



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

PRINTED: 03/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>A standard health survey was conducted 03/19/13 through 03/21/13. A Life Safety Code survey was conducted on 03/19/13-03/20/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</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 observation, interview, and record review, it was determined the facility failed to develop a care plan for one (1) of fifteen (15)</p>	F 279	<p>Corrective action to be accomplished for the resident affected by the deficient practice: The resident's ARD was April 3, 2013. His care plan was assessed on that date by the MDS coordinator, the Director of Social Services, the resident's staff nurse, the dietitian, and the Activities Director. The resident's integrated care plan meeting was held on April 17, 2013 at 1:10 pm. Attending this meeting were the Director of Social Services, Director of Nursing, the Chaplain, the Dietitian, the Activities Director, the Hospice Chaplain and nurse, and the resident and his POA. The Hospice care plan was integrated with the facility's care plan on April 3, 2013 by the Director of Social Services. The interdisciplinary team will also meet with the hospice team on a quarterly basis or more often as needed. The chaplain will visit the resident at least weekly or more often as needed to assess grief issues. Appropriate interventions for the resident's care related to "grief" will be implemented and evaluated at least quarterly for effectiveness by the facility's interdisciplinary team. A journal is being left in the resident's room to document discussions and the resident's feelings to aid in his/her memory. A copy of the journal is kept by the Director of Social Services.</p>	<p>5-2-13 5-3-13 <i>J. J. Hoganson</i> by PB 5-1-13</p>

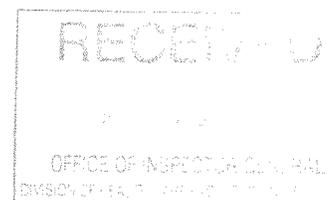
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>JERRY L. HOGANSON</i>	TITLE  <b>Administrator</b>	(X8) DATE  <b>4/18/2013</b>
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Copy following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.

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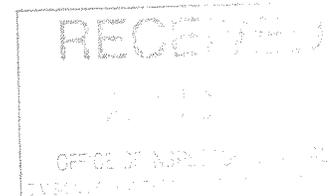
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F 279	<p>Continued From page 1</p> <p>sampled residents and one (1) unsampled resident in regard to the grieving process. Resident #7 was given a terminal diagnosis with less than six months to live. The facility assessed the resident as depressed with mood decline. The facility failed to develop a care plan to address the resident's grief. In addition, the resident was enrolled into a Hospice program prior to admission and the facility failed to integrate Hospice into the resident's comprehensive care plan.</p> <p>The findings include:</p> <p>The facility did not provide a specific policy for care plan development. The facility utilized the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) tool to develop the comprehensive care plan with an interdisciplinary team.</p> <p>Review of the MDS 3.0 manual, Section 4, page 4-8 revealed facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions. The comprehensive care plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>Record review revealed the facility admitted Resident #7, on 10/05/13, with diagnoses of Malignant Neoplasm of Prostate with Secondary</p>	F 279	<p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u></p> <p>All residents in the facility will be assessed for issues of grief upon admission and during quarterly care conferences. Any issues related to grief will be addressed in the residents' plan of care and appropriate interventions of care will be implemented.</p> <p><u>Measures to be put into place or systematic changes made to ensure that the deficient practice will not recur:</u></p> <p>The chaplain will visit the resident at least weekly or more often as needed to assess grief issues. Appropriate interventions for the resident's care related to "grief" will be implemented and evaluated at least quarterly for effectiveness by the facility's interdisciplinary team. A journal is being left in the resident's room to document discussions and the resident's feelings to aid in his/her memory. A copy of the journal is kept by the Director of Social Services.</p> <p>A facility social worker is in attendance for all morning meetings to review and discuss the 24-hour report for any new onset grief issues identified and a new care plan is developed at that point according to the resident's needs.</p> <p style="text-align: center;"><i>Continued on next page</i></p>		



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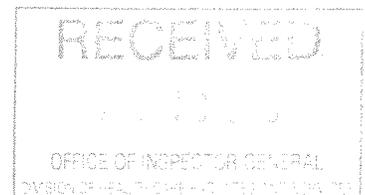
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F 279	<p>Continued From page 2</p> <p>Malignant Neoplasm of Digestive Organs and Spleen, Major Depression, Anxiety Disorder, and Hypertension. The record revealed the resident was admitted from a hospital Hospice unit. Review of the Hospice certification completed, on 09/17/13, revealed the physician documented the resident had a limited life expectancy of six months or less. The physician documented the resident had Advance Prostate Cancer Metastatic to the Peritoneum with increased girth, pain, weakness, decreased oral intake, expanding tumor and increased comfort needs. The physician documented no further cancer treatment options were available. Further review of the Hospice documentation revealed treatment options were discussed with the resident and the resident chose Hospice Palliative Care.</p> <p>Review of the most recent Quarterly MDS, dated 01/17/13, revealed the resident's cognition was intact with a score of fourteen (14) out of fifteen (15) on the Brief Interview for Mental Status (BIMS). The facility assessed the resident to have mood indicators to include little interest, frequently depressed, tired, and feeling bad about self.</p> <p>Review of the comprehensive care plan, revision dated of 01/16/13, for mood, psychosocial, and palliative care, revealed no care plan was developed to address the resident's grief and did not include Hospice interventions.</p> <p>Continued review of the clinical record revealed Hospice had developed their own care plan that included anticipatory grief process; however, the care plan was not integrated with the nursing</p>	F 279	<p><u>How the facility will monitor its performance to ensure that solutions are sustained:</u></p> <p>The procedure of specifically evaluating all residents for issues of grief and developing interventions will be reviewed at each care conference relative to the residents discussed during that conference. The relative success of this change in policy and procedure will be evaluated at each quarterly meeting of the Quality Assurance Committee, and changes will be made by the committee as needed. Specifically, an audit is performed by the MDS Coordinator or their designee to determine if any Hospice resident's care plan is integrated with the resident's facility care plan. This report is presented to the QA committee on a quarterly basis. The Director of Social Services ensures continued compliance develop and has developed an "on-the-spot" inservice on grief for all facility employees on how to identify, monitor, and report signs and symptoms of grief. This inservice will begin on April 18, 2013, and signatures of attendance will be complete by May 2, 2013. Information gathered by the conversations with staff is reported to the QA committee quarterly. The QA committee makes recommendations to the plan of care and changes are made as warranted.</p> <p><u>Person responsible:</u> Director of Social Services.</p>		



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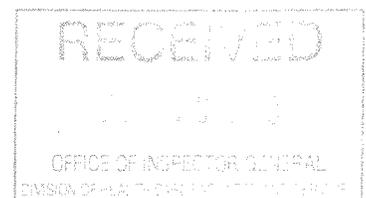
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F 279	<p>Continued From page 3</p> <p>facility. The Hospice care plan had goals and interventions for only Hospice staff. The Hospice care plan stated they would coordinate care with nursing facility staff; but did not give specific interventions on how that would be accomplished.</p> <p>Observation of Resident #7, on 03/19/13 at 11:15 AM, revealed the resident was laying on the bed. Interview with the resident revealed he/she was anticipating death and was depressed. The resident became tearful during the interview. Another interview with the resident, on 03/20/13 at 10:00 AM, revealed the resident became tearful again when talking about his/her impending death. The resident stated he/she wished they could die today, but denied suicidal ideation. The resident voiced he/she did not want to go through the dying process.</p> <p>Interview with the North Unit Manager, on 03/20/13 at 1:45 PM, revealed the resident was depressed and all the resident wanted to do was lay in bed. She stated the Hospice nurse visited 1-2 times a week and the Hospice Chaplain visited frequently. She revealed the Hospice nurse had visited the resident earlier today; however, the Hospice nurse was unavailable for interview.</p> <p>Interview with the MDS Coordinator, on 03/20/13 at 1:50 PM, revealed Hospice communicated with the nursing facility staff at each visit; however, the Hospice staff (nurse, social worker, and chaplain) did not attend the care plan conference. She stated Hospice had their own program and the nursing facility tried to include some of those interventions on their care plans. She stated the nursing facility care plan and the Hospice goals</p>	F 279		



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F 279	Continued From page 4 and interventions were integrated when Hospice talked to the staff during their visits. She stated the Social Worker would be responsible for the development of a care plan to address grief.  Interview with the nursing facility Social Worker, on 03/20/13 at 3:45 PM, and on 03/21/13 at 2:20 PM, revealed she had not developed a care plan that was specific to the resident's grief. She indicated she spoke with the Social Worker for Hospice after their visits with the resident and read the Social Worker's notes. She stated the resident had expressed that he/she was depressed, but did not say anything about grieving. She stated the care plan did not specifically address the resident's grief.	F 279			



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5/22/13 POC accepted. Administrator notified. B. Barnes notified via email - SA Tinkler R

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F 000	INITIAL COMMENTS  A Comparative Federal Monitoring Survey was conducted at Wesley Manor on April 22-25, 2013. The facility was not in substantial compliance with Medicare regulations. The following deficiencies resulted from the facility's non-compliance. The census was 66.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on the group interview, observation, and staff interview the facility failed to ensure residents knew the location of the most recent survey results. Seven (7) of seven (7) residents who participated in the group meeting complained they were unaware of the location of the facility's most recent survey results.  The findings include:  The group interview was conducted 4/23/13, beginning at 9:40 a.m. Seven (7) of seven (7) residents complained during the interview they were unaware of the location of the survey	F 167	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residents will be given a notice explaining the location of the facility's survey results. (See attachment A) At the upcoming monthly residents' council meetings, the residents will be informed of the location of the survey results by the Director of Social Services. The rack which holds the survey results will be lowered to a level which is accessible to wheelchair-bound residents. A new sign will be posted near the survey binder. The resident admission packet has a new form (see attachment B) utilized which says that residents have the right to examine the most recent facility survey. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have equal potential to be affected by this deficient practice. Communicating to all residents by notice, at the monthly residents council meeting, and upon admission will ensure that the corrective action is successful. MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Informing all new residents upon admission, and at each monthly residents council meeting, informing new residents of their right to read the survey, and making the survey results more accessible will ensure that the deficient practice does not recur.	6/1/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>JERRY L. Hodganson</i>	TITLE  Administrator	(X6) DATE  May 17, 2013
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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 167	Continued From page 1 results. All seven (7) stated they would be interested in reviewing the survey results.  Observation at the nurse's station, on 4/24/13, at 4:00 p.m., revealed a binder which contained the facility's survey reports. The binder was positioned approximately four (4) feet from the floor and was not easily accessible for wheelchair bound residents.  During an interview with the Director of Nursing (DON) on 4/24/13, at 4:45 p.m. revealed the survey results were located at the nurse's station, in a binder and she had not been made aware of any previous concerns involving their location.	F 167	HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE WILL BE PUT INTO PLACE: The corrective actions will be reported to the QA committee for approval. The administrator will question the residents at each monthly residents council meeting to assess if they know where the survey results are posted. Additional changes will be made if needed. Results of the audits will be reviewed by the QA committee and monitored for 1 year. PERSON RESPONSIBLE: The administrator	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy, and record review, the facility failed to ensure a bruise of unknown origin was investigated for one (1) of 15 sampled residents (Resident #6) and failed to conduct reference checks to verify previous employment for five (5) of five (5) employees hired within the last four months.	F 226	Concern #1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #6 received a head to toe skin assessment. Occupational therapy is currently working with resident #6 on neck contractures and resident is improving with sitting in a reclining back wheelchair. She has a contoured neck pillow behind her head for support. Resident continues to have involuntary movements and remains on muscle relaxers three times a day and is currently on an aspirin 81 mg daily, which does increase her risk for bruising. Resident #6 will wear Geri-arms and legs daily to provide an extra layer of protection against bruising. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED, AND CORRECTICE ACTION(S) TAKEN: Any resident with a bruise of unknown origin that has not received a proper investigation is at risk for this deficient practice. All bruises of unknown origin will receive a complete investigation to determine causal factors at the time the bruise has been identified	06/01/2013

