was close to the resident's meal time.</p> <p>3. Observation of the medication administration for resident #26 on June 28, 2010, at 8:55 a.m., revealed the Licensed Practical Nurse (LPN) filled a 30-milliliter medicine cup with Megace. The LPN then proceeded to pour the medication back into the bottle.</p> <p>A review of the Medication Administration Record for resident #26 revealed the resident was to receive Megace 10 milliliters orally. The label on the Megace stated the concentration was 40 milligrams per each milliliter of Megace.</p> <p>An interview conducted on June 29, 2010, at 10:10 a.m., with the LPN responsible for administering medications to resident #26 revealed the nurse was aware he/she should not pour medications back into the bottle. The nurse stated, "I should have wasted it."</p> <p>4. Observation of the medication administration for resident #29 on June 28, 2010, at 9:25 a.m., revealed the resident was observed to drop a Vitamin C tablet onto the resident's bed. The LPN was observed to pick up the medication with</p> | F 281 | <p>3. The Director of Nursing/Assistant Director of Nursing inserviced all licensed staff on July 16, 2010 on policy and procedures for appropriate medication pass and expectation of performance during medication passes.</p> <p>4. The Director of Nursing/Nursing Management Team/Unit Managers will observe and audit medication pass administration weekly x 4 weeks then monthly x 3 months.</p> <p>All licensed staff will be inserviced and observation will be performed of medication administration upon hire, quarterly, and as needed.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |

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| F 281 | <p>Continued From page 12</p> <p>his/her bare hands and place the medication into the resident's mouth.</p> <p>An interview conducted on June 29, 2010, at 10:10 a.m., with the LPN responsible for administering medications to resident #29 revealed the nurse was aware he/she should have donned gloves prior to handling medication, and should have replaced the medication after it was dropped onto the resident's bed.</p> <p>5. Observation of the medication administration to resident #28 on June 28, 2010, at 9:30 a.m., revealed the LPN prepared a Vitamin E 400-unit capsule for gastrostomy tube administration by using her/his bare hands and with scissors cut the end off the capsule. The LPN then with his/her bare hands squeezed the medication out of the capsule, prior to placing in the resident's gastrostomy tube. Approximately one-half of the medication was observed to be left in the capsule.</p> <p>The LPN was also observed to cut off the end of a Coenzyme 100-milligram capsule. The nurse with her/his bare hands squeezed the medication out of the capsule, and into a cup to dilute with water, prior to placing in the resident's gastrostomy tube. However the LPN was observed to leave approximately one-third of the medication in the capsule.</p> <p>An interview conducted on June 29, 2010, at 10:10 a.m., with the LPN responsible for administering medications to resident #28 revealed the nurse was aware he/she should have donned gloves prior to handling medications. The nurse also stated she/he should have made certain the resident was getting all of the medication. The nurse further</p> | F 281 | | |
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| F 281 | <p>Continued From page 13</p> <p>stated he/she was going to notify the resident's physician due to he/she felt the resident was not getting all the Coenzyme because the medication was "so sticky" and hard to remove from the capsule and the cup.</p> <p>6. Observation of the medication administration for resident #28 on June 28, 2010, at 9:30 a.m., revealed the LPN verified gastrostomy tube placement, and administered Vitamin E into the resident's gastrostomy tube. The LPN took the spoon out of the cup which held the Vitamin E, and laid it down on the overbed table. The LPN then laid the opened end of the gastrostomy tube, with the syringe still attached, down onto the resident's bed and fluid spilled out onto the resident's sheet. The LPN then proceeded to flush the gastrostomy tube. The LPN then picked the spoon up from the overbed table and placed it in the cup with the Coenzyme, and administered Coenzyme per the gastrostomy tube.</p> <p>An interview was conducted on June 29, 2010, at 10:10 a.m., with the LPN who administered medications to resident #28. The LPN stated she/he should not have left the gastrostomy tube open and further was aware the resident might not have gotten all the medication. The LPN also stated he/she should not have laid the spoon down onto the overbed table.</p> | F 281 | <p><u>Tag # F 323</u></p> <ol style="list-style-type: none"> The Director of Nursing immediately, upon being notified by the surveyor on June 30, 2010, secured the Hope Unit and Faith Unit shower room cabinets. The large box on the floor was removed from the shower room. All residents have the potential to be affected. The Director of Nursing began one-on-one inservices on June 30, 2010 with staff working regarding proper storing/securing items to protect the health and safety of all residents. Inservices were completed on July 23, 2010. The Director of Nursing/Nursing Management Team/Executive Director/Unit Managers are assigned daily inspections of all shower rooms for proper storage and properly securing items that could be a safety hazard to all residents. | |
| F 323 SS=E | <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> | F 323 | <ol style="list-style-type: none"> The Director of Nursing/Nursing Management Team/Executive Director/Unit Managers will perform shower room audits daily x 1 month. Then unit managers or charge nurses will audit shower room daily. The Director of Nursing/Nursing Management Team will audit shower room randomly. | |

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| F 323 | <p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the MSDS, facility policy, and the facility's Census and Condition Report, it was determined the facility failed to ensure the residents' environment was free from accident hazards. The facility failed to ensure potentially hazardous items were properly stored/secured and not accessible to residents. Personal hygiene products, wound cleanser, ointments, lice treatment, disposable razors, men's aftershave, light bulbs, denture cleanser tablets, and other potentially hazardous items were observed in the shower rooms in unsecured wall cabinets and in boxes on the shower room floor of the Hope Wing shower room and the Faith Wing shower room. The shower room doors were not locked/secured.</p> <p>The findings include:</p> <p>Observation on June 28, 2010, at 1:45 p.m., of the Hope Unit shower room revealed an unsecured wall cabinet that contained:</p> <ul style="list-style-type: none"> -Ten disposable razors; -One can of Noxzema Shaving Cream; -One Dial roll-on antiperspirant; -One 2-ounce bottle of Permethrin Lotion Lice Treatment; -Two 16.9-ounce tubes of Tena Wash Cream; -One partially used 8-ounce tube of Aloe Vista skin conditioner/protectant; and -One 3-ounce bottle of Afta by Mennen aftershave. | F 323 | <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance - July 31, 2010.</p> | |
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| F 323 | <p>Continued From page 15</p> <p>A large box was observed on the floor in the Hope Unit shower room that contained:</p> <ul style="list-style-type: none"> -Five 6.5-ounce tubes of Sween Cream; -A box of disposable razors; -A box that contained 18 Efferdent tablets; -Twelve containers of Tena Wash Cream; and -Two 8-ounce half-full spray bottles of Dermal Wound Cleanser. <p>Further observation of a wall cabinet in the Faith Unit shower room revealed:</p> <ul style="list-style-type: none"> -Thirty-six Personna disposable razors; -A box of manicure sticks; -Two loose light bulbs; -Seven 8-ounce tubes of ConvaTec protective skin ointment; and -One 10-ounce can of Right Guard Sport spray. <p>Interview on June 30, 2010, at 3:00 p.m., with the Director of Nursing (DON) revealed the items found in the resident bathrooms should be locked in a secured area and any item that would be harmful to residents should never be accessible to residents. The DON stated he/she had been at the facility for approximately two months. The DON stated no one was assigned to check the shower rooms for potentially hazardous items.</p> <p>Review of the facility's policy related to storage of hazardous materials dated March 15, 2004, revealed the facility would provide safe storage of hazardous materials and would protect the safety and health of all residents.</p> <p>Review of the facility's Census and Condition Record dated June 27, 2010, revealed 58 residents who resided at the facility had been</p> | F 323 | | | |

