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	445139	A. BUILDING _____ B. WING _____	C 08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT ST PETER VILLA	141 N MCLEAN MEMPHIS, TN 38104

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F 000	INITIAL COMMENTS An abbreviated survey was initiated on August 14, 2014 for complaint #'s TN00033506, TN00033532, TN00033605, TN00033862, TN00033863, TN00034016, TN00034107, TN00034235, TN00034355, TN00034446 and TN00034529. There were no deficiencies cited for complaint #'s TN00033506, TN00033862, TN00033863, TN00034016, TN00034107, TN00034235, TN00034355, TN00034446 and TN00034529. Complaints #TN00033532 had deficiencies cited at F225 J, F226 J, F490 J and F520 J and TN00033605 had deficiencies cited at F224 J, F281 J, F282 J, F309 J, F365 J, F490 J and F520 J. The recertification survey was conducted from August 14, 2014 through August 27, 2014. The following citations were cited at immediate jeopardy level on the recertification survey F224 J, F225 J, F226 J, F281 J, F282 J, F309 J, F328, F329 J, F365 J, F456 J, F505 J, F490 J and F520 J. The immediate jeopardy (IJ) existed from 2/14/14 through 8/25/14. The IJ was removed on 8/26/14. The facility was cited an IJ which is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious harm, injury, impairment, or death to a resident for the following citations: a. F224 J - The failure of the facility to follow accepted POC 9/19/14 sppln	F 000	Signature HealthCARE at St. Peter's Villa does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. RECEIVED SEP 2 2 2014	9/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bette Dodson
TITLE: Administrator
(X6) DATE: 9/17/2014

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.

This same POC was faxed 9/19/14 dd

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physician orders for a therapeutic diet, to monitor a resident during dining or perform the Heimlich Maneuver when a resident was noted to be choking placed Resident #261 in IJ.

b. F225 J - The failure of the facility to ensure the abuse policies were implemented to ensure allegations of abuse were thoroughly investigated and reported to administration placed Resident #130 in IJ.

c. F226 J - The failure of the facility to ensure residents were protected from potential staff-to-resident abuse during investigation of an abuse allegation placed Resident #130 in IJ.

d. F281 J - The failure of the facility to ensure adherence to current medical standards of practice related to emergency services for choking resulted in IJ and the subsequent choking death of Resident #261.

e. F282 J - The failure of the facility to ensure the care plan interventions were followed for serving the correct therapeutic diet, and receiving assistance with dining resulted in an IJ for Residents #261 and 6.

f. F309 J - The failure of the facility to ensure physician's orders were followed related to therapeutic diets resulted in an IJ for Residents #261 and 6 when they received the incorrect diets which resulted in the choking death of Resident #261.

g. F328 J and F456 J - The failure of the facility to ensure timely tracheostomy care was provided when functioning suction equipment was not readily available placed Resident #193 in IJ.

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F 000	Continued From page 2	F 000		

h. F329 J - The failure of the facility to ensure drug regimens were accurate with adequate monitoring and reporting of lab values related to anticoagulant medications resulted in IJ for Residents #25 and 205.

i. F365 J - The failure of the facility to ensure residents received the correct therapeutic diet resulted in an IJ for Residents #261 and 6 which resulted in the choking death of Resident #261.

j. F490 J - The failure of the facility to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable physical and psychosocial well-being of residents as evidenced by the IJ's as noted above.

k. F505 J - The failure of the facility to notify the physician in a timely manner of Prothrombin Time / International Normalized Ratio (PT/INR) lab values related to anticoagulant therapy resulted in IJ for Residents #25 and 257.

l. F520 J - The failure of the facility to ensure the Quality Assessment and Assurance (QAA) committee implemented a method of identifying concerns and implementing plans of action to correct identified concerns related to chocking, therapeutic diets and improper suctioning equipment which resulted in IJ.

The IJ for F224 "J," F225 "J," F226 "J," F309 "J," F328 "J" and F329 "J" constitutes Substandard Quality of Care.

An extended survey was conducted from August 26, 2014 to August 27, 2014.

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The Administrator and the Director of Nursing (DON) were informed of the IJ related to abuse and choking in the conference room on August 18, 2014 at 4:52 PM.

An acceptable Allegation of Compliance, which removed the immediacy of the IJ, was received on August 25, 2014, and corrective actions were validated onsite by the surveyors on August 26, 2014.

The Administrator and the DON were informed of the IJ related to failure to promptly notify the physician of lab results in the conference room on August 20, 2014 at 12:15 PM.

An acceptable Allegation of Compliance, which removed the IJ, was received on August 25, 2014, and corrective actions were validated onsite by the surveyors on August 26, 2014.

The Administrator and the DON were informed of the IJ related to the suctioning equipment malfunction in the conference room on August 21, 2014 at 12:46 PM.

An acceptable Allegation of Compliance, which removed the IJ, was received on August 26, 2014, and corrective actions were validated onsite by the surveyor on August 26, 2014.