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F 226	<p>Continued From page 2</p> <p>The findings include:</p> <p>1. Resident #6 was readmitted to the facility on 5/24/12 with diagnoses of Alzheimers Disease, Mental Disorder, Hypertension, Anxiety, Depressive Disorder, and Seizures. Review of the most recent Minimum Data Set (MDS) dated 2/21/13 revealed the resident had severely impaired cognition, and was totally dependent on staff for assistance with activities of daily living.</p> <p>Observation of Resident #6 conducted on 4/22/13 at 2:35 p.m., revealed the resident lying on her bed with eyes closed. Observation on 4/23/13 at 9:00 a.m., revealed the resident seated in a high back wheelchair being fed by Certified Nursing Assistant (CNA) #2 in the dining room.</p> <p>Review of Nurse's Notes dated 3/31/13 at 6:00 a.m., revealed, "Bruise observed to right side chin, purple-red in color, approx (approximately) 1.5 cm (centimeters) circumference, unknown origin. No c/o (complaints of pain or discomfort). Call light within reach. Safety precautions in place."</p> <p>Review of the Incident Report dated 3/31/13 at 6:00 a.m., revealed, "Bruise to right side chin, approx. (approximately) 1.5 cm (centimeters) circumference. Unknown origin." It was documented the resident's spouse and physician was notified of the bruise. There were no names of witnesses, or further documentation regarding the bruise documented on the sheet.</p> <p>Review of the Abuse Detection and Prevention policy dated 10/2011 provided by the facility revealed, "...4. Identification: a. Events such as</p>	F 226	<p>The staff person identifying the bruise will report the bruise immediately to the resident's nurse, the nurse will assess the resident and the bruised area discussing with the resident (as able) what might have occurred. The nurse will complete the incident report promptly, if no cause has been identified the Nurse Team Leader will begin her investigation by talking to all the staff currently working to see if they had seen anything that may have contributed to the bruise. The Nurse Team Leader will obtain statements from each person she talks to regarding the incident. Once complete if the Nurse Team Leader has not determined the cause of the bruise, the nurse will turn the incident report over to the Nurse Team Manager for review. The Nurse Team Manger will review the information and begin contacting the previous shift to attempt to determine the cause of the bruise. The Nurse Team Manager will document all statements obtained. The Nurse Team Manager will reassess the resident chart for medication changes, and other environmental changes that could have contributed to the bruising. All information and finding are turned into the ADON/ VPN on the next working day. Information is then reviewed by the ADON/VPN to ensure all information is complete and thorough; this will include assessing the resident's injuries. The ADON/VPN will follow-up on any investigation needed and will make a determination regarding the findings.</p> <p><b>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATICE CHANGES MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>New policy Accidents/Incidents has been implemented (see attachment). The Checklist for Determining Abuse (willful intent) and Plan of Action (see attachment B) has been revised to include Injuries of Unknown Origin. This checklist will prompt staff through the process of the investigation, staff education, resident care planning as well as ensure proper follow-up has occurred. The Medical Director will review all completed information.</p>		

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F 226	<p>Continued From page 3</p> <p>suspicious bruising or injuries of unknown origin or patterns of complaints, which are not immediately identified as abuse, neglect or misappropriation of resident property will be reported as soon as possible to the Vice President of Nursing &amp; Client Services and/or Director of Social Services. b. These events will be investigated by Vice President of Nursing &amp; Client Services or designee and Director of Social Services for the potential of abuse, neglect and/or misappropriation of property."</p> <p>During an interview with the Director of Nursing (DON) conducted 4/23/13 at 5:25 a.m., she revealed the bruise occurred on a Sunday, and she did not get around to reviewing the incident report until Wednesday. She went and looked at the resident on Wednesday, but did not do an investigation of the bruise. She confirmed no one did an investigation of the bruise to the chin.</p> <p>2. Review of personnel files for employees who were hired within the last four months was conducted on 4/25/13 at 11:20 a.m., along with the Director of Nursing. Five (5) files were reviewed for criminal background checks, licensure, registries and reference checks. The five (5) files reviewed did not contain documentation a reference check had been requested from previous employers. Each file had a request that had been addressed to previous employers for each potential hire, but did not indicate if it had been mailed or if a response had been received as verification of past employment.</p> <p>Review of the Abuse Detection and Prevention policy dated 10/2011 provided by the facility</p>	F 226	<p>An on-the-spot in-service was began on 5-13-13 regarding the new form and how critical it is to assess all bruises to determine cause (see attachment). HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE WILL BE PUT INTO PLACE: Director of Social Services will do a final review all incident reports involving Injuries of Unknown Origin and Checklist for Determining Abuse (willful intent) and Plan of Action to ensure that nothing was missed throughout the investigation process. The Director of Social Service will submit a report to the monthly Quality Assessment and Assurance committee for review and recommendations, if any.</p> <p>PERSON RESPONSIBLE: Vice President of Nursing &amp; Client Services/ Assistant Director of Nursing Concern #2.</p> <p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were found to be affected by this deficient practice.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED, AND CORRECTICE ACTION(S) TAKEN: All residents have the potential to be affected by this deficient practice. Attempting to get a reference check may prevent the facility from hiring an employee with poor work habits that can affect the quality of care that resident receive. Beginning May 1, 2013 the facility will make a good faith effort to obtain a reference check on every potential new hires last employer.</p> <p>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Authorization for Reference Check (see attachment) will be mailed or faxed to the potential candidate at the time of the of the Interview process. The form allow for prevlous employers to return fax or mail information within 3 business days.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSCLICK RD LOUISVILLE, KY 40219</b>		
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F 248	<p>Continued From page 5</p> <p>The goal of the activity plan of care indicated the resident would attend spiritual programs with positive participation and that he would participate in small group activities. A list of interventions to accomplish this goal that were listed on the care plan included, "provide in room socialization visitations, provide outside time and to invite/provide music programs in and out of room."</p> <p>Review of the medical record revealed the resident resided on the South Hall but due to an increase in falls, as of March 2013, he was transferred to the West Hall for constant supervision (locked unit) except for meals, care and sleep.</p> <p>Observations of the resident throughout the survey revealed he was sitting in the activity/dining room in the West Hall in his wheelchair and was not engaged in any of the activities. The resident had a lap buddy cushion across the lap of the wheel chair and he was pulling on the cushion, removing it and attempting to unzip the cover.</p> <p>During an interview with the Occupational Therapy Assistant (OTA) on 4/25/13 at 9:15 a.m., she stated she was working with the resident on sensory stimuli activities as part of his wheel chair positioning. She also stated she had conducted staff education on 2/16/13 on the use of the activities and provided a list to staff.</p> <p>Review of the Activity Progress Notes revealed the last note was entered on 8/26/12, which described the resident as having one on one activity in the Wood area activity room. For the</p>	F 248	<p>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE PRACTICE DOES NOT RECUR: The Activities Department will meet weekly using a current census to review all residents in the Health Care Center and the current activity plan for each resident. The Activity staff will discuss if each resident is currently able to participate in the activity plan, and is the plan meeting the resident's needs. Plans will be modified at the time of meeting as indicated based on changes/declines in functional status, resident preferences and/or other factors. The staff will discuss if short term modifications need to be made in the resident plan of care based on an acute illnesses when the resident is expected to return to base line status. Documentation of these temporary changes will be made in the Activity Section of the resident's medical records. All residents will have documentation in the Activity notes at least quarterly.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: New Activity care plan/charting Audit (see Attachment B) has been put in place. Audit will be completed monthly and will review 5 charts from each hall at random to ensure care plans and charting is up to date. Issues will be corrected immediately. Audit information will be provided monthly to the Quality Assessment and Assurance Committee for 1 year for review and recommendations, if any.</p> <p>RESPONSIBLE PERSON: Director of Activities</p>		

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

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F 248	Continued From page 6 months of February and March 2013, a copy of the Activity Calendar had been placed in the activity section. There was no current documentation from the Activity Department of activities that had been attempted or indication the sensory stimulation activities had been attempted or if they were successful.  During an interview with the Activity Director on 4/25/13 at approximately 2:30 p.m., she stated the resident was in a small activity group she held in the mornings but he has not been attending in a while. She described the small group activities as the use of sensory items and aromatherapy. She also stated that since the resident is back on the West Hall, she did not provide him with any activities.	F 248			
F 249 SS=E	<b>483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</b>  The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.  This REQUIREMENT is not met as evidenced	F 249	<b>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</b> Beginning May 1, 2013, the activities department resumed activities for the West Hall residents. The calendar is provided by the activities department. <b>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN:</b> All residents on West Hall had the potential of being affected by this deficient practice. Beginning May 1, 2013 the activities department resumed activities for the West Hall residents. The calendar is provided by the activities department. All charting regarding the activities attended will be completed by the activity staff. The CNA assigned to the common area will assist the activity staff person and will monitor the residents during the activity. Between activities time that CNA assigned to the common area will be provided with activity items appropriate for dementia residents to maintain/promote stimulation and functioning.	06/01/2013	

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F 249	<p>Continued From page 7</p> <p>by: Based on observation, and staff interview, the facility failed to ensure a qualified activities professional directed the activities program for one (1) of two (2) units (West Hall).</p> <p>The findings include:</p> <p>The West Hall of the facility was designated a locked unit. During the days of the survey, very little activities were observed to occur on the unit. The Certified Nursing Assistants (CNAs) assigned to the unit kept residents in the common area, and directed them to color and/or draw. No formal activities were observed.</p> <p>Interview with the Activities Director (AD), on 4/25/13 at 3:10 p.m., revealed she did not plan the activities for the West Hall. She stated this was a recent change and that the CNAs were now supposed to conduct all the activities for the hall. She further stated she did not keep any records of participation for the West Hall. Upon inquiry, the AD said, "To my knowledge, the Assistant Director of Nursing (ADON) is planning all the activities on the locked unit." The AD further stated she had not provided any training or instruction regarding the activities program to the nursing staff who worked on the West Hall.</p> <p>Interview with the Director of Nursing (DON) on 4/25/13, at 3:15 p.m., confirmed all of the activities for the West Hall were planned by the nursing staff or the ADON. The DON stated the different departments were currently having a "discussion" regarding who would be in charge of documentation. The DON further stated the nursing staff on the West Hall had received no</p>	F 249	<p>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Activity staff will begin a formalized Activity training program of all the West Hall staff this will work as a supplement to the activity program provided by the activities department. The activity staff will begin with the 12 hour staff assigned to the common area. Once that aide has been trained then other staff will begin training until all others have completed their training. The CNA's will be training on setting up the activity, performing the activity and provide this information to the activities department following the resident's plan of care. This training will begin in August and will be completed by 9/30/13.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; I.E., WHAT QUALITY ASSURANCE WILL BE PUT INTO PLACE: Activity staff to monitor through documentation and weekly meetings to ensure all residents are receiving and participating in activities appropriate for the resident level of functioning. All concerns to be followed up with the Quality Assessment and Assurance Committee for recommendation, if any, for a period of 1 year.</p> <p>PERSON RESPONSIBLE: Activities Director</p>		

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F 249	Continued From page 8 training regarding how to provide activities or training on how to develop activities for residents with Dementia.  Interview with the ADON on 4/25/13 at 3:50 p.m. revealed she did plan all of the activities for the West Hall. She further stated she had no experience and/or training with activities.	F 249			
F 252 SS=D	483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b>  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.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a homelike environment for one (1) of three (3) dining rooms by the use of bed sheets to cover the outside windows and the use of torn, worn table cloths on three (3) of five (5) dining room tables.  The findings include:  The environmental tour of the facility was conducted on 4/25/13 beginning at 4:45 p.m., along with the Administrator and the Chief Financial Officer. An observation was made in the section of the main dining room that was used for independent residents. Three (3) of five(5) table cloths used on the dining tables were thin and worn. The cloths were noted with missing or	F 252	<b>CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</b> Horiztonal mini-blinds have been installed on all eleven windows in the dining room. New table cloths for all tables were ordered on 04/22/13 and are scheduled to arrive on 05/13/13. They will be placed into service when they arrive. <b>HOW OTHE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN:</b> All residents who eat meals in this dining room have the potential to be affected equally. The enhanced dining room environment will improve the dining experience for all residents. <b>MEASURES PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b> Proper lighting and control of glare from outdoor sunlight will enhance the dining environment. The new tablecloths will also enhance the dining environment and will be checked for wear upon regular changing of the table cloths by the dietary staff. <b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; I.E., WHAT QUALITY ASSURANCE WILL BE PUT INTO PLACE:</b> The window blinds will be opened/closed by the CNA's assisting with meals during each meal depending on the position of the sun and at the request of the residents. The table cloths will be changed by the dietary staff as needed.	06/01/2013	

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F 252	Continued From page 9 partially missing hems and contained multiple holes. Small nail holes were noted above the windows on one (1) of the three (3) walls in the same dining section. Earlier observations made on 4/23/13, during the breakfast and lunch meal, revealed bed sheets were being used to cover the windows on one of three walls.  The Administrator and Chief Financial Officer, confirmed the tablecloths were worn and needed replaced. The sheets were not present at the time of the observation but when questioned, window coverings had not been used in the past or had been ordered for use instead of bed sheets.	F 252	The environmental condition of the dining room will be reported at every QA committee meeting for a period of one year, and recommendations will be made by the committee for any needed changes in policy and procedure. RESPONSIBLE PERSON: Food Service Director.		
F 279 SS=E	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.  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).	F 279	CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE: The 5 residents found to be affected by this deficient practice will have their care plans revised. Each of these residents will have a comprehensive care plan developed for High Risk Medication Usage that will have an individualized measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The Medical Director and the Psychiatrist will provide input into the development of each resident's individualized plan of care as appropriate. HOW OTHER RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Any resident receiving a high risk medication has the potential of being affected by this deficient practice. The Director of RAI and Director of Social Services will review all residents receiving high risk medications and develop a comprehensive care plan for each resident that contains individualized measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the	06/01/2013	