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| F 323 | <p>Continued From page 16 diagnosed with Dementia.</p> <p>Review of the facility's Material Safety Data Sheet revealed the recommended first aid measures, precautions, and health hazard data for the following hazardous products:</p> <p>Efferdent Denture Cleansing tablets-- Eye Contact: May cause eye irritation/burns. Skin: May cause skin irritation/burns. Ingestion: May cause burns to the mouth, esophagus, and stomach. Do not induce vomiting. Get medical attention immediately.</p> <p>Sween Cream-- Eye Contact: Immediately flush eyes with running water for at least 15 minutes.</p> <p>Permethrin Lice treatment-- Eyes: Avoid contact with eyes. May result in mild to moderate irritation. Skin: Prolonged contact may result in irritation and redness. Ingestion: May cause gastric upset with irritation and nausea.</p> <p>Dermal Wound Cleanser-- Eyes: May cause eye irritation. Ingestion: May be harmful if swallowed. Dilute by drinking water. Do not induce vomiting. Contact the poison control center and physician immediately.</p> <p>Dawnmist Shave Cream-- Eyes: Avoid contact with eyes. Rinse immediately with plenty of water for at least 15 minutes. Ingestion: Rinse mouth immediately. Call a physician or the poison control center</p> | F 323 | | |

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| F 323 | Continued From page 17 immediately. Inhalation: Avoid breathing vapor. Move to fresh air. Seek medical attention if respiratory problems occur. Afta Pre-Electric Shave Lotion-- Eyes: May cause eye irritation on direct contact. Flush eyes with large amounts of water for 15 minutes. Seek medical attention if irritation persists. Skin: May cause irritation with prolonged or repeated contact. Rinse with plenty of water. Ingestion: May be harmful if swallowed. Seek medical attention. Inhalation: May cause respiratory tract irritation. Move to fresh air. Seek medical attention if respiratory symptoms persist. | F 323 | Tag # F 328 1. Resident #12's toenails were trimmed by licensed nurse on June 29, 2010. The Podiatrist visited resident on July 20, 2010. The right great toenail was removed and the left great toenail was trimmed. 2. A 100% audit was completed on June 29, 2010 on all residents by the Nursing Management Team. Any resident's identified to require toenails be trimmed were addressed by licensed nurses. Podiatrist was notified on July 6, 2010 and was scheduled to visit facility on July 20, 2010. The podiatrist did visit the facility on July 20, 2010. 3. The Director of Nursing/Assistant Director of Nursing inserviced all nursing staff on July 23, 2010 on assessment of nails and feet, providing proper foot/nail care, and reporting of nails that require podiatrist services to the Director of Nursing. The Director of Nursing/Nursing Management Team will maintain a log of resident's requiring Podiatry Services. The log will be faxed to the Podiatrist prior to podiatry visit. The fax cover sheet will be kept with log. | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that one (1) of twenty-nine (29) sampled residents was provided proper foot/nail care. | F 328 | | |

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| F 328 | <p>Continued From page 18</p> <p>Resident #12 was observed to have long, thick, discolored, and jagged toenails of both feet. However, there was no evidence resident #12 had been provided foot care or podiatry services by the facility.</p> <p>The findings include:</p> <p>A review of the medical record revealed resident #12 was admitted to the facility on November 20, 2008, with diagnoses to include Vitamin Deficiency, Schizophrenia, Psychosis, Alzheimer's Disease, and Urinary Frequency. On May 31, 2010, a new diagnosis of Diabetes Mellitus was added to the diagnoses list for resident #12.</p> <p>A review of the significant change comprehensive assessment conducted on June 4, 2010, revealed resident #12 was assessed to be totally dependent on staff for activity of daily living (ADL) needs and to have received preventative/protective foot care during the assessment reference period. A review of the care plan for resident #12 revealed the resident was receiving wound care daily to a pressure ulcer of each ankle. The care plan also included interventions to conduct a weekly head to toe skin assessment, to report abnormalities to the resident's physician, and to keep the resident's nails trimmed and clean.</p> <p>During a wound care observation to resident #12's ankles conducted on June 29, 2010, at 1:30 p.m., each toenail of both of the resident's feet was observed to be discolored, long, thick, and jagged. The length of the second toe of the left foot measured 1.25 cm, the thickness of the left great toe was 1.0 cm, and the thickness of the</p> | F 328 | <p>The Podiatrist was notified by the Director of Nursing of the need for a visit form to be filled out before exiting the facility.</p> <p>The podiatrist stated that he would fill out a visit form during the visit and a copy of the visit will be placed in the residents' chart under the consult tag.</p> <p>4. The Director of Nursing/Nursing Management Team will observe and audit 5 residents' weekly x 4 weeks then 5 residents randomly x 3 months to ensure foot/nail care is correctly assessed, performed, and documented.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
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| F 328 | <p>Continued From page 19 right great toe was .75 cm.</p> <p>An interview conducted with the wound care nurse (WCN) on June 29, 2010, at 1:40 p.m., revealed the charge nurse was responsible to make a list of residents who were assessed to need podiatry services and the medical records (MR) staff contacted the podiatrist for the services. The WCN stated the podiatrist conducted visits at the facility every four to six weeks. The WCN stated he/she was not aware of a recent podiatry visit to the facility. The WCN stated he/she had been providing wound care to the resident's feet for approximately six weeks and had not identified resident #12's toenails as being long, thick, and jagged.</p> <p>An interview conducted with the Unit Manager (UM) on June 29, 2010, at 4:35 p.m., revealed the UM provided a list to the MR staff of residents who needed podiatry services. The UM stated he/she was not sure how often the podiatrist visited the facility or the when the last visit had been conducted. The UM further stated he/she had conducted weekly skin assessments for resident #12, but had not identified the resident's toenails to be long, thick, and jagged.</p> <p>An interview conducted with the MR staff on June 29, 2010, at 4:30 p.m., revealed the podiatrist visited the facility every three months and the MR staff faxed a list of residents needing podiatry services to the podiatrist's office prior to the doctor's visit. The MR staff stated no podiatry visits had been conducted from September 2009 through December 2009. The MR staff further stated the podiatrist had been scheduled to see residents at the facility in December 2009; however, the podiatrist did not call or show up at</p> | F 328 | | |
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| F 328 | Continued From page 20 the facility. The MR staff stated the podiatrist was at the facility in May 2010. However, there was no documented evidence that any residents were seen by the podiatrist in May 2010. An interview conducted with the corporate nurse consultant (CNC) on June 30, 2010, at 11:40 a.m., revealed the podiatrist had not seen any residents at the facility since February 17, 2010. The CNC stated the podiatrist had not seen resident #12 during the February 2010 visit and could not provide evidence the resident had been seen in the past by the podiatrist. | F 328 | Tag # F 363 1. No residents were found to be affected by this practice. 2. All residents with oral diets have the potential to be affected. Dietary Manager completed an inservice with dietary staff on July 16, 2010 on how to identify and the importance of using weight appropriate scoops when serving. 3. Dietary Manager has purchased different colored scoop for different weights. Dietary was inserviced on July 23, 2010 on what weight color represents each weight and a chart was placed in the Dietary Department to visually identify each scoop by weight. | |
| F 363 SS=C | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to follow the menu at the evening meal on June 27, 2010. The menu spreadsheet specified that the serving size for the turkey and dumplings was to be six (6) ounces. However, dietary staff served four (4) ounces of the turkey and dumplings to all of the facility residents. | F 363 | 4. Dietary Manager will monitor the serving line daily x 7 days, then weekly x 3 months to ensure dietary staff are using the correct weighted scoop. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5. Date of Compliance – July 31, 2010. | |