Noncompliance for F224, F225, F226, F281, F282, F309, F328, F329, F365, F456, F490, F505 and F520 continues at a "D" level citation, which is an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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F 000	Continued From page 4 The facility is required to submit a plan of correction for all deficiencies cited.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, review of the investigator's report, review of an autopsy, medical record review and interview, it was determined the facility neglected to follow physician orders for a therapeutic diet, neglected to monitor a resident during dining and failed to perform the Heimlich Maneuver (action to remove what is blocking the airway) when a resident was noted to be choking for 1 of 15 (Resident #261) sampled residents reviewed for neglect of the 39 residents included in the stage 2 review. The facility neglected to monitor Resident #261 during dining and staff neglected to perform the Heimlich Maneuver to prevent choking and suffocation which resulted in the choking death of Resident #261. This incident resulted in an immediate jeopardy (IJ) which is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is	F 224	1. Resident #261expired 3/27/14. LPN# 20 and CNA #30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. 2. All residents have the potential to be affected by the same practice. • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. 3. What measures will be put into place to insure that this practice does not recur? • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to effect correct diets on the MAR. •A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.	9/25/14

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F 224	Continued From page 5 likely to cause, serious injury, harm, impairment, or death to a resident. The immediate jeopardy for F224 constitutes substandard quality of care. An extended survey was completed on 8/26/14 and 8/27/14. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) when they were informed of the IJ. The facility provided an acceptable Allegation of Compliance on August 25th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the Immediate Jeopardy. The immediate jeopardy (IJ) existed from 3/27/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F224 continues at a "D" level citation. The facility is required to submit a Plan of Correction. The findings included: Review of the facility's neglect policy documented, "...neglect... of the resident... are prohibited..." Review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, third edition, page 576, management of obstructed airway, documented, "The two techniques for relieving foreign body airway obstruction are	F 224	• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies. • Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse. • Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations. • Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room. • Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14	

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F 224	Continued From page 6 manual chest and abdominal thrusts (Heimlich maneuver) and finger sweeps." Medical record review for Resident #261 documented an admission date of 6/4/12 with a readmission date of 12/13/12 with diagnoses of Hemiplegia affecting Non Dominant Side, Lack of Coordination, Difficulty in Walking, Oropharyngeal Dysphagia, Aphasia, Dysarthria, Hypertension, Hemiplegia affecting Dominant Side, Muscle Weakness, Cerebral Vascular Accident with Left Sided Weakness, History of Cerebral Vascular Accidents, Diabetes Type 2, Benign Prostatic Hypertrophy, Dementia and Hyperlipidemia. Review of the physician's orders dated 3/1/14 through 3/31/14 and signed by the physician on 3/18/14 documented, "...MECHANICAL SOFT DIET WITH PUREED MEAT..." Review of a care plan dated 5/16/13 and reviewed 2/14 documented a problem that Resident #261 is a nutrition risk due to a swallowing problem related to dysphagia and requires a mechanically altered diet. The interventions to provide the diet as ordered by the physician, monitor the intake and no bread. The care plan documented Resident #261 was to be upright for all meals, staff to feed all meals and aspiration precautions. Review of a nurses note dated 3/28/14 documented, "...cna [certified nursing assistant #30] served resident's [Resident #261] supper. The supper consisted of the following items 4 oz [ounces] of pulled pork... at approximately 5:31 PM the cna [#30] returned to check on him [Resident #261]... the cna [#30] immediately sought out the nurse [#20] at 5:32pm... LPN	F 224	4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? • A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained. • A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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[licensed practical nurse] #20 immediately responded... noticed that the resident was in ditress [distress] and noted resident's [#261] lips were bluish in color... the resident was still breathing at this time. The LPN [#20] stimulated the resident with cardiac massage... a code blue was called... compressions were commenced until EMT's [Emergency Medical Technicians] arrived. Breaths were administered between compressions... EMT arrived at 5:45pm...The EMT's and the first responder hooked him [Resident #261] up to a monitor... stopped the code at approximately 5:55pm..." There was no documentation the facility staff performed the Heimlich maneuver on Resident #261.

Review of the investigator's report signed and dated on 3/27/14 documented, "... [Named Rescue Team] arrived on the scene and cleared his [Resident #261] airway but asystole [no heart beat] was confirmed at 1755 [5:55 PM] by paramedics... [Named Officer] advised the following: this black male was eating dinner and began choking on his food... Fire department paramedics removed the food from his airway and staff threw it away. Due to this accident jurisdiction was accepted and this black male was transported to the [Named] forensic center for further examination [autopsy]..."

Review of the autopsy report signed and dated on 5/16/14 documented, "...Date of Autopsy Examination: March 28, 2014... CAUSE OF DEATH: Asphyxia due to choking... INTERNAL EXAMINATION... RESPIRATORY SYSTEM... Non-digested food and mucus partially occlude the upper airway, and pieces of non-digested food occlude the lobar bronchi and some more distal branches... SUMMARY AND

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F 224	Continued From page 8 INTERPRETATION... Based on the autopsy findings... the cause of death is attributed to asphyxia due to choking..." During an interview in the conference room on 8/14/14 at 4:30 PM, the DON was asked what Resident #261 choked on. The DON stated, "I believe it was pulled pork or roast beef." During an interview in the conference room on 8/14/14 at 5:00 PM, CNA #30 was asked if she was present during Resident #261's choking incident. CNA #30 stated, "I brought his tray in his room... He usually would eat out in the dining room... I went back in to check on him and he seemed like he was in stress, like something was wrong. I asked him if he was okay, and he raised up his hand... When black people hold their hand up we know something's wrong. I went immediately and got the nurse. After that, the nurses took over..." CNA #30 was asked about how long it took the nurse to respond. CNA #30 stated, "It didn't really take long... I yelled in the hallway. 'Mr. [first name of Resident #261] is in distress'. She [Nurse #20] came right there." CNA #30 was then asked what type of diet was Resident #261 on. CNA #30 stated, "I don't really remember if he was on a regular diet or a pureed diet. It looked like roast beef, it was like stringy. I can't remember what else he had." CNA #30 was asked if the meat was pureed and if it had gravy on it. CNA #30 stated, "It [meat] didn't look like pureed. I don't remember any gravy on it." The facility neglected to ensure Resident #261 received the proper therapeutic diet, neglected to monitor Resident #261 during dining, and neglected to perform the Heimlich maneuver when Resident #261 was noted to be in distress,	F 224		

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which resulted in an immediate jeopardy when Resident #261 subsequently choked to death.

