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

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Southern Enforcement Branch

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185168		09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

(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 000	INITIAL COMMENTS An abbreviated standard survey (KY17080) was initiated on 09/14/11, and a standard health/extended survey was conducted on 09/19/11-09/21/11. The complaint was substantiated with deficient practice identified. Immediate Jeopardy was identified on 09/15/11, and determined to exist on 09/14/11. The facility was notified on 09/15/11. Observation, interview, and record review revealed the facility was allowing Paid Feeding Assistants to feed residents with complicated feeding problems and failed to provide residents with specialized swallowing precautions the supervision and assistance that each resident was assessed by the facility to require. Deficiencies were cited at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F309), 42 CFR 483.35 Dietary Services (F373), and 42 CFR 483.75 Administration (F490) at a scope and severity of "K." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F309). An acceptable Allegation of Compliance was received on 09/21/11, which alleged removal of immediate Jeopardy on 09/21/11. The State Agency determined the Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F309), 483.35 Dietary Services (F373), and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	F282 Services by Qualified Persons/Per Care Plan On 9/16/2011 Residents #7, #9,#10,#11, and #12 were screened by the speech therapist. Any noted new or revised recommendations were made at that time. On 9/16/2011 the dietary manager added all swallowing precautions to residents #7,#9,#10,#11, and #12 tray cards. On 9/16/2011 the ADON ensured swallowing precautions for residents #7, #9, #10, #11, and #12 were with the personal care records. On 9/16/2011 the DON and Administrator audited the personal care plans and tray cards for the residents #7,#9,#10,#11, and #12 to ensure accuracy. On 9/16/2011 the DON, infection control nurse, and the MDS Coordinator educated the nurse aides on the location of the swallowing precautions on the tray cards and in the personal care record books. On 9/16/2011 Administrative Nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mitzy Payne Cook	Administrator	10/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Additional deficiencies were cited as a result of the standard health survey.	F 000	aware of swallowing precautions. On 9/16/2011 the speech therapist screened all residents on swallowing precautions for accuracy. Any noted new or revised recommendations were made at that time. Beginning on 9/16/2011 and ending on 9/30/2011 the speech therapist screened all residents at the facility to determine awareness of swallowing concerns. Any noted new or revised recommendations were made at that time. On 9/16/2011 a master list of the residents on swallowing precaution was developed and was made available to all nursing staff members. The dietary manager is responsible for keeping the master list updated. A Swallowing Precaution Communication Procedure was established on 9/16/2011 and was revised on 9/26/2011, and is presently as follows: The Speech therapist will give a copy of the Swallowing Precautions to the Dietary Manager, the ADON, the	
F 282 SS=K	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide five (5) of twenty (20) sampled residents (Residents #7, #9, #10, #11, and #12) with services in accordance with each resident's written plan of care. The facility assessed Residents #7, #9, #10, #11, and #12 to require specialized swallowing/feeding precautions during meals and indicated this intervention on the residents' plan of care. However, observations on 09/14/11, during the evening meal and on 09/15/11, during the noon meal revealed the facility failed to ensure the swallowing precautions were implemented for each resident in accordance with the resident's written plan of care. The facility's failure to ensure each resident was provided with swallowing precautions as directed by their written plan of care caused, or is likely to cause serious injury, harm, impairment, or death to Residents #7, #9, #10, #11, and #12, and other residents in the facility assessed to have feeding precautions. Immediate Jeopardy and	F 282		

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F 282	Continued From page 2 Substandard Quality of Care (SQC) were determined to exist on 09/14/11. An acceptable Allegation of Compliance (AOC) was received from the facility on 09/21/11, and alleged removal of Immediate Jeopardy on 09/21/11. The State Agency determined the Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities. The findings include: 1. Review of Resident #7's medical record revealed the facility admitted the resident on 11/17/09. Resident #7 had diagnoses including Dysphagia and Alzheimer's Disease. A review of a Speech Therapy Dysphagia Medical Work Up, dated 02/07/11, for Resident #7 revealed the resident experienced oral motor retention, had difficulty in biting, chewing, sucking, or shaping food into a bolus, and had a negative reaction to food texture/consistency. A review of the swallowing Strategies for Resident #7, dated 02/11/11, revealed staff was to ensure the resident alternated bites of solids/sips of liquids at a one to one (1:1) ratio, be checked for "pocketing" of food during/after meals, and be provided decreased distractions with increased time allotted for meals. Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment dated 06/30/11, revealed the facility assessed the resident's cognition to be severely impaired and to require extensive assistance for eating. A review of Resident #7's	F 282	infection control nurse and the DON. The Dietary Manager will ensure that the swallowing precautions are attached to the resident's tray card at each meal. The ADON will put a copy of the swallowing precautions with the resident's personal care record. The Swallowing Precaution Books were created to include a master list of the residents with swallowing precautions, a copy of the swallowing precaution strategies, a copy of the Emergency Care for Choking Poster, and a copy of the signs and symptoms of aspiration. A copy of the swallowing precaution books will be kept in the dining room, at both nurses station, and on the snack carts. The dietary manager is responsible for keeping books up to date. On 9/16/2011 the administrator educated the dietary manager, the speech therapist, the DON, the infection control nurse and the ADON on the Swallowing Precaution Communication Procedure and on the Swallowing	

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F 282	Continued From page 3 comprehensive plan of care, dated 07/30/11, and the resident's Nurse Aide Care Plan, dated 08/21/11, revealed staff was to "see swallowing strategies" related to the provision of assistance to the resident with each meal. An observation on 09/14/11, at 6:35 PM, of the evening meal service in the dining room revealed Resident #7 feeding himself/herself without staff cueing or interaction, the resident was observed taking large bites in repeated succession, without fluid intake, and coughed throughout the meal. A review of Resident #7's tray card revealed staff was to "check for pocketing, down distraction" during the meal. Paid feeding assistant #2 was observed on 09/14/11, at 6:35 PM, to assist residents at the same table that Resident #7 had been seated during the meal. An interview conducted on 09/15/11, at 5:30 PM, with paid feeding assistant #2 revealed if a resident required anything such as "a special spoon or cup" it would be on the tray card that comes out of the kitchen on each resident tray. Paid feeding assistant #2 stated Resident #7 "most times feeds (himself/herself) and don't get anything special because if (he/she) did it would be on the tray card." Paid feeding assistant #2 was unable to explain what the "check for pocketing, down distraction" referenced on Resident #7's tray card meant and stated, "I don't know." 2. Review of Resident #11's medical record revealed the facility admitted the resident on 09/11/09. Resident #11 had diagnoses including Oropharyngeal Dysphagia and Alzheimer's Disease. A review of the Swallowing Precautions	F 282	Precaution Books. On 9/20/2011 a copy of the Emergency Care for Choking Poster was posted in the dining room. On 9/16/2011 the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The form that Speech Therapy uses to inform staff of what swallowing interventions are needed was explained. Any questions that the staff members had regarding swallowing precautions and the form were answered. Also, nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies can be found. They were told that the locations include: the personal care records, the tray cards, and in binders located in the dining room, on the snack cart, and at both nurses stations. Beginning on 9/19/2011 and ending on 10/3/2011 the DON and the infection control nurse reeducated nursing personnel on the choking section of the nurse aide training curriculum. Beginning	

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F 282	Continued From page 4 dated 09/30/10, revealed staff was to ensure the resident took small bites/sips, to alternate bites of solids to sips of liquid at a two to one (2:1) ratio, to allow two swallows per bite of food/sip of liquid, and to ensure straws were not utilized. According to Resident #11's Quarterly Minimum Data Set (MDS) assessment dated 08/09/11, the facility assessed the resident's cognition as severely impaired and the resident as totally dependent on staff for eating. A review of Resident #11's comprehensive care plan dated 08/30/11, revealed the resident was to be fed per staff and straws were not to be utilized. A review of the resident's Nurse Aide Care plan dated 08/31/11, revealed an entry under dietary listing "see swallow precaution" and "no straws." An observation of Resident #11 on 09/14/11, at 6:36 PM, during the evening meal service revealed paid feeding assistant #1 provided Resident #11 with large bites in rapid succession of each other without offering the resident fluids. During approximately 14 minutes of observation of the meal on 09/14/11, paid feeding assistant #1 provided no verbal communication or cueing to Resident #11. A review of Resident #11's tray card revealed feeding instructions that included "at least two swallows per bite of food and sip of liquid." 3. Review of Resident #12's medical record revealed the facility admitted the resident on 02/27/03. Resident #12 had diagnoses including Oropharyngeal Dysphagia, Feeding Problem, Feeding Difficulty and Mismanagement, and Mental Disorder.	F 282	on 9/20/2011 and ending on 10/3/2011 the DON and the infection control nurse reeducated nursing personnel on the signs and symptoms of aspiration. Nursing Assistants were trained on what to do when a resident shows sign and symptoms of aspiration. Beginning on 9/20/2011 and ending on 10/3/2011 the DON reeducated nurses on what to do when a nurse aide reports signs and symptoms of aspiration. On 9/26/2011 the DON and the speech therapist educated nursing personnel and the dietary manager on the revised swallowing precaution sheets and that the swallowing precaution sheet would be attached to the tray card going forward. Employees on leave of absense will be educated before they are allowed to work. In-services on swallowing precautions, choking and signs and symptoms of aspiration will be repeated monthly for 3 months then every six months for one year then no less than annually. All new hires will be educated during orientation.	

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F 282	Continued From page 5 According to the Quarterly Minimum Data Set (MDS) assessment dated 08/17/11, for Resident #12 the facility assessed the resident's cognition as severely impaired and the resident required supervision for eating. A review of Resident #12's swallowing strategies dated 08/18/11, revealed staff was to ensure the resident maintained a slow intake, took small bites, alternated solids and liquids at a two to one (2:1) ratio, cue the resident to chew food before swallowing, and assess the resident for "pocketing" of food. A review of Resident #12's Comprehensive Care Plan and Nurse Aide Care Plan dated 08/31/11, revealed staff was to "see swallowing strategies" when assisting the resident with a meal. An observation of Resident #12 on 09/15/11, at 6:30 PM, during the evening meal, revealed Resident #12 eating a whole hamburger on a bun very rapidly and was observed to continually bite, chew, and swallow the hamburger until it was completely consumed; eating a bowl of coleslaw and a bowl of dessert by holding the bowls under his/her chin and continually eating spoonful after spoonful until the food was gone; and completely filling his/her oral cavity with a whole tomato slice, which the resident then swallowed with very minimal chewing observed. A review of Resident #12's tray card revealed the only instruction listed on the card was "unsweet tea." An interview was conducted on 09/15/11, at 7:40 PM, with LPN #5 who was present in the dining room while Resident #12 ate dinner. LPN #5 stated although the resident's care plan directed staff to cue the resident to slow down and eat slowly, she had not "noticed" staff was not	F 282	Beginning 9/17/2011 at 5:00pm the licensed nurse assigned to the wing and the licensed nurse assigned to the dining room will monitor each resident on swallowing precautions to ensure that the nursing assistants are aware of the swallowing precautions, the swallowing precautions are being followed, and the swallowing precautions are attached to the tray card. This QA will be done at every meal for eight weeks and then one meal for four weeks. Results of the QA will be documented on the Swallowing Precaution QA form kept in folders in the dining room and on each wing. Nurses will be educated on procedure before they are allowed to work. Weekly the DON will review the swallowing precaution sheets that she has received from the speech therapist. When she sees that the correct swallowing precautions are attached to the tray card and that the swallowing strategies are in the	

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F 282	Continued From page 6 providing the interventions as directed by the resident's plan of care. 4. Review of Resident #9's medical record revealed the facility admitted the resident on 10/20/08. Resident #9 had diagnoses including Dysphagia and Alzheimer's Disease. A review of Swallowing Strategies developed on 04/06/11, for Resident #9 revealed staff was to provide the resident with small, one-half teaspoon bites, to alternate bites of solids/sips of liquid at a ratio of one to one (1:1), and to feed the resident at a slow rate to ensure the resident swallowed before another bite was offered. According to Resident #9's Quarterly Minimum Data Set (MDS) assessment dated 06/30/11, the facility assessed the resident's cognition to be severely impaired and the resident was assessed to require extensive assistance for eating. A review of Resident #9's comprehensive care plan, dated 04/04/11, and Nurse Aide Care plan, dated 08/31/11, revealed staff was to "see swallowing strategies" when providing the resident with assistance during meals. An observation on 09/14/11, at 6:40 PM, during the evening meal in the dining room revealed Resident #9 being fed by paid feeding assistant #4. Paid feeding assistant #4 was observed to give the resident large, full bites of food with a regular spoon and to provide several bites in succession before fluids were offered. Based on observation, the paid feeding assistant failed to provide verbal or tactile cues to Resident #9 during the meal. A review of Resident #9's tray card listed feeding instructions as "fed per staff, no straws."	F 282	Personal Care Record books she will sign her copy of the Swallowing Strategies. She will keep a copy of this sheet in a binder in her office for 30 days. Results will be reported to the QA subcommittee monthly for at least six months. The Administrator will audit the Swallowing Precaution Books at least weekly to ensure that they are up to date. The DON and Administrator will review meal audits weekly to ensure that they are being completed. The DON and Administrator will provide reports to the facility QA committee no less than quarterly for one year. The facility will establish a QA subcommittee that will meet monthly for six months then no less than quarterly for one year that includes the following: the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Dietary Director, the facility Corporate Consultant, and at least one staff nurse and two nursing assistants to	

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F 282	Continued From page 7 An interview was conducted with paid feeding assistant #4 on 09/15/11, at 3:00 PM. The paid feeding assistant stated if a resident required special precautions during meals, it would be listed on the resident's tray card. The paid feeding assistant stated Resident #9 required "nothing special" during meals. 5. Review of Resident #10's medical record revealed the facility admitted the resident on 11/16/01. Resident #10 had diagnoses including Dysphagia and Alzheimer's Disease. A review of Resident #10's Swallowing Strategies, dated 02/21/11, revealed staff was required to ensure the resident's head/neck was in an upright position when sitting, that he/she took one-half teaspoon bites, to alternate bites of solids/sips of liquids at a one to one (1:1) ratio, to ensure the resident ate at a slow rate, to allow the resident to swallow before presenting another bite/sip, and to wait for the resident to open his/her mouth for a bite. According to Resident #10's Quarterly Minimum Data Set (MDS) assessment dated 09/02/11, the facility assessed the resident's cognition to be severely impaired and noted the resident required extensive assistance for eating. A review of Resident #10's comprehensive care plan, dated 09/13/11, revealed Resident #10 was "a total feed" and the Nurse Aide Care plan, dated 08/31/11, revealed an entry under dietary to "see swallowing precautions/strategies." An interview with Certified Nursing Assistant (CNA) #12 on 09/15/11, at 6:40 PM, revealed Resident #10 required no special feeding	F 282	review the facility plan of correction and the implementation of the same to ensure that the deficient practice is resolved and compliance is sustained.	10/14/11