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| F 363 | <p>Continued From page 21</p> <p>The findings include:</p> <p>Review of the menu spreadsheet for the evening meal on June 27, 2010, revealed that turkey and dumplings was the planned entree. Further review of the menu spreadsheet revealed the specified serving size for the turkey and dumplings was supposed to be six ounces.</p> <p>Observation of the evening meal at 5:00 p.m. on June 27, 2010, revealed staff was utilizing a #8 scoop to equal four ounces to serve the turkey and dumplings to all of the facility residents. Therefore, the residents received two ounces less than the specified amount for the entree (protein) food item.</p> <p>Interview with staff during the evening meal service on June 27, 2010, revealed that was an oversight, and six ounces of the turkey and dumplings was the amount that should have been served instead of the four ounces that was served.</p> | F 363 | <p>Tag # F 364</p> <ol style="list-style-type: none"> No residents were found to be adversely affected by this practice. All residents with oral diets have the potential to be affected. The Registered Dietician performed an inservice with the Dietary Manager and dietary staff on July 21, 2010 on time frame to prepare and place food on the steam table in relation to the serving of the food and overcooking the vegetables. Registered Dietician and Dietary Manager inserviced all dietary staff regarding the preparation chart, how to use it, and the placement of the chart in the dietary department. <p>The Registered Dietician/Dietary Manager have created a chart for the dietary staff instructing them when to begin preparation of food in related to serving time. Chart will be available for dietary staff in the dietary department.</p> | |
| F 364 SS=F | <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prepare and serve food by methods that conserve nutritive value,</p> | F 364 | <ol style="list-style-type: none"> Dietary Manager will audit dietary staff during food preparation to ensure correct times of preparation and serving times are followed weekly x 4 weeks then monthly x 3 months. <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement</p> | |

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| F 364 | <p>Continued From page 22</p> <p>and with an attractive appearance, by prolonged storage of the food on the steam table. Observation revealed food was stored on the steam table two and one-half (2 1/2) hours prior to serving the food to the facility residents. In addition, the Capri vegetables and green beans were overcooked, mushy, and dark in color.</p> <p>The findings include:</p> <p>An initial tour was conducted in the kitchen at 2:30 p.m. on June 27, 2010. Observation revealed that turkey and dumplings and beef patties were already stored on the steam table. Interview with staff revealed that the evening meal did not begin until 5:00 p.m. However, staff stated that the turkey and dumplings and beef patties were to be served at the evening meal at 5:00 p.m. Further observation at 5:00 p.m. on June 27, 2010, revealed that staff was serving the same turkey and dumplings and beef patties that had been stored on the steam table prior to the initial tour at 2:30 p.m. on June 27, 2010. Interview with staff confirmed the food was the same food that was stored at 2:30 p.m. In addition, observation of the Capri vegetables revealed the vegetables were overcooked, the texture was mushy, and they were dark in color.</p> <p>Observation of the lunch meal at 12:20 p.m. on June 28, 2010, revealed that the green beans were overcooked, mushy in texture, and dark in color. An interview with the Dietary Manager at 5:45 p.m. on June 28, 2010, revealed the vegetables appeared to be overcooked.</p> | F 364 | <p>Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
| F 371 SS=F | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> | F 371 | | |

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| F 371 | <p>Continued From page 23</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> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare and distribute, and serve food under sanitary conditions. The dishwasher failed to maintain the minimum required final rinse temperature of 180 degrees Fahrenheit on two (2) different occasions. In addition, the steam table in the back dining room failed to maintain the minimum required holding temperature of 135 degrees Fahrenheit for the hot foods served on June 28-29, 2010, at the lunch meals, and the cold desserts (pudding and cream pie) were served too warm at the lunch meal on June 28, 2010.</p> <p>The findings include:</p> <p>1. Observation during the initial tour of the kitchen at 2:30 p.m. on June 27, 2010, revealed the final rinse temperature of the dishwasher was 167 degrees Fahrenheit. Further observations revealed the dishwasher's final rinse temperature did not reach the minimum required temperature of 180 degrees Fahrenheit until the dishwasher had run through four cycles (167, 171, 178, and 181 degrees Fahrenheit). Staff stated that the dishwasher had been running for at least one hour. Another observation of the dishwasher was</p> | F 371 | <p><u>Tag # F 371</u></p> <ol style="list-style-type: none"> No residents were found to be adversely affected by this practice. All resident with oral diets have the potential to be affected. Registered Dietician performed an inservice on July 21, 2010 for Dietary Manager/Dietary Staff on correct temperatures for dishwasher and the steam table. This included that temperatures must be taken at the beginning of the dishwasher cycle and be greater than 180°, that temperatures are to be taken before food is placed on the steam table, and how to maintain food temperature once on the steam table. Dietary Manager contacted Hobart technician when surveyor addressed water temperatures not being 180° F at beginning of dishwashing cycle. Service and maintenance was performed on June 28, 2010 by Hobart technician. <p>Dietary Manager contacted manufacturer's of steam table to perform maintenance and service. Steam table will be placed out of service until maintenance and service is performed.</p> <p>Dietary Manager will perform temperature checks on dishwasher daily x 7 days then weekly x 3</p> | |
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| F 371 | <p>Continued From page 24</p> <p>conducted at 2:25 p.m. on June 29, 2010. Again, the dishwasher ran four cycles three consecutive times (to equal 12 total cycles) with the temperature reaching 181 degrees Fahrenheit every fourth cycle. The final rinse temperatures ranged from 171 to 181 degrees Fahrenheit.</p> <p>Interview with dietary staff at 2:30 p.m. on June 27, 2010, revealed the dishwasher had been worked on, but the final rinse was not reaching the minimum 180 degrees Fahrenheit.</p> <p>2. Observation of the noon meals on June 28 and 29, 2010, revealed the steam table in the back dining room did not maintain food at the required minimum holding temperature of 135 degrees Fahrenheit. Temperatures obtained from the steam table in the back dining room on June 28, 2010, were as follows: the tuna casserole was at 117 degrees Fahrenheit, and the green beans were at 106 degrees Fahrenheit. In addition, on June 28, 2010, the chocolate pudding was too warm at 63.5 degrees Fahrenheit, and the chocolate cream pie was at 74 degrees Fahrenheit.</p> <p>Temperatures of the steam table in the back dining room taken at 1:50 p.m. on June 29, 2010, were as follows: barbecue chicken at 127.6 degrees Fahrenheit, pureed beef at 123.7 degrees Fahrenheit, and carrots at 129 degrees Fahrenheit.</p> <p>Interview with dietary staff at 1:50 p.m. on June 29, 2010, revealed two resident trays were yet to be served. Dietary staff said the steam table had been brought from the kitchen to the back dining room at approximately 1:15 p.m. Thirteen residents were observed to be eating in the back</p> | F 371 | <p>months. Dietary staff will perform water temperatures three times daily.</p> <p>Dietary Manager will perform temperature checks on the steam table before and after meals x 7 days then weekly x 3 months.</p> <p>Any issued identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
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| F 371 F 425 SS=D | <p>Continued From page 25 dining room.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</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 observation, interview, and policy review, the facility failed to provide pharmaceutical services to assure the accurate administering of all drugs and biologicals. The facility failed to assure that out-of-date medications were not available for resident use. Three (3) pre-packaged syringes of Heparin 100 units/milliliter were available for resident use even though the Heparin was five (5) months past the date of expiration.</p> | F 371 F 425 | <p><u>Tag # F 425</u></p> <ol style="list-style-type: none"> 1. Outdated medications were discarded and replaced by pharmacy. 2. All residents have the potential to be affected. The Director of Nursing/Nursing Management Team audited all medication carts and emergency boxes to ensure no other outdated medications were available for use. 3. The Director of Nursing/SDC inserviced all licensed staff on how to audit the emergency boxes and medication carts to ensure that no out of date medications is present. The consulting licensed pharmacist was notified by the facility to audit the emergency boxes each month with his monthly visits to ensure that no out of date medications are present. The consulting licensed pharmacist will provide the facility with a report each month following his visit. 4. The consulting licensed pharmacist will audit the emergency box monthly for expired medications. The licensed nurse will audit the emergency box daily for expired medications. The Director of Nursing/Nursing Management Team will audit the emergency boxes and | |
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| NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 300 ELKHORN CITY, KY 41522 |
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| F 425 | <p>Continued From page 26 The findings include:</p> <p>Observation on June 30, 2010, at 6:45 p.m., of the Faith Hall emergency box revealed three 5-milliliter unopened pre-packaged syringes of Heparin 100 units/milliliter. The three pre-packaged syringes of Heparin had an expiration date of January 2010.</p> <p>An interview was conducted with the Unit Coordinator (UC) of the Faith Hall on June 30, 2010, at 6:45 p.m. The UC stated the nurses working the 7:00 p.m. to 7:00 a.m. shift were assigned to check for expired medications. The UC pointed to a notice posted in the medication room that informed staff the 7:00 p.m. to 7:00 a.m. shift nurses were to check for expired medications.</p> <p>The facility failed to provide a policy regarding expired medications.</p> | F 425 | <p>medication carts weekly x 4 weeks then monthly x 3 months.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
| F 431 SS=E | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> | F 431 | | |