Validation of the Credible Allegation of Compliance (AOC) was accomplished on August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with nursing, dietary and administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the immediate jeopardy.

The facility provided evidence of in-service training with sign in sheets, for all staff on the Heimlich maneuver, tray service to include review of each meal ticket for verification of correct diet served and color coded meal tickets for therapeutic diets.

The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager.

The facility provided evidence of audits for accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays.

Interviews with CNAs, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets, what a colored meal ticket means, and how to do the Heimlich maneuver. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery.

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F 224	Continued From page 10 Observations in the kitchen on 8/26/14 revealed the meal ticket being checked at each station, the condiments and fluid station, the entree station and at the bread and dessert station the entire meal tray was reviewed by that staff member to ensure the tray was correct. Observations in the facility on 8/26/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then a second check by the staff member when the tray is delivered to the resident. The facility will remain out of compliance at a scope and severity level of "D", an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 224		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	1. The allegation of abuse was reported to the State of Tennessee on 2/21/14 on Resident #130 by the Director of Nursing. Resident #130 full body assessment was completed on 2/17/14 by a licensed nurse and 2/18/14 by the nurse practitioner and no physical signs of injuries were noted. Resident #130 was seen by the psychiatrist on 3/16/14 and no recommendation or medication changes were made. CNA#34 was suspended on 2/17/14 and resigned 2/21/14. Nurse #22 resigned on 2/21/14. 2. All residents are at risk for mistreatment, neglect, abuse, injuries of unknown injuries or unknown source and misappropriation of resident property. The facility plans to protect the residents by: a. Reporting abuse allegations immediately to the Abuse Coordinator. b. Suspending the perpetrator immediately. c. All allegation of abuse must be reported to the police, APS, Ombudsman, and State of Tennessee. d. Transfer all residents with an allegation of rape to the ER for examination by a physician. e. All alleged violations will be thoroughly investigated and prevent further potential abuse while the investigation is in progress.	9/25/14

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F 225	Continued From page 11 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a time detail sheet, review of a suspension form, medical record review and interview, it was determined the facility failed to immediately report an alleged rape to the Director of Nursing (DON) or administrator, failed to thoroughly investigate this allegation and failed to prevent further potential abuse during the investigation for 1 of 15 (Resident #130) sampled residents reviewed for abuse of the 39 residents included in the stage 2 review, which placed Resident #130 in immediate jeopardy. Immediate jeopardy is a situation in which the provider's noncompliance with one or	F 225	3. What measures will be put into place to insure that this practice does not recur? • All residents on 8/20/14 were interviewed related to abuse and neglect. And all residents that are non-interviewable were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident's POA were attempted to be contacted to question on any abuse/neglect concerns on 8/20/14. A total of 70 POA contacted and interviewed on 8/29/14. Abuse audits, assessments, interviews and questionnaires were reviewed by the Administrator, Director of Nursing and Social Services Director on 8/19/14 for any indications of abuse/neglect concerns. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Social Services Director. • 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation. • Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14.	

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F 225	Continued From page 12 more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The immediate jeopardy for F225 constitutes substandard quality of care. An extended survey was completed on 8/26/14 and 8/27/14. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON) at which time they were informed of the Immediate Jeopardy. The facility provided an acceptable Allegation of Compliance (AOC) on August 25th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the Immediate Jeopardy. The immediate jeopardy (IJ) existed from 2/14/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F225 continues at a "D" level citation. The facility is required to submit a Plan of Correction. The findings included: Review of the facility's abuse policy documented, "...Verbal, sexual, physical and mental abuse... are prohibited... If the person reporting the abuse believes there is a lack of response from the charge nurse the person will then notify the DON and/or Administrator. If DON/Administrator are not in the facility staff will notify them via phone... The charge nurse will immediately remove the suspected perpetrator from resident care areas,	F 225	• 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation. • Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14. 4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put in place. • A staff questionnaire regarding abuse is being administered by Administrator, DON, ADONs, MDSC, Activities director, Chaplain, Dietary manager, Chaplain, Marketing, Admissions/Marketing, Rehab Manager, Medical Records, HR director to staff members beginning 8/19/2014 with 20 staff members per week for one month, then 15 staff members per week for one month, then 10 staff members per week for one month, then 5 staff members per week for one month, then weekly random audit for 3 months. If less than 100% was met on the questionnaire a re-education will be conducted until 100% is met. • Elder Justice Act signs have been moved and made more visible in the facility. • HR completed an audit on 8/23/14 of all active employees related to background checks. Audit revealed that all active employees have a background check with no issues. • The Administrator, Social Services Director, Director of Nursing or Weekend Supervisor will review the grievances, incidents and accidents reports daily beginning 8/23/14 to determine if there are reportable allegations that have not been identified. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Administrator, Director of Nursing and Social Services Director. The Director of Nursing will report any allegations of abuse, neglect or misappropriation to the outside agency • A resident council meeting held on 8/27/14 with Activities Director going over Resident's Rights and Abuse.	