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F 279	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan with specific goals and interventions to monitor the effectiveness of psychotropic medications for five (5) of nine (9) sampled residents receiving psychotropic medications, out of a total sample of 15 (Resident #'s 1, 2, 3, 6 and 7).  The findings include:  1. Resident #1 was admitted to the facility 3/5/12 with diagnoses of Depressive Disorder, Mental Disorder and Psychosis. Review of the Physician's Orders for April 2013 revealed the resident received Haloperidol 0.05 ML (milliliter) (0.25 mg (milligram)) IM (intramuscular) every 12 hours as needed, and Lorazepam 0.25 ML (0.5 mg) every 2 hours as needed for Agitation.  Review of the care plan, last updated 2/27/13, with a problem of "high risk medication usage" revealed a goal of, "Resident will have stable mood and behavior maintained on least effective dosage of psychotropic meds with no significant side effects and positive outcomes outweighing any potential side effects of these meds." Approaches included, "Monitor mood and behavior and side effects of meds-notify charge nurse of significant findings, administer meds per physician orders, follow-up on pharmacy's monthly medication recommendations, monitor for regular BMs (bowel movements)-treat as needed per physician orders, monitor any GDR (gradual dose reduction) attempts closely, review	F 279	comprehensive assessment. The Medical Director and the Psychiatrist will provide input into the development of each resident's individualized plan of care as appropriate. <b>MEASURES PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b> The Director of RAI, the Director of Social Services and an Activities Representative will begin having a monthly meeting to review all residents on high risk Psychotropic medications. At the time of this meeting the members of the committee will review the care plan, nurses notes, AIM's, CNA assignment sheet and physician orders. This committee will seek insight from the resident's direct caregivers when planning revisions in the plan of care. Information gathered in this meeting will be documented in the resident's medical record in the Social Service section and the resident care plan will be updated to reflect any changes. a. The Director of Social Services will meet weekly with the Psychiatrist to review any resident exhibiting mood and behavioral changes. b. The committee after reviewing the resident's information will provide an update to the resident physician as needed and may request additional medical work-up as warranted. c. The clinical team meets daily during the work week; this team is comprised of the Director of Social Services, Director of RAI, ADON and or VP, NPM and Therapy. As part of this meeting the 24 hour report is reviewed and any resident incidents from the past 24 hours. The clinical team will discuss any immediate concerns, review the chart and document plan in the chart. New interventions will be placed on the care plan and the CNA assignment sheet. <b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR; I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE:</b> The Social Service Assistant will review from the pharmacy the list of residents on high risk medications that is sent out at the beginning of each month. The Social Service Assistant will compare this list with the care plans in the resident's medical		

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F 279	Continued From page 11 and update AIMS (abnormal involuntary movement scale) bi-annually, see fall care plan and consult with Psych MD (physician)." This was the exact same plan of care for all residents who received psychotropic medications and was not individualized to address Resident #1's agitation, or any non-drug interventions to utilize prior to using the medication.  2. Resident #2 was admitted to the facility 11/29/10 with diagnoses of Alzheimer's Disease, Dementia with Behaviors, Depressive Disorder, Anxiety and Insomnia. Review of the April 2013 Physician's Orders revealed the resident had orders for Ativan .25 mg every day for Anxiety, Trazadone 50 mg every hour of sleep for Insomnia and Divaproxex 250 mg three times daily for Dementia.  Review of the care plan, last updated 1/30/13, with a problem of "high risk medication usage" revealed a goal of, "Resident will have stable mood and behavior maintained on least effective dosage of psychotropic meds with no significant side effects and positive outcomes outweighing any potential side effects of these meds." Approaches included, "Monitor mood and behavior and side effects of meds-notify charge nurse of significant findings, administer meds per physician orders, follow-up on pharmacy's monthly medication recommendations, monitor for regular BMs (bowel movements)-treat as needed per physician orders, monitor any GDR (gradual dose reduction) attempts closely, review and update AIMS (abnormal involuntary movement scale) bi-annually, see fall care plan and consult with Psych MD (physician)." This was the exact same plan of care for all residents	F 279	records to ensure that each resident that is on a high risk medication has a care plan to support its use. This information will be provided to each meeting of the Quality Assessment and Assurance Committee for review and recommendations, if any, for a period of one year. RESPONSIBLE PERSON: Director of Social Services	

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F 279	<p>Continued From page 12</p> <p>who received psychotropic medications and was not individualized to address Resident #2's Insomnia or Anxiety. There were no non-drug approaches to the plan of care.</p> <p>3. Resident #3 was admitted to the facility 12/23/12 with diagnoses of Dementia, Glaucoma and Osteoplasia. Review of the April 2013 Physician's Orders revealed the resident received Divalproex 125 mg four times daily for Dementia.</p> <p>Review of the care plan, last updated 2/27/13, with a problem of "high risk medication usage" revealed a goal of, "Resident will have stable mood and behavior maintained on least effective dosage of psychotropic meds with no significant side effects and positive outcomes outweighing any potential side effects of these meds." Approaches included, "Monitor mood and behavior and side effects of meds-notify charge nurse of significant findings, administer meds per physician orders, follow-up on pharmacy's monthly medication recommendations, monitor for regular BMs (bowel movements)-treat as needed per physician orders, monitor any GDR (gradual dose reduction) attempts closely, review and update AIMS (abnormal involuntary movement scale) bi-annually, see fall care plan and consult with Psych MD (physician)." This was the exact same plan of care for all residents who received psychotropic medications and was not individualized to address any side effects from the medication or specific target behaviors to be monitored.</p> <p>4. Resident #6 was re-admitted to the facility on 5/24/12 with diagnoses of Alzheimer's Disease, Mental Disorder, Anxiety, Hypertension, and</p>	F 279		

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

PRINTED: 05/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/25/2013</b>
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F 279	<p>Continued From page 13</p> <p>Seizures. Review of the Physician's Orders revealed the resident had an order dated 2/1/13 to receive Ativan (a medication used to treat Anxiety) 0.5 mg three times.</p> <p>Review of the care plan with a problem of Psychotropic drug use revealed a goal of, "Resident will have stable mood and behavior maintained on least effective dosage of psychotropic meds with no significant side effects and positive outcomes outweighing any potential side effects of these meds." Approaches included, "Monitor mood and behavior and side effects of meds-notify charge nurse of significant findings, administer meds per physician orders, follow-up on pharmacy's monthly medication recommendations, monitor for regular BMs (bowel movements)-treat as needed per physician orders, monitor any GDR (gradual dose reduction) attempts closely, review and update AIMS (abnormal involuntary movement scale) bi-annually, see fall care plan." A review date was documented, but no specific goals, interventions or evaluation of the effectiveness of the Ativan was present.</p> <p>5. Resident #7 was readmitted to the facility on 12/12/11 with diagnoses that included Anxiety, Depression, Vascular Dementia and Parkinson's Disease. The most recent Minimum Data Set (MDS) dated 2/13/13, assessed the resident with cognitive impairment.</p> <p>Review of the care plan last updated on 2/20/13 identified the resident at risk for side effects for the use of psychotropic medication. Approaches and interventions to prevent potential side effects included: "Administer meds per physician orders,</p>	F 279			

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

PRINTED: 05/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 279	Continued From page 14 follow up pharmacy's monthly medication recommendations, monitor any gradual dose reductions closely, review and update AIMS bi-annually and see fall care plan." There were no interventions for a problem of insomnia, the use of hypnotic medications or the use of non-pharmacological interventions.  6. Interview with the Director of RAI (Resident Assessment Instrument) on 4/23/13, at 2:50 p.m. revealed there was a psychotropic medication plan of care used for all residents. She further stated she tried not to get too specific on care plans. She also agreed all of the care plans were the same.	F 279			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review, review of the "Medication Administration" policy and staff interview, the facility failed to ensure Haloperidol was administered according to the physician's orders, on three (3) occasions, for one (1) of 15 sampled residents (Resident #1).	F 309	<b>CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE:</b> For resident #1, a Nurse Manager had identified that the deficient practice had occurred and immediately took action for correction. The resident had been ordered this medication as an as needed medication. It was a high risk medication and was ordered to be given intramuscularly. Because of the nature of the medication and the risk of future error the medication was discontinued. <b>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN:</b> Any resident receiving high risk medications that require the medications to be drawn up in a syringe (oral or injection) have the risk of being affected by this deficient practice. <b>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b> On April 24, 2013 the Staff Development Coordinator began a mandatory in-service on dosage calculations with all license nurses (see attachment A). This training was completed on 5/20/13 for regularly-scheduled employees and will be completed by	06/01/2013	

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

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F 309	Continued From page 15  The findings include:  Resident #1 was admitted to the facility 3/5/12 with diagnoses of Depressive Disorder, Mental Disorder and Psychosis. Review of the Physician's Orders for April 2013 revealed the resident had orders for Haloperidol 0.05 ML (milliliter) (0.25 mg (milligram)) IM (intramuscular) every 12 hours as needed for Agitation.  Review of the "Narrative Notes," dated 4/23/13 revealed the resident had been seen by the physician related to increased agitation. The note further documented Resident #1 had received the wrong concentration of Haloperidol on 4/21/13, due to the pharmacy had sent the incorrect concentration.  Interview with the Unit Manager (UM) on 4/24/13, at 9:10 a.m. revealed Resident #1 had received the wrong dose of medication on 4/21/13 and it had been recognized by the 2nd Shift Supervisor. The UM stated she had never questioned the small dose and didn't think the facility had a needle that small to administer such a small amount IM. The UM said, "The pharmacy sent the Haloperidol on February 19, 2013. It has not been re-ordered since then. I would consider this a significant medication error." The UM suspected the resident had received 1.25 mg instead of 0.25 mg of Haloperidol. The UM stated the dose on the bottle should have been checked with the order prior to administration.  Review of the 2012 Nursing Drug Handbook revealed the optimal dose of Haloperidol for	F 309	6/1/13 for all PRN employees. The information for the class was obtained from the PCA in-service manual and reviewed measuring liquid medications, conversions, and calculations of medication doses. The Pharmacist at PCA, Chris Miles has scheduled mandatory in-services for all licensed nurses on May 14, 2013 at 3:00pm on Dosage Calculations. Chris will also stress the importance when giving a high risk medication IM of having another nurse double check the medication order against what is being given to ensure accuracy. Chris will review the importance of checking the label of the medication against the order on the resident's MAR, making sure everything matches including the name of the medications, dose, route and the times to be given. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: The Vice President of Nursing and Client Services/ Assistant Director of Nursing will review any medication errors daily and provide immediate investigation should one occur. A monthly report will be provided to the Quality Assessment and Assurance Committee for review and recommendations, if any. Each license nurse at the time of the annual evaluation will complete the PCA in-service on dosage calculation—nurses that fail this information will receive additional instruction from the VPN/ADON before continuing on the medication cart. RESPONSIBLE PERSON: VP of Nursing and Client Services/Assistant Director of Nursing		

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

PRINTED: 05/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 16 Psychotic disorder management was 2 mg - 5 mg IM ever four (4) to eight (8) hours. Even though the resident received more than ordered, it still was not at an optimal recommended amount to achieve desired results. Some adverse reactions listed were: tardive dyskinesia, sedation, drowsiness, headache, or anorexia. The resident was observed 4/22-24/13 and displayed none of adverse reactions.  Further review of the Medication Administration Record (MAR) revealed Resident #1 had received the incorrect dose of Haloperidol 3/30/13 and 4/1/13 and 4/21/13.  On 4/24/13, at 1:45 p.m., the Director of Nursing (DON), contacted the pharmacy per surveyor request. The Pharmacist stated they had sent the smallest amount of Haloperidol that they had, but never contacted the facility to let them know it was not what the physician had ordered. The Pharmacist also stated the resident had received less than the therapeutic dose for an adult.  Review of the facility's "Medication Administration" policy revealed the following, "Check the label of the medication against the order on the resident's MAR, making sure that everything matches including the: i. Name of medication, ii. Dose, iii. Route and iv. Times to be given."	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315	CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENT(S) FOUND TO HAVE AFFECTED BY THIS DEFICIENT PRACTICE: There has been no change in resident #6 condition since the improper incontinence care. Resident has had no signs or symptoms of infection. Urine is dark in color related to poor fluid intake but no foul odor is indicated and resident has no fever. Resident is on the butterfly program, this is the in-house	06/01/2013	