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| F 431 | <p>Continued From page 27</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and label all drugs and biologicals in accordance with currently accepted professional principles. Five (5) vials of insulin and two (2) vials of Tuberculin skin test serum were not dated when opened and remained available for use. A partially used 10-ounce bottle of Magnesium Citrate remained available for resident use. Several bottles of liquid medications were not dated when opened. Additionally, the medication cart for the Rose Garden Unit (secured/locked unit) failed to securely lock.</p> <p>The findings include: Observation of the facility's medication rooms and medication carts on June 30, 2010, at 7:35 p.m.,</p> | F 431 | <p>Tag # F 431</p> <ol style="list-style-type: none"> 1. Insulin, tuberculin skin test serum, Promethazine, SSS Tonic, Tamsulosin, Magnesium Citrate, and liquid medications were discarded and replaced at the facilities expense. 2. Pharmacy was notified concerning medication cart in Rose Garden not locking. Medication cart locking mechanism was replaced by pharmacy. The Nursing Management Team completed a 100% audit of all insulin, tuberculin skin test serum, biologicals, and liquid medications in use or stored. No other insulin, tuberculin skin test serum, liquid medications, or biologicals were found to be opened, expired, or not dated. 3. The Director of Nursing/SDC inserviced all licensed staff on July 23, 2010 regarding following the state and federal laws related to storage of all drugs and biologicals in a locked compartment with correct labeling, expiration dates, and how to file a work order for broken equipment. Charge nurses and Unit Managers will maintain a daily log monitoring insulin, tuberculin skin test serum, liquid medications, and biologicals | |
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| F 431 | <p>Continued From page 28</p> <p>revealed the Faith Hall medication cart contained:</p> <ul style="list-style-type: none"> -Four vials of insulin (two Novolog, one Lantus, one Humalog) that were not dated when opened; -Two 10-ounce bottles of SSS Tonic that were not dated as to the date when opened; -One Tamsulosin 4-milligram capsule was observed in the compartment of the medication cart where drinking cups were stored. <p>Further observation of the Faith Hall medication room revealed:</p> <ul style="list-style-type: none"> -Two vials of Tuberculin skin test serum were not dated when opened and remained available for use and one partially used bottle of Magnesium Citrate was observed in a cabinet. <p>Observation of the Hope Station medication cart revealed one vial of Novolin R insulin was not dated as to the date when opened and remained available for resident use. Further observation revealed a Promethazine HC 12.5-milligram tablet in a resident's drawer but the resident had not been prescribed Promethazine.</p> <p>Interview with the Unit Coordinator (UC) on June 30, 2010, at 6:45 p.m., revealed all multi-dose vials should be dated when opened and discarded after 30 days.</p> <p>Observation on June 30, 2010, at 6:50 p.m., revealed the Rose Garden medication cart would not securely lock.</p> <p>Interview on June 30, 2010, at 6:55 p.m., with LPN #5 revealed the Rose Garden cart had not locked for approximately one month. LPN #5 stated the LPN informed the Administrator of the</p> | F 431 | <p>for correct labeling, storage, expiration dates, and functional locking mechanisms of medication carts.</p> <p>4. The Director of Nursing/Nursing Management Team will audit insulin vials, tuberculin skin test serum, liquid medications, biologicals, and medication carts for functional locking mechanisms weekly x 4 weeks then monthly x 3 months. This is to ensure that medications have a marked open date and expiration date, that medications are stored correctly, and that each medication cart has a functional locking mechanism.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of compliance – July 31, 2010.</p> | |
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| F 431 | Continued From page 29 medication cart not being able to be locked and was informed new medication carts would be received. Interview with the Director of Nursing (DON) on June 30, 2010, at 7:15 p.m., revealed all vials should be dated when opened. The DON stated insulin should be dated and then discarded in 28 days from opening. The DON stated any remaining amount of Magnesium Citrate should always be discarded. The DON revealed the DON was not aware that the Rose Garden cart would not lock. Review of the facility's recommended minimum medication storage parameter chart dated April 12, 2007, revealed all insulin should be dated when opened and discarded after 28 days and multiple dose vials for injections should be dated when opened, and the unused portion discarded in 30 days. Further review of the parameter chart revealed liquid medications should be dated when opened. | F 431 | <u>Tag # F 441</u> 1. Resident's # 1 and # 26 were not found to have been adversely affected by this practice. The nurse that gave resident # 26 medication without wearing gloves and the Wound Care Nurse were re-educated about infection control by the Director of Nursing/Assistant Director of Nursing. Please note the LPN did state to the surveyor that she knew gloves should have been worn with the handling of oral medication. The wound care nurse did state to the surveyor that she knew handwashing was required after performing incontinent care and donning clean gloves after washing hands and prior to performing wound care. | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and | F 441 | 2. All resident's have the potential to be affected. The Director of Nursing/Nursing Management Team immediately began performing one on one medication pass observations to ensure that licensed staff wore gloves when administering oral medications by hand when resident was unable to take medication from medication cup. The Director of Nursing/Infection Control Nurse observed Wound Care Nurse performing wound care to ensure that infection control | |

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| F 441 | <p>Continued From page 30</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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, record review, and interview, the facility failed to ensure proper infection control practices were maintained for two (2) of twenty-nine (29) sampled residents. The staff failed to conduct appropriate handwashing during wound care for resident #1. The staff failed to don gloves prior to handling medication for resident #26 and then placing medication in the resident's mouth.</p> <p>The findings include:</p> <p>1. Observation of the medication administration</p> | F 441 | <p>measures were being followed. The Wound Care Nurse was observed following proper infection control measures. Competency was also given to the Wound Care Nurse by the Infection Control Nurse on July 16, 2010. All other licensed nurses have completed competencies as of July 23, 2010.</p> <p>3. The Director of Nursing/Infection Control Nurse began competencies on July 9, 2010 and completed on July 23, 2010 for all staff related to infection control, handwashing, and wound care.</p> <p>The Director of Nursing/Infection Control Nurse will maintain a log of all infections, and track and trend monthly for education/re-education opportunities for staff. All new staff will be inserviced and given competencies for medication pass and infection control upon hire, annually, and as needed.</p> <p>4. The Director of Nursing/Nursing Management Team will observe and audit medication administration weekly x 4 weeks then monthly x 3 months.</p> <p>The Director of Nursing/Infection Control Nurse will observe wound care performance for compliance with infection control measures and handwashing weekly x 4 weeks then monthly x 3 months.</p> | |