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F 225	Continued From page 13 obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation... The charge nurse will immediately notify the Administrator, DON, and/or Abuse Coordinator... All allegations of abuse will be investigated..." Medical record review for Resident #130 documented an admission date of 2/13/13 with diagnoses of Congestive Heart Failure, Hypertension, Chronic Angina, Status Post Automatic Implantable Cardioverter Defibrillator, Digoxin Toxicity, Deconditioning, Hyperlipidemia, Urinary Retention, Benign Prostatic Hypertrophy, Bladder Outlet Obstruction, Peptic Ulcer Disease, Anemia, Acute Renal Disease Secondary to Post Obstructive Uropathy and Dementia. Review of an annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/21/14 documented Resident #130 had a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident is moderately cognitively impaired, and required extensive assistance from staff for all Activities of Daily Living (ADLs). The MDS documented Resident #130 had no mood or behavioral symptoms. Review of a quarterly MDS for Resident #130 with an ARD of 7/12/14 documented a BIMS of 7, indicating the resident is severely cognitively impaired, and the resident was totally dependent on staff for all ADLs. The MDS documented that Resident #130 had no mood or behavioral symptoms. Review of a nurse's note dated 2/15/14 at 2:30 PM, documented, "...CNA [certified nursing assistant #33] reported, [Resident #130] stated he was raped. Reported to Supervisor [Nurse	F 225	• A family council meeting scheduled for 9/25/14 with Social Services Director to go over Resident's rights and Abuse. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluation of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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F 225	Continued From page 14 #22] of what resident said..." This note was written by Nurse #21. Review of the social service progress notes documented the following: a. 2/17/14 - "...[CNA #33] informed Nurse [#22] that resident [#130] stated he had been raped 2-14-14. DSS [Director of Social Services]... spoke with resident... Resident [#130] stated the name of a male CNA [#34] who raped him..." b. 2/20/14 - "...DSS visited with resident. Resident [#130] said everything he reported [alleged rape on the night of 2/14/14 by CNA #34] to me the other day was true..." Review of CNA #34's "TIME DETAIL" sheet documented CNA #34 worked Friday, 2/14/14, from 3:00 PM to 9:45 PM and 10:15 PM until 10:58 PM, Saturday, 2/15/14, from 3:28 PM to 9:53 PM and 10:27 PM to 11:06 PM, Sunday, 2/16/14, from 2:59 PM to 9:56 PM and 10:26 PM to 11:00 PM, and Monday, 2/17/14 from 2:58 PM to 4:01 PM. Review of a suspension form dated 2/17/14 documented, "...[CNA #34] name... Date of Incident: 2/14/14..." The suspension form was signed and dated by the DON, the Administrator, a Human Resources witness and accused CNA #34 on 2/17/14. Accused CNA #34 was not suspended until 3 days after the alleged rape. Review of a physician's progress note on Resident #130 dated 3/20/14 documented, "...allegation of sexual contact/assault last month..." Review of Resident #130's mental health and behavioral health visit notes documented the	F 225		

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following:
a. 3/27/14 - "...RECENT PHYSICAL DECLINE AND CLAIMS OF SEXUAL ABUSE BY STAFF... APPETITE REMAINS POOR AND OVERALL MOOD APPEARS HOPELESS AND WITHDRAWN..."
b. 4/3/14 - "...Chief Complaint... RECENT PHYSICAL DECLINE AND CLAIMS OF SEXUAL ABUSE BY STAFF... Delusions... None... Hallucinations... None..."
c. 4/4/14 - Resident #130 was demonstrating sleep disturbances, loss of appetite, weight loss, increased dependency in self-care, increased withdrawal/isolation, depressed mood, decreased energy, decreased enjoyment/interest, and tearfulness. The psychiatric consult documented, "...Processed alleged assault experience w [with] / patient-reviewed / explored details of incident & [and] related thoughts, emotions... Patient was initially guarded re [related to]: alleged assault & his depressive symptoms; however, he became more forthcoming as session progressed. He discussed as many details as he could recall, as well as his thoughts and emotions re: incident [alleged rape on night of 2/14/14]..."

During an interview in Resident #130's room on 8/14/14 at 2:10 PM, Resident #130 was asked whether anyone had ever mistreated him here at the facility. Resident #130 stated that once a homosexual man had spoken inappropriately to him. The interview was postponed due to Resident #130's roommate being present in the room. Later on 8/14/14 at 3:25 PM, Resident #130 was asked for more information regarding the mistreatment he had spoken of earlier. Resident #130 stated, "He [CNA #34] tried to have sexual intercourse, tried to penetrate, the girl [CNA #33] that washed me and cleaned me

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up asked me why I had all this grease on me." Resident #130 stated he had told her [CNA #33] what happened and she told the nurse [#21]. Resident #130 was asked whether he had been taken to the doctor when the incident occurred. Resident #130 stated he had not.

During an interview in the conference room on 8/14/14 at 3:00 PM, the DON was asked what should happen if a resident reports rape or sexual abuse. The DON stated, "Staff should tell me immediately, interview the resident for details, body audit of the resident." The DON was asked what type of exam was performed and how soon was it done after the alleged rape was reported. The DON stated, "A body audit, remove the clothes, look at the area, look at the anal area if they say they were penetrated. Physician and families are notified, suspend the alleged perpetrator if identified, try to get them done immediately." The DON was asked whether the resident should be sent to the emergency room (ER) for a rape kit after an instance where there was possible physical evidence, such as jelly-like substance found on the resident's buttocks. The DON stated, "Yes, then we could send them to the ER."

Resident #130 was not examined immediately nor was he sent to the ER for a rape kit.

During an interview in the conference room on 8/14/14 at 6:05 PM, the DON was asked why the exam on Resident #130 was not performed until 3 days after the alleged incident. The DON stated the incident "Was not reported to us [administrative staff] until later [2/17/14]." The DON was asked whether the police had been notified. The DON stated, "No." The DON was

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asked whether a physician had examined Resident #130 after the incident occurred. The DON stated, "I don't know."

During an interview in the conference room on 8/14/14 at 6:10 PM, the Administrator was asked what is the facility's protocol if an alleged rape is reported. The Administrator stated, "We would definitely investigate thoroughly." The Administrator was asked whether the resident would be sent to the hospital for a rape kit. The Administrator was nodding her head in agreement and stated, "We would do that or get a doctor or nurse practitioner to examine him."