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F 282	Continued From page 8 precautions and none had been provided for the resident during the evening meal on 09/15/11. CNA #12 stated if the resident required any specialized precautions or devices for meals, it would be detailed on the resident's tray card for staff awareness. An interview with the Dietary Director on 09/16/11, at 9:30 AM, revealed she was responsible for updating the dietary tray cards. The Dietary Director stated she thought all the swallowing precautions were listed on the tray cards for each resident and was unaware that the cards were not accurate. An interview with the Administrator and Director of Nursing (DON) on 09/15/11, at 8:51 PM, revealed the facility utilized dietary tray cards to ensure swallowing interventions were implemented as directed by each resident's individualized comprehensive care plan. The Administrator and DON stated facility staff had been informed in a training provided by the facility that all equipment/instructions the resident had been assessed to require would be listed on the tray card, and should be provided to each resident accordingly. --A review of the Allegation of Compliance revealed the following: On 09/16/11, the Speech Therapist screened all residents on swallowing precautions. Any new or revised recommendations were made. On 09/16/11, the Director of Nursing (DON) and Administrator audited the personal care plans and tray cards for the residents on swallowing	F 282		

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F 282	Continued From page 9 precautions to ensure accuracy. A Swallowing Precaution Communication Procedure was established. The Speech Therapist will give a copy of each resident's swallowing precautions to the Dietary Manager, the Assistant Director of Nursing (ADON), the Infection Control Nurse, and the Director of Nursing (DON). The DON will monitor the communication procedure. The DON will also ensure the swallowing precautions have been added by the Dietary Manager to the tray cards. The DON will ensure the ADON has put a copy of swallowing precaution strategies in each resident's personal care record books. Each week the DON will review the swallowing precaution sheets that she received from the Speech Therapist. After the DON sees the swallowing precautions on the tray card are correct and the swallowing strategies are in the personal care record she will sign her copy of the swallowing strategies. She will keep a copy of this sheet in a binder in her office. Swallowing precaution books were created to include a master list of residents with swallowing precautions, a copy of the book, a copy of the emergency care for choking poster, and a copy of the signs and symptoms of aspirations. The Dietary Manager will be responsible for keeping the book up to date. The Administrator will audit the swallowing precaution book at least weekly to ensure that they are up to date.	F 282		

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F 282	Continued From page 10 On 09/16/11, the Administrator educated the Dietary Manager, Speech Therapist, DON, Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and on the swallowing precaution book. On 09/20/11, a copy of the emergency care for choking poster was posted in the dining room. On 09/16/11, the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The Speech Therapist form used to inform staff of what swallowing interventions each resident required was explained. On 09/16/11, nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies could be found. They were told the locations included: the personal care records, the tray cards, and in binders located in the dining room on the snack cart, and at both nurses' stations. Beginning 09/19/11, all nursing personnel will be reeducated on the choking section of the nurse aide training curriculum. Beginning 09/20/11, all nursing personnel were reeducated on the signs and symptoms of aspiration. Nursing assistants were trained on what to do when a resident showed signs and symptoms of aspiration. No nursing personnel will work until trained. Beginning 09/20/11, nurses were reeducated on what to do when a nurse aide reports signs and	F 282		

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	185168		C 09/21/2011

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MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

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F 282	Continued From page 11 symptoms of aspiration. No nursing personnel will work until trained. Upon hire all employees will be educated on the facility swallowing procedures and the signs and symptoms of aspiration. On 09/16/11, administrative nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were aware of swallowing precautions. Beginning 09/17/11, the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor each resident on swallowing precautions to ensure the nursing assistants were aware of the swallowing precautions, the swallowing precautions were being followed, and the swallowing precautions were on the tray card. This quality assurance is to be done at every meal. During the lunch meal the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor all residents for signs and symptoms of aspiration to ensure that nursing assistants were aware of the signs and symptoms of swallowing issues. All nurses on duty on 09/20/11, were educated on the monitoring procedure, and no nurse will be allowed to work before being educated. The Medical Director was informed of the immediate jeopardy. Weekly the Administrator will observe meal service and will audit the plan of correction. The Administrator will report the audit to the quality assurance committee quarterly.	F 282		

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F 282	Continued From page 12 --The surveyors validated the corrective actions taken by the facility as follows: Observation of the noon meal on 09/21/11, revealed RN #4 in the dining room supervising CNAs feeding residents. Interview at this same time revealed she was responsible for observing residents in the dining room to assure they have received the correct diet, that the diet and swallowing precautions were printed on the tray card, to assure the nursing aides were following swallowing precautions and observing for signs and symptoms of aspiration and choking. Interview further revealed there was a poster on the wall with interventions for choking, and there was a book with each resident on swallowing precautions, what the precautions were, what to do in the event of choking, and signs and symptoms of aspiration. RN #4 further stated she was in-serviced on 09/19/11, regarding the need to supervise nursing aides while feeding residents, what swallowing precautions were, the swallowing precaution book, that all swallowing precautions were required to be on the tray card, choking, and aspiration. Further observation of the noon meal on 09/21/11, revealed Residents #7, #11, and #10, in the dining room at a table assisted by a nursing assistant. Review of their tray cards revealed their swallowing precautions were listed on the card. Observation of the dining room on 09/21/11, revealed an emergency care for choking sign posted on the wall. Observation on 09/21/11, revealed a swallowing precaution book in the dining room, at each	F 282		

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F 282	Continued From page 13 nurses' station, and on each snack cart. Interview with the Speech Therapist (ST) on 09/21/11, at 3:30 PM, revealed she had conducted a current screening for all residents on swallowing precautions and had made any revisions or new recommendations for each resident. The ST went on to say she was responsible for providing a copy of the current swallowing precautions for each resident to the Dietary Manager (DM), ADON, Infection Control Nurse, and the DON. Interview further revealed she had been educated by the Administrator related to the need to provide a current copy of each resident's swallowing precautions to the DM, ADON, Infection Control Nurse, and the DON; and the swallowing precaution book. Interview with the Administrator on 09/21/11, at 3:45 PM, revealed she is responsible for auditing the swallowing precaution book weekly to ensure it is up to date. She further stated she had educated the Dietary Manager, Speech Therapist, DON, Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and the swallowing precaution book. Further interview revealed she would be observing meal service weekly and would perform an audit during that time to ensure the plan of correction was being followed. The Administrator stated she would report this audit at the quality assurance meeting quarterly. Interview with the DON on 09/21/11, at 3:15 PM, revealed she along with the Administrator had audited all personal care plans and tray cards and found no problems. Interview further revealed she is responsible for assuring the Dietary	F 282		

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F 282	Continued From page 14 Manager puts all swallowing precautions on each resident's tray card. Further interview revealed she had assured the ADON had put a copy of the swallowing precautions strategies in each resident's personal care book. The DON further stated she was in-serviced on 09/16/11, related to the swallowing precaution communication procedure and the swallowing precaution book. Interview further revealed each week the DON would verify the swallowing precautions were on the tray cards and in each resident's personal care book. She further stated after verifying the swallowing precautions were on the tray cards and in the personal care books, she would then sign her copy of the swallowing strategy for each resident and it would be kept in a binder in her office. Interview further revealed the DON had been in-serviced by the Administrator regarding the swallowing precaution communication procedure and the swallowing precaution book. Interview on 09/21/11, at 2:03 PM, with the Dietary Manager revealed it was her responsibility to ensure all swallowing strategies were on each resident's tray card. Further interview revealed the Dietary Manager is responsible for ensuring the swallowing precaution books are current and up to date for each resident on special feeding precautions. Interview further revealed she had been educated by the Administrator regarding the swallowing precaution communication procedure and the swallowing precaution book.. Interview on 09/21/11, at 3:38 PM, with CNA #9, at 3:42 PM, with Nurse Aide #1, at 4:00 PM, with CNA #11, and at 4:10 PM, with CNA #4 revealed they had been in-serviced on swallowing precautions, where each resident's swallowing	F 282		

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F 282	Continued From page 15 precautions were located, what to do when a resident chokes, and signs and symptoms of aspiration. Interview further revealed a nurse has to be in the dining room before they can begin feeding the residents, and they are required to look at each resident's tray card and ensure any precautions are followed. Interview with LPN #5 on 09/21/11, at 3:47 PM, and RN #2 at 4:15 PM, revealed they had been in-serviced on resident swallowing precautions, and that all precautions have to be on the tray card and in the swallowing strategy book. They further stated they had also been in-serviced on signs and symptoms of aspiration, and what to do when a resident chokes. Interview further revealed they were instructed when they were in the dining room or on the floor with residents they were to monitor to ensure nurse aides were following swallowing precautions, and observe for aspiration/choking. Interview on 09/21/11, at 2:00 PM, with the Medical Director revealed she had been informed of the immediate jeopardy identified at the facility. Review of the personal care records audit revealed the DON and Administrator had audited all personal care plans and tray cards for each resident on swallowing precautions on 09/16/11, and found no discrepancies. A review of the new swallowing precaution communication procedure revealed it was implemented on 09/16/11. A review of the facility's training records revealed evidence employees of the facility, except for	F 282		

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F 282	Continued From page 16 those on vacation or on medical leave, had received training on swallowing precautions and how they are effective on 09/16/11. Any employee who did not attend training was informed they are not allowed to work until trained. Further review revealed nursing assistants had received training on 09/16/11, on where the swallowing precautions master list and the swallowing precaution strategies could be found. Review further revealed on 09/19/11, nursing personnel were educated on the choking section of the nurse aide training curriculum. Facility training records further revealed on 09/20/11, nursing personnel were educated on signs and symptoms of aspiration. A review of "Swallowing Precaution Education," to be given to employees upon hire, revealed the facility would ensure any new hires would be educated on each resident's swallowing precautions, signs and symptoms of aspiration, and emergency preparedness for choking. A review of facility tray cards for the nine residents, assessed by the facility to require swallowing strategies, revealed each card had the resident's required strategies on them. A review of the facility's swallowing precaution quality assurance log revealed from 09/16/11-09/21/11, staff had observed to ensure each resident with a swallowing strategy had the strategy on their tray card, that the nurse aide was adhering to the swallowing precautions, and if education had to occur. Based on the above findings, the State Agency determined Immediate Jeopardy was removed on	F 282		

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F 282	Continued From page 17 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of systemic changes and quality assurance actions.	F 282	F309 Provide Care and Services for Highest Well Being	
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, record review, and review of the Fundamental Procedures instruction text book, it was determined the facility failed to ensure that nine (9) of twenty (20) sampled residents received the necessary care and services to attain or maintain their highest practicable physical well being. The facility failed to ensure the system in place to identify residents requiring specific care with feeding needs and supervision during meal service was implemented, and failed to ensure that staff providing feeding services to residents with complicated feeding problems had received appropriate training to ensure each resident's safety during meals. Five (5) sampled residents (Residents #7, #9, #10, #11, and #12) required specialized swallowing/feeding precautions to be implemented during meals. However, observations and interviews on 09/14/11 and 09/15/11, revealed the residents were not	F 309	On 9/16/2011 Residents #7,#9,#10,#11, and #12 were screened by the speech therapist. Any noted new or revised recommendations were made at that time. On 9/16/2011 the dietary manager added all swallowing precautions to residents #7,#9,#10,#11, and #12 tray cards. On 9/16/2011 the ADON ensured swallowing precautions for residents #7, #9, #10, #11, and #12 were with the personal care records. On 9/16/2011 the DON and Administrator audited the personal care plans and tray cards for the residents #7,#9,#10,#11, and #12 to ensure accuracy. On 9/16/2011 the DON, infection control nurse, and the MDS Coordinator educated the nurse aides on the location of the swallowing precautions on the tray cards and in the personal care record books. On 9/16/2011 Administrative Nurses observed nurse aides feeding residents on swallowing precautions	

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F 309	Continued From page 18 provided the required supervision/assistance to ensure their safety. In addition, facility staff failed to implement the facility's bowel protocol, for seven (7) sampled residents (Residents #3, #6, #7, #9, #11, #15, and #17). Facility staff documented no bowel movement for at least three (3) days for each resident; however, no interventions were put in place as per the bowel protocol. The facility's failure to ensure residents received specialized feeding/swallowing precautions and supervision/assistance the facility assessed them to require has caused, or is likely to cause serious injury, harm, impairment, or death to Residents #7, #9, #10, #11, and #12, and other residents in the facility assessed to have feeding precautions. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 09/14/11. An acceptable Allegation of Compliance (AOC) was received from the facility on 09/21/11, and alleged removal of Immediate Jeopardy on 09/21/11. The State Agency determined the Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities. The findings include: Upon requesting the facility's feeding/swallowing precautions policy and procedures, the facility stated they did not have a specific policy, but utilized the Fundamental Procedures instruction text book as a guide. A review of the "Feeding"	F 309	to ensure that nursing assistants were aware of swallowing precautions. On 9/16/2011 the speech therapist screened all residents on swallowing precaution for accuracy. Any noted new or revised recommendations were made at that time. Beginning on 9/16/2011 and ending on 9/30/2011 the speech therapist screened all resident at the facility to determine appropriateness of swallowing concerns. Any noted new or revised recommendations were made at that time. On 9/16/2011 a master list of the residents on swallowing precaution was developed and was made available to all nursing staff members. The dietary manager is responsible for keeping the master list updated. On 10/10/2011 DON audited personal care records on all residents to confirm resident care planned for no straws. On 10/10/2011 Water Pitchers for residents on No Straw list were audited by the DON to ensure compliance.	