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| F 441 | <p>Continued From page 31</p> <p>for resident #26 on June 28, 2010, at 8:55 a.m., revealed the Licensed Practical Nurse (LPN) administered Isordil 20 milligrams, Theo SR 200 milligrams, Sucratab 1 gram, and Librium 25 milligrams. The LPN took the medication out of the medicine cup into his/her bare hands and placed the medication in the resident's mouth.</p> <p>An interview conducted on June 29, 2010, at 10:10 a.m., with the LPN responsible for administering medications to resident #26 revealed the nurse was aware he/she should have donned gloves prior to handling medication.</p> <p>2. Observations of a wound care treatment on June 28, 2010, at 10:45 a.m., revealed the Wound Care Nurse (WCN) removed the brief from resident #1 to provide wound care to the coccyx/buttock area. The resident's brief was observed to be soiled with diarrhea stool. The WCN and the charge nurse were observed to provide incontinence care to resident #1. The WCN was then observed to perform handwashing and to put on disposable gloves; however, the resident had experienced another loose stool. The WCN continued to provide incontinence care to the resident and then proceeded to pick up the dressing from the overbed table and place the dressing on the resident's right inner buttock area. The WCN was not observed to perform handwashing or change gloves prior to applying the dressing to the resident's inner buttock area.</p> <p>An interview with the facility WCN on June 29, 2010, at 1:40 p.m., revealed the WCN believed he/she had washed her hands after providing incontinence care for resident #1. The WCN stated handwashing was required after providing incontinence care and before applying a dressing</p> | F 441 | <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | |
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| F 465 | <p>Continued From page 33</p> <p>loose.</p> <ul style="list-style-type: none"> -In resident room 616, the tissue paper bar dispenser was missing and a rust stain was observed at the commode base. -In resident room 610, the commode was not secured to the floor. -In resident room 605, the tissue paper bar dispenser was missing and the commode anchors extended up approximately one and one-half inches with sharp edges. -The baseboard under the resident's closet was loose and lying on the floor in resident room 607. Additionally, a gap in the baseboard was observed under the air conditioner. -The footboard in resident room 608, bed 1, had rough, splintered edges. -The Formica was chipped, exposing rough edges at the sink in resident room 604. -A hole was observed in the wall at the air conditioner in resident room 602 and the baseboard under the air conditioner had a gap where the two pieces did not meet. <p>Observations of the Hope and Faith Units:</p> <ul style="list-style-type: none"> -In resident room 405, the drywall was peeling behind the entry door. -In resident rooms 406 and 407, the porcelain sink was chipped, exposing sharp edges. -The bathroom baseboard was loose in resident rooms 407, 408, and 409. -In resident room 407, the baseboard was loose under the air conditioner. -In resident room 409, the commode tank would not fill and allowed the water to run continuously. Additionally, a drawer was missing from the resident's bedside table in resident room 409. -In resident room 806, the drywall was peeling in the bathroom and the commode anchors were | F 465 | | | |

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| F 465 | <p>Continued From page 34</p> <p>exposed.</p> <p>-In resident room 804, a hole was observed in the wall at the air conditioner and the drywall was peeling above the air conditioner.</p> <p>-In resident room 801, a vertical blind slat was missing.</p> <p>-The entry door to resident room 204 had rough, splintered areas.</p> <p>An interview was conducted on June 29, 2010, at 8:40 a.m., with the Maintenance Assistant (MA). The MA stated the Director of Maintenance had been terminated one week prior to the survey. The MA stated the MA was filling in as much as possible until a replacement was hired. The MA reported daily checks of assigned resident rooms were performed to observe for any items in need of repair. The MA stated any areas reported by facility staff or observed by the maintenance staff were immediately addressed with appropriate action taken. However, the MA stated the areas observed by the surveyor had not been reported by the staff and the MA had been unaware the areas were in need of repair/maintenance.</p> <p>2. Further observation on June 30, 2010, at 6:50 p.m., revealed the Rose Garden medication cart was visibly soiled. Observation of the drinking cup holder revealed a moderate amount of a black dried substance and a rubber band was observed to be submersed in the dried substance. Additionally, the side compartment also had a dried brownish substance, as did some of the resident medication drawers.</p> <p>Observation of the Hope Unit medication cart revealed several of the resident medication drawers had a dried brownish-black substance.</p> | F 465 | <p>facility rounds using facility rounds tools. Findings will be discussed in the morning stand-up meeting Monday-Friday. Maintenance Assistant will report to the Executive Director when maintenance issues are completed.</p> <p>A cleaning schedule has been put into place for all medication carts and all licensed staff were inserviced on July 16, 2010.</p> <p>4. Management team will conduct facility rounds Monday – Friday. These audits will be maintained by the Executive Director. Maintenance and the Executive Director will audit five resident rooms weekly x 4 weeks, monthly x 3 months, and randomly.</p> <p>The Director of Nursing/Nursing Management Team will audit medication carts weekly x 4 weeks then monthly x 3 months.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010.</p> | | |

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| F 465 | Continued From page 35 An interview with the Director of Nursing at 7:15 p.m. on June 30, 2010, revealed the medication carts were to be cleaned at the end of each shift by the staff nurses. | F 465 | Tag # F 469 | |
| F 469 SS=F | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Flies and gnats were observed throughout the facility during the survey conducted on June 27-30, 2010. The findings include: During the initial tour of the facility on June 27, 2010, at 2:25 p.m., a fly was observed in resident rooms 405, 406, 409, 609, 602, 603, 604, 606, and 608, and two flies were observed in resident room 407. In addition, flies were observed in the hallway and dining area of the locked unit at 2:40 p.m. Observation on June 27, 2010, at 5:30 p.m., revealed a resident sitting in the hallway with a fly swatter. The unsampled resident pointed to a dead fly lying on the hallway floor and a dead fly on the wall. Additional observations conducted during the | F 469 | <ol style="list-style-type: none"> Executive Director contacted the pest control company on June 28, 2010 related to increased gnats and flies and to question when fly lights would be installed. The lights were ordered on June 17, 2010. Six fly lights were installed in the facility on June 29, 2010 by the pest control company. The pest control company re-treated the facility on July 14, 2010. All residents have the potential to be affected. Six new fly lights were installed by the pest control company and facility was treated for gnats and flies. Executive Director inserviced all staff on July 16, 2010 of importance of notifying the Executive Director/Maintenance when pest are identified in the facility. Staff is to use maintenance work order for pest request. Executive Director has ordered door drafts for each entrance/exit in the facility. These will be installed upon arrival. The pest control services has been increased to biweekly. Management Team will complete daily audits Monday-Friday of resident rooms and facility to ensure they are pest free. | |