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

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FORM APPROVED  
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F 315	<p>Continued From page 17</p> <p>resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure incontinence care was provided in a manner to prevent the spread of infection for one (1) of three (3) residents observed for incontinence/catheter care (Resident #6).</p> <p>The findings include:</p> <p>Resident #6 was re-admitted to the facility on 5/24/12 with diagnoses of Alzheimers Disease, Anxiety, Mental Disorder, Depressive Disorder, Hypertension, and Seizures. Review of the most recent Minimum Data Set (MDS) dated 2/21/13, revealed the resident was always incontinent of bowel and bladder.</p> <p>During an observation of incontinence care for Resident #6 conducted 4/23/13 at 9:25 a.m., CNA #1 cleaned the resident of an incontinent bowel movement using the correct front to back motion, but then turned the resident over and cleaned the front of the resident's perineal area, wiping from back to front.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 4/24/13 at 2:10 p.m., revealed the facility did not have a specific policy of how to</p>	F 315	<p>palliative care program and the family wishes for no labs, IV or hospitalization.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN: Any resident with urinary or bowel incontinence has the potential to be affected by the same deficient practice. Staff that is not providing proper perineal care to a resident that has been incontinent puts the resident at greater risk for infection.</p> <p>MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility's ADL policy (see attachment A, pages 2-3, that reflect the changes in incontinence care) was updated to include the proper procedure for perineal care after an incontinent episode. All CNA's will be checked off on providing perineal care using the "Giving Perineal Care" procedure checklist (see attachment B - CHECKLIST) to ensure accuracy and compliance. Training for the CNAs began on 5/6/13, regularly-scheduled CNAs completed their training on 5/16/13, and PRN CNAs will be trained before 6/1/13. Any CNA unable to perform the task at a satisfactory level will be removed from care, additional training will be provided and the aide will not return to the work area until performance is accurate and consistent on the "Giving Perineal Care" procedure checklist.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: The "Giving Perineal Care" procedure checklist will be added to the CNA evaluation. Each CNA as part of the probationary and annual evaluation process will be checked-off on proper perineal care. Any CNA</p>		

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

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F 315	Continued From page 18 perform incontinence care. According to Prometric Clinical Skills Checklist for Certified Nursing Assistants (CNAs) regarding female incontinence dated 1/1/2008, "...Wipe from front to back with all washing and rinsing strokes ..."  Interview with CNA #1 conducted 4/24/13 at 1:35 p.m., revealed she did not realize that she had washed from back to front when she provided incontinence care to Resident #6. She agreed a front to back motion should always be used when providing incontinence care.  Interview with the ADON conducted 4/25/13 at 2:45 p.m., confirmed when providing incontinence care, the CNAs should always wipe from front to back.	F 315	unable to perform the task at a satisfactory level will be removed from care, additional training will be provided and the aide will not return to the work area until performance is accurate and consistent on the "Giving Perineal Care" procedure checklist. RESPONSIBLE PERSON(S): Staff Development Coordinator/ Nurse Team Managers	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure one (1) out of six (6) sampled residents (Resident #8) with a history of falls, out of a total sample of 15, received appropriate interventions to prevent falls.	F 323	CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOS RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE: Resident #8 remains free from fall since last fall on 4-14-13. New Happy Hands Overlay was ordered and applied on May 1, 2013. South hall and West hall staff received an on-the-spot education (see attachment A) on the Happy Hands Overlay at the time of the new order. Resident continues to go to West Hall during the day-except for meals. Activity Staff have resumed activities on the unit and is assisting resident with textured books, balloon toss, shapes in a bag, working with him on his Happy Hands Overlay and reading the paper to him. Chewing gum decreasing his anxiety and all these activities help to keep the resident mind active and decrease his risk of falls. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTICE ACTION TO BE TAKEN: Residents with multiple falls have the potential to be affected by the same deficient practice and or resident having falls related to functional declines have the potential to be affected by the same	06/01/2103

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

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F 323	<p>Continued From page 19</p> <p>The findings include:</p> <p>Resident #8 was admitted to the facility on 3/10/11 with diagnoses of Alzheimer's Disease , Anxiety, Depression and Insomnia. The most recent Minimum Data Set (MDS) dated 3/13/13, assessed the resident with, long/short term memory problems, severely impaired cognitive status, requiring extensive assistance with all activities of daily living and was non ambulatory. Review of the resident's plan of care originating on 12/10/12, identified the resident as being at risk for falls, related to poor balance, poor cognition and muscle weakness with a goal to keep the resident free from preventable falls while remaining restraint free in order to decrease the risk of injury from falls.</p> <p>Observations of the resident on 4/23/13 at 10:30 a.m., 12:05 p.m. and 4:05 p.m., revealed the resident was sitting in his wheelchair in the West Hall activity/dining room. A chair alarm was attached to the wheel chair and a lap buddy was across the resident's lap. The left side of the lap buddy was attached to the arm of the wheel chair but the right side was not attached and therefore, applied incorrectly. The resident was zipping and unzipping the cover of the lap buddy.</p> <p>Interview with Certified Nursing Assistant #5 on 4/23/13 at 11:15 a.m., revealed the resident was capable of removing the lap buddy, but staff was always in attendance to prevent him from standing or leaning forward, to prevent falls.</p> <p>Review of the medical record revealed the resident had sustained falls without injury on the</p>	F 323	<p>deficient practice.</p> <p>a. Every fall must be investigated at the time of the fall to attempt to determine causal factors. When a fall occurs the nurse must first assess the resident for injuries. After the assessment is complete the nurse must complete the Incident Report and the Falls Monitoring Form. The nurse should complete the questions then review the answers to see reason for the fall can be determined. The nurse must always take time to discuss the fall with the resident ask the resident simple questions about the fall such as "do they know why they fell", "did they have to go to the bathroom" "are they in pain", sometimes even the most cognitively impaired residents will answer a yes/no question. After all information has been gathered the nurse will work with the CNA's and the Nurse Team Manager to develop a new intervention for the resident. The new intervention will be placed on the care plan and on the CNA assignment sheet.</p> <p>b. The Physician/ARNP will be notified of all falls within 24 hours of occurrence, immediately for serious injuries.</p> <p><b>MEASURES TO BE PUT INTO PLACE, OR SESTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>A mandatory nurse and nurse manager meeting took place on May 2, 2013. (see Attachment A). All staff training will be completed by 6/1/13.</p> <p>a. Discussion included—every fall must have an investigation to determine cause, part of that investigation may include chart review medication changes, changes in health status, and changes in gate or surrounding environment (this information is located on the falls monitoring form). Every fall must include a new intervention. Contact RN on-call for serious injuries or to assist in identifying interventions.</p> <p>b. All falls will be reviewed daily during the work week by the VPN/ADON during the morning clinical meeting. During this time the incident report will be reviewed as well as the fall monitoring and the new intervention initiated, the clinical team will discuss additional care needs.</p> <p>c. Time-lines will be completed on all residents with 3 or more falls monthly to assess the pattern of falls, interventions used and additional care needs.</p>	
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F 323	Continued From page 20 following dates:  3/5/13: Resident #8 fell from his wheel chair 3/10/13: Resident #8 was found on floor 3/14/13: Resident #8 was fell from his wheel chair  After the 3/14/13 fall, the resident was re-evaluated by Occupational Therapy (OT) for positioning in the wheel chair. An intervention was added to assist the resident to the West Hall, except for meals and care, to provide increased supervision. Although the facility completed an investigation after each fall, the root cause of the falls was never determined.  Resident #8 fell from his wheel chair again on 4/14/13 at 1:45 p.m. and sustained an abrasion to his face. The investigation of the fall indicated the clip alarm and lap buddy were in use at the time of the fall. No additional interventions were added as a result of the fall. Even though the resident continued to sustain falls without injury, the facility failed to put additional interventions in place to prevent further falls, since the current interventions were ineffective.  In an interview with the Director of Nursing (DON) on 4/25/13 at 2:10 p.m., she stated all approaches had been discussed to prevent the resident from falling. The DON stated she thought they had done all they could do.	F 323	d. Medical Director will be made aware of any resident having multiple falls, showing functional decline. Copy of the Time-line will be given to the Medical Director for review and recommendations. e. All fall policies have been revised-Using Med-Pass format (see attached-attachment B). All staff is currently receiving on-the-spot training on these new policies. <b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE:</b> A falls reports with a total of all falls is provided to the Quality Assessment and Assurance Committee monthly. a. All resident with 3 or more falls that time-lines have been completed on will be brought to the Quality Assessment and Assurance Committee for review and recommendations by the committee. b. Discussions with the Medical Director for all residents having a pattern of falls to review medications, changes in condition, changes in health status etc. that could contribute to the cause of the falls. c. Staff will maintain contact will family: for resident having 3 or more falls in a month. Once time-line has been complete and information has been reviewed by Medical Director, QA team and clinical team, a family meeting will be requested to discuss findings and current functional status. <b>RESPONSIBLE PERSON:</b> VP of Nursing and Client Services/ Assistant Director of Nursing	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services:	F 328	<b>CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE:</b> Corrective action for those resident fount to be affected by the deficient practice: a. W2-1 has nebulizer covered and stored when not in use in resident's cabinet unit.	06/01/2013