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F 309	Continued From page 19 and "Impaired Swallowing and Aspiration Precautions" sections in the textbook revealed if a resident had swallowing difficulties a consultation with Speech Therapy should be obtained. According to the text, choking and aspiration of food could occur if the patient was fed too quickly or was given excessively large mouthfuls of food. Additionally, the text indicated caregivers should develop a management plan that included common swallowing strategies, nutritional status, and supervision. The text went on to instruct caregivers to monitor residents for signs and symptoms of swallowing problems and aspiration. 1. Review of Resident #7's medical record revealed the facility admitted the resident on 11/17/09. Resident #7 had diagnoses including Dysphagia and Alzheimer's Disease. According to Resident #7's Quarterly Minimum Data Set (MDS) assessment dated 06/30/11, the facility assessed the resident's cognition to be severely impaired and noted the resident required extensive assistance for eating. Additionally, the facility obtained a chest x-ray for Resident #7 on 08/21/11, due to Resident #7 experiencing a cough and congestion, which revealed "small lower lung field infiltrates." Review of the comprehensive plan of care dated 07/30/11, and the resident's Nurse Aide Care Plan dated 08/21/11, revealed staff was instructed to "see swallowing strategies." A review of a Speech Therapy Dysphagia Medical Work Up dated 02/07/11, for Resident #7 revealed the resident had been referred for evaluation due to having experienced a decrease in oral intake with weight loss. The therapist's	F 309	A Swallowing Precaution Communication Procedure was established on 9/16/2011 and was revised on 9/26/2011, and is presently as follows: The Speech therapist will give a copy of the Swallowing Precautions to the Dietary Manager, the ADON, the infection control nurse and the DON. The Dietary Manager will ensure that the swallowing precautions are attached to the resident's tray card at each meal. The ADON will put a copy of the swallowing precautions with the resident's personal care record. Swallowing Precaution Books were created to include a master list of the residents with swallowing precautions, a copy of the swallowing precaution strategies, a copy of the Emergency Care for Choking Poster, and a copy of the signs and symptoms of aspiration. The Swallowing Precaution Books are kept in the dining room, at both nurses stations, and on the snack carts. The dietary manager is	

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F 309	Continued From page 20 report revealed Resident #7 experienced oral motor retention, had difficulty in biting, chewing, sucking, or shaping food into a bolus, and had a negative reaction to food texture/consistency. A review of the Speech Therapy Discharge Summary for Resident #7 dated 02/18/11, revealed the resident would be placed on a functional maintenance program for eating/swallowing. The maintenance program required staff to provide strategies and compensatory techniques to increase safety and reduce Resident #7's risk for injury. A review of the Swallowing Strategies for Resident #7 dated 02/11/11, revealed staff was to ensure the resident alternated bites of solids/sips of liquids at a one to one (1:1) ratio, be checked for "pocketing" of food during/after meals, and be provided decreased distractions with increased time allotted for meals. The Discharge Summary further revealed staff and Resident #7 were educated regarding the swallowing strategies and feeding techniques to be utilized during meals. Observations on 09/14/11, at 6:35 PM, of the evening meal service in the dining room revealed Resident #7 was seated at a table with five peers, feeding him/herself without staff cueing or interaction. Although two paid feeding assistants were feeding/supervising residents at the table, Resident #7 was observed taking large bites in repeated succession, without fluid intake, and coughed throughout the meal. A review of Resident #7's tray card revealed feeding instructions included "check for pocketing, down distraction." An interview conducted on 09/15/11, at 5:30 PM, with paid feeding assistant #2 who was assisting	F 309	responsible for keeping books up to date. On 9/16/2011 the administrator educated the dietary manager, the speech therapist, the DON, the infection control nurse and the ADON on the Swallowing Precaution Communication Procedure and on the Swallowing Precaution Books. On 9/20/2011 a copy of the Emergency Care for Choking Poster was posted in the dining room. On 9/16/2011 the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The form that Speech Therapy uses to inform staff of what swallowing interventions are needed was explained. Any questions that the staff members had regarding swallowing precautions and the form were answered. On 9/16/2011 nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies can be found.	

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F 309	Continued From page 21 at Resident #7's table on 09/14/11, revealed he was unaware that Resident #7 required swallowing strategies to be implemented for safety and was unaware of what a swallowing strategy was, answering, "I don't think I know what that is," when asked. Paid feeding assistant #2 stated he had completed a paid feeding assistants class at the facility in July 2011 but had never received training in feeding residents with swallowing precautions or had instruction from a Speech Therapist regarding proper feeding techniques. Paid feeding assistant #2 explained that if a resident required anything such as "a special spoon or cup" it would be on the tray card that comes out of the kitchen on each resident tray. Paid feeding assistant #2 stated Resident #7 "most times feeds (himself/herself) and don't get anything special because if (he/she) did it would be on the tray card." Paid feeding assistant #2 was unable to explain the "check for pocketing, down distraction" referenced on Resident #7's tray card, stating, "I don't know." 2. Review of Resident #11's medical record revealed the facility admitted the resident on 09/11/09. Resident #11 had diagnoses including Oropharyngeal Dysphagia, Organism Pneumonia, and Alzheimer's Disease. According to Resident #11's Quarterly Minimum Data Set (MDS) assessment dated 08/09/11, the facility assessed the resident's cognition as severely impaired and noted the resident was totally dependent on staff for eating. A review of Resident #11's comprehensive care plan dated 08/30/11, revealed the resident was to be fed per staff and utilize no straws, and review of the resident's Nurse Aide Care plan dated 08/31/11, revealed an entry under dietary listing, "see	F 309	They were told that the locations include: the personal care records, the tray cards, and in binders located in the dining room, on the snack cart, and at both nurses stations. Beginning on 9/19/2011 and ending on 10/3/2011 the DON, the infections control nurse, and the MDS nurse reeducated all nursing personnel on the choking section of the nurse aide training curriculum. Beginning on 9/20/2011 and ending on 10/3/2011 the DON, the infection control nurse, and the MDS coordinator reeducated all nursing personnel on the signs and symptoms of aspiration. Also, Nursing Assistants were trained on what to do when a resident shows sign and symptoms of aspiration. Beginning on 9/20/2011 and ending on 10/3/2011 the DON reeducated the nurses on what to do when a nurse aide reports signs and symptoms of aspiration. On 9/26/2011 the DON and speech therapist educated all nursing personnel and the dietary manager on the revised swallowing precaution sheets and explained that	

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F 309	Continued From page 22 swallow precaution" and "no straws." A review of the Speech Therapy Discharge Summary for Resident #11 dated 10/16/10, revealed the resident had received therapy services from 08/13/10 until 10/16/10. The Discharge Summary revealed Resident #11 had received Therapy Services related to oropharyngeal dysphagia and would be placed on a functional maintenance program with staff utilizing compensatory swallowing strategies. A review of the Swallowing Precautions dated 09/30/10, and the Speech Therapy Discharge Summary dated 10/16/10, revealed staff was to ensure Resident #11 was supervised during all oral intake by a swallowing therapist or trained staff. In addition, staff was directed to ensure the resident took small bites/sips, to alternate bites of solids to sips of liquid at a two to one (2:1) ratio, to allow two swallows per bite of food/sip of liquid, and to ensure straws were not utilized. An observation of Resident #11 on 09/14/11, at 6:36 PM, during the evening meal service revealed the resident was seated at a table being fed by paid feeding assistant #1. The paid feeding assistant was observed to provide Resident #11 with large bites in rapid succession of each other without offering the resident fluids. During approximately 14 minutes of observation, paid feeding assistant #1 provided no verbal communication or cueing to Resident #11. The resident was observed at a minimum of four times to cough loudly and forcibly, and audible wheezes were heard. The paid feeding assistant appeared to be concerned regarding Resident #11's continued coughing and wheezing and stated to paid feeding assistant #2 who was in	F 309	the swallowing precaution sheet would be attached to the tray card going forward. Beginning on 10/10/2011 the DON and the infection control nurse educated nursing personnel on labeling water pitchers with no straws for residents care planned for no straws. Employees will not be allowed to work until trained on labeling procedure. Employees on leave of absense will be educated before they are allowed to work. Weekly the DON will review the swallowing precaution sheets that she has received from the speech therapist. When she sees that the correct swallowing precautions are attached to the tray card and that the swallowing strategies are in the Personal Care Record books she will sign her copy of the Swallowing Strategies. She will keep a copy of this sheet in a binder in her office for 30 days. She will report the results of her audit to the QA subcommittee monthly for at least six months.	

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F 309	Continued From page 23 close proximity, "What do I do, (he/she) is coughing." Feeding assistant #2 replied, "Give (him/her) a minute it will be all right," but failed to alert the nurse or provide Resident #11 with further assistance. A review of Resident #11's tray card revealed listed feeding instructions that included "at least two swallows per bite of food and sip of liquid." 3. Review of Resident #12's medical record revealed the facility admitted the resident on 02/27/03. Resident #12 had diagnoses including Oropharyngeal Dysphagia, Feeding Problem, Feeding Difficulty and Mismanagement, and Mental Disorder. According to the facility's Quarterly Minimum Data Set (MDS) assessment dated 08/17/11, for Resident #12, the facility assessed the resident's cognition as severely impaired and the resident required supervision for eating. A review of Resident #12's comprehensive care plan and Nurse Aide Care plans dated 08/31/11, revealed an entry under dietary to "see swallowing strategies." A review of the Speech Therapy Discharge Summary for Resident #12 dated 08/04/11, revealed the resident had received a dysphagia evaluation, and was being placed on a restorative program to increase safety and decrease the resident's risk for injury. The Discharge Summary and a Restorative Swallowing Program, dated 08/18/11, for Resident #12 indicated compensatory swallowing strategies were to be utilized for the resident that included to ensure the resident's rate of intake was slow, the resident took small bites, to alternate solids and liquids at a two to one (2:1) ratio, to cue the resident to chew food before swallowing, and to assess the	F 309	The Administrator will audit the Swallowing Precaution Books at least weekly to ensure that they are up to date. Beginning 9/17/2011 at 5:00pm the licensed nurse assigned to the wing and the licensed nurse assigned to the dining room will monitor each resident on swallowing precautions to ensure that the nursing assistants are aware of the swallowing precautions, the swallowing precautions are being followed, and the swallowing precautions are attached to the tray card. This QA will be done at every meal for eight weeks and then one meal for four weeks. Nurses were educated on the procedure before they were allowed to work. Beginning on 10/10/2011 for eight weeks on Monday, Wednesday, and Friday the treatment nurse will audit water pitchers to ensure residents care planned for no straws do not have a straw in the water pitcher. After eight weeks the treatment	

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F 309	Continued From page 24 resident for "pocketing" of food. The summary further indicated Resident #12 and staff had been trained regarding the swallowing strategies. An observation of Resident #12 on 09/15/11, at 6:30 PM, during the evening meal, revealed the resident was seated at a table with three peers and was eating independently with no staff supervision present at the table. Resident #12 was observed eating very rapidly, consuming a whole hamburger on a bun in one act by continually biting, chewing, and swallowing the hamburger until it was completely consumed; eating a bowl of coleslaw and a bowl of dessert by holding the bowls under his/her chin and continually eating spoonful after spoonful until the food was gone; and completely filling his/her oral cavity with a whole tomato slice, which the resident then swallowed with very minimal chewing observed. A review of Resident #12's tray card revealed the only instruction listed on the card was "unsweet tea." Licensed Practical Nurse (LPN) #5 was observed to be in the Dining Room on 09/15/11. An interview conducted on 09/15/11, at 7:40 PM, with LPN #5 revealed she was aware of how fast Resident #12 eats and stated, "I've told him ain't nobody going to take it." However, LPN #5 stated she had not realized that Resident #12 was not being provided with the required supervision during the meal. 4. Review of Resident #9's medical record revealed the facility admitted the resident on 10/20/08. Resident #9 had diagnoses including Dysphagia and Alzheimer's Disease. According to Resident #9's Quarterly Minimum Data Set	F 309	nurse will audit water pitchers weekly to ensure residents care planned for no straws do not have a straw in the water pitcher. The DON and Administrator will review meal audits weekly to ensure that they are being completed. The DON and Administrator will provide reports to the facility QA committee no less than quarterly for one year. The facility will establish a QA subcommittee that will meet monthly for six months then no less than quarterly for one year that includes the following: the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Dietary Manager, the facility Corporate Consultant, and at least one staff nurse and two nursing assistants to review the facility plan of correction and the implementation of the same to ensure that the deficient practice is resolved and compliance is sustained. Beginning on 9/22/2011 and ending on 9/23/2011 Residents #6, #7, #9,	

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F 309	Continued From page 25 (MDS) assessment dated 06/30/11, the facility assessed the resident to be severely cognitively impaired and require extensive assistance for eating. A review of Resident #9's comprehensive care plan dated 04/04/11, revealed interventions of "total feed" and "see swallowing strategies;" the Nurse Aide Care plan dated 08/31/11, revealed an entry under dietary to "see swallowing strategies." A review of the Speech Therapy Plan of Care dated 04/05/11, revealed a dysphagia evaluation for Resident #9 indicated the resident had severe dysphagia with a high risk of aspiration. The evaluation further revealed the resident required maximum verbal and tactile cues to swallow solids and liquids. A review of Swallowing Strategies, dated 04/06/11, for Resident #9 revealed staff was to provide the resident with small, one-half teaspoon bites, to alternate bites of solids/sips of liquid at a ratio of one to one (1:1), to feed the resident at a slow rate to ensure the resident swallowed before another bite was offered, and based on the assessment the resident was not to utilize straws. An observation on 09/14/11, at 6:40 PM, in the dining room during the evening meal revealed Resident #9 was being fed by paid feeding assistant #4. Paid feeding assistant #4 was observed to give the resident large full bites with a regular spoon, and to provide several bites in succession before fluids were offered. The paid feeding assistant was observed to provide no verbal or tactile cues to Resident #9 during the observation. A review of Resident #9's tray card listed feeding instructions as "fed per staff, no straws."	F 309	#11, #15, and #17 were reassessed by the Bowel Management Nurse. After re-assessment Care plans and nursing assistant care plans were updated as indicated. Physician orders were requested as indicated. Resident #3 was discharged from the facility on 9/21/2011. Beginning on 9/22/2011 and ending on 9/30/2011 all residents were reassessed by the Bowel Management Nurse. After re-assessment Care plans and nursing assistant care plans were updated as indicated. Physician orders were requested as indicated. On 9/22/2011 the Bowel Management Protocol was reviewed by the director of nursing and the administrator. Changes were made to include the 7pm-7am nurses printing out a No BM report from care tracker at approximately 6:00am and placing it in a binder at the nurses' station. 7am-7pm will be responsible for assessing residents on the No BM list. The nurses will put	