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| F 469 | <p>Continued From page 36</p> <p>evening meal on June 27, 2010, at 5:45 p.m., revealed flies were observed to be on the drinking cups on the food cart transported to the locked unit of the facility. A fly was observed to land on top of an unsampled resident's head when the resident was eating the evening meal in the dining area of the locked unit.</p> <p>Observation on June 28, 2010, at 8:55 a.m., revealed a fly landed on resident #3's breakfast tray while the resident was eating breakfast. Further observation at 12:40 p.m., revealed a fly landed on resident #4's lunch tray.</p> <p>A group meeting was conducted with 11 alert/oriented residents on June 28, 2010, at 1:55 p.m. The residents reported "flies are everywhere" and also reported a problem with gnats. The residents stated the flies had been a problem for several months and they had reported the concern to the local ombudsman.</p> <p>An interview conducted on June 28, 2010, at 2:30 p.m., revealed the residents had reported concerns related to flies and the ombudsman had reported the problem to Administration.</p> <p>Interview with an unsampled resident that resided in room 401 stated flies were everywhere in the facility and the resident stated the resident had seen more flies than usual in the facility recently.</p> <p>An observation of the evening meal on June 27, 2010, at 6:30 p.m., revealed an unsampled resident in the back dining room with a gnat moving in his/her tomato juice.</p> <p>Interview on June 29, 2010, at 8:45 a.m., with the Maintenance Assistant (MA) revealed the MA was</p> | F 469 | <p>Any issues identified related to pest will be addressed in the daily stand-up meeting Monday-Friday by the Executive Director/Maintenance. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – July 31, 2010</p> | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 0 /30/2010 |
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| NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 330 ELKHORN CITY, KY 41522 |
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| F 469 | Continued From page 37 not aware of any gnats in the facility; however, the MA stated the flies had been bad. The MA stated the only treatment for the flies was the fly lights installed by the pest control company; however, the fly lights had not decreased the number of flies. Interview on June 29, 2010, at 9:00 a.m., with the Housekeeping Supervisor (HS) revealed more fly lights were ordered. The HS stated the HS had observed gnats in the facility but the pest control company had not treated for gnats. The HS stated the flies were being killed with fly swatters. Review of a service agreement from the pest control company dated June 17, 2010, revealed three fly lights were reset and six fly lights were ordered on that date but the six lights had not been installed. | F 469 | <u>Tag # F 502</u> 1. Resident # 14's physician was notified of urine culture and sensitivity not being collected as ordered. No new orders were received at that time. Resident was not adversely affected by not having this culture and sensitivity performed. Resident had completed a two week course of antibiotic therapy. Resident was not exhibiting any signs or symptoms of a urinary tract infection. Physician has requested that all urinalysis be ordered with a culture and sensitivity if indicated. | |
| F 502 SS=D | 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to obtain laboratory tests as ordered by the physician for one (1) of twenty-nine (29) sampled residents. The facility failed to obtain a urine culture and sensitivity result for resident #14. The findings include: | F 502 | 2. All residents have the potential to be affected. The Director of Nursing/Nursing Management Team obtained a 100% audit of all resident's urinalysis to ensure that culture and sensitivity had been completed per physician order. No other residents were identified as not having culture and sensitivity performed by lab as ordered on the lab request. 3. The Director of Nursing/Assistant Director of Nursing inserviced all licensed staff to write urinalysis orders on lab request for culture and sensitivity if indicated per physician orders. The facility contacted the physician and an order was obtained for all | |

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| F 502 | <p>Continued From page 38</p> <p>A review of the medical record for resident #14, revealed resident #14 was admitted to the facility on April 19, 2010, with the following diagnoses: Urinary Retention, Alzheimer's Dementia, Hypertension, Congestive Heart Failure, Reflux Esophagitis, Constipation, Urinary Tract Infection, Osteoporosis, and Dysphagia. A physician's order dated May 17, 2010, was received by the facility for resident #14 to receive Tetracycline 500 milligrams four times daily for two weeks, and then repeat a urinalysis and culture and sensitivity. A review of the laboratory records for resident #14 reveal a urinalysis was obtained, however, the culture and sensitivity was not obtained.</p> <p>A review of the laboratory calendar for June 2010 revealed resident #14 was on the calendar on June 3, 2010, for the facility to obtain a urinalysis and culture and sensitivity.</p> <p>A review of the laboratory request which was completed for resident #14 on June 3, 2010, revealed only the request for a urinalysis with culture and sensitivity only if indicated. The urinalysis report dated June 3, 2010, revealed 4+ blood, 2 to 5 white blood cells, 5 to 10 red blood cells, 0 to 4 epithelial cells, trace of bacteria, and budding yeast with hyphae. A culture and sensitivity was not obtained.</p> <p>An interview conducted with the Unit Manager (UM) for the Faith Unit of the facility was conducted on June 30, 2010, at 9:35 a.m. The UM stated the test had been omitted. The UM stated the laboratory tests to be obtained are placed on a calendar and the requests are filled out by the night shift nurse. The laboratory staff then comes in to obtain the laboratory specimens.</p> | F 502 | <p>urinalysis request be completed for culture and sensitivity if indicated. The infection control nurse will monitor urinalysis lab request for accuracy of physician orders, track each urinalysis obtained by maintaining a log and follow urinalysis results through completion.</p> <p>4. The Director of Nursing/Assistant Director of Nursing will audit urinalysis request for accuracy and follow through weekly x 4 weeks then monthly x 3 months.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Completion – July 31, 2010.</p> | |
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| F 502 | Continued From page 39 The UM states this has been a problem with the laboratory and the facility has recently hired an Infection Control Nurse to monitor the urine cultures. An interview was conducted with the physician of resident #14 on June 30, 2010, at 10:30 a.m. The physician stated he/she would have preferred resident #14 have a culture and sensitivity related to the resident's history of Urinary Retention and history of Urinary Tract Infections. | F 502 | <u>Tag # F 505</u> 1. Residents # 15,16,23, and 24 were found to have lab values that were not reported to the physician in a timely manner. Physician was notified of this per surveyor. No new orders were obtained pertaining to residents # 15,16,23, and 24. Please note residents # 15,16,23, and 24 did not have any adverse effect because of the physician not being notified in a timely manner. | |
| F 505 SS=EE | 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to promptly notify the attending physician regarding critical/abnormal laboratory values for four (4) of twenty-nine (29) sampled residents (residents #15, #16, #23, and #24). Resident #16 had "critical" lab values as follows: Blood/Urea/Nitrogen (BUN) level was sixty (60) mg/dL (elevated) on May 7, 2010, Potassium level was 6.5 mEq/L (elevated) on October 16, 2009, and Potassium level was 6.1 mEq/L (elevated) on October 23, 2009. Resident #6 had a Hemoglobin level of 6.7 gm/dL (low) and a Hematocrit level of 21.2% (low) on June 7, 2010, and required a blood transfusion. Resident #24 had a urinalysis with a culture and sensitivity conducted on June 25, 2010, that revealed Enterobacter Coaccae with Gram Positive Cocci and resident #23 had a Sputum C&S with Methicillin Resistant Staphylococcus Aureus | F 505 | 2. All residents have the potential to be affected. The Director of Nursing/Nursing Management Team completed a 100% audit of all labs obtained from May 1, 2010 through July 1, 2010 to assess time frame from receiving lab result until the physician was notified. Any lab result identified not reported to the physician timely were reported to the physician and new orders were obtained per physician request. 3. The Director of Nursing/Assistant Director of Nursing inserviced licensed staff to follow the facilities policy and procedure related to diagnostic services. The nurse that is responsible for the resident is responsible to fax/notify the physician of lab results within 2 hours of receiving the lab results. The nurse will fax and notify physician of the lab results and | |