During a telephone interview on 8/15/14 at 3:37 PM, accused CNA #34 was asked what had happened during his shift on 2/14/14 regarding Resident #130 and the alleged abuse allegation. Accused CNA #34 stated, "The allegation was false. I resigned. They [facility] did no rape kit or anything. If they would have called the police, I would have been fine with it. They [facility] did not do a proper investigation." Accused CNA #34 was asked whether he had been suspended during the investigation. Accused CNA #34 stated, "No Ma'am. I was not suspended. I worked all the way through. I worked that weekend."

During a telephone interview on 8/18/14 at 2:56 PM, CNA #33 was asked what she recalled of the alleged rape of Resident #130 on the night of 2/14/14. CNA #33 stated she had gone in to talk to Resident #130 at the beginning of her shift on 2/15/14, like she normally does. He told her that he thought he had been raped. CNA #33 stated she had told the nurse on duty (Nurse #21) and the nurse supervisor (Nurse #22). CNA #33 stated, "They [Nurse #21 and Nurse #22] did not

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tell me anything. I waited a couple of hours, and then I went and cleaned him [Resident #130] up. There was a jelly-like substance on him that was clear." CNA #33 was asked whether the police were called. CNA #33 stated she did not know. CNA #33 was asked whether Resident #130 had been taken to the hospital for an exam after the alleged incident. CNA #33 stated, "Not that I know of."

During an interview in the conference room on 8/18/14 at 3:15 PM, the DSS was asked what is the facility's policy if a resident reports abuse. The DSS stated, "It's reported to the supervisor immediately. They call the Administrator and the DON. The accused is suspended immediately, authorities are notified, police, elder abuse, [Named Administrator]. Have been talking about that. We should have reported this one to the police."

During an interview at the nurses' station on 8/19/14 at 8:05 AM, Nurse Practitioner (NP) #1 was asked if she remembered the incident that occurred with Resident #130 on 2/14/14 regarding the alleged abuse. NP #1 stated, "It was such a significant event. [Named Nurse #12 nurse manager for the floor] told me there had been an occurrence. The resident had complained he was molested or raped, and she [Nurse #12] said could you examine him. She [Nurse #12] said it had happened 3 or 4 days ago [2/14/14]. Cannot find my progress note. I vaguely remember asking someone to copy it, and handed it to someone, but cannot remember who it was. There is a billing sheet attached to my sheets, and every time I document, I tear it off and put it in my bag. I don't have that either. It's not at the office either, very unfortunate." This

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F 225	Continued From page 19 was not done. During an interview at the fourth floor nurse's station on 8/20/14 at 8:45 AM, Nurse #12 was asked about the alleged rape of Resident #130 that occurred on the night of 2/14/14. Nurse #12 stated, the allegation "happened over the weekend [2/14/14]. Was a couple of days before I found out. I did a body audit." Nurse #12 was asked what is the facility's policy regarding sexual abuse allegations. Nurse #12 stated, "They are supposed to report to the nurse. Suppose to triage it. The person they are accusing is suspended, police should be called, the patient should actually be sent out at the time of the incident, immediately do a body audit, send patient to the hospital. Notify the DON." The facility was unable to provide any written evidence that a physical exam had been performed on Resident #130 concerning the alleged sexual assault on 2/14/14. The facility failed to promptly suspend the alleged perpetrator; failed to notify the police; failed to provide a complete and appropriate medical examination; failed to promptly notify the DON or Administrator and failed to thoroughly investigate an allegation of rape which placed Resident #130 in immediate jeopardy. Validation of the Credible Allegation of Compliance (AOC) was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records and interviews with nursing and administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the immediate jeopardy.	F 225		

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F 225	Continued From page 20 The facility provided evidence that all staff received an abuse in-service and an abuse questionnaire, on which they were required to answer 100 percent correctly. Review of 5 of 5 new hire personnel files were reviewed and contained evidence of background and abuse registry checks before hire. Interviews were completed with nursing and administrative staff to ensure staff were knowledgeable of proper procedures regarding the reporting of abuse and protection of the residents. An interview was conducted with the Abuse Prevention Coordinator, in which she stated that weekly Performance Improvement meetings have been scheduled. The facility will remain out of compliance at a scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	1. The allegation of abuse was reported to the State of Tennessee on 2/21/14 on Resident #130 by the Director of Nursing. Resident #130 full body assessment was completed on 2/17/14 by a licensed nurse and 2/18/14 by the nurse practitioner and no physical signs of injuries were noted. Resident #130 was seen by the psychiatrist on 3/16/14 and no recommendation or medication changes were made. CNA#34 was suspended on 2/17/14 and resigned 2/21/14. Nurse #22 resigned on 2/21/14.	9/25/14

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F 226	Continued From page 21 Based on policy review, review of a time detail sheet, review of a suspension form, medical record review and interview, it was determined the facility failed to implement their abuse policy when staff failed to immediately report an alleged rape to the Director of Nursing (DON) or administrator, failed to thoroughly investigate this allegation and failed to protect residents from potential abuse during an alleged abuse investigation for 1 of 15 (Resident #130) sampled residents reviewed for abuse of the 39 residents included in the stage 2 review. The facility failed to notify the police after a staff to resident rape allegation; failed to provide an appropriate medical exam and failed to promptly suspend the alleged perpetrator which placed Resident #130 in immediate jeopardy. Immediate jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The immediate jeopardy for F226 constitutes substandard quality of care. An extended survey was completed on 8/26/14 and 8/27/14. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON) at which time they were informed of the immediate jeopardy. The facility provided an acceptable Allegation of Compliance on August 25th. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the immediate jeopardy.	F 226	2. All residents are at risk for mistreatment, neglect, abuse, injuries of unknown injuries or unknown source and misappropriation of resident property. The facility plans to protect the residents by: a. Reporting abuse allegations immediately to the Abuse Coordinator. b. Suspending the perpetrator immediately. c. All allegation of abuse must be reported to the Police, APS, Ombudsman, and State of Tennessee. d. Transfer all residents with an allegation of rape to the ER for examination by a physician. e. All alleged violations will be thoroughly investigated and prevent further potential abuse while the investigation is in progress. 3. What measures will be put into place to insure that this practice does not recur? • All residents on 8/20/14 were interviewed related to abuse and neglect. And all residents that are non-interviewable were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident's POA were attempted to be contacted to question on any abuse/neglect concerns on 8/20/14. A total of 70 POA contacted and interviewed on 8/29/14. Abuse audits, assessments, interviews and questionnaires were reviewed by the Administrator, Director of Nursing and Social Services Director on 8/19/14 for any indications of abuse/neglect concerns. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Social Services Director. • 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation. • Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14.	