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F 309	Continued From page 26 Observation of Resident #9's room on 09/14/11, at 7:45 PM, revealed the resident had a full water pitcher containing a straw on his/her bedside table. An interview was conducted with paid feeding assistant #4 on 09/15/11, at 3:00 PM. The paid feeding assistant stated she had not been trained to feed residents with specialized feeding/swallowing precautions and was not aware of any resident in the facility who required special precautions when eating. The paid feeding assistant went on to state if a resident required special precautions during meals, it would be listed on the resident's tray card. The paid feeding assistant stated Resident #9 required "nothing special" during meals. 5. Review of Resident #10's medical record revealed the facility admitted the resident on 11/16/01. Resident #10 had diagnoses including Dysphagia and Alzheimer's disease. According to Resident #10's Quarterly Minimum Data Set (MDS) assessment dated 09/02/11, the facility assessed the resident to be severely cognitively impaired and require extensive assistance for eating. A review of Resident #10's comprehensive care plan dated 09/13/11, revealed the resident was to be a "total feed" and the Nurse Aide Care plan dated 08/31/11, revealed an entry under dietary to "see swallowing precautions/strategies." Review of the Speech Therapy Discharge Summary for Resident #10 dated 03/15/11, revealed the resident had been evaluated for feeding difficulties and holding solids in his/her	F 309	interventions in place to prevent constipation. The nurses will document interventions in the nurses notes. On 9/26/2011 DON educated bowel management nurse and ADON on the Bowel Management Protocol. On 9/26/2011 DON educated all nursing staff members on the revised protocol and proper documentation of bowel movements. Beginning 9/26/2011 Bowel Management Nurse, ADON in her absence, will check the BM binders on Monday, Wednesday, and Friday for eight weeks and then weekly thereafter. The bowel management nurse will ensure that nurses have printed the BM report off of care tracker each day. She will ensure that any residents who have not had a bowel movement within 48 hours have been assessed by the nurse. The bowel management nurse will look to see that interventions have been put in the BM book and that the assessment and interventions are	

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F 309	Continued From page 27 mouth. The summary revealed Resident #10 would be placed on a functional maintenance plan and staff was to utilize strategies to increase safety and reduce the risk of injury. According to the discharge summary and a review of Swallowing Strategies, dated 02/21/11, for Resident #10, staff was to ensure the resident sat with head/neck upright, that he/she took one-half teaspoon bites, and to alternate bites of solids/sips of liquids at a one to one (1:1) ratio, eat at a slow rate and allow resident to swallow before presenting another bite/sip, and wait for the resident to open mouth for a bite. The Speech Therapy Discharge Summary indicated staff had been trained on the swallowing strategies to be utilized by Resident #10. An interview with Certified Nursing Assistant (CNA) #12 on 09/15/11, at 6:40 PM, revealed she had fed Resident #10 at around 4:30 PM. CNA #12 stated Resident #10 took a long time to feed so the resident was fed each meal early. Interview with CNA #12 further revealed Resident #10 required no special feeding precautions and none had been provided for the resident during the evening meal on 09/15/11. CNA #12 stated if the resident required any specialized precautions or devices for meals, it would be detailed on the resident's tray card so the staff would know to provide it for the resident. A review of Resident #10's tray card listed feeding instructions as "fed per staff." Additional interviews were conducted on 09/15/11, at 3:37 PM, with Nursing Assistant (NA) #1; at 4:03 PM, with CNA #9; at 4:30 PM, with CNA #5; at 4:53 PM, with CNA #6, and at 5:08 PM, with LPN #4. All the staff interviewed stated	F 309	documented in the nurse's notes. Reeducation will be done by the bowel management nurses as needed. At least weekly the DON will review the system to ensure compliance. The DON will report her review to the administrator weekly. The DON will report her findings to the QA subcommittee monthly for 6 months then no less than quarterly for one year to review the plan of correction to ensure the deficient practice is resolved and compliance is sustained.	10/14/11

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F 309	Continued From page 28 they relied on the resident's tray cards to know what, if any, specialized interventions or equipment was to be provided to residents during meals. An interview with the Dietary Director on 09/16/11, at 9:30 AM, revealed she was responsible for updating the dietary tray cards. The Dietary Director stated she thought all the swallowing precautions were listed on the tray cards for each resident, and was unaware that the cards were not accurate. The Dietary Director stated a former Speech Therapist (ST) had verbally told her the instructions that were to be provided on "some" of the tray cards. Per interview the facility did not have a system in place for ensuring the Dietary Director was aware of all the precautions for each resident to ensure the precautions were listed on the resident's tray cards. An interview conducted on 09/21/11, at 9:15 AM, with ST #2, the current Speech Therapist, revealed the nine residents who were on swallowing precautions were not currently receiving Speech Therapy services and had been "discharged to a restorative program." The ST stated the swallowing precautions/strategies were to be utilized by the staff who assisted the residents with meals. The ST stated that each of the nine residents had been placed on the restorative program prior to her employment at the facility and she had not trained residents or staff responsible on implementation of the feeding strategies. The ST went on to state that since none of the residents had been actively receiving Therapy services, she had not been responsible to ensure any of the swallowing	F 309		

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F 309	Continued From page 29 precautions/strategies were followed. An interview conducted on 09/15/11, at 7:43 PM, with LPN #5, who was responsible for training the CNAs, revealed any specialized swallowing/feeding precautions the residents required were listed on the resident's individualized tray card by the kitchen staff. LPN #5 stated the CNAs were trained to rely on the tray cards to know what each resident required. LPN #5 stated to her knowledge there "was no one person" responsible to ensure the tray cards were accurate or that residents were receiving the supervision/assistance they had been assessed to require in regards to the swallowing precautions/strategies. An interview with the Administrator and Director of Nursing (DON) on 09/15/11, at 8:51 PM, confirmed the facility staff was trained to rely on the tray cards for any specialized instructions, including feeding precautions to be provided for residents. However, the Administrator and DON explained they had not realized the feeding precautions were not on the tray cards until informed on 09/15/11. In addition, facility staff failed to implement the facility's bowel protocol, for seven of twenty sampled residents (Residents #3, #6, #7, #9, #11, #15, and #17). Facility staff documented no bowel movement for at least three days for each resident; however, no interventions were put in place as per the bowel protocol. Review of the facility's undated "Bowel Management Program" revealed residents were assessed upon admission, quarterly, and with any	F 309		

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F 309	Continued From page 30 significant change in condition for risk of constipation. The review revealed staff was required to document all bowel movements on the "Care Tracker." The program stated the 7 PM-7 AM shift nurse was responsible to review each resident's Care Tracker, and place the name of each resident that had not had a bowel movement for three days on the Communication Flow sheet. In addition, the program revealed the charge nurse was responsible to administer medications as appropriate. 6. A review of the medical record revealed the facility admitted Resident #11 on 09/11/09. Resident #11 had diagnoses which included Senile Dementia, Diabetes Mellitus, Muscle Weakness, and Debility. A review of the quarterly Minimum Data Set, dated 08/09/11, revealed the facility assessed Resident #11 to be incontinent of bowel and bladder. A review of the "Resident Bowel and Bladder by Shift Chart" revealed no evidence Resident #11 had a bowel movement on 06/22/11, 06/23/11, 06/24/11, and 06/25/11, a total of four days; on 07/18/11, 07/19/11, 07/20/11, and 07/22/11, a total of four days; and on 08/20/11, 08/21/11, and 08/22/11; a total of three days. Review of the facility Medication Administration Record (MAR) for Resident #11 revealed no intervention was provided for Resident #11 in June, July, or August 2011 related to the absence of a bowel movement for three days as per policy. Review of the nursing notes for June, July, and August 2011, revealed no documentation of any bowel intervention provided for Resident #11. 7. A review of the medical record revealed the facility admitted Resident #6 on 07/15/11, with	F 309		

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F 309	Continued From page 31 diagnoses to include Alzheimer's, Senile Dementia, Contracture, and Difficulty Walking. A review of the admitting MDS, dated 07/22/11, revealed the facility assessed Resident #6 to be continent of bowel. A review of the "Resident Bowel and Bladder by Shift Chart" revealed no evidence Resident #6 had a bowel movement on 07/17/11, 07/18/11, 07/19/11, 07/20/11 (four days); 07/24/11, 07/25/11, 07/26/11, 07/27/11 (four days); 07/30/11, 07/31/11, 08/01/11 (three days); 08/08/11, 08/09/11, 08/10/11 (three days); 08/17/11, 08/18/11, 08/19/11 (three days); or on 09/13/11, 09/14/11, 09/15/11, or 09/16/11 (four days). A review of Resident #6's MAR for July, August, and September 2011, revealed no evidence medications were administered to the resident related to the absence of a bowel movement. A review of nursing notes for July, August, and September 2011 also revealed no documentation that any medication was administered related to the resident's lack of a bowel movement. 8. Review of Resident #7's medical record revealed the facility admitted the resident on 11/17/09. Resident #7 had diagnoses to include Dysphagia, Fractured Hip, Dementia with Behaviors, and Depression. Review of the resident's Quarterly Minimum Data Set (MDS) assessment dated 06/30/11, revealed the facility assessed the resident to be severely cognitively impaired, and always incontinent of bowel and bladder. Review of Resident #7's "Resident Bowel and Bladder by Shift Chart" sheet revealed the resident had not experienced a bowel movement on 08/14/11, 08/15/11, 08/16/11 (three days); 08/31/11, 09/01/11, 09/02/11 (three days); or on 09/11/11, 09/12/11, or 09/13/11 (three	F 309		

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F 309	Continued From page 32 days). Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2011 and September 2011 revealed no evidence bowel interventions were implemented related to the absence of a bowel movement for three days, as per facility policy. Further review of Resident #7's nurse's notes for August 2011 and September 2011 revealed no documentation of bowel interventions implemented by staff for the resident's absence of bowel movement for three days as per facility policy. 9. Review of Resident #9's medical record revealed the facility admitted the resident on 10/20/08, with diagnoses of Alzheimer's, Dysphagia, Dehydration, and Congestive Heart Failure. Review of the resident's Quarterly MDS assessment dated 06/23/11, revealed the facility had assessed the resident to be severely cognitively impaired, occasionally incontinent of bowel, and frequently incontinent of bladder. Review of Resident #9's "Resident Bowel and Bladder by Shift Chart" sheet revealed the resident had not experienced a bowel movement on 08/05/11, 08/06/11, 08/07/11 (three days); 08/18/11, 08/19/11, 08/20/11 (three days); or on 08/28/11, 08/29/11,08/30/11, or 08/31/11 (four days). Review of the resident's MARs and TARs for August 2011 revealed no evidence bowel interventions were implemented related to the absence of a bowel movement for three days as per facility policy. Further review of Resident #9's nurse's notes for August 2011 revealed no documentation of bowel interventions implemented by staff for the resident's absence of bowel movements for three days as per facility policy.	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33 10. Review of the medical record revealed the facility admitted Resident #3 on 01/07/09, with diagnoses that included Alzheimer's Disease. Review of the Bowel and Bladder flow sheet for the month of August 2011 revealed no documented evidence of a bowel movement from 08/05/11 through 08/10/11 (six days). Review of the MAR for the same period revealed no evidence medication was administered to Resident #3 per facility bowel protocol. 11. Medical record review revealed Resident #15 was admitted by the facility on 10/20/09, with diagnoses that included Hypertension and Congestive Heart Failure. Review of the Bowel and Bladder flow sheet for the month of August 2011 revealed no documented evidence of a bowel movement between 08/03/11 and 08/07/11 (five days) for Resident #15. Review of the MAR revealed no evidence medications were administered during the five-day period. 12. Review of the medical record revealed the facility admitted Resident #17 on 05/31/07. Review of the Bowel and Bladder flow sheets for the months of July, August, and September 2011 revealed no documented evidence of a bowel movement for the following dates: 07/11 through 07/15 (five days); 07/19 through 07/24 (six days); 07/25 through 7/30 (six days); 08/05 through 08/17 (thirteen days); 08/22 through 08/27 (six days); 09/05 through 09/08 (four days); and 09/12 through 09/20 (nine days). Continued review of the MAR revealed no indication Resident #17 was treated for no bowel movement when indicated, per facility policy.	F 309		

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F 309	Continued From page 34 Interview with LPN #1 on 09/21/11, at 8:57 AM, revealed she had reviewed each resident's medical record of the above mentioned timeframe and was unable to find where the resident had been assessed for use of possible interventions including prune juice, contacting physician for stool softener, or consulting the dietitian as per the bowel protocol. Interview on 09/21/11, at 10:32 AM, with LPN #2 revealed the night shift nurse was responsible for printing a bowel list to provide for the day shift nurse and then to place a copy in the bowel log book. The day shift nurse was then responsible for providing bowel care for residents who had not had a bowel movement for two days. LPN #2 stated she thought bowel care used to be provided after three days with no bowel movement, however, now it was provided after two days. Interview with LPN #2 further revealed when an intervention had been provided for a resident related to bowel care, the intervention would be documented either in the nurse's notes on or the MAR. Interview with LPN #4, the bowel and bladder nurse, revealed she was not aware that there was a bowel book that tracked residents who had not had a bowel movement for three days. LPN #4 went on to state she had just assumed the responsibility as bowel and bladder nurse in May 2011. Therefore, LPN #4 stated staff had not tracked each resident's bowel movement to assure interventions were provided. –A review of the Allegation of Compliance revealed the following:	F 309		