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| F 505 | <p>Continued From page 40 (MRSA). There was no evidence the facility reported these critical/abnormal laboratory values to the physician promptly.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Resident #16 was admitted to the facility on July 6, 2006, with diagnoses of Chronic Kidney Disease, Hypertension, Hyperpotassemia, Diabetes Mellitus, Angina Pectoris, Peripheral Vascular Disease (PVD), and Fluid Overload. <p>A review of the physician's orders dated June 11, 2010, revealed resident #16 had physician's orders for a Potassium level to be obtained weekly on Friday morning and BUN and Creatinine levels to be obtained every two weeks.</p> <p>A review of the medical record revealed laboratory (lab) tests were conducted on October 16, 2009, for resident #16's potassium level. A review of the lab results revealed the potassium level was 6.5 mEq/L (normal value is 3.5 to 5.1 mEq/L). Further review of the lab report revealed documentation the potassium level was "critical" and was reported via telephone to facility staff on October 16, 2009, at 15:44 p.m. The lab report contained further documentation the resident's physician was not notified of the critical potassium level until October 17, 2009. No time was documented to reflect when the physician was notified.</p> <p>Further review of the physician's orders dated October 17, 2009, revealed Kayexalate 120 ml (medication used to lower potassium levels) was ordered to be administered to resident #16 every Monday and Friday.</p> | F 505 | <p>document on lab/chart that the lab was faxed, the nurse will call and verify receipt of lab, and any new orders that were obtained. The Unit Manager will maintain a log of all labs obtained and discuss any issues during the nursing clinical meeting Monday-Friday. The Unit Manager will monitor labs for completion.</p> <ol style="list-style-type: none"> The Director of Nursing/Nursing Management Team will audit labs obtained for completion daily Monday-Friday x 1 week, weekly x 3 weeks, and then monthly x 3 months. Review of labs for completion will continue in the Performance Improvement Committee Meeting until 95% threshold is met. Date of Compliance – July 31, 2010. | |
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| F 505 | <p>Continued From page 41</p> <p>An interview conducted with LPN #3 on June 30, 2010, at 7:40 p.m., revealed she could not recall being notified via phone regarding the potassium levels on October 16, 2009. LPN #3 stated she did not notify resident #16's physician of the potassium levels and believed the Unit Manager (UM) was responsible to notify the physician of lab values.</p> <p>An interview conducted with the UM on June 30, 2010, at 3:00 p.m., revealed the facility received lab test results via fax from the hospital. The UM stated the UMs were responsible to check the fax machine every morning at 7:00 a.m., unless the facility was expecting lab results to be faxed from the hospital. The UM further stated the fax machine was in a locked room and the UMs, staff nurses, and the front office manager had a key to the locked room. The UM stated the staff nurse was responsible to notify the resident's physician regarding lab test results. The UM stated if lab results were faxed from the hospital after 7:00 a.m., nine out of ten lab tests would not be removed from the fax machine until the following day. The UM also stated notification of the physician should be documented in the nurse's notes and on the lab results.</p> <p>Further review of the medical record revealed a Potassium level was obtained on October 23, 2009, for resident #16. A review of the lab test results revealed the potassium level was again critical and elevated at 6.1 mEq/L and was called to the facility staff on October 23, 2009, at 16:09 p.m.</p> <p>A review of the nurse's notes dated October 24, 2009, at 11:00 a.m., revealed resident #16's physician was informed of the potassium level</p> | F 505 | | | |

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| F 505 | <p>Continued From page 42</p> <p>and orders were obtained to increase the Kayexalate to 120 ml every Monday, Wednesday, and Friday.</p> <p>An interview conducted with LPN #6 on June 30, 2010, at 1:35 p.m., revealed LPN #6 could not recall receiving the phone call regarding critical lab results (Potassium) for resident #16. LPN #6 further stated she did not recognize the Potassium results were critical at 6.1 mEq/L and required immediate physician notification.</p> <p>Further review of the medical record revealed a BUN and Creatinine level was obtained for resident #16 on May 7, 2010. A review of the lab test results revealed the BUN was critical at 60 mg/dL (normal range is 7 to 18 mg/dL) and the Creatinine was high at 2.2 mg/dL (normal range is 0.6 to 1.3 mg/dL). The lab results contained documentation that the facility was notified regarding these lab values on May 7, 2010, at 19:00 p.m. However, a review of the nurse's notes revealed resident #16's physician was not informed of the lab results for resident #16 until May 9, 2010, at 1:00 p.m., and no new orders were noted.</p> <p>LPN #7, the nurse who cared for resident #16 on May 7, 2010, was no longer employed by the facility and attempts to contact LPN #7 per phone were not successful.</p> <p>A review of the facility's policy/procedure related to Diagnostic Services (dated June 2008) revealed facility staff was required to notify the resident's physician within two hours of receipt of a lab report. The policy/procedure further noted when the facility nurse provided a verbal/phone report to the physician, the nurse was required to</p> | F 505 | | |
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| F 505 | <p>Continued From page 43</p> <p>request a verification read-back from the physician and to document the verification in the medical record. In addition, the policy/procedure noted the charge nurse who received the lab results was responsible for notifying the resident's physician.</p> <p>An interview conducted with resident #16's attending physician on June 30, 2010, at 5:12 p.m., revealed the physician stated he was not notified of the critical/high lab test results for the resident promptly. The physician stated resident #16 had a diagnosis of Chronic Renal Failure and did not suffer adverse effects as a result of the delay.</p> <p>2. A review of the closed medical record revealed resident #23 was assessed on February 17, 2010, at 10:00 a.m., to have thick, yellow/brownish mucus with bilateral wheezing. The resident was further assessed to have a pulse oximetry of 95 percent on room air. According to the medical record, resident #23's physician was contacted and orders were received to obtain a Sputum culture and sensitivity test (C&S) and to administer nebulizer treatments every four hours for five days. However, a review of the medical record revealed there was no evidence the lab test had been conducted for resident #23.</p> <p>The MDS Coordinator confirmed in an interview conducted on June 30, 2010, at 4:30 p.m., that the medical record did not contain the results of the Sputum C&S obtained on February 17, 2010. However, after the MDS Coordinator contacted the hospital, the lab test results were presented to the surveyor.</p> | F 505 | | |
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| F 505 | <p>Continued From page 44</p> <p>A review of the lab tests results dated February 19, 2010, revealed the sputum was identified to have a moderate growth of Gram Positive Cocci and Methicillin Resistant Staphylococcus Aureus (MRSA). However, there was no documentation the resident's physician was notified of the abnormal sputum results. Resident #23 was discharged home on March 23, 2010.</p> <p>An additional interview conducted with the MDS Coordinator on June 30, 2010, at 4:30 p.m., revealed the facility had not received the lab report from the hospital and the resident's physician had not been informed of the results of the sputum C&S obtained on February 17, 2010.</p> <p>An interview conducted with resident #23's physician on June 30, 2010, at 5:12 p.m., revealed the physician was not notified of the abnormal C&S results. The physician stated he should have been notified.</p> <p>3. A review of the medical record revealed resident #15 was admitted to the facility on August 10, 2009, with diagnoses of Diabetes Mellitus, Hypertension, Chronic Renal Failure, and Atrial Fibrillation. On December 20, 2009, a new diagnosis of Iron Deficiency Anemia was added to the diagnoses list.</p> <p>A review of the physician's orders revealed a new order dated June 2, 2010, for a Complete Blood Count (CBC), Renal Panel, Serum Iron, and Ferritin level to be obtained and results were to be faxed to the physician.</p> <p>A review of the lab results dated June 7, 2010, revealed resident #15's Red Blood Count (RBC) was 2.34 (normal range is 4.70 to 6.10), the Hgb</p> | F 505 | | |