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F 226	Continued From page 22 The immediate jeopardy (IJ) existed from 2/14/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F226 continues at a "D" level citation. The facility is required to submit a plan of correction. The findings included: Review of the facility's abuse policy documented, "...sexual, physical and mental abuse... are prohibited... All allegations of abuse... Protection of the Resident... If the person reporting the abuse believes there is a lack of response from the charge nurse the person will then notify the DON and/or Administrator. If DON / Administrator are not in the facility staff will notify them via phone... The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation... The charge nurse will immediately notify the Administrator, DON, and/or Abuse Coordinator as appropriate... Investigation... All allegations of abuse will be investigated... The Administrator/designee will make all reasonable efforts to investigate and address alleged reports..." Medical record review for Resident #130 documented an admission date of 2/13/13 with diagnoses of Congestive Heart Failure, Status Post Automatic Implantable Cardioverter Defibrillator, Hypertension, Chronic Angina, Digoxin Toxicity, Deconditioning, Hyperlipidemia, Urinary Retention, Benign Prostatic Hypertrophy, Bladder Outlet Obstruction, Peptic Ulcer Disease, Anemia, Acute Renal Disease Secondary to Post	F 226	4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put in place. • A staff questionnaire regarding abuse is being administered by Administrator, DON, ADONs, MDSC, Activities director, Chaplain, Dietary manager, Chaplain, Marketing, Admissions/Marketing, Rehab Manager, Medical Records, HR director to staff members beginning 8/19/2014 with 20 staff members per week for one month, then 15 staff members per week for one month, then 10 staff members per week for one month, then 5 staff members per week for one month, then weekly random audit for 3 months. If less than 100% was met on the questionnaire a re-education will be conducted until 100% is met. • Elder Justice Act signs have been moved and made more visible in the facility. • HR completed an audit on 8/23/14 of all active employees related to background checks. Audit revealed that all active employees have a background check with no issues. • The Administrator, Social Services Director, Director of Nursing or Weekend Supervisor will review the grievances, incidents and accidents reports daily beginning 8/23/14 to determine if there are reportable allegations that have not been identified. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Administrator, Director of Nursing and Social Services Director. The Director of Nursing will report any allegations of abuse, neglect or misappropriation to the outside agency.	

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F 226	Continued From page 23 Obstructive Uropathy and Dementia. Review of a nurse's note dated 2/15/14 at 2:30 PM, documented, "...CNA [certified nursing asssitant #33] reported, [Resident #130] stated he was raped. Reported to Supervisor [Nurse #22] of what resident said..." This note was written by Nurse #21. Review of the social service progress notes documented the following: a. 2/17/14 - "...[CNA #33] informed Nurse [#22] that resident [#130] stated he had been raped 2-14-14. DSS [Director of Social Services]... spoke with resident... Resident [#130] stated the name of a male CNA [#34] who raped him..." b. 2/20/14 - "...DSS visited with resident. Resident [#130] said everything he reported [alleged rape on the night of 2/14/14 by CNA #34] to me the other day was true..." Review of the CNA #34's "TIME DETAIL" sheet documented CNA #34 worked Friday, 2/14/14, from 3:00 PM to 9:45 PM and 10:15 PM until 10:58 PM, Saturday, 2/15/14, from 3:28 PM to 9:53 PM and 10:27 PM to 11:06 PM, Sunday, 2/16/14, from 2:59 PM to 9:56 PM and 10:26 PM to 11:00 PM, and Monday, 2/17/14 from 2:58 PM to 4:01 PM. Review of a suspension form dated 2/17/14 documented, "...[CNA #34] name... Date of Incident: 2/14/14..." The suspension form was signed and dated by the DON, the Administrator, a Human Resources witness and CNA #34 on 2/17/14. The accused CNA was not suspended until 3 days after the alleged incident was reported.	F 226	• A resident council meeting held on 8/27/14 with Activities Director going over Resident's Rights and Abuse. • A family council meeting scheduled for 9/25/14 with Social Services Director to go over Resident's rights and Abuse. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluation of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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F 226	Continued From page 24 During an interview in Resident #130's room on 8/14/14 at 2:10 PM, Resident #130 was asked whether anyone had ever mistreated him here at the facility. Resident #130 stated that once a homosexual man had spoken inappropriately to him. The interview was postponed due to Resident #130's roommate being present in the room. Later on 8/14/14 at 3:25 PM, Resident #130 was asked for more information regarding the mistreatment he had spoken of earlier. Resident #130 stated, "He [CNA #34] tried to have sexual intercourse, tried to penetrate, the girl [CNA #33] that washed me and cleaned me up asked me why I had all this grease on me." Resident #130 stated he had told her [CNA #33] what happened and she told the nurse [#21]. Resident #130 was asked whether he had been taken to the doctor when the incident occurred. Resident #130 stated he had not. During an interview in the conference room on 8/14/14 at 3:00 PM, the DON was asked what should happen if a resident reports rape or sexual abuse. The DON stated, "Staff should tell me immediately, interview the resident for details, body audit of the resident." The DON was asked what type of exam was performed and how soon was it done after the incident was reported. The DON stated, "A body audit, remove the clothes, look at the area, look at the anal area if they say they were penetrated. Physician and families are notified, suspend the alleged perpetrator if identified, try to get them done immediately." The DON was asked whether the resident should be sent to the emergency room (ER) for a rape kit after an instance where there was possible physical evidence, such as jelly-like substance found on the resident's buttocks. The DON stated, "Yes, then we could send them to the ER."	F 226		