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F 309	Continued From page 35 On 09/16/11, the Speech Therapist screened all residents on swallowing precautions. Any new or revised recommendations were made. On 09/16/11, the Director of Nursing (DON) and Administrator audited the personal care plans and tray cards for the residents on swallowing precautions to ensure accuracy. A Swallowing Precaution Communication Procedure was established. The Speech Therapist will give a copy of each resident's swallowing precautions to the Dietary Manager, the Assistant Director of Nursing (ADON), the Infection Control Nurse, and the Director of Nursing (DON). The DON will monitor the communication procedure. The DON will also ensure the swallowing precautions have been added by the Dietary Manager to the tray cards. The DON will ensure the ADON has put a copy of swallowing precaution strategies in each resident's personal care record books. Each week the DON will review the swallowing precaution sheets that she received from the Speech Therapist. After the DON sees the swallowing precautions on the tray card are correct and the swallowing strategies are in the personal care record she will sign her copy of the swallowing strategies. She will keep a copy of this sheet in a binder in her office. Swallowing precaution books were created to include a master list of residents with swallowing precautions, a copy of the book, a copy of the	F 309		

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F 309	Continued From page 36 emergency care for choking poster, and a copy of the signs and symptoms of aspirations. The Dietary Manager will be responsible for keeping the book up to date. The Administrator will audit the swallowing precaution book at least weekly to ensure that they are up to date. On 09/16/11, the Administrator educated the Dietary Manager, Speech Therapist, DON, Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and on the swallowing precaution book. On 09/20/11, a copy of the emergency care for choking poster was posted in the dining room. On 09/16/11, the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The Speech Therapist form used to inform staff of what swallowing interventions each resident required was explained. On 09/16/11, nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies could be found. They were told the locations included: the personal care records, the tray cards, and in binders located in the dining room on the snack cart, and at both nurses' stations. Beginning 09/19/11, all nursing personnel will be reeducated on the choking section of the nurse aide training curriculum. Beginning 09/20/11, all nursing personnel were reeducated on the signs and symptoms of	F 309		

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F 309	Continued From page 37 aspiration. Nursing assistants were trained on what to do when a resident showed signs and symptoms of aspiration. No nursing personnel will work until trained. Beginning 09/20/11, nurses were re-educated on what to do when a nurse aide reports signs and symptoms of aspiration. No nursing personnel will work until trained. Upon hire all employees will be educated on the facility swallowing procedures and the signs and symptoms of aspiration. On 09/16/11, administrative nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were aware of swallowing precautions. Beginning 09/17/11, the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor each resident on swallowing precautions to ensure the nursing assistants were aware of the swallowing precautions, the swallowing precautions were being followed, and the swallowing precautions were on the tray card. This quality assurance is to be done at every meal. During the lunch meal the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor all residents for signs and symptoms of aspiration to ensure that nursing assistants were aware of the signs and symptoms of swallowing issues. All nurses on duty on 09/20/11, were educated on the monitoring procedure, and no nurse will be allowed to work before being educated.	F 309		

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F 309	Continued From page 38 The Medical Director was informed of the immediate jeopardy. Weekly the Administrator will observe meal service and will audit the plan of correction. The Administrator will report the audit to the quality assurance committee quarterly. –The surveyors validated the corrective actions taken by the facility as follows: Observation of the noon meal on 09/21/11, revealed RN #4 in the dining room supervising CNAs feeding residents. Interview at this same time revealed she was responsible for observing residents in the dining room to assure they have received the correct diet, that the diet and swallowing precautions were printed on the tray card, to assure the nursing aides were following swallowing precautions and observing for signs and symptoms of aspiration and choking. Interview further revealed there was a poster on the wall with interventions for choking, and there was a book with each resident on swallowing precautions, what the precautions were, what to do in the event of choking, and signs and symptoms of aspiration. RN #4 further stated she was in-serviced on 09/19/11, regarding the need to supervise nursing aides while feeding residents, what swallowing precautions were, the swallowing precaution book, that all swallowing precautions were required to be on the tray card, choking, and aspiration. Further observation of the noon meal on 09/21/11, revealed Residents #7, #11, and #10 in the dining room at a table assisted by a nursing assistant. Review of their tray cards revealed their swallowing precautions were listed on the card.	F 309		

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F 309	Continued From page 39 Observation of the dining room on 09/21/11, revealed an emergency care for choking sign posted on the wall. Observation on 09/21/11, revealed a swallowing precaution book in the dining room, each nurses' station, and on each snack cart. Interview with Speech Therapist (ST) #2 on 09/21/11, at 3:30 PM, revealed she had conducted a current screening for all residents on swallowing precautions and had made any revisions or new recommendations for each resident. The ST went on to say she was responsible for providing a copy of the current swallowing precautions for each resident to the Dietary Manager (DM), ADON, Infection Control Nurse, and the DON. Interview further revealed she was educated by the Administrator related to the need to provide a current copy of each resident's swallowing precautions to the DM, ADON, Infection Control Nurse, and the DON; and the swallowing precaution book. Interview with the Administrator on 09/21/11, at 3:45 PM, revealed she was responsible for auditing the swallowing precaution book weekly to ensure it is up to date. She further stated she had educated the Dietary Manager, Speech Therapist, DON Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and the swallowing precaution book. Further interview revealed she would be observing meal service weekly and would perform an audit during that time to ensure the plan of correction was being followed. The Administrator stated she would report this audit at	F 309		

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F 309	Continued From page 40 the quality assurance meeting quarterly. Interview with the DON on 09/21/11, at 3:15 PM, revealed she along with the Administrator had audited all personal care plans and tray cards and found no problems. Interview further revealed she was responsible for assuring the Dietary Manager puts all swallowing precautions on each resident's tray card. Further interview revealed she had assured the ADON had put a copy of the swallowing precautions strategies in each resident's personal care book. The DON further stated she was in-serviced on 09/16/11, related to the swallowing precaution communication procedure and the swallowing precaution book. Interview further revealed each week the DON would verify the swallowing precautions were on the tray cards and in each resident's personal care book. She further stated after verifying the swallowing precautions were on the tray cards and in the personal care books, she would then sign her copy of the swallowing strategy for each resident and it would be kept in a binder in her office. Interview further revealed the DON had been in-serviced by the Administrator regarding the swallowing precaution communication procedure and the swallowing precaution book. Interview on 09/21/11, at 2:03 PM, with the Dietary Manager revealed it was her responsibility to ensure all swallowing strategies were on each resident's tray card. Further interview revealed the Dietary Manager was responsible for ensuring the swallowing precaution books were current and up to date for each resident on special feeding precautions. Interview further revealed she had been educated by the Administrator regarding the swallowing precaution	F 309		

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F 309	Continued From page 41 communication procedure and the swallowing precaution book. Interview on 09/21/11, at 3:38 PM, with CNA #9, at 3:42 PM, with Nurse Aide #1, at 4:00 PM, with CNA #11, and at 4:10 PM, with CNA #4 revealed they had been in-serviced on swallowing precautions; where each resident's swallowing precautions were located, what to do when a resident chokes, and signs and symptoms of aspiration. Interview further revealed a nurse has to be in the dining room before they can begin feeding the residents, and they are required to look at each resident's tray card and ensure any precautions are followed. Interview with LPN #5 on 09/21/11, at 3:47 PM, and RN #2 at 4:15 PM, revealed they had been in-serviced on resident swallowing precautions, and that all precautions have to be on the tray card and in the swallowing strategy book. They further stated they had also been in-serviced on signs and symptoms of aspiration, and what to do when a resident chokes. Interview further revealed they were instructed when they were in the dining room or on the floor with residents they were to monitor to ensure nurse aides were following swallowing precautions, and observe for aspiration/choking. Interview on 09/21/11, at 2:00 PM, with the Medical Director revealed she had been informed of the immediate jeopardy identified at the facility. Review of the personal care records audit revealed the DON and Administrator had audited all personal care plans and tray cards for each resident on swallowing precautions on 09/16/11,	F 309		

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F 309	Continued From page 42 and found no discrepancies. A review of the new swallowing precaution communication procedure revealed it was implemented on 09/16/11. A review of the facility's training records revealed evidence employees of the facility, except for those on vacation or on medical leave, had received training on swallowing precautions and how they were effective on 09/16/11. Any employee who did not attend training was informed they were not allowed to work until trained. Further review revealed nursing assistants had received training on 09/16/11, on where the swallowing precautions master list and the swallowing precaution strategies could be found. Review further revealed on 09/19/11, nursing personnel were educated on the choking section of the nurse aide training curriculum. Facility training records further revealed on 09/20/11, nursing personal were educated on signs and symptoms of aspiration. A review of "Swallowing Precaution Education," to be given to employees upon hire, revealed the facility would ensure any new hires would be educated on each resident's swallowing precautions, signs, and symptoms of aspiration, and emergency preparedness for choking. A review of facility tray cards for the nine residents assessed by the facility to require swallowing strategies revealed each card had the resident's required strategies on them. A review of the facility's swallowing precaution quality assurance log revealed from	F 309		

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F 309	Continued From page 43 09/16/11-09/21/11, staff had observed to ensure each resident with a swallowing strategy had the strategy on their tray card, that the nurse aide was adhering to the swallowing precautions, and if education had to occur. Based on the above findings, The State Agency determined Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of systemic changes and quality assurance actions.	F 309	F323 Free of Accident Hazards/Supervision Devises The Director of Maintenance checked all toilets in the building for exposed bolts. All bolts were covered as of 9/30/2011 The Director of Maintenance is responsible to ensure that all toilet bolts are covered at all times. The Housekeeping Manager met with her staff on 10/3/2011 to direct her staff to observe the toilet bolts when cleaning the rooms and to put any missing bolt covers on a Maintenance Request when noted. The administrative staff was instructed by the Administrator on 9/23/2011 to look for exposed toilet bolts on their weekly room rounds and to report any bolt cover that is noted missing to the maintenance director at the weekly room round meeting. The Director of Maintenance will check each toilet monthly for three months to ensure that any missing	
F 323 SS=E	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 and interview it was determined the facility failed to ensure the environment was safe and as free of accident hazards as possible. A tour of the facility on 09/21/11, revealed the facility had thirty (30) bathrooms utilized by residents. Observations of twenty-six (26) of the bathrooms revealed bolts that secured resident toilets to the floor that were exposed, crusted with rust, sharp, and created a safety hazard.	F 323		

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F 323	Continued From page 44 The findings include: A tour conducted on 09/21/11, at 10:30 AM, of 26 of 30 resident bathrooms revealed exposed bolts that secured the toilet to the floor. The bolts were observed to be encrusted with rust. In addition, the bolts were sharp and located in a way that presented a safety hazard to residents if contact with the bolts was made. An additional tour of the resident bathrooms was conducted on 09/21/11, at 11:20 AM, with the Director of Housekeeping and the Maintenance Director. The Director of Housekeeping and the Maintenance Director acknowledged in interview on 09/21/11, at 11:20 AM, that the exposed bolts created a safety hazard for the residents.	F 323	bolt cover has been reported and replaced as needed. He will report his findings to the facility QA committee no less than quarterly for one year to ensure the procedure is effective and that toilet bolts are covered.	10/4/11
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, interview, record review, and review of the facility policy regarding "Food Preparation and Safety" (policy 9.62, dated 2005) it was determined the facility failed to ensure proper hand washing and glove techniques were	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary The employees noted to use gloves inappropriately were reeducated by the dietician on 9/28/2011 on proper use of gloves and when it is appropriate and necessary to change them. All unlabeled, undated and expired items were removed from the refrigerators and discarded on 9/19/2011 by the nurse on B wing and the housekeeping manager. On 9/22/2011 Administrator and Dietary Manager reviewed the Resident Food Storage Policy. The policy was revised to include	

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F 371	Continued From page 45 used during the evening tray line service on 09/19/11. Two (2) Dietary staff members were observed handling food items with gloved hands after touching other surfaces. In addition, refrigerated resident snacks contained expired food items. Opened beverages were not labeled, and ice cream and juices were not labeled or dated. The findings include: Review of the facility policy regarding "Food Preparation and Safety" (dated 2005) revealed: 1) Disposable gloves are used when preparing ready-to-eat foods such as sandwiches, salads, desserts, etc, which will not be heated to bacteria-killing temperatures ...; 2) ...When donning gloves, minimal contact is made with the surfaces that will come in actual contact with the food such as the fingers ...; 5) Gloves are discarded when they are contaminated in any way. Contamination can occur when touching unclean surfaces such as a refrigerator handle, trash can, contact with bodily fluids, or if they become torn ...; 9) When gloves become worn, torn, or heavily soiled, they are discarded. Hands are washed prior to putting on new gloves. Observation of the evening tray line service on 09/19/11, at 5:30 PM, revealed the Dietary Aide picked up the raw diced tomatoes with her gloved hands and placed them in a salad bowl. The Dietary Aide then proceeded to walk to the other side of the kitchen, picked up a crate of bowls, and returned to the tray line service with the bowls. The Dietary Aide was observed to continue the tray line service with the same	F 371	compliance checks done by the dietary manager or the dietary assistant. The Dietary Manager or the Dietary Manager Assistant will check the refrigerators at the nurse's stations on Monday, Wednesday, and Friday. Any outdated or unlabeled food will be discarded. On 9/22/2011 the Administrator and the Dietary Manager reviewed the Use of Disposable Gloves Policy, the Personal Hygiene Policy, and the Hand washing Policy. On 9/26/2011 the Administrator educated the dietary manager on the revised resident food storage policy and on the tray line audit that she will be required to perform on a weekly basis for four weeks and then monthly thereafter. On 9/26/2011 the DON educated nursing personnel on the Resident Food Storage Policy. On 9/28/2011 the dietician educated the dietary manager and her staff members on the Use of Gloves Policy, the Personal Hygiene Policy and the Hand washing Policy and on the Resident Food Storage Policy.	