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 328	<p>Continued From page 21</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure respiratory equipment was stored in a manner to prevent the spread of infection on three (3) of four (4) Halls.</p> <p>The findings include:</p> <p>During the initial tour, on 4/22/13, at beginning at 2:30 p.m., the following concerns were identified:</p> <p>A nebulizer and mask were on the bed, uncovered in Room W2-1.</p> <p>Respiratory treatment tubing was not bagged or labeled in Room N 3-2.</p> <p>Room N 6-2 nebulizer machine, O2 tubing and nebulizer tubing was on the bed in Room N 6-2.</p> <p>On 4/25/13 at 9:10 a.m. during the medication pass observation, there was a nebulizer machine, tubing and a clear plastic bag on the chair in Room W 10-2 . The nurse administering medications moved the machine and tubing to a shelf at the bedside and placed the bag on top of</p>	F 328	<p>b. N3-2 has had nebulizer tubing changed, dated and bagged.</p> <p>c. N6-2 had a night stand added to room. All equipment was checked to ensure it was dated and bagged. Equipment was removed from bed and placed on night stand.</p> <p>d. W10-2 will have nebulizer stored in cabinet unit. Tubing and bag were checked for date.</p> <p>e. N6-1 night stand has been added to room. All tubing and mask have been changed; all items have been dated and bagged. Equipment will be stored on the night stand.</p> <p>f. South 2-1 and South 2-2 --nebulizers were separated and cleaned. Both nebulizers received new tubing and the items were dated and bagged. Night stands were added to both beds, the nebulizers will be stored on each.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN: All residents receiving respiratory treatments and having respiratory equipment have the potential to be affected by the same deficient practice. The Vice President of Nursing and Client Services and Assistant Director of Nursing have met with the oxygen company to ensure compliance. The oxygen staff weekly is scheduled to change the tubing on all equipment, date the change and bagged all items. Oxygen Company was requested to see VPN/ADON to get invoice signed to ensure accuracy.</p> <p>MEASURES TO BE PUT INTO PLACE,OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Vice President of Nursing and Client Services and Assistant Director of Nursing have met with the oxygen company to ensure compliance. The oxygen staff weekly is scheduled to change the tubing on all equipment, date the change and bagged all items. Oxygen Company was requested to see VPN/ADON to get invoice signed to ensure accuracy of procedures. All rooms were audited to see if the room had an adequate space to store nebulizer-10 residents required a night stand to be added to the room. All 10 have been obtained and placed in room.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	Continued From page 22 the machine.  The environmental tour of the facility was conducted on 4/25/13 at 4:45 p.m., along with the Administrator and the Chief Financial Officer. Concerns were identified with the storage of respiratory nebulizers in two (2) of three rooms:  On the North Hall- Room 6-1-the oxygen mask, tubing and nebulizer was stored on the resident's bed, uncovered and not dated.  On the South Hall- Room 2-two nebulizers were noted stored in the recliner between bed 1 and 2, uncovered and without a name or date.  During the time of the observation, the Administrator stated the equipment should be stored properly and should not be stored in the chair or on the bed.  In an interview with the Assistant Director of Nursing on 4/25/13 at 6:05 p.m., she revealed the facility did not have a policy for the use and care of nebulizer equipment.	F 328	New policy Departmental (Respiratory Therapy) Prevention of Infection (see attachment A) has been implemented. All staff have been in-serviced on the policy and the requirements for storage of respiratory equipment in the room (see attachment B). <b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:</b> New audit has been initiated Oxygen/Nebulizer Audit (see attachment C). This audit will be completed weekly by the night shift manager. Completed audit will be reviewed by the ADON for investigation/ corrective action. Summary of the will be provided by the ADON to the Quality Assurance and Assessment Committee for recommendations and review, as indicated, at each monthly meeting for a period of one year. <b>RESPONSIBLE PERSON(S):</b> Vice President of Nursing and Client Services/ Assistant Director of Nursing		
F 329 SS=E	<b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	<b>CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE:</b> Plan for each resident found to have been affected by this deficient practice: a. Resident #1: Haldol 0.05ml was discontinued. Resident has continued on current medication regime. The Behavior/Intervention Monthly Flow Record has been modified to focus on the high risk medications and the behaviors associated with those with the medication use. The Flow Record also monitors for medication side effects. Resident also will receive a bi-annual AIMS.	06/01/2103	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 23</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy, and record review, the facility failed to ensure psychotropic medications were being monitored for five (5) of 15 sampled residents (Resident #'s 1, 2, 3, 6 and 7).</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Resident Behaviors" revealed, "...Anxiety or Agitation- A person with Alzheimer's may feel anxious or agitated ...6. Document: Document any of the above behaviors and intervention ..."</p> <p>1. Resident #1 was admitted to the facility 3/5/12 with diagnoses of Depressive Disorder, Mental Disorder and Psychosis. Review of the Physician's Orders for April 2013 revealed the resident received Haloperidol 0.05 ML (milliliter) (0.25 mg (milligram)) IM (intramuscular) every 12</p>	F 329	<p>b. Resident #2 Trazadone 50mg qhs ordered for sleep was not ordered by the psychiatrist. On 4-30-13 the psychiatrist assessed the resident and ordered for a decrease in the Trazadone to 25 mg po qhs. No sleeplessness reported. On 5-14-13 the psychiatrist assessed the resident and ordered the Trazadone to be discontinued. Nursing requested that night staff document for at least 3 nights the effectiveness of the discontinuation and if the resident is able to sleep, if unable to sleep to document what intervention were tried to help with sleep. Resident has continued on current medication regime. The Behavior/Intervention Monthly Flow Record has been modified to focus on the high risk medications and the behaviors associated with those with the medication use. The Flow Record also monitors for medication side effects. Resident also will receive a bi-annual AIMS</p> <p>c. Resident #3: Resident has continued on current medication regime. The Behavior/Intervention Monthly Flow Record has been modified to focus on the high risk medications and the behaviors associated with those with the medication use. The Flow Record also monitors for medication side effects. Resident also will receive a bi-annual AIMS.</p> <p>d. Resident #6: Resident has continued on current medication regime. The Behavior/Intervention Monthly Flow Record has been modified to focus on the high risk medications and the behaviors associated with those with the medication use. The Flow Record also monitors for medication side effects. Resident also will receive a bi-annual AIMS</p> <p>e. Resident #7: Current order for Restoril used as needed for sleep has been discontinued and resident has a new order from the physician for Melatonin 3mg at HS for sleep. Melatonin is an herbal remedy and has less risk to have harmful side effects.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN: Any resident listed in this unnecessary drug or high risk drug category would be considered affected by the same deficient practice. A list of all resident receiving Unnecessary medication has been obtained from the PCA pharmacy and compared to the current MAR's, all residents receiving any Unnecessary/high</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 24</p> <p>hours as needed, Seroquel 25 mg twice daily and Lorazepam 0.25 ML (0.5 mg) every 2 hours as needed for Agitation. Resident #1 was observed on 4/23/13, at 8:50 a.m. seated in the dining room eating his breakfast. The resident was observed later that morning at 10:45 a.m. seated in his room. The resident displayed no behaviors at the time of the observations.</p> <p>Review of the resident's Behavior/Intervention Monthly Flow Record revealed the only behavior the resident was monitored for was exit seeking. The form did not list the medications Resident #1 was taking, or the potential side effects that should be monitored, as indicated on the form. There were no target behaviors for the staff to monitor or any interventions listed to prevent medications from being the first option. There was no documentation to provide a baseline for behaviors to continue use of Seroquel and Orangeman. The documentation provided did not show</p> <p>Interview with the Unit Manager on 4/24/13, at 9:10 a.m., confirmed the medications were not monitored using the sheets provided by the pharmacy.</p> <p>2. Resident #2 was admitted to the facility 11/29/10 with diagnoses of Alzheimer's Disease, Dementia with Behaviors, Depressive Disorder, Anxiety and Insomnia. Review of the April 2013 Physician's Orders revealed the resident had orders for Ativan .25 mg every day for Anxiety, Trazadone 50 mg every hour of sleep for Insomnia and Divaproxel 250 mg three times daily for Dementia.</p>	F 329	<p>risk medications will have both the medication and behavior monitored on the Behavior/Intervention Monthly Flow Record. The Flow Record also monitors for medication side effects. Resident also will receive a bi-annual AIMS MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>a. Behavior/Intervention Monthly Flow Record has been modified to focus on the high risk medications and the behaviors associated with those with the medication use. The Flow Record also monitors for medication side effects.</p> <p>b. Resident will receive a bi-annual AIMS</p> <p>c. The Director of Social Services will make weekly round with the contract Psychiatrist.</p> <p>d. The Director of Social Services, Director of RAI, NPM, ADON/VPN and Therapy meet every morning during the work week for a daily clinical meeting. During this meeting the 24 hour report is reviewed, any incident reports that have occurred since the team last met and the team will discuss interventions on any behavioral concerns identified. New approaches/interventions are placed on the care plan and CNA assignment sheet. The clinical team discusses concerns, repeated behaviors with the residents physician/Medical Director as well the residents psychiatrist.</p> <p>e. The Director of Social Services, Director of RAI and Director of Activities has begun a new Psychotropic Medication Review Meeting. This meeting will be held monthly. During the meeting the staff will review the following information:</p> <p>i. Care plans: To determine that interventions and approaches are individualized to manage behaviors. Manage high risk medication use and gradual dose reeducation trials.</p> <p>ii. Review the Behavior/Intervention Monthly flow Record. Review any side-effects related to the medication use and what plan of action was taken if needed.</p> <p>iii. Review Mood and Behavior Flow Sheet completed by the nurses to capture for the MDS. Compare in information and discuss any conflict in information.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 25</p> <p>Review of the medical record revealed the facility had no documentation any target behaviors were monitored to ensure the use of the medication was needed. In addition, the resident routinely received a sleep aide and no non-drug alternatives had been attempted prior to using a sleep aide.</p> <p>The Director of RAI (Resident Assessment Instrument) confirmed no sleep hygiene program had been attempted and no target behaviors were monitored for Resident #2 on 4/23/13, at 2:50 p.m.</p> <p>3. Resident #3 was admitted to the facility 12/23/12 with diagnoses of Dementia, Glaucoma and Osteoplasia. Review of the April 2013 Physician's Orders revealed the resident received Divalproex 125 mg four times daily for Dementia. Review of the medical record revealed the facility had no documentation of what behaviors were monitored to ensure the use of the medication was needed. There was no list of potential side effects the medication could cause nor was there a baseline for behaviors developed to ensure a gradual dose reduction could be attempted.</p> <p>Interview with the Social Worker (SW) on 4/24/13, at 11:45 a.m. revealed she uses a sheet to code the Mood/Behavior section of the Minimum Data Set (MDS) but it was not related to any specific medication or to monitor it's use.</p> <p>4. Resident #6 was readmitted to the facility on 5/24/12 with diagnoses of Alzheimer's Disease, Mental Disorder, Anxiety, Hypertension, and Seizures. Review of the most recent Minimum Data Set (MDS) dated 2/21/13 revealed the</p>	F 329	<p>iv. Review all pharmacy reports: The Psychoactive and Sedative/Hypnotic Utilization report and the pharmacy notification for gradual dose reductions (GDR)</p> <p>v. All resident medical record information, particularly any documentation in the nurses notes regarding resident behaviors will be reviewed</p> <p>vi. Team will discuss and make recommendations for any non-drug interventions appropriate for the resident's plan of care.</p> <p>vii. All information and discussion will be documented in the Social Service section of the resident medical records.</p> <p>viii. Copy of the monthly report to be given to the Medical Director for review and recommendations</p> <p><b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE:</b></p> <p>Resident will be monitored monthly during the monthly Psychotropic Review Meeting (PRM Team). Any resident found at this meeting not having a Behavior/ Intervention monthly Flow record in their records will be noted and immediately corrected. The Director of Social Services will make a list of any resident and give this list to the Assistant Director of Nursing promptly for investigation and future correction.</p> <p>a. The Quality Assessment and Assurance Committee will receive a report each month from the PRM team on how many residents are currently on Unnecessary/High risk medications and how effectively their behavior is being managed. Also plan for further GDR.</p> <p>b. The Quality Assessment and Assurance Committee will discuss on going in-servicing options for staff to assist with training on behavior management, non-drug related interventions, high risk medications and the side effects. Working with residents with Alzheimer's disease, all staff currently attending the Hand to Hand in-services offered monthly.</p> <p><b>RESPONSIBLE PERSON(S):</b> Director of Social Services</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 26</p> <p>resident had severe cognitive impairment. Observation of the resident on 4/22/13 at 2:35 p.m., revealed the resident lying on her bed with her eyes closed. Review of the Physician's Orders revealed the resident had been receiving Ativan (a medication used to treat Anxiety) 0.5 mg three times a day since 2/1/13.</p> <p>Review of the resident's Mood and Behavior Flow Sheet revealed the sheet was not specific for monitoring the medication, or for monitoring a specific behavior. There were no side effects listed that could potentially effect the resident nor was there a baseline developed to determine how and/or when the medication could be reduced. In addition, there were no non-drug interventions in place to reduce anxiety prior to administering medication.</p> <p>An interview with the Social Worker (SW) conducted 4/24/13 at 11:50 a.m., revealed sheets for monitoring the medication and behaviors should be with the Medication Administration Record (MAR). She said, "The pharmacy sends the sheets. I have no idea why they don't make it to the chart."</p> <p>5. Resident #7 was readmitted to the facility on 12/12/11 with diagnoses that included Anxiety, Depression, Vascular Dementia and Parkinson's Disease. The most recent Minimum Data Set (MDS) dated 2/13/13, assessed the resident with cognitive impairment. The resident was observed on 4/23/13 at 8:20 a.m. and 12:35 p.m. sitting up in his bed drinking a soda.</p> <p>Review of the March 2013 Physician's Orders revealed an order for the resident to receive 15</p>	F 329			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 27 milligrams of Restoril every night as needed for insomnia. Review of the February 2013 Medication Administration Record (MAR) revealed the resident received the medication on seven (7) occasions. Review of the March 2013 MAR revealed the resident received the medication on five (5) occasions. Further review of the resident's record did not reveal any documentation how the use of Restoril would be monitored for effectiveness or potential side effects.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired food items were not available for use, hood vent filters were free of dust, range top grease trough was free of food spills, steam table pans were not stacked wet, the ice machine door was clean and in good repair, facial hair restraints were utilized in the serving area, and food service staff were able to correctly calibrate food thermometers.  The findings include:	F 371	CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE: The Dietary Department manager conducted an inservice with the dietary department staff to discuss the following topics: 1. labelling of food items in the freezer(s) and refrigerator(s). 2. sanitation concerns; i.e., cleaning of range, stacking of steam table pans and other utensils, personal hygiene, and calibration of food thermometers. The kitchen staff was given an on the spot in-service on the proper procedures to calibrate the thermometer before using it. 1) Each kitchen has a pocket thermometer to utilize for taking food temperatures. Thermometers are tested for accuracy of hot foods by immersing in boiling water (212 degrees F) and checking for a reading of 212 degrees F. Immersing in a 50/50 ice and water slush until the reading reaches a temp of 32 degrees F for cold food items. 2) Thermometers will be calibrated by the Cooks in the Hoskinson House/Assisted Living kitchen and by the dietary aides in the Healthcare Center kitchen every meal. The temperature will be logged on a daily basis every meal to be entered in the Steam table Temperature Log Form.	06/01/2013	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/25/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 28  An initial tour of the food service areas and central kitchen was conducted 4/22/13, beginning at 2:30 p.m., with the Food Service Supervisor (FSS) present. The following concerns were identified:  Central Kitchen  1. There was a Boston Cream Pie dated 4/24/13 in the walk in refrigerator. The FSS stated staff should never pre-date food and it was facility policy to write the date the food was placed in the refrigerator on the label.  2. There was half of a turkey breast dated 4/11/13 in the walk in refrigerator. The FSS discarded the item.  3. There was a package of bologna that had expired 4/11/13 available for use in the walk in refrigerator. The FSS discarded the item.  4. The hood vent filters had a heavy accumulation of dust and debris that had the potential to contaminate food items during the preparation process.  5. The range top grease trough had a heavy accumulation of grease, crumbs and burnt carbon debris.  6. Four (4) of five (5) steam table pans were stacked wet and two (2) of five (5) had food debris, which increased the risk for cross contamination.  7. The ice machine door was stained with hard	F 371	HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN: All residents have the same potential to be affected as all residents meals are prepared in the kitchen. The range hood vent and filters were cleaned on April 24, 2013 by GPS of Kentuckiana, and are scheduled to be cleaned again on August 24, 2013. The range was moved to allow complete cleaning of the hood and will be moved during each cleaning. The ice machine door was cleaned and coated with a protective finish. The employee with the facial hair issue was counseled regarding the need to be clean-shaven or to wear a protective covering over his facial hair on April 24, 2013. MEASURES TO BE PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Food Service Supervisor will perform daily inspections of the dietary department for compliance with standards of cleanliness, thermometer calibration, employee hygiene, and the condition of the equipment and will take any appropriate steps necessary to correct any issues. Daily audit to check for expired foods will be conducted by the Food Service Supervisors and spot checks will be done by the Food Service Director. The range cleaning scheduled has been revised to be completed twice a week. Range hood cleaning is done every six months by an outside company and can be called if needed. Between cleaning schedules, the dietary aide in-charge of sanitation is responsible for cleaning vents/hood on a weekly basis or as often as needed. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: Reports of compliance with this Plan of Correction will be made to the monthly meetings of the QA committee and recommendations for any needed change will be made to the Food Service Director.		