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F 226	Continued From page 25 Resident #130 was not examined immediately nor was he sent to the ER for a rape kit. During an interview in the conference room on 8/14/14 at 6:05 PM, the DON was asked why Resident #130 was not examined until 3 days after the alleged incident. The DON stated the incident "Was not reported to us until later [2/17/14]." The DON was asked whether the police had been notified. The DON stated, "No." The DON was asked whether a physician had examined Resident #130 after the incident occurred. The DON stated, "I don't know." During an interview in the conference room on 8/14/14 at 6:10 PM, the Administrator was asked what is the facility's protocol if a rape is reported. The Administrator stated, "We would definitely investigate thoroughly." The Administrator was asked whether the resident would be sent to the hospital for a rape kit. The Administrator was nodding her head in agreement and stated, "We would do that or get a doctor or nurse practitioner to examine him." During a telephone interview on 8/15/14 at 3:37 PM, accused CNA #34 was asked what had happened during his shift on 2/14/14 regarding Resident #130 and the alleged abuse allegation. Accused CNA #34 stated, "The allegation was false. I resigned. They [facility] did no rape kit or anything. If they would have called the police, I would have been fine with it. They [facility] did not do a proper investigation." Accused CNA #34 was asked whether he had been suspended during the investigation. Accused CNA #34 stated, "No Ma'am. I was not suspended. I worked all the way through. I worked that weekend."	F 226		

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During a telephone interview on 8/18/14 at 2:56 PM, CNA #33 was asked what she recalled of the alleged rape of Resident #130 on the night of 2/14/14. CNA #33 stated she had gone in to talk to Resident #130 at the beginning of her shift on 2/15/14, like she normally does. He told her that he thought he had been raped. CNA #33 stated she had told the nurse on duty (Nurse #21) and the nurse supervisor (Nurse #22). CNA #33 stated, "They [Nurse #21 and Nurse #22] did not tell me anything. I waited a couple of hours, and then I went and cleaned him [Resident #130] up. There was a jelly-like substance on him that was clear." CNA #33 was asked whether the police were called. CNA #33 stated she did not know. CNA #33 was asked whether Resident #130 had been taken to the hospital for an exam after the alleged incident. CNA #33 stated, "Not that I know of."

During an interview in the conference room on 8/18/14 at 3:15 PM, the DSS was asked what is the facility's policy if a resident reports abuse. The DSS stated, "It's reported to the supervisor immediately. They call the Administrator and the DON. The accused is suspended immediately, authorities are notified, police, elder abuse, [Named Administrator]. Have been talking about that. We should have reported this one to the police."

During an interview at the nurses' station on 8/19/14 at 8:05 AM, Nurse Practitioner (NP #1) was asked if she remembered the incident that occurred with Resident #130 on 2/14/14 regarding the alleged abuse. NP #1 stated, "It was such a significant event. [Named Nurse #12 the nurse manager] told me there had been an

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occurrence. The resident [#130] had complained he was molested or raped, and she [Nurse #12] said could you examine him. She [Nurse #12] said it had happened 3 or 4 days ago [2/14/14]. Cannot find my progress note. I vaguely remember asking someone to copy it, and handed it to someone, but cannot remember who it was. There is a billing sheet attached to my sheets, and every time I document, I tear it off and put it in my bag. I don't have that either. It's not at the office either, very unfortunate."

During an interview at the fourth floor nurse's station on 8/20/14 at 8:45 AM, Nurse #12 was asked about the alleged rape of Resident #130 that occurred on the night of 2/14/14. Nurse #12 stated, the allegation "happened over the weekend [2/14/14]. Was a couple of days before I found out. I did a body audit." Nurse #12 was asked what is the facility's policy regarding sexual abuse allegations. Nurse #12 stated, "They are supposed to report to the nurse. Suppose to triage it. The person they are accusing is suspended, police should be called, the patient should actually be sent out at the time of the incident, immediately do a body audit, send patient to the hospital. Notify the DON."

The facility was unable to provide any written evidence that a physical exam had been performed on Resident #130 concerning the alleged sexual assault on 2/14/14.

The facility failed to implement and follow their abuse policy when they failed to thoroughly investigate an alleged rape by not promptly notifing the DON or Administrator; failed to promptly complete a medical examination; failed to notify the police and failed to protect residents

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from potential abuse by not promptly suspending the alleged perpetrator which placed Resident #130 in immediate jeopardy.

Validation of the Credible Allegation of Compliance (AOC) was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records and interviews with nursing and administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the immediate jeopardy.

The facility provided evidence that all staff received an abuse in-service and an abuse questionnaire, on which they were required to answer 100 percent correctly. Random new hire personnel files were reviewed and contained evidence of background and abuse registry checks before hire.

Interviews were completed with nursing and administrative staff to ensure staff were knowledgeable of proper procedures regarding the reporting of abuse and protection of the residents. An interview was conducted with the Abuse Prevention Coordinator, in which she stated that weekly Performance Improvement meetings have been scheduled.

The facility will remain out of compliance at a scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The facility is required to submit a plan of correction.