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F 371	Continued From page 46 gloved hands with no evidence of hand washing or changing gloves. Observation at 5:45 PM, revealed the Dietary Aide again picked up raw diced tomatoes with the same gloved hands and placed the tomatoes in a bowl. No hand washing was observed during this process. Interview with the Dietary Aide on 09/21/11, at 2:00 PM, revealed she would change her gloves if handling milk cartons. The Dietary Aide revealed she should have used tongs to remove the diced tomatoes, or changed her gloves prior to doing so. In addition, observation of the Dietary Cook on 09/19/11, during the evening service at 5:50 PM, revealed the Cook removed a square of cornbread from a covered pan on the stove with her gloved hands. However, observation revealed the Dietary Cook touched counter surfaces and plate covers prior to the removal of the cornbread. There was no evidence of hand washing or application of new gloves. Interview with the Dietary Cook on 09/21/11, at 1:46 PM, revealed staff should always wash their hands and change gloves when leaving the tray line or getting any other items for the tray line service. Interview with the Dietary Director on 09/21/11, at 1:45 PM, revealed all staff should wash hands and apply new gloves after touching hair, face, or any surfaces in the kitchen. The Dietary Manager stated that training on hand washing had been given in April of this year and the Dietary Cook and Aide had attended.	F 371	Weekly for four weeks and then monthly thereafter the dietary manager will observe tray line to check for Employee Hygiene while employees are on tray line. The dietary manager will observe for proper glove use. The dietary manager will turn in a copy of this audit to the administrator. The Dietary Manager will reeducate as needed. Weekly the administrator will observe the refrigerators at the nurses' station to make sure all outdated and unlabeled food and drink items are being discarded. Results of these audits will be reported to the QA subcommittee monthly for six months and then quarterly for one year.	10/10/11

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	185168		C 09/21/2011

NAME OF PROVIDER OR SUPPLIER: MONROE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 706 N MAGNOLIA STREET, PO BOX 367, TOMPKINSVILLE, KY 42167

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F 371	Continued From page 47 Additional observations on 09/19/11, at 2:45 PM, revealed the snack refrigerator located on the B Hall contained a partially used bottle of ketchup with an expiration date of 08/28/11. Continued observation revealed a carton of skim milk that expired on 09/17/11. In addition, one bottle of water and a bottle of Propel had been opened and were half-empty. No labels for specific residents or dates when opened were present. Further observation revealed four cups of red juice covered with plastic wrap and labeled with a "C." No other markings indicated when the juice was poured or placed in the refrigerator. Observation of the freezer revealed seven individual servings of ice cream. The ice cream did not have a manufacturer's expiration date and staff had not labeled the ice cream with the date the ice cream had been placed in the freezer. Interview with Licensed Practical Nurse #3 on 09/19/11, at 2:50 PM, revealed the snack refrigerator on the B Hall supplied the entire facility. The nurse stated all food and drink for resident use should be labeled, indicating when the product expired. The nurse further stated the "C" on the juice wrap indicated it was cranberry juice. Continued interview revealed there should have been a "use by" date as well, as there was no way to know when the juice or the ice cream had been supplied for resident use. Further interview revealed the opened bottles of water and Propel should not have been returned to the refrigerator without a date when the products were opened.	F 371		
F 373 SS=K	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	F 373		

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F 373	Continued From page 48 A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration.	F 373	F373 Feeding Assistant-Training/Supervision/Resident Residents #7, #9, and #11 were on swallowing precautions and were being feed by paid feeding assistants. On 9/15/2011 the facility determined that paid feeding assistants would no longer be used to feed residents. Only residents #7, #9, and #11 were being feed in the dining room. Paid feeding assistants were only allowed to feed in the dining room. No other residents were being feed by paid feeding assistants. Effective 9/15/2011 paid feeding assistants were no longer allowed to feed residents at the facility. A Sign Notifying all employees that paid feeding assistants were no longer allowed to feed residents at the facility was posted in the dining	

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F 373	Continued From page 49 Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure paid feeding assistants did not assist residents assessed to have complicated feeding precautions with their meals. A review of twenty (20) residents revealed six (6) of the residents had complicated feeding precautions. Observation revealed paid feeding assistants assisted three (3) of the six (6) residents (Residents #7, #9, and #11) assessed to have complicated feeding precautions with their meals on 09/14/11, during the evening meal. Residents #7, #9, and #11 were assessed by the facility to require specialized swallowing precautions during oral intake. (Refer to F309.) The facility's failure to ensure paid feeding assistants did not assist/feed residents assessed to have complicated feeding precautions has	F 373	room and at the time clock. Also, the information was reported on the 24 hour nursing report. Going forward we will not use paid feeding assistants at this facility. On 9/16/2011 the Administrator and/or the Activity Director informed the paid feeding assistants of their job duties at the facility. Going forward one of the paid feeding assistants will work only in the activity department. The other three paid feeding assistants will be assigned the title of nursing helper. On 9/19/2011 each nursing helper signed a list of tasks that she will be performing. All nursing personnel and dietary staff members were informed that paid feeding assistants would no longer be used at Monroe Health and Rehabilitation Center.	9/22/2011

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F 373	Continued From page 50	F 373		

caused, or is likely to cause serious injury, harm, impairment, or death to Residents #7, #9, and #11 and other residents in the facility assessed to have feeding precautions. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 09/14/11.

An acceptable Allegation of Compliance (AOC) was received from the facility on 09/21/11, and alleged removal of Immediate Jeopardy on 09/21/11. The State Agency determined the Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.

The findings include:

Observations on 09/14/11, from 6:35 PM until 7:30 PM, (of the evening meal in the facility's dining room) revealed four paid feeding assistants were observed to feed/assist Residents #7, #9, and #11 with their meal.

1. A review of Resident #7's medical record revealed the facility admitted the resident on 11/17/09. Resident #7 had diagnoses that included Dysphagia. A review of Resident #7's Minimum Data Set (MDS) assessment dated 06/30/11, revealed the facility had assessed the resident's cognition as severely impaired and the resident required extensive assistance with eating. A review of Resident #7's Speech Therapy Plan of Care dated 02/07/11, revealed Resident #7 required staff to utilize compensatory swallowing strategies (to help with swallowing) while feeding/assisting the resident during meals

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F 373	Continued From page 51 to increase the resident's safety and decrease the resident's risk for injury. An observation on 09/14/11, at 6:35 PM, revealed Resident #7 was seated at the table with five peers, all of which were being fed/assisted by paid feeding assistant #1 and paid feeding assistant #2. 2. A review of Resident #9's medical record revealed the facility admitted the resident on 10/20/08, and the resident's diagnoses included Dysphagia. A review of Resident #9's Minimum Data Set (MDS) assessment dated 06/23/11, revealed the facility had assessed the resident's cognition to be severely impaired and he/she required extensive assistance with eating. A review of Resident #9's Speech Therapy Plan of Care dated 04/11/11, revealed staff was required to utilize compensatory swallowing strategies while feeding the resident to increase the resident's safety and decrease the resident's risk for aspiration. An observation on 09/14/11, at 6:40 PM, revealed paid feeding assistant #4 was feeding Resident #9 in the dining room. 3. A review of Resident #11's medical record revealed the facility admitted the resident on 09/11/09. Resident #11 had diagnoses to include Oropharyngeal Dysphagia and Organism Pneumonia. A review of Resident #11's Minimum Data Set (MDS) assessment dated 08/09/11, revealed the facility had assessed the resident's cognition to be severely impaired and totally dependent on staff for eating. A review of Resident #11's Speech Therapy Plan of Care	F 373		

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F 373	Continued From page 52 dated 11/24/10, revealed the resident had impaired pharyngeal function and required compensatory swallowing strategies to be provided by staff to reduce the likelihood of aspiration. An observation on 09/14/11, at 6:36 PM, revealed Resident #11 was seated in a wheelchair at a table and paid feeding assistant #1 was feeding the resident. Interviews conducted on 09/15/11, at 3:00 PM, with paid feeding assistant #4; at 5:32 PM, with paid feeding assistant #2; and at 5:49 PM, with paid feeding assistant #3 revealed they had completed the Paid Feeding Assistants Program at the facility and functioned as paid feeding assistants. A review of the Paid Feeding Assistants Program exam results revealed paid feeding assistant #4 successfully completed the training on 03/08/11; paid feeding assistants #2 and #3 successfully completed the training on 07/04/11; and paid feeding assistant #1 successfully completed the training on 09/05/11. The paid feeding assistants all stated they were permitted to feed/assist any resident that ate in the dining room and had never been instructed they could not feed certain residents. According to the paid feeding assistants, feeding assignments were not made. They stated staff fed/assisted "the first resident you come to" that required assistance. The paid feeding assistants stated they had not been trained to feed residents with specialized feeding precautions and, in addition, stated they were not aware of any resident in the facility that required special feeding precautions.	F 373		

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F 373	Continued From page 53 An interview with Licensed Practical Nurse (LPN) #5 on 09/15/11, at 7:43 PM, revealed she had the responsibility to facilitate the Paid Feeding Assistants Program in the facility. A review of the Paid Feeding Assistants Manual and Paid Feeding Assistant Exam utilized by the facility revealed it was a state approved training course, which indicated residents with complicated feeding problems could not be fed by a paid feeding assistant. LPN #5 stated the facility implemented the Paid Feeding Assistant Program on 03/08/11, and utilized four paid feeding assistants. According to LPN #5, the facility had not developed a formal written policy/procedure that governed the Paid Feeding Assistant Program, and stated the paid feeding assistants were only utilized in the dining room and could feed/assist any resident who required assistance when they ate in the dining room. LPN #5 stated she, the Administrator, and the Director of Nursing (DON) discussed the Paid Feeding Assistant Program and decided the paid feeding assistants would only be utilized in the dining room and that "if a resident was well enough to eat in the dining room, they could be fed by a paid feeding assistant." LPN #5 stated she was not aware paid feeding assistants were not permitted to feed/assist residents who had complicated feeding problems. In an interview on 09/15/11, at 8:50 PM, the Administrator and DON confirmed the facility had utilized paid feeding assistants since 03/08/11, and stated they were not aware that paid feeding assistants could not feed residents with complicated feeding problems. The DON stated, "I thought it was just state to state, I didn't realize there was a Federal Regulation about it." Both	F 373		

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F 373	Continued From page 54 the Administrator and DON confirmed the facility had never implemented restrictions on which residents could be fed by a paid feeding assistant as long as the resident was fed/assisted in the dining room. --A review of the Allegation of Compliance revealed the following: As of 09/15/11, the facility will no longer utilize paid feeding assistants to feed residents. On 09/15/11, the Administrator and Director of Nursing (DON) informed nursing and dietary staff that paid feeding assistants would no longer be utilized to feed residents at the facility. On 09/15/11, a sign was posted at the employee time clock and in the dining room notifying staff that paid feeding assistants would no longer be utilized to feed residents at the facility. This information was also reported to staff on the 24-hour nursing report. On 09/15/11, all paid feeding assistants were informed they would no longer be utilized to feed residents at the facility. --The surveyors validated the corrective actions taken by the facility as follows: Interview on 09/16/11, at 10:10 AM, with the DON and Administrator revealed as of 09/15/11, the facility would no longer utilize paid feeding assistants to feed residents. The interview also revealed a sign had been posted at each time clock to inform employees paid feeding assistants would no longer be utilized to feed residents.	F 373		

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F 373	Continued From page 55 Further interview revealed facility staff had been informed that paid feeding assistants would no longer be used, and this information had been placed on the 24-hour report for staff to see. Interview revealed all four paid feeding assistants were notified on 09/15/11, they would no longer be utilized at the facility to feed residents. Interview on 09/16/11, with paid feeding assistant #3 at 9:45 AM, and paid feeding assistant #1 at 9:53 AM, revealed they had been notified by the DON and Administrator that they would no longer be utilized at the facility as paid feeding assistants and would no longer be permitted to feed residents at the facility. Interview on 09/16/11, at 9:15 AM, with Licensed Practical Nurse (LPN) #4 revealed she had been informed by the DON and Administrator the facility would no longer employ and use paid feeding assistants to feed residents. Interview on 09/16/11, at 9:22 AM, with Registered Nurse (RN) #4 revealed she had been informed by the DON and Administrator the facility would no longer employ and use paid feeding assistants to feed residents. Interview on 09/16/11, at 9:27 AM, with Certified Nursing Assistant (CNA) #4 revealed she had been informed by the DON and Administrator the facility would no longer use paid feeding assistants to feed residents. Interview on 09/16/11, at 10:17 AM, with a dietary aide revealed she had been informed the facility would no longer use paid feeding assistants as of 09/15/11.	F 373		

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F 373	Continued From page 56 Observation on 09/16/11, at 9:00 AM, of the facility time clocks revealed signs were posted on the time clocks to inform employees the facility would no longer utilize paid feeding assistants effective 09/15/11. A review of the 24-hour nursing report on 09/16/11, revealed the facility would no longer use paid feeding assistants to feed residents. Based on the above findings, the State Agency determined Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of systemic changes and quality assurance actions.	F 373	F490 Administration Services by Qualified Persons/Per Care Plan On 9/16/2011 Residents #7, #9,#10,#11, and #12 were screened by the speech therapist. Any noted new or revised recommendations were made at that time. On 9/16/2011 the dietary manager added all swallowing precautions to residents #7,#9,#10,#11, and #12 tray cards. On 9/16/2011 the ADON ensured swallowing precautions for residents #7, #9, #10, #11, and #12 were with the personal care records. On 9/16/2011 the DON and Administrator audited the personal care plans and tray cards for the residents #7,#9,#10,#11, and #12 to ensure accuracy. On 9/16/2011 the	
F 490 SS=K	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, interview, record review, and facility policy review, it was determined the facility failed to be administered in an effective/efficient manner to maintain the highest physical well-being for five (5) of twenty (20) sampled residents (Residents #7, #9, #10, #11, and #12). The facility failed to have an effective system in place to ensure paid feeding assistants	F 490	DON, infection control nurse, and the MDS Coordinator educated the nurse aides on the location of the swallowing precautions on the tray cards and in the personal care record books. On 9/16/2011 Administrative Nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were aware of swallowing precautions. On 9/16/2011 the speech therapist screened all residents on swallowing precautions for accuracy. Any noted new or revised recommendations were made at that time. Beginning on 9/16/2011 and ending on 9/30/2011 the speech therapist screened all residents at the facility to determine awareness of swallowing concerns. Any noted new or revised recommendations were	