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| F 505 | <p>Continued From page 45</p> <p>level was 6.7 gm/dL (normal range is 14.0 gm/dL to 18.0 gm/dL), and the Hematocrit (HCT) was 21.2% (normal range is 42.0% to 52.0%). Further lab test results obtained on June 7, 2010, revealed the Ferritin level was 19 (normal range is 24 to 336) and the Iron level was 10 mcg/dL (normal range is 35 mcg/dL to 150 mcg/dL). According to the lab report, the test results were faxed to the facility on June 7, 2010, at 16:20 p.m. Further documentation on the lab reports revealed the resident's attending physician was notified of the results of the lab tests on June 8, 2010.</p> <p>A review of the nurse's notes revealed resident #15's physician was notified of the abnormal lab tests results on June 8, 2010, at 2:00 p.m. Further review of the nurse's notes revealed orders were received to Type and Crossmatch resident #15 and to transfuse three units of Packed Red Blood Cells (PRBC). However, the nurse's notes reflected the appointment for the transfusion could not be scheduled until June 9, 2010, at 8:00 a.m.</p> <p>An interview conducted with LPN #1 on June 30, 2010, at 2:40 p.m., revealed the lab results are faxed to the facility from the hospital. LPN #1 stated the UMs obtain the faxed reports from the facility fax machine every morning. LPN #1 stated the UM delivered resident #15's lab reports to LPN #1 on June 8, 2010, and LPN #1 notified the physician. LPN #1 stated the hospital was unable to schedule the transfusion for resident #15 until June 9, 2010.</p> <p>An interview was conducted with resident #15's physician on June 30, 2010, at 10:00 a.m. The physician stated he was not informed of the</p> | F 505 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | X3) DATE SURVEY COMPLETED C 07/30/2010 |
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| NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 800 ELKHORN CITY, KY 41522 |
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| F 505 | <p>Continued From page 46</p> <p>abnormal lab results for resident #15 until June 8, 2010, in the afternoon. The physician stated he should have been notified on June 7, 2010, when the facility received the lab report. The physician further stated the transfusion had to be delayed as a result of the facility's failure to notify him promptly regarding the abnormal lab test results. The physician stated resident #15's low Hgb/Hct was not a result of acute bleeding, but was related to the resident's diagnosis of Chronic Renal Failure and Chronic Anemia.</p> <p>4. A review of the medical record for resident #24 revealed the resident had a urine culture and sensitivity that was received by the facility on June 25, 2010, at 1:51 p.m. The report revealed the resident was growing Enterobacter Cloacae and also had mixed Gram Positive Cocci and mixed Gram Negative Bacilli in the resident's urine. The resident's physician was not notified of the urine culture results until June 28, 2010, at 5:00 p.m., three days later. The physician gave new orders at that time for Meropenem 500 milligrams intravenously every eight hours for seven days.</p> <p>The Unit Manager (UM) for the Faith Unit of the facility stated she/he was responsible for obtaining the laboratory results from the fax machine during the week. The UM gives the reports to the Charge Nurse, who is responsible for notifying the physician with any abnormal reports. The UM further stated on the weekends the Charge Nurses are responsible for obtaining the laboratory reports from the fax machine and then notifying the resident's physician of the abnormal values. The fax machine is kept in a locked room and the Charge Nurses have a key to get into the room.</p> | F 505 | | |
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| F 520 SS=F | <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</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 structured to identify quality concerns, and develop action plans to correct the concerns. The QA committee failed to ensure resident lab test results were obtained as ordered by the physician and failed to ensure the physician was informed of critical/abnormal laboratory (lab) values promptly.</p> | F 520 | <p>Tag # F 520</p> <ol style="list-style-type: none"> Residents # 15,16,23 and 24 were found to have a delay in physician notification related to lab values. Physician was aware of the daily in physician notification. Please note residents # 15,16,23, and 24 did not have any adverse effect because of the physician not being notified timely. All residents have the potential to be affected. The Director of Nursing/Nursing Management Team completed a 100% audit of all labs obtained from May 1, 2010 through July 1, 2010 to assess time frame from receiving lab results until the physician was notified. Physician was notified of labs identified during audit. No new orders were given. A Quality Assurance Meeting was held on July 14, 2010. The meeting was attended by the Medical Director, Executive Director, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Wound Care Nurse, etc. The physician not being notified timely was addressed during this meeting. <p>A new system of physician notification was put into place. System as follows: The nurse that is responsible for the resident is responsible to fax/notify the</p> | |

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| F 520 | <p>Continued From page 48</p> <p>In addition, there was no evidence the designated physician had attended the facility's QA committee meetings conducted in August 2009 through June 2010. (Refer to F502 and F505.)</p> <p>The findings include:</p> <p>An interview conducted with the Administrator/Quality Assurance (QA) Coordinator on June 30, 2010, at 7:30 p.m., revealed QA committee meetings were conducted weekly and audits were conducted routinely by individual disciplines in the facility. The Administrator/QA Coordinator stated the UMs were responsible for tracking the lab tests and presented the tracking log results to the QA committee weekly. The Administrator/QA Coordinator explained the lab tracking/audit consisted of a review to determine if lab tests were obtained per the physician's order and results were reported timely to the resident's physician. The Administrator/QA Coordinator stated the results of the tracking log/audits had been reported during the most recent QA meeting conducted on June 10, 2010, and no problems had been identified related to lab tests not being conducted as ordered by the physician. The Administrator/QA Coordinator further stated he/she was aware of only one critical lab not being reported promptly to the physician and no other problems/concerns had been identified. However, no action plan had been implemented to ensure lab tests were reported promptly to the physician.</p> <p>A review of the facility's policy/procedure related to Diagnostic Services (dated June 2008) revealed all diagnostic services would be promptly carried out as ordered by the physician</p> | F 520 | <p>physician of lab results within 2 hours of receiving the lab results. The nurse will fax and notify physician of the lab results and document on lab/chart that the lab was faxed, the nurse will call and verify receipt of lab, and any new orders that were obtained. The Unit Manager will maintain a log of all labs obtained and discuss any issues during the nursing clinical meeting Monday-Friday. The Unit Manager will monitor labs for completion.</p> <p>Quality Assurance Meetings will be conducted monthly by facility members. Medical Director will be invited monthly and will be required to attend Quality Assurance Meetings quarterly. Medical Director is aware of being invited monthly and being required to attend quarterly.</p> <p>4. The Director of Nursing/Nursing Management Team will audit labs obtained for completion daily Monday-Friday x 1 week, weekly x 3 weeks, and then monthly x 3 months. Review of labs for completion will continue in the Performance Improvement Committee Meeting until 95% threshold is met.</p> <p>5. Date of Compliance – July 31, 2010.</p> | | |

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| F 520 | <p>Continued From page 49</p> <p>and the physician would be informed of the test results within two hours after the facility received the test results. The policy/procedure stated the facility would collect data on the timeliness of reporting critical tests and critical results/values. The policy/procedure noted the timeliness of reporting critical test results/values was considered an adverse event if not done according to the facility policy. In addition, the policy/procedure stated if an adverse event related to the untimely reporting of critical values/tests was identified the QA team would begin a process for improvement using an action plan format.</p> <p>Additional interview conducted with the Administrator/QA Coordinator on June 30, 2010, at 7:30 p.m., revealed each committee member who attended the QA meetings was required to sign an attendance list to verify attendance. The Administrator/QA Coordinator stated the Medical Director attended the QA committee meetings weekly and signed the attendance list. However, the Administrator/QA Coordinator was unable to provide documented evidence that the Medical Director had attended a QA committee meeting from August 2009 through June 10, 2010.</p> <p>An interview was conducted with the Medical Director (MD) on June 30, 2010, at 10:00 a.m. The MD stated he was the only physician on staff at the facility. The MD stated there had been several incidents related to the facility's failure to obtain lab tests as ordered and/or to report abnormal/critical labs promptly to the physician. The MD stated he had been unable to obtain cooperation with administrative staff to resolve concerns and had not attended a QA committee meeting for at least six months.</p> | F 520 | | |

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