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

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F 371	Continued From page 29 water and had open scraped areas which increased the risk for cross contamination.  On 4/23/13, at 11:45 a.m., the tray line service was observed with the FSS and Food Service Director present. The following concerns were identified:  8. The Morning Cook testing the food temperatures was unable to calibrate the food thermometer. The Morning Cook asked if the thermometer should be calibrated to 0 degrees Fahrenheit. She requested assistance from the FSS, who said, "You want it as low as you can get it. Am I right?" Dietary Aide #1 finally gave instruction on how to accurately calibrate the food thermometer.  9. A male dietary staff member, with a beard, worked on the tray line without any type of restraint for his facial hair.	F 371	RESPONSIBLE PERSON: Food Service Director.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  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.  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.	F 425	CORRECTIVE ACTION(S) TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS DEFICIENT PRACTICE: Part 1 It appears that the Haldol order sent for resident #1 was filled accurately by the Pharmacy as ordered. Given that this is the only concentration of the ordered medication manufactured, it was in fact the product ordered by the physician, and was correctly labeled by the pharmacy for the specified dose. (See attachment A) Resident #1 was administered the wrong dose of medication on 4-21-13 and this was identified by the facility. A plan of correction was initiated by the Staff Development Coordinator on 4-24-13 on dosage calculations for all nursing staff to avoid the possibility of error being repeated. The consultant pharmacist was notified of the error and did identify that the dose given to Resident #1 received was not in excess of a normal therapeutic adult dose and was not likely to cause an adverse effect. 2. No other residents were identified as affected or at risk. All nurses were provided the Dosage Calculation written in-service from the facility in-service binder provided by the Staff Development	06/01/2013	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	<p>Continued From page 30</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 and staff interview, the facility failed to ensure the accurate dispensing and administering of Haloperidol for one (1) of 15 sampled residents (Resident #1). In addition, the facility failed to ensure expired Juven (a nutritional supplement), was not stored in the medication storage room and available for resident use. 69 of 128 packets of Juven were expired.</p> <p>The findings include: Resident #1 received the wrong concentration of Haloperidol on 3/30/13, 4/1/13 and 4/21/13, due to the pharmacy had sent the incorrect concentration. The resident received 1.25 milligrams (mg) instead of 0.25 mg.</p> <p>Interview with the Unit Manager (UM) on 4/24/13, at 9:10 a.m. revealed Resident #1 had received the wrong dose of medication on 4/21/13 according to the 2nd Shift Supervisor. The facility was unaware Resident #1 had received the wrong dose on two (2) other occasions. The UM said, "The pharmacy sent the Haloperidol on February 19, 2013. It has not been re-ordered since then..." The UM stated the pharmacy had not contacted the facility to make them aware</p>	F 425	<p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN: No other residents were identified as affected or at risk. All nurses were provided the Dosage Calculation written in-service from the facility in-service binder provided by the Staff Development Coordinator. (same information that was provided in F309) MEASURES PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Subsequently, staff were again trained on proper dose calculations (to verify dose), required procedures for verifying name, medication, dose, route, and time with the medication label and MAR prior to administering, a new procedure was instituted for nurses to verify all injectable medication doses with another nurse prior to giving, and staff was reminded of the availability of the pharmacy for questions/reference on a 24/7 basis in a in-service given by Chris Miles, Consultant Pharmacist on 5-14-13 at 3pm. All staff acknowledges understanding of the presented material. a. In addition, Pharmacy staff reviewed this medication concern in a Pharmacists Meeting on 5-15-13 and has implemented an additional procedure to help prevent this error in the future. (see attachment B) b. This is PCA's policy on clarification any illegible or unclearly written medication order (see attachment C). HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: 4.The Quality Assessment and Assurance Committee will monitor ongoing effectiveness of this training by ongoing monitoring of nursing staff on medication pass procedures. The facility manager will observe medication pass with each nurse's annual evaluation or as needed for identified concerns and the consultant Pharmacist will observe 1 staff per month on medication pass procedures and these results will be reviewed in the quarterly QAA meetings for 1 year. All new nursing staff will receive the Medication Pass procedure in-service and calculations in-service during orientation and will receive a medication pass audit at the time of the introductory evaluation. All nurses will as well preform dosage calculations annually at the time of the nurse's annual evaluation. CORRECTIVE ACTIONS TO BE ACCOMPLISHED: Part 2 The Juven packets found expired in the medication room cabinet were not ordered for a specific resident. This item is a dietary protein supplement and is purchased by the case (4 boxes to a case). The Dietician writes a recommendation for this supplement when a</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 31 they did not have the dose as ordered by the physician.  On 4/24/13, at 1:45 p.m., the Director of Nursing (DON), contacted the pharmacy per surveyor request. The Pharmacist stated they had sent the smallest amount of Haloperidol that they had, but never contacted the facility to let them know it was not what the physician had ordered. The Pharmacist also stated the resident had received less than the therapeutic dose for an adult.	F 425	resident has a skin concern and the resident's physician reviews and writes orders for the supplement if indicated. At the time of the survey there were two residents using this product. Both of these residents have had skin concerns resolved and the orders have been discontinued. HOW OTHER RESIDENTS ARE IDENTIFIED: All residents have the potential of being affected by the same deficient practice. If the medication room/ cabinets have not been monitored for expired items then all residents receiving items from this area are at potential risk. The medication room/cabinets will now be added to the weekly audit to ensure all areas are checked for expired items. MEASURES PUT INTO PLACE, OR SYSTEMATIC CHANGES MADE TO ENSURE THE THE DEFICIENT PRACTICE DOES NOT RECUR: Medication Cart-Cabinet Audit forms (see attachment-D) revised to include Medication room and cabinets. This audit will be done weekly by the night shift staff and the results given to the ADON for review. Any expired items will be immediately removed from the medication cart, room or cabinet and reordered if required. PCA pharmacy audits all medication carts and the medication room quarterly. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE: All audit information will be provided to the ADON. Immediate corrective action will be taken to ensure all medications and supplements are in date. The ADON will provide training to nurses as needed regarding expiration dates. Outcome from the audit will be presented to the Quality Assessment and Assurance Committee for review and recommendation, if any. RESPONSIBLE PERSON: Assistant Director of Nursing		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520	There were no resident found to be affected by this deficient practice. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ARE IDENTIFIED AND THE CORRECTIVE ACTION TO BE TAKEN:	06/01/2013	

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F 520	<p>Continued From page 32 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 record review and staff interview, the facility failed to ensure the Quality Assessment and Assurance Committee met at least quarterly and had physician representation at least quarterly. The Committee had no physician representation from November 2012 through March 2013 (5 months), and did not conduct one (1) of four (4) quarterly meetings.</p> <p>The findings include:</p> <p>Review of the attendance records for the Committee revealed a physician was not present for the meeting the following months: November</p>	F 520	<p>All residents have the potential to be affected by this deficient practice. Not having the Medical Director involved in the QAA on at least a quarterly basis could affect the outcome of how you are planning the care of your residents and resident care driven outcomes. The Assistant Director of Nursing/ Chairperson for the QAA committee will begin meeting with the Medical Director each month after the QAA meeting if he has been unable to attend. The QAA Chairperson will review the minutes from most recent meeting, discuss any comments or suggestions with the Medical Director and document all information. The QAA Chairperson will have the Medical Director sign demonstrating a review of minutes and any new addition to information or changes. The Medical Director will continue to be scheduled to attend the QAA meeting quarterly.</p> <p><b>MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>The Assistant Director of Nursing/Chairperson for the QAA committee will begin meeting with the Medical Director each month after the QAA meeting if he has been unable to attend. The QAA Chairperson will review the minutes from most recent meeting, discuss any comments or suggestions with him and document all information. The QAA Chairperson will have the Medical Director sign demonstrating a review of minutes and any new addition to information or changes. The Medical Director will continue to be schedule to attend the QAA meeting quarterly. All information will be kept on file in the Assistant Directors Office. The Quality Assessment and Assurance Policy (see attachment A) were updated to reflect these changes.</p> <p><b>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR, I.E., WHAT QUALITY ASSURANCE MEASURES WILL BE PUT INTO PLACE:</b></p> <p>At the beginning of each Quality Assessment and Assurance meeting the QAA Chairperson will review minutes from last month's meeting, this will include and changes or addendums added by the Medical Director.</p>		

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F 520	Continued From page 33 2012, December 2012 and March 2013 (no meetings were conducted January 2013 and February 2013), which resulted in him not being made aware of issues for five (5) months.  Interview with the Assistant Director of Nursing (ADON) on 4/25/13 at 5:00 p.m. revealed the facility had not conducted the quarterly meeting in January 2013. The ADON stated there had been scheduling conflicts and the meeting was not conducted. The ADON further stated the Committee met on a monthly basis, but the physician was only required to attend quarterly. The ADON stated the physician had not been present at a meeting from November 2012 through March 2013, and not been provided any information identified by the Committee for review.	F 520	The Medical Director is scheduled to be on campus weekly and is therefore easily accessible to discuss resident and facility concerns. He can also be contacted easily during when not on campus by calling the answering service. RESPONSIBLE PERSON: Assistant Director of Nursing (QAA Chairperson)		

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{F 000}	INITIAL COMMENTS  AMENDED 07/17/13 AMENDED 07/19/13  An onsite revisit survey was conducted by the State Agency on 06/13/13 to determine if the facility had achieved substantial compliance and corrected all deficiencies cited on the Federal Comparative Monitoring Survey of 04/25/13. This survey determined the facility had not achieved compliance as alleged on 06/01/13 with ongoing non-compliance in F328 and new non-compliance noted in F441 and F490.  After CMS review and consultation with both CMS and the SSA, it was determined the facility had not achieved compliance in F520 as alleged. The facility failed to ensure corrective action was taken to achieve compliance as alleged in the facility's Plan of Correction after the facility's audits identified continued non-compliance. An amended SOD was issued to include non-compliance in F520.	{F 000}			
{F 328} SS=E	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.	{F 328}	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All resident found to be affected by the deficient practice received immediate intervention. All affected residents had their tubing replaced, dated and stored properly. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Vice President of Nursing and Client Services (VPN) and the Assistant Director of Nursing (ADON) have met with the oxygen company to review compliance expectations. The oxygen company staff is scheduled to	07/17/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*JERRY L. Hodgson*

TITLE

Administrator

(X6) DATE

07/19/2013

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.

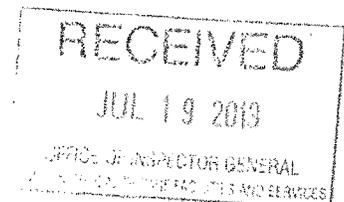
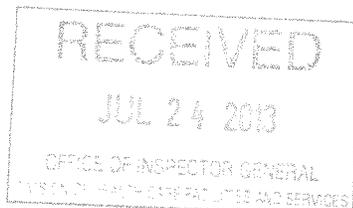
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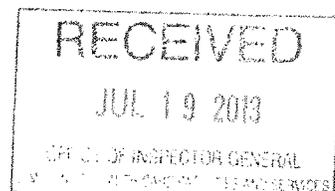
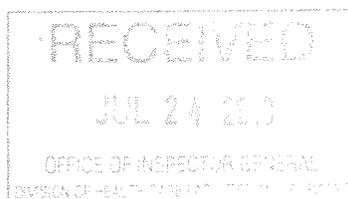
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{F 328}	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the facility's new policy for Respiratory Therapy, audits, and the Plan of Correction, it was determined the facility failed to ensure respiratory equipment was stored in a manner to prevent the spread of infection on three (3) of three (3) Halls; and, for three (3) of six (6) residents using respiratory equipment (Unsampled residents: A, B, and C).  The findings include:  Review of the new policy and procedure developed by the facility titled "Departmental Respiratory Therapy, prevention of infection", undated, revealed the purpose of the procedure was to guide staff in the prevention of infection associated with respiratory therapy tasks and equipment. The staff was to keep oxygen and tubing in a plastic bag when not in use and weekly checks would be done to ensure infection control guidelines were met.  Review of the Plan of Correction revealed the facility alleged compliance on June 1, 2013. The corrective actions would be to change the oxygen tubing weekly, educate the staff on the new policy and procedures and conduct weekly audits to ensure compliance. The audits were to be reviewed by the Assistant Director of Nursing (ADON) for investigation/corrective action. These results would be taken to the Quality Assurance	{F 328}	change the tubing on all equipment, date the change, and bag all items on a weekly basis. All nebulizers and concentrators shall be cleaned each week by the Oxygen company. The VPN or ADON will audit the Oxygen company after each weekly visit to ensure proper changes/dating of equipment, also that the equipment has been cleaned. Concerns will be addressed immediately with the company for resolution. New information was added to the nursing RESPIRATORY ASSESSMENT SHEET requesting nurses to check and sign each shift ensuring that equipment is stored, masks and tubing in bag, and that they are dated. DAILY WING RECORD is updated to include daily rounds for nurses to check and document this form that the Nebulizer/O2 equipment is dated/bagged/stored appropriately. A weekly audit of all residents utilizing oxygen will be performed by the VPN/ADON utilizing the "Nebulizer/Oxygen Audit" form (see attached). The VPN will be notified of the results on the same day that the audit is performed, and the administrator will receive the audit record within 24 hours for reading and sign-off. Where needed, resident room furniture was re-arranged to assist in resident having appropriate storage and use of equipment. MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The policy, DEPARTMENTAL (RESPIRATORY THERAPY) PREVENTION OF INFECTION, (see attached), has been given back to all nurses to review with on-the-spot education regarding the information on this citation and tag F328 (see attached). All full-time and part-time staff have been		