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F 490	Continued From page 57 did not assist residents assessed to have complicated feeding precautions with their meals, and also failed to ensure policies/procedures related to impaired swallowing precautions/aspiration precautions were implemented. Record review and interview revealed from 03/08/11, until 09/14/11, the facility permitted paid feeding assistants to feed/assist residents identified to have swallowing precautions. The facility failed to ensure the system in place to aid staff in identifying residents that required specific care with feeding needs and supervision during meal service was implemented. Additionally, the facility failed to ensure that staff providing feeding services to residents with complicated feeding problems had received appropriate training to ensure each resident's safety during assistance with feedings. (Refer to F282, F309, and F373.) The Administrator's failure to ensure paid feeding assistants did not feed residents assessed to have complicated feeding precautions, and to ensure facility policies/procedures related to residents with impaired swallowing and aspiration precautions were implemented caused, or is likely to cause, serious injury, harm, impairment, or death to residents in the facility, to include Residents #7, #9, #10, #11, and #12. Immediate Jeopardy and Substandard Quality of Care (SQC) were determined to exist on 09/14/11. An acceptable Allegation of Compliance (AOC) was received on 09/21/11, which alleged removal of Immediate Jeopardy on 09/21/11. The State Agency determined the Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered	F 490	made at that time. On 9/16/2011 a master list of the residents on swallowing precaution was developed and was made available to all nursing staff members. The dietary manager is responsible for keeping the master list updated. A Swallowing Precaution Communication Procedure was established on 9/16/2011 and was revised on 9/26/2011, and is presently as follows: The Speech therapist will give a copy of the Swallowing Precautions to the Dietary Manager, the ADON, the infection control nurse and the DON. The Dietary Manager will ensure that the swallowing precautions are attached to the resident's tray card at each meal. The ADON will put a copy of the swallowing precautions with the resident's personal care record. The Swallowing Precaution Books were created to include a master list of the residents with swallowing precautions, a copy of the swallowing precaution strategies, a copy of the Emergency Care for Choking Poster, and a copy of the signs and symptoms of aspiration. A copy of the swallowing precaution books will be kept in the dining room, at both nurses station, and on the snack carts. The dietary manager is responsible for keeping books up to date. On 9/16/2011 the administrator educated the dietary manager, the speech therapist, the DON, the infection control nurse and the ADON on the Swallowing Precaution Communication Procedure and on the Swallowing Precaution Books. On	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 58 the scope and severity to "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities. The findings include: Upon request to view the facility's feeding/swallowing precautions policy/procedure, the Director of Nursing stated they did not have a specific policy/procedure, but utilized the Fundamental Procedures Instruction textbook as a guide. A review of the "Feeding" and "Impaired Swallowing and Aspiration Precautions" sections revealed if a resident had swallowing difficulties a consultation with Speech Therapy should be obtained prior to feeding the resident. Choking and aspiration of food could occur if the patient is fed too quickly or is given excessively large mouthfuls. Additionally, the text indicated caregivers should develop a management plan that included common swallowing strategies, nutritional status, and supervision. The text went on to instruct caregivers to monitor residents for signs and symptoms of swallowing problems and aspiration. 1. Observation of the evening meal on 09/14/11, revealed paid feeding assistants feeding/supervising Residents #7, #9, and #11 during the meal. The facility's assessments revealed the residents required swallowing strategies for diagnosis of dysphasia. Interviews were conducted on 09/15/11, at 3:00 PM, with paid feeding assistant #4; at 5:32 PM, with paid feeding assistant #2; and at 5:49 PM, with paid feeding assistant #3. The paid feeding assistants stated they had completed the Paid	F 490	9/20/2011 a copy of the Emergency Care for Choking Poster was posted in the dining room. On 9/16/2011 the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The form that Speech Therapy uses to inform staff of what swallowing interventions are needed was explained. Any questions that the staff members had regarding swallowing precautions and the form were answered. Also, nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies can be found. They were told that the locations include: the personal care records, the tray cards, and in binders located in the dining room, on the snack cart, and at both nurses stations. Beginning on 9/19/2011 and ending on 10/3/2011 the DON and the infection control nurse reeducated nursing personnel on the choking section of the nurse aide training curriculum. Beginning on 9/20/2011 and ending on 10/3/2011 the DON and the infection control nurse reeducated nursing personnel on the signs and symptoms of aspiration. Nursing Assistants were trained on what to do when a resident shows sign and symptoms of aspiration. Beginning on 9/20/2011 and ending on 10/3/2011 the DON reeducated nurses on what to do when a nurse aide reports signs and symptoms of aspiration. On 9/26/2011 the DON and the speech therapist educated nursing personnel and the dietary manager on the revised swallowing	

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F 490	Continued From page 59 Feeding Assistants Program at the facility and functioned as paid feeding assistants. The paid feeding assistants all stated they were permitted to feed/assist any resident that ate in the dining room and had never been instructed they could not feed any particular residents. The paid feeding assistants stated they had not been trained to feed residents with specialized feeding precautions and, they were not aware of any resident in the facility that required special feeding precautions. An interview with Licensed Practical Nurse (LPN) #5 on 09/15/11, at 7:43 PM revealed she was responsible to facilitate the Paid Feeding Assistants Program in the facility. LPN #5 stated the facility implemented the Paid Feeding Assistant Program on 03/08/11, and utilized four paid feeding assistants. According to LPN #5, the facility had not developed a formal written policy/procedure that governed the Paid Feeding Assistant Program and stated the paid feeding assistants were only utilized in the dining room and could feed/assist any resident who required assistance when they ate in the dining room. LPN #5 stated she, the Administrator, and the Director of Nursing (DON) discussed the Paid Assistant Feeding Program and decided the paid feeding assistants would only be utilized in the dining room and that "if a resident was well enough to eat in the dining room, they could be fed by a paid feeding assistant." LPN #5 stated she was not aware paid feeding assistants were not permitted to feed/assist residents who had complicated feeding problems. In an interview on 09/15/11, at 8:50 PM, the Administrator and the Director of Nursing (DON)	F 490	precaution sheets and that the swallowing precaution sheet would be attached to the tray card going forward. Employees on leave of absence will be educated before they are allowed to work. In-services on swallowing precautions, choking and signs and symptoms of aspiration will be repeated monthly for 3 months then every six months for one year then no less than annually. All new hires will be educated during orientation. Beginning 9/17/2011 at 5:00pm the licensed nurse assigned to the wing and the licensed nurse assigned to the dining room will monitor each resident on swallowing precautions to ensure that the nursing assistants are aware of the swallowing precautions, the swallowing precautions are being followed, and the swallowing precautions are attached to the tray card. This QA will be done at every meal for eight weeks and then one meal for four weeks. Results of the QA will be documented on the Swallowing Precaution QA form kept in folders in the dining room and on each wing. Nurses will be educated on procedure before they are allowed to work. Weekly the DON will review the swallowing precaution sheets that she has received from the speech therapist. When she sees that the correct swallowing precautions are attached to the tray card and that the swallowing strategies are in the Personal Care Record books she will sign	

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F 490	Continued From page 60 revealed the facility had utilized paid feeding assistants since 03/08/11. She stated she was not aware paid feeding assistants could not feed residents with complicated feeding problems. The DON stated, "I thought it was just state to state, I didn't realize there was a Federal Regulation about it." Per interview, the Administrator revealed the facility had never implemented restrictions on which residents could be fed by a paid feeding assistant as long as the resident was fed/assisted in the dining room. 2. Observation and interviews from 09/14-16/11, revealed Residents #7, #9, #10, #11, and #12, required swallowing strategies for feeding and were not provided the required assistance with feeding. Furthermore, facility staff was not knowledgeable of the resident's swallowing strategies. Interviews conducted on 09/15/11, with four staff persons that had been observed feeding residents, and with four CNAs and a Licensed Practical Nurse revealed if a resident required any special feeding assistance it would be on the resident's tray card that was placed on each resident's food tray by dietary personnel. The staff interviewed stated if the tray card did not contain any special instructions related to feeding/assisting residents with meals assistance was not required and/or provided. However, a review of Residents #7, #9, #10, #11, and #12's tray cards revealed specialized instructions related to feeding were not documented on the cards and only portions of the feeding instructions were documented on the meal cards of Residents #7, #10, and #12.	F 490	her copy of the Swallowing Strategies. She will keep a copy of this sheet in a binder in her office for 30 days. Results will be reported to the QA subcommittee monthly for at least six months. The Administrator will audit the Swallowing Precaution Books at least weekly to ensure that they are up to date. The DON and Administrator will review meal audits weekly to ensure that they are being completed. The DON and Administrator will provide reports to the facility QA committee no less than quarterly for one year. The facility will establish a QA subcommittee that will meet monthly for six months then no less than quarterly for one year that includes the following: the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Dietary Director, the facility Corporate Consultant, and at least one staff nurse and two nursing assistants to review the facility plan of correction and the implementation of the same to ensure that the deficient practice is resolved and compliance is sustained. Provide Care and Services for Highest Well Being On 9/16/2011 Residents #7,#9,#10,#11, and #12 were screened by the speech therapist. Any noted new or revised recommendations were made at that time. On 9/16/2011 the dietary manager added all swallowing precautions to residents #7,#9,#10,#11, and	

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F 490	Continued From page 61 The Administrator stated in interview on 09/15/11, that facility staff had been trained to rely on the tray cards for any specialized instructions which included feeding precautions for each resident that had been assessed to require the precautions. However, the Administrator explained that she had not realized the feeding precautions were not on the tray cards until 09/15/11. --A review of the Allegation of Compliance revealed the following: On 09/16/11, the speech therapist screened all residents on swallowing precautions. Any new or revised recommendations were made. On 09/16/11, the Director of Nursing (DON) and Administrator audited the personal care plans and tray cards for the residents on swallowing precautions to ensure accuracy. A Swallowing Precaution Communication Procedure was established. The Speech Therapist will give a copy of each resident's swallowing precautions to the Dietary Manager, the Assistant Director of Nursing (ADON), the Infection Control Nurse, and the Director of Nursing (DON). The DON will monitor the communication procedure. The DON will also ensure the swallowing precautions have been added by the Dietary Manager to the tray cards. The DON will ensure the ADON has put a copy of swallowing precaution strategies in each resident's personal care record books.	F 490	#12 tray cards. On 9/16/2011 the ADON ensured swallowing precautions for residents #7, #9, #10, #11, and #12 were with the personal care records. On 9/16/2011 the DON and Administrator audited the personal care plans and tray cards for the residents #7,#9,#10,#11, and #12 to ensure accuracy. On 9/16/2011 the DON, infection control nurse, and the MDS Coordinator educated the nurse aides on the location of the swallowing precautions on the tray cards and in the personal care record books. On 9/16/2011 Administrative Nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were aware of swallowing precautions. On 9/16/2011 the speech therapist screened all residents on swallowing precaution for accuracy. Any noted new or revised recommendations were made at that time. Beginning on 9/16/2011 and ending on 9/30/2011 the speech therapist screened all resident at the facility to determine appropriateness of swallowing concerns. Any noted new or revised recommendations were made at that time. On 9/16/2011 a master list of the residents on swallowing precaution was developed and was made available to all nursing staff members. The dietary manager is responsible for keeping the master list updated. On 10/10/2011 the DON audited personal care records on all residents to confirm resident care planned for no straws. On 10/10/2011 Water	

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F 490	Continued From page 62 Each week the DON will review the swallowing precaution sheets received from the Speech Therapist. After the DON ensures swallowing precautions on the tray card are correct and swallowing strategies have been included in the personal care record, she will sign her copy of the swallowing strategies to acknowledge receipt/approval. The DON will also keep a copy of this sheet in a binder in her office. Swallowing precaution books were created to include a master list of residents with swallowing precautions and also included a copy of the emergency care for choking poster and a copy of the signs and symptoms of aspirations. The Dietary Manager will be responsible to keep the book up to date. In addition, the Administrator will audit the swallowing precaution book at least weekly to ensure the books are kept up to date. On 09/16/11, the Administrator educated the Dietary Manager, Speech Therapist, DON, Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and on the swallowing precaution book. On 09/20/11, a copy of the emergency care for choking poster was posted in the dining room. On 09/16/11, the DON, MDS Coordinator, and the Infection Control Nurse educated all nursing personnel on swallowing precautions and how they are effective. The form used by the Speech Therapist to inform staff of what swallowing interventions each resident required was explained to staff.	F 490	Pitchers for residents on No Straw list were audited to ensure compliance by the DON. A Swallowing Precaution Communication Procedure was established on 9/16/2011 and was revised on 9/26/2011, and is presently as follows: The Speech therapist will give a copy of the Swallowing Precautions to the Dietary Manager, the ADON, the infection control nurse and the DON. The Dietary Manager will ensure that the swallowing precautions are attached to the resident's tray card at each meal. The ADON will put a copy of the swallowing precautions with the resident's personal care record. Swallowing Precaution Books were created to include a master list of the residents with swallowing precautions, a copy of the swallowing precaution strategies, a copy of the Emergency Care for Choking Poster, and a copy of the signs and symptoms of aspiration. The Swallowing Precaution Books are kept in the dining room, at both nurses stations, and on the snack carts. The dietary manager is responsible for keeping books up to date. On 9/16/2011 the Administrator educated the dietary manager, the speech therapist, the DON, the infection control nurse and the ADON on the Swallowing Precaution Communication Procedure and on the Swallowing Precaution Books. On 9/20/2011 a copy of the Emergency Care for Choking Poster was posted in the dining room. On 9/16/2011 the DON, MDS Coordinator, and the Infection Control	

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F 490	Continued From page 63 On 09/16/11, nursing assistants were educated on where to locate the swallowing precautions master list where the residents' swallowing precaution strategies could be found. Staff was instructed on the locations of the master list: the personal care records, the tray cards, in binders located in the dining room on the snack cart, and at both nurses' stations. Beginning 09/19/11, all nursing personnel will be reeducated on the choking section of the nurse aide training curriculum. Beginning 09/20/11, all nursing personnel were reeducated on the signs and symptoms of aspiration. Nursing assistants were trained on what to do when a resident showed signs and symptoms of aspiration. No nursing personnel will work until trained. Beginning 09/20/11, nurses were reeducated on what to do if a nurse aide reports a resident has exhibited signs and symptoms of aspiration. No nursing personnel will work until trained. Upon hire, all employees will be educated on the facility swallowing procedures and the signs and symptoms of aspiration. On 09/16/11, administrative nurses observed nurse aides feeding residents on swallowing precautions to ensure that nursing assistants were aware of swallowing precautions. Beginning 09/17/11, the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor each	F 490	Nurse educated all nursing personnel on swallowing precautions and how they are effective. The form that Speech Therapy uses to inform staff of what swallowing interventions are needed was explained. Any questions that the staff members had regarding swallowing precautions and the form were answered. On 9/16/2011 nursing assistants were educated on where the swallowing precautions master list and the swallowing precaution strategies can be found. They were told that the locations include: the personal care records, the tray cards, and in binders located in the dining room, on the snack cart, and at both nurses stations. Beginning on 9/19/2011 and ending on 10/3/2011 the DON, the infections control nurse, and the MDS nurse reeducated all nursing personnel on the choking section of the nurse aide training curriculum. Beginning on 9/20/2011 and ending on 10/3/2011 the DON, the infection control nurse, and the MDS coordinator reeducated all nursing personnel on the signs and symptoms of aspiration. Also, Nursing Assistants were trained on what to do when a resident shows sign and symptoms of aspiration. Beginning on 9/20/2011 and ending on 10/3/2011 the DON reeducated the nurses on what to do when a nurse aide reports signs and symptoms of aspiration. On 9/26/2011 the DON and speech therapist educated all nursing personnel and the dietary manager on the revised swallowing precaution sheets and explained that the swallowing precaution sheet would be attached to the tray card going forward.	

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F 490	Continued From page 64 resident on swallowing precautions to ensure the nursing assistants were aware of the swallowing precautions, the swallowing precautions were being followed and the swallowing precautions were on the tray card. This quality assurance is to be done at every meal. During the lunch meal the licensed nurse assigned to the resident halls and the licensed nurse assigned to the dining room were to monitor all residents for signs and symptoms of aspiration to ensure that nursing assistants were aware of the signs and symptoms of swallowing issues. All nurses on duty on 09/20/11, were educated on the monitoring procedure, and nurses will be not allowed to work before being educated on the signs and symptoms of swallowing issues. The Medical Director was informed of the immediate jeopardy. Weekly the Administrator will observe meal service and will conduct audits to ensure compliance with the plan of correction. The Administrator will report the audit to the quality assurance committee on a quarterly basis. —The surveyors validated the corrective actions taken by the facility as follows: Observation of the noon meal on 09/21/11, revealed RN #4 in the dining room supervising CNAs feeding residents. Interview at this same time revealed the nurse was responsible for observing residents in the dining room to assure they have received the correct diet, that the diet and swallowing precautions were printed on the tray card, to assure the nursing aides were following swallowing precautions and observing	F 490	Beginning on 10/10/2011 the DON and the infection control nurse educated nursing personnel on labeling water pitchers with no straws for residents care planned for no straws. Employees will not be allowed to work until trained on labeling procedure. Employees on leave of absence will be educated before they are allowed to work. Weekly the DON will review the swallowing precaution sheets that she has received from the speech therapist. When she sees that the correct swallowing precautions are attached to the tray card and that the swallowing strategies are in the Personal Care Record books she will sign her copy of the Swallowing Strategies. She will keep a copy of this sheet in a binder in her office for 30 days. She will report the results of her audit to the QA subcommittee monthly for at least six months. The Administrator will audit the Swallowing Precaution Books at least weekly to ensure that they are up to date. Beginning 9/17/2011 at 5:00pm the licensed nurse assigned to the wing and the licensed nurse assigned to the dining room will monitor each resident on swallowing precautions to ensure that the nursing assistants are aware of the swallowing precautions, the swallowing precautions are being followed, and the swallowing precautions are attached to the tray card. This QA will be done at every meal for eight weeks and then one meal for four weeks.	

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F 490	Continued From page 65 for signs and symptoms of aspiration and choking. Interview further revealed there was a poster on the wall with interventions for choking; and there was a book with each resident on swallowing precautions, what the precautions were, what to do in the event of choking, and signs and symptoms of aspiration. RN #4 further stated she received in-service training on 09/19/11, regarding the need to supervise nursing aides while the aides fed residents, what swallowing precautions were, the swallowing precaution book, that all swallowing precautions were required to be on the tray card, and on choking and aspiration. Further observation of the noon meal on 09/21/11, revealed Residents #7, #11, and #10, in the dining room at a table assisted by a nursing assistant. Review of their tray cards revealed swallowing precautions were listed on the cards. Observation of the dining room on 09/21/11, revealed an emergency care for choking sign posted on the wall. Observation on 09/21/11, revealed a swallowing precaution book in the dining room, each nurses' station, and on each snack cart. Interview with the Speech Therapist (ST) on 09/21/11, at 3:30 PM, revealed she had conducted a current screening for all residents on swallowing precautions and had made any revisions or new recommendations for each resident. The ST went on to say she was responsible for providing a copy of the current swallowing precautions for each resident to the Dietary Manager (DM), ADON, Infection Control Nurse, and the DON. Interview further revealed	F 490	Nurses were educated on the procedure before they were allowed to work. Beginning on 10/10/2011 for eight weeks on Monday, Wednesday, and Friday the treatment nurse will audit water pitchers to ensure residents care planned for no straws do not have a straw in the water pitcher. After eight weeks the treatment nurse will audit water pitchers weekly to ensure residents care planned for no straws do not have a straw in the water pitcher. The DON and Administrator will review meal audits weekly to ensure that they are being completed. The DON and Administrator will provide reports to the facility QA committee no less than quarterly for one year. The facility will establish a QA subcommittee that will meet monthly for six months then no less than quarterly for one year that includes the following: the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Dietary Manager, the facility Corporate Consultant, and at least one staff nurse and two nursing assistants to review the facility plan of correction and the implementation of the same to ensure that the deficient practice is resolved and compliance is sustained. Beginning on 9/22/2011 and ending on 9/23/2011 Residents #6, #7, #9, #11, #15, and #17 were reassessed by the Bowel Management Nurse. After re-assessment Care plans and nursing assistant care plans were updated as indicated. Physician orders	

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F 490	Continued From page 66 the therapist had been educated by the Administrator on the need to provide a current copy of each resident's swallowing precautions to the DM, ADON, Infection Control Nurse, and the DON, and in the swallowing precaution book. Interview with the Administrator on 09/21/11, at 3:45 PM, revealed she is responsible for auditing the swallowing precaution book weekly to ensure it is up to date. She further stated she had educated the Dietary Manager, Speech Therapist, DON, Infection Control Nurse, and the ADON on the swallowing precaution communication procedure and the swallowing precaution book. Further interview revealed she would be observing meal service weekly and would perform an audit during that time to ensure the plan of correction was being followed. The Administrator stated she would report this audit at the quality assurance meeting quarterly. Interview with the DON on 09/21/11, at 3:15 PM, revealed she, along with the Administrator, had audited all personal care plans and tray cards and found no problems. Interview further revealed she is responsible to ensure the Dietary Manager puts all swallowing precautions on each resident's tray card. Further interview revealed she had assured the ADON had put a copy of the swallowing precautions strategies in each resident's personal care book. The DON further stated she received in-service training on 09/16/11, on swallowing precaution communication procedures and the swallowing precaution book. Interview further revealed each week the DON would verify the swallowing precautions were on the tray cards and in each resident's personal care book. She further stated	F 490	were requested as indicated. Resident #3 was discharged from the facility on 9/21/2011. Beginning on 9/22/2011 and ending on 9/30/2011 all residents were reassessed by the Bowel Management Nurse. After re-assessment Care plans and nursing assistant care plans were updated as indicated. Physician orders were requested as indicated. On 9/22/2011 the Bowel Management Protocol was reviewed by the director of nursing and the administrator. Changes were made to include the 7pm-7am nurses printing out a No BM report from care tracker at approximately 6:00am and placing it in a binder at the nurses' station. 7am-7pm will be responsible for assessing residents on the No BM list. The nurses will put interventions in place to prevent constipation. The nurses will document interventions in the nurses notes. On 9/26/2011 DON educated bowel management nurse and ADON on the Bowel Management Protocol. On 9/26/2011 DON educated all nursing staff members on the revised protocol and proper documentation of bowel movements. Beginning 9/26/2011 Bowel Management Nurse, ADON in her absence, will check the BM binders on Monday, Wednesday, and Friday for eight weeks and then weekly thereafter. The bowel management nurse	

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F 490	Continued From page 67 that after verifying the swallowing precautions were on the tray cards and in the personal care books, she would then sign her copy of the swallowing strategy for each resident and it would be kept in a binder in her office. Interview further revealed the DON had been in-serviced by the Administrator on the swallowing precaution communication procedures and the swallowing precaution book. Interview on 09/21/11, at 2:03 PM, with the Dietary Manager revealed it was her responsibility to ensure all swallowing strategies were on each resident's tray card. Further interview revealed the Dietary Manager is responsible for ensuring the swallowing precaution books are current and up to date for each resident on special feeding precautions. Interview further revealed she had been educated by the Administrator regarding the swallowing precaution communication procedure and the swallowing precaution book. Interview on 09/21/11, at 3:38 PM, with CNA #9, at 3:42 PM, with Nurse Aide #1, at 4:00 PM, with CNA #11, and at 4:10 PM, with CNA #4 revealed they had been in-serviced on swallowing precautions, where each resident's swallowing precautions were located, what to do when a resident chokes, and signs and symptoms of aspiration. Interview further revealed a nurse has to be in the dining room before they can begin feeding the residents, and they are required to look at each resident's tray card and ensure precautions are followed. Interview with LPN #5 on 09/21/11, at 3:47 PM, and RN #2 at 4:15 PM, revealed they had been in-serviced on resident swallowing precautions	F 490	will ensure that nurses have printed the BM report off of care tracker each day. She will ensure that any residents who have not had a bowel movement within 48 hours have been assessed by the nurse. The bowel management nurse will look to see that interventions have been put in the BM book and that the assessment and interventions are documented in the nurse's notes. Reeducation will be done by the bowel management nurses as needed. At least weekly the DON will review the system to ensure compliance. The DON will report her review to the administrator weekly. The DON will report her findings to the QA subcommittee monthly for 6 months then no less than quarterly for one year to review the plan of correction to ensure the deficient practice is resolved and compliance is sustained. Feeding Assistant- Training/Supervision/Resident Residents #7, #9, and #11 were on swallowing precautions and were being feed by paid feeding assistants. On 9/15/2011 the facility determined that paid feeding assistants would no longer be used to feed residents. Only residents #7, #9, and #11 were being feed in the dining room. Paid feeding assistants were only allowed to feed in the dining room. No other residents were being feed by paid feeding assistants.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185168		C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

(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 490	Continued From page 68 and all precautions have to be on the tray card and in the swallowing strategy book. They further stated they had also been in-serviced on signs and symptoms of aspiration and what to do if a resident chokes. Interview further revealed they were instructed to monitor the dining room and/or the resident floors to ensure nurse aides were following swallowing precautions, and to observe for aspiration/choking. Interview on 09/21/11, at 2:00 PM, with the Medical Director revealed she had been informed of the immediate jeopardy identified at the facility. Review of the personal care records audit revealed the DON and Administrator had audited all personal care plans and tray cards for each resident on swallowing precautions on 09/16/11, and found no discrepancies. A review of the new swallowing precaution communication procedure revealed the procedure was implemented on 09/16/11. A review of the facility's training records revealed evidence that employees of the facility, except for those on vacation or on medical leave, had received training on swallowing precautions and how they are effective on 09/16/11. Any employee who did not attend training was informed they will not be allowed to work until trained. Further review revealed nursing assistants had received training on 09/16/11, on the location of the swallowing precautions master list, and the swallowing precaution strategies. Review further revealed on 09/19/11, nursing personnel were educated on the choking section of the nurse aide training curriculum. Facility	F 490	Effective 9/15/2011 paid feeding assistants were no longer allowed to feed residents at the facility. A Sign Notifying all employees that paid feeding assistants were no longer allowed to feed residents at the facility was posted in the dining room and at the time clock. Also, the information was reported on the 24 hour nursing report. Going forward we will not use paid feeding assistants at this facility. On 9/16/2011 the Administrator and/or the Activity Director informed the paid feeding assistants of their job duties at the facility. Going forward one of the paid feeding assistants will work only in the activity department. The other three paid feeding assistants will be assigned the title of nursing helper. On 9/19/2011 each nursing helper signed a list of tasks that she will be performing. All nursing personnel and dietary staff members were informed that paid feeding assistants would no longer be used at Monroe Health and Rehabilitation Center. The facility corporate consultant visited the facility on 9/19/11, 9/20/11, 9/22/11 and on 9/29/11 to review with the Administrator and Director of Nursing the deficiencies and the plan of correction. She verified on 9-22-11 that the plan of correction had been implemented as directed and that documentation to support the implementation was present. The administrator called an intermittent QA subcommittee meeting on 9/22/2011 that	

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	185168		C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 69 training records further revealed on 09/20/11, nursing personnel were educated on signs and symptoms of aspiration. A review of "Swallowing Precaution Education" to be given to employees upon hire revealed the facility would ensure newly hired employees were educated on each resident's swallowing precautions, signs and symptoms of aspiration, and emergency preparedness for choking. A review of facility tray cards for the nine residents assessed by the facility to require swallowing strategies revealed each card contained the resident's required strategies. A review of the facility's swallowing precaution quality assurance log revealed from 09/16/11-09/21/11, staff had monitored tray cards to ensure each resident with a swallowing strategy had the strategy on their tray card, that the nurse aide was adhering to the swallowing precautions, and if further staff education was needed. Based on the above findings, the State Agency determined Immediate Jeopardy was removed on 09/21/11, prior to exit, which lowered the scope and severity to "E" while the facility monitors the effectiveness of systemic changes and quality assurance actions.	F 490	included the Medical Director, the Administrator, the Director of Nursing, the MDS Coordinator, an LPN, the Dietary Manager, the Infection Control Nurse, and the facility Corporate Consultant. The facility's deficient practices and plan of correction were discussed. The Medical Director gave her input regarding the deficiencies and the plan of correction. The facility will establish a QA subcommittee (beginning 10/18/2011) that will meet monthly for 6 months then no less than quarterly for one year that includes the following: the Administrator, the Director of Nursing, the Assistant Director of Nuirsing, the Dietary Director, the facility Corporate Consultant, and at least one staff nurse and two nursing assistants to review the facility plan of correction and the implementation of the same to ensure that the deficient practice is resolved and compliance is sustained. The corporate consultant will report on these meeting to the Vice President of Operations.	10/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185168	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/20/2011

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Six COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 09/20/11, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.