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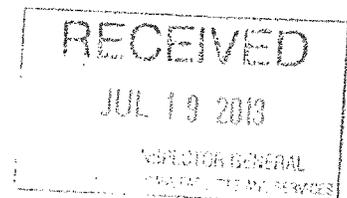
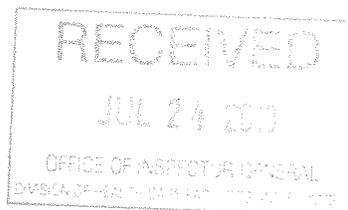
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NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 EAST MANSLICK RD LOUISVILLE, KY 40219		
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{F 328}	Continued From page 2 meetings.  Observation during tour of the facility, on 06/13/13 at 8:30 AM-9:20 AM revealed the following: Room #2 on the West Wing had an oxygen concentrator with oxygen tubing (nasal cannula) placed on top of the oxygen concentrator. The tubing was not in a bag. In addition, a portable tank of oxygen with oxygen tubing and nasal cannula wrapped around the top of the portable oxygen tank was not bagged. No resident was in the room. Continuation of the tour on the Wing revealed Room #10 had an oxygen face mask hanging by itself on a hook on Unsamped Resident C's bathroom door. Interview with the resident revealed the oxygen face mask did not belong to him/her because they had not used oxygen therapy.  Interview with Licensed Practical Nurse (LPN) #1, on 06/13/13 at 8:40 AM, revealed the resident in Room #10 had not used oxygen therapy and she did not know why the face mask was hanging on the bathroom door. She stated the only resident on oxygen therapy was the resident in Room #2 and that resident was in the hospital. She stated the oxygen equipment should have been removed or bagged for the resident in Room #2.  Interview with Certified Nursing Assistant (CNA) #1, at 8:45 AM, revealed she had removed the oxygen mask and didn't know to whom it belonged. She stated maybe a confused resident had placed the face mask there.  Observation during tour of the North Wing, on 06/13/13 at 9:00 AM, revealed a BIPAP machine in Room #6. The face mask to the BiPAP	{F 328}	in-serviced on the policy and the requirements for storage of respiratory equipment in the room. Staff was in-serviced on the changes in forms, RESPIRATORY ASSESSMENT SHEET AND DAILY WING RECORD. The Respiratory Assessment Sheet was implemented with the July MARs and the Daily Wing Record began on July 1, 2013. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The OXYGEN/NEBULIZER AUDIT (see attached) will be completed weekly after the changing of the tubing supplies. This weekly audit will be done by the VPN or the ADON. At least 3 other audits will be done at random throughout the week to ensure that equipment is stored properly. The audits will be done by the VPN, ADON, and the MDS Coordinator. The staff development coordinator will act as an alternate if any of these staff members are not available to perform their audit on any given week. Any deficient practice identified in the audit will be immediately corrected and the staff person identified and corrective action taken. The form which is used to complete these audits is attached (Nebulizer/Oxygen Audit Form). All information will be presented to the regularly scheduled Quality Assurance Committee meetings for review and recommendations. STAFF PERSON(S) RESPONSIBLE FOR COMPLIANCE: Vice President of Nursing and Client Services (VPN) and the Assistant Director of Nursing (ADON).  Addendum: Education for #3 was completed on 7-03-13 for review of policy on departmental respiratory therapy prevention of infection. Inservice on respiratory assess-		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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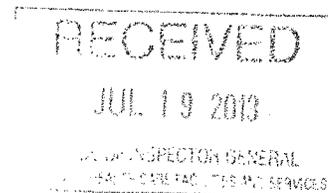
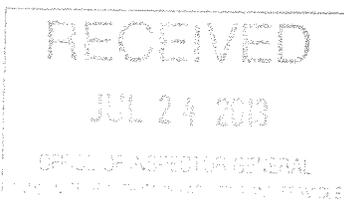
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{F 328}	Continued From page 3 machine was lying face down on a beside table. Unsampled Resident B was sitting on the side of the bed. Interview with the resident revealed he/she used the BIPAP machine at night. Observation revealed the resident also required oxygen therapy. The nasal cannula and oxygen tubing were in a plastic bag.  Interview with LPN #2 at the time of the observation, revealed the face mask should be in a plastic bag when not in use. She stated a plastic bag was available but she could not find the bag at this time. She stated the resident would remove the mask and tubing from the plastic bag at times.  Observation of the South Wing, Room #12, revealed oxygen tubing and face masks were stored inside the resident's top drawer to the night stand. The drawer was opened for anyone to see inside. The resident was not in the room at the time of observation.  Review of the facility's weekly audits for oxygen equipment revealed only one audit had been conducted since the compliance date of 06/01/13. On 06/03/13, the audit revealed there were ten (10) residents that utilized oxygen equipment. Eight (8) of ten (10) residents' oxygen equipment was not stored in a bag as indicated by the Plan of Correction and policy. The other two (2) were presently being used by the residents.  Interview with the Vice President of Nursing, on 06/13/13 at 4:32 PM, revealed she was responsible for the oversight of the Plan of Corrections and the oversight of the ADON's implementation of the Plan of Correction. She	{F 328}	ment and wing records was completed on 6-27-13. The audits are reported to QA on a monthly basis by the VPN or ADON. The duration of reporting the audits to QA is one year. "Random" audits means that there will be 4 audits total performed each week on various shifts, various days of the week, and at various times, to ensure compliance at any time during the day.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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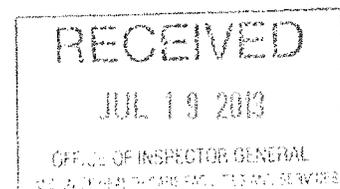
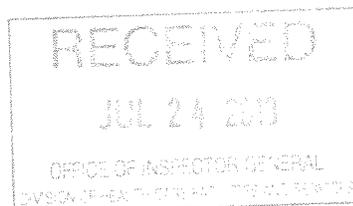
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{F 328}	Continued From page 4 stated the audits for oxygen equipment show non-compliance with equipment not being stored properly in the bags. Further interview revealed the ADON was responsible for the audits and she would update her. She stated all nurses were to make rounds and were responsible to ensure the oxygen equipment was stored properly. The Vice President of Nursing stated there was still a problem.  Interview with the ADON, on 06/13/13 at 5:05 PM, revealed she had identified ongoing non-compliance through the audits. When asked what actions were taken, she replied the oxygen equipment was replaced with new tubing, face mask, or nasal cannula. A read and sign document was posted in the employee's break room. This was the same "on the spot" inservice information that was provided to the staff during the all staff training conducted May 16-30, 2013. Review of the training records prior to the compliance date of 06/01/13, revealed thirty-seven (37) regular staff and fifteen (15) PRN staff had received the training. When asked how many staff had read and signed the posted re-education information, she replied, two (2). Continued Interview with the ADON revealed she was responsible for reviewing the audits for oxygen equipment. She indicated the nurses were to make rounds to ensure oxygen equipment was properly stored at the beginning of the shift and at the end. However, she could not say what oversight she provided other than review the audits. In addition, after reviewing the weekly audits conducted on 05/20/13 and 05/27/13, the ADON acknowledged compliance with oxygen equipment had not been achieved.	{F 328}			
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE	07/17/13	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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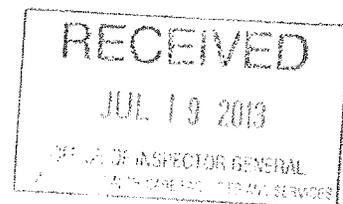
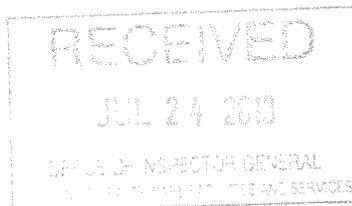
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F 441 SS=D	Continued From page 5 SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease 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 (3) Maintains a record of incidents and corrective actions related to infections.  (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	DEFICIENT PRACTICE: Resident #8 has not exhibited any signs or symptoms of infection as evidenced by elevated temperature, changes in level of orientation, discoloration in urine, or changes in urine output (as identified on brief). Vital signs including temperature, will be obtained every shift for one week and staff will document for positive or negative signs of infections. Any positive signs of infection will make for further evaluation by the physician. Will have the MD/NP on next visit review vital signs and determine if labs or other follow-up should be completed related to any sign or symptoms of infection. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. The VPN will request a monthly report from the laboratory outlining all labs that were done to identify infections. The VPN will also request the pharmacy to send monthly a report that will identify all residents having received an antibiotic in the past month. From these reports, the facility can begin to identify types of infections and areas of concern and begin to plan a course of action. MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A new HAND WASHING - HAND HYGIENE POLICY has been implemented (see attached) and has become a part of the infection control program. This program has been reviewed and approved by the administrator and will be also reviewed by the QAAC at its regular meetings. This policy more clearly outlines to staff when		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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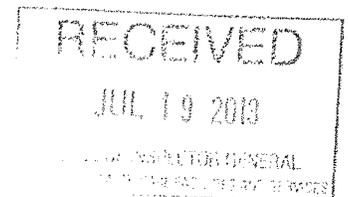
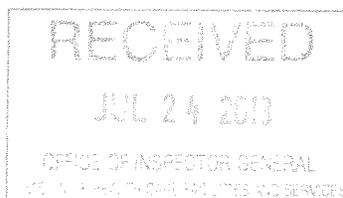
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F 441	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy for Handwashing and Perineal Care checklist, it was determined the facility failed to consistently implement their Infection Control Program to prevent the transmission of disease and infection. Observation of perineal care revealed the Nurse Aide failed to change gloves and wash hands after cleaning of feces.  The findings include:  Review of the facility's policy titled Hand Washing, revised February 2010, revealed personnel shall always wash their hands between all resident contacts and after contact with a source that was likely to be contaminated with microorganism or pathogens. Review of the perineal care checklist (Mosby 2005, chapter 11, page 170) revealed Step #33 was to remove and discard gloves and decontaminate hands after providing perineal care.  Observation of perineal care for Resident #8, on 06/13/13 at 1:40 PM by Certified Nursing Assistant (CNA) #2 revealed the resident was incontinent of bowel. Observation revealed the CNA washed her hands and applied clean gloves. The resident was observed to have large amounts of feces coming out of the incontinent brief and up the resident's back. The CNA removed the soiled brief and clothing. She performed perineal care according to the facility's policy and procedures. However, after the perineal care was completed, the CNA did not	F 441	to wash hands and when to use alcohol. A copy of this policy will be given to each nursing staff member, a copy placed in the nursing guidelines manual, and a copy placed in the general Wesley Manor Employee handbook. The hand washing/hand hygiene policy will be reviewed with all staff in new employee orientation. Hand washing/Hand Hygiene will be a part of all employee's annual performance with their annual review. An in-service was held with all full-time and part-time staff beginning on 06-25-13 regarding state survey deficiency on infection control. After July 7, 2013, all PRN staff will have to complete their training before returning to work. Specific discussion was held with staff regarding the hand-washing policy, the importance of proper hand-washing in the prevention of infection. Each staff member performed proper hand-washing and was checked off on this procedure. The VPN and Staff Development Coordinator (SDC) demonstrated with the staff using the GLO GERM tools to demonstrate how proper hand-washing was performed and how quickly germs could be spread. Staff had to repeat the hand-washing technique until it was performed and no "glo germs" were left on the hands. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The VPN/ADON will review both the monthly infections and the antibiotic report. Using these reports, the VPN/ADON will look for infections that appeared to be clustered in one area of rooms (teams) or halls that may indicate poor hygiene or hand-washing techniques and indicate a problem. Identified concerns will receive immediate intervention		



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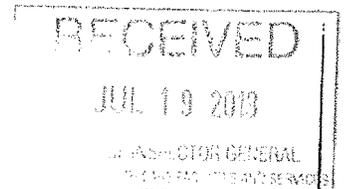
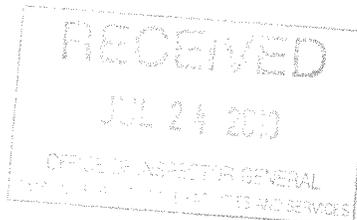
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F 441	<p>Continued From page 7</p> <p>remove the soiled gloves and wash her hands. Instead, the CNA kept the soiled gloves on, went to the resident's closet, obtained clean pants and brief and went back to the resident and touched the resident's shoulder, hands and chest. A mechanical lift (sit-stand) was utilized to transfer the resident from a sitting to standing position. The CNA touched the mechanical lift's controls, arms, and sling with the soiled gloves. She touched the resident's lap cushion, pants, shoes and socks. She needed a new pair of hipsters; she called for assistance by using the call light. She touched the call light button with the same soiled gloves. She then went back to the resident's closet and removed another clothing article. The resident was leaning forward in the wheelchair. She touched the resident's left shoulder and told the resident to sit back. Another staff member brought the clean hipsters to the room. Continued observation revealed CNA #2 applied the clean hipsters with the soiled gloves. She placed the resident back into the mechanical lift touching the resident's hands and the lift's sling. She then inserted the lap buddy cushion, and pulled the privacy curtain away from the resident with the same soiled gloves. She bagged up the soiled washcloths, towels, and clothing. CNA #2 removed the soiled gloves and then washed her hands.</p> <p>Observation revealed the mechanical lift was placed into the hallway outside Resident #8's room to be used by other staff to transfer other residents using the same sling that was touched with the soiled gloves.</p> <p>Interview with CNA #2, on 06/13/13 after observation of perineal care, revealed she did not</p>	F 441	<p>and action and this information reported to the Quality Assurance and Assessment Committee for recommendations and review, if indicated.</p> <p>STAFF PERSON(S) RESPONSIBLE FOR COMPLIANCE: VPN/ADON</p> <p>Addendum: If the pharmacy does not send a monthly report as requested, the VPN will audit the MARs or medical record to attain antibiotic use for the month.</p> <p>The VPN is responsible for receiving, reviewing, and analyzing the pharmacy's report.</p> <p>The new handwashing hand hygiene policy was effective July, 2013 (It was in use on July 1, 2013).</p> <p>Audits for F441 will be reported to the QAAC on a monthly basis by the VPN or ADON/QA coordinator for one year.</p>		



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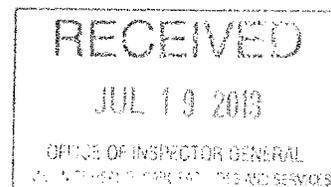
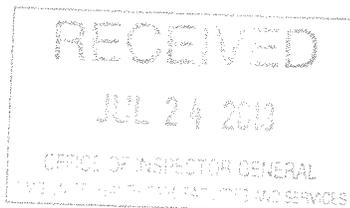
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F 441	Continued From page 8 usually work this wing. She revealed she had recent training on proper perineal care. She said she would have changed her gloves if she had seen feces on her gloves and not have waited until she was finished with all tasks. She stated she had been taught to remove gloves and her wash hands when the task was completed.  Interview, on 06/13/13 at 5:30 PM, with the Staff Development Nurse, who had conducted the training on proper perineal care, revealed she had conducted the original training on 05/16/13. She stated she had taught staff to wash hands and put on clean gloves and to remove soiled gloves after the perineal care was completed. However, she also instructed staff to change soiled gloves and wash hands prior to touching any clean clothing, or objects. She indicated the CNA should have removed the soiled gloves and washed her hands after perineal care was completed.	F 441			
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, staff Interview, review of the facility's policies and review of the facility's Plan of Correction (POC) with a compliance date	F 490	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: All audits performed for compliance with the perineal care policy and the proper storage and use of oxygen supplies and equipment will receive additional monitoring and oversight by the administrator. These audits will be personally reviewed by the administrator, who will prescribe changes, if needed, and sign-off when complete. Any issues of non-compliance will be addressed by the administrator and recommendations made to the VPN and other responsible nursing department staff, when appropriate, and changes made to the policy and procedure when warranted. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVE THE POTENTIAL TO	07/17/13	



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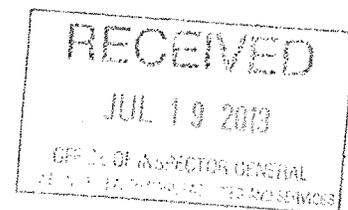
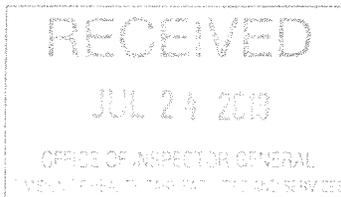
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F 490	<p>Continued From page 9 of 06/01/13, it was determined the facility failed to have an effective system in place to ensure programs, policies and procedures, and the facility's Plan of Correction (POC) were implemented to correct deficiencies cited during the CMS Comparative Monitoring Survey. This failure resulted in continued non-compliance at 42 CFR 483.25 Quality of Care, F-328 and new non-compliance at 42 CFR 483.65 Infection Control, F-441.</p> <p>The finding include:</p> <ol style="list-style-type: none"> <li>1. Refer to F-328: Observation during tour of the facility revealed oxygen equipment was not stored according to facility policy and the POC. Interview with the Assistant Director of Nursing (ADON) revealed she had identified through weekly audits that ongoing non-compliance regarding storage of oxygen equipment when not in use. She provided a "read and sign" re-education with no timeframe requirements to ensure staff completed the education. In addition, she failed to provide oversight to staff to ensure they were conducting rounds to check the oxygen equipment. The Vice President of Nursing Services failed to provide oversight of the audits and ensure the POC was implemented.</li> <li>2. Refer to F-441: Observation revealed infection control practices were not implemented according to facility policy and guidelines utilized by the perineal care checklist. Interview with the staff development nurse revealed the education provided was not successfully implemented.</li> </ol> <p>Interview with the Vice President of Nursing Services, on 06/13/13 at 4:32 PM, revealed she</p>	F 490	<p>BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents receiving perineal care or those using oxygen have the potential to be affected by the deficient practice. Also, failure to follow proper infection control protocols could affect a larger portion of the resident population as well.</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Additional monitoring and oversight of the audit process by the administrator will ensure that these policies and procedures are followed and that any appropriate changes to policies and procedures are made on a timely basis.</p> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: Audit results will be reported to the Quality Assurance Committee at its regularly-scheduled meetings. Changes will be recommended by the committee when warranted.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: Administrator.</p> <p>Addendum: The administrator will review the audits within 24 hours of their completion. The monitoring is completed by the administrator in the following manner: The administrator reviews each completed audit and discusses the results with the VPN. Any identified issues in any audit are discussed and a plan to deal with those issues is implemented according to the</p>		



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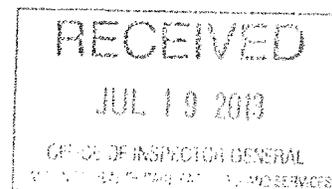
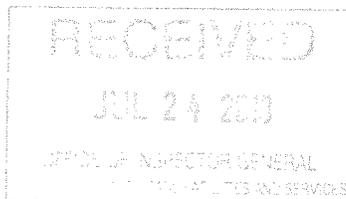
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 06/13/2013
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F 490	Continued From page 10 was responsible for the oversight and implementation of the Plan of Correction as well as oversight of the staff assigned tasks to accomplish compliance. She stated the audits showed non-compliance and was ongoing in regard to oxygen equipment storage. She had given the task of reviewing the audits to the ADON and she had not provided oversight to ensure compliance and that the POC was followed.	F 490	joint decision of the VPN and administrator.		
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  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.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: Residents receiving oxygen or nebulizer treatments have had multiple systems put into place to ensure compliance (see F328 and F441). Staff have had multiple charting changes as identified in F328 to ensure compliance. To ensure this compliance, we are now auditing the storage of the oxygen and nebulizer equipment at least 4 times a week. The audit will be done after the oxygen company has completed rounds which includes exchanging tubing and supplies, dated new supplies, and cleaned the equipment. The audits will also be completed at least 3 other times throughout the week to ensure continued compliance. These audits will be completed by the VP of Nursing and Client Services (VPN), ADON, and the MDS Coordinator Assistant. If none of these staff members are available, the the Staff Development Coordinator (SDC) will complete the audit. All completed audits will be turned into the ADON for review. All staff completing the audits have been educated on this process, and counseling will be performed on staff found not following the policy up to, and including termination.	07/17/13	



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{F 520}	Continued From page 11  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Plan of Correction (POC) for the Federal Comparative survey conducted on 04/25/13, with an alleged compliance date of 06/01/13, it was determined the facility failed to maintain a Quality Assessment and Assurance Program (QA) that developed, Implemented, and monitored to ensure ongoing compliance. The facility identified through their audits that respiratory equipment was not stored according to the facility's policy. Review of the audits revealed the facility had not achieved compliance with F328. However, the staff designated to review these audits failed to investigate and take corrective action per the facility's POC to achieve compliance. The facility was found to be non-compliant in F328 during the re-visit survey which was conducted on 06/13/13. (Refer to F328).  The findings include:  Review of the facility's policy regarding Quality Assessment & Assurance Committee, revised on May 2013, revealed the committee would meet to oversee facility systems and processes related to improving quality of care and services. The QA committee would help identify negative and positive outcomes of care and services. They would establish quality indicators and identify pertinent standards and practices and develop and implement appropriate plans of action to address identified quality deficiencies. The QA	{F 520}	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: New orders are reviewed daily in the morning clinical meetings. New residents who utilize oxygen or nebulizers will be added to the audit list to ensure compliance. MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility's Quality Assessment and Assurance Committee (QAAC) policy has been reviewed and revised. (See attachment 2). The key area of revisions are under section 3 of the policy, "The committee will meet on the next business day after all state/federal inspections", and section 4, "The committee will meet within the next business day for any identified deficient practice." Also, the QA coordinator shall ensure the meeting minutes are distributed to the administrator, VPN, and the medical director on a monthly basis, if unable to attend any meeting. These minutes shall be signed and kept as a record of receiving the minutes. Each month, the ADON or the VPN will meet with the Medical Director to review all information from the QAAC meeting. The medical director will provide input and recommendations as needed. The medical director attends regular quarterly QAAC meetings and others as needed. The administrator will review and sign all audits related to F328. All QAAC members received a copy of F520 for review and signed, stating they received and are responsible for the information. An emergency QAAC meeting was held on July 16, 2013 to review the current POC and the QA process. All current audits were		



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{F 520}	Continued From page 12 committee audit process included development of corrective plans, tracking of progress of any active plans of correction, policy or procedural changes if needed, and would monitor to ensure that such changes are implemented, if needed.  Review of the facility's Plan of Correction submitted for the Federal Comparative survey of 04/25/13 with a compliance date of 06/01/13 revealed all residents receiving respiratory treatments and having respiratory equipment (oxygen, nebulizer) were checked and stored in plastic bags. The oxygen company would change the tubing on all equipment, date the change, and bag all items. A new policy "Departmental (Respiratory Therapy) of Infection" was developed and implemented. All staff had been in-serviced on the policy and requirements for storage of respiratory equipment. New audit tools were developed and would be completed weekly by the night shift nurse. Completed audits would be reviewed by the Assisted Director of Nursing (ADON) for investigation/corrective actions. Summary of the audits would be provided by the ADON to the QA committee for recommendations and review, as indicated, at each monthly QA meeting for a period of one year. The Vice President of Nursing and Client Services would be responsible for compliance.  Observation during tour of the facility, on 06/13/13 from 8:30 AM-9:20 AM, revealed respiratory equipment was not stored according to the facility's policy and POC.  Review of the facility's weekly audits for respiratory equipment revealed only one audit had been conducted since the compliance date of	{F 520}	reviewed for their level of compliance. The next quarterly QAAC meeting is scheduled for July 18, 2013. <b>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</b> The ADON/VPN are meeting weekly with the medical director to review on-going compliance on all state/federal regulatory information. The administrator has developed an audit monitor grid (see attachment 3). The grid reviews all survey citation information over the past year and what information requires QAAC oversight and the staff person responsible. Each month, this grid will be brought to the QAAC meeting and staff will ensure information is covered and compliance is met and maintained. If compliance is not maintained, the committee will develop a plan of correction to resolve the concerns. All issues will be tracked and documented. A new form, The Quality Assessment and Assurance Plan of Correction and Implementation Record (see attachment 1), has been added to the QA process. This tool provides the committee with documentation for problem-solving when there are areas of concern or areas of deficient practice. <b>STAFF PERSON(S) RESPONSIBLE FOR COMPLIANCE:</b> QA Coordinator (ADON).  Addendum: The QAAC utilizes root cause analysis to identify the factors which contribute to any issues of non-compliance. Emergency QAAC meeting are called by the VPN or Administrator when issues of non-compliance are identified so that they can be corrected in short-order. The failure of the QAAC to ensure compliance has been addressed by calling emergency QAAC meetings and timely evaluation of the		