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F 281 SS=J	Continued From page 29 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of Sorensen and Luckmann's Basic Nursing reference, medical record review review of the investigator's report, review of an autopsy and interview, it was determined the facility failed to ensure services provided met professional standards of quality as evidenced by staff not performing the Heimlich maneuver (action to remove what is blocking the airway) when a resident was noted to be choking for 1 of 15 (Resident #261) sampled residents reviewed for neglect of the 39 residents included in the stage 2 review. The facility failed to perform the Heimlich maneuver to prevent choking and suffocation which resulted in the choking death of Resident #261, which resulted in immediate jeopardy, a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) when they were informed of the immediate jeopardy (IJ). The facility provided an acceptable Allegation of Compliance on August 25th, 2014. It was determined on August 26, 2014 the corrective	F 281 F 281	1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. 2. All residents have the potential to be affected by the same practice. • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. 3. What measures will be put into place to insure that this practice does not recur? • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.	9/25/14

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F 281	Continued From page 30 actions implemented on August 25, 2014, had removed the immediate jeopardy. The immediate jeopardy (IJ) existed from 3/27/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F281 continues at a "D" level citation. The facility is required to submit a Plan of Correction. The findings included: Review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, third edition, page 576, management of obstructed airway, documented, "The two techniques for relieving foreign body airway obstruction are manual chest and abdominal thrusts (Heimlich maneuver) and finger sweeps." Medical record review for Resident #261 documented an admission date of 6/4/12 with a readmission date of 12/13/12 with diagnoses of Hemiplegia affecting Non Dominant Side, Lack of Coordination, Difficulty in Walking, Oropharyngeal Dysphagia, Aphasia, Dysarthria, Hypertension, Hemiplegia affecting Dominant Side, Muscle Weakness, Cerebral Vascular Accident with Left Sided Weakness, History of Cerebral Vascular Accidents, Diabetes Type 2, Benign Prostatic Hypertrophy, Dementia and Hyperlipidemia. Review of a care plan dated 5/16/13 and reviewed 2/14 documented a problem that Resident #261 is a nutrition risk due to a swallowing problem related to dysphagia and requires a mechanically altered diet. The care plan documented Resident #261 is to be upright for all meals, staff to feed all meals and aspiration	F 281	• A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies. • Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.	

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F 281	Continued From page 31 precautions. Review of a nurses note dated 3/28/14 documented, "...cna [certified nursing assistant #30] served resident's [Resident #261] supper. The supper consisted of the following items 4 oz [ounces] of pulled pork... at approximately 5:31 PM the cna [#30] returned to check on him... the cna immediately sought out the nurse at 5:32pm... LPN [licensed practical nurse] #20 immediately responded... noticed that the resident was in ditress [distress] and noted resident's [Resident #261] lips were bluish in color... the resident was still breathing at this time. The LPN [#20] stimulated the resident with cardiac massage... a code blue was called... compressions were commenced until EMT's [Emergency Medical Technicians] arrived... EMT arrived at 5:45pm... The EMT's and the first responder hooked him up to a monitor... stopped the code at approximately 5:55pm... " There was no documentation the facility staff performed the Heimlich maneuver for Resident #261. Review of the investigator's report signed and dated on 3/27/14 documented, "...[Named Rescue Team] arrived on the scene and cleared his airway but asystole [no heart beat] was confirmed at 1755 [5:55 PM] by paramedics... [Named Officer] advised the following: this black male was eating dinner and began choking on his food... Fire department paramedics removed the food from his airway and staff threw it away. Due to this accident jurisdiction was accepted and this black male was transported to the [Named] forensic center for further examination [autopsy]..." Review of the autopsy report signed and dated on	F 281	• Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations. • Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room. • Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14	

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F 281	Continued From page 32 5/16/14 documented, "...Date of Autopsy Examination: March 28, 2014... CAUSE OF DEATH: Asphyxia due to choking... INTERNAL EXAMINATION... RESPIRATORY SYSTEM... Non-digested food and mucus partially occlude the upper airway, and pieces of non-digested food occlude the lobar bronchi and some more distal branches... SUMMARY AND INTERPRETATION... Based on the autopsy findings... the cause of death is attributed to asphyxia due to choking..." During an interview in the conference room on 8/14/14 at 5:00 PM, CNA #30 was asked if she was present during Resident #261's choking incident. CNA #30 stated, "I brought his tray in his room... I went back in to check on him and he seemed like he was in stress, like something was wrong. I asked him if he was okay, and he raised up his hand... When black people hold their hand up we know something's wrong. I went immediately and got the nurse. After that, the nurses took over..." CNA #30 was asked about how long it took the nurse to respond. CNA #30 stated, "It didn't really take long... I yelled in the hallway. 'Mr. [first name of Resident #261] is in distress'. She [Nurse #20] came right there." The facility staff failed to perform the Heimlich maneuver when Resident #261 was noted to be in distress, which resulted in an immediate jeopardy when Resident #261 subsequently choked to death. Validation of the Credible Allegation of Compliance (AOC) was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with nursing, dietary	F 281	4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? • A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained. • A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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F 281	Continued From page 33 and administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the immediate jeopardy. The facility provided evidence of in-service training with sign in sheets, for all staff on the Heimlich maneuver. Interviews with CNAs, dietary staff, nurse managers, charge nurses conducted in the facility, staff verbalized how to do the Heimlich maneuver. The facility will remain out of compliance at a scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 281		
F 282 SS=J	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 medical record review, review of an autopsy, review of a meal ticket, observation and interview, it was determined the facility failed to follow the care plan interventions for a therapeutic diet and/or assistance with dining for 2 of 39	F 282	1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. Resident #6 was given a correct diet on 8/22/14. CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14 CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14. Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager by 8/28/14.	9/25/14

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F 282	Continued From page 34 (Residents #261 and 6) sampled residents of the 39 residents included in the stage 2 review. The failure of the facility to follow the care plan interventions for a therapeutic diet or provide assistance with dining resulted in an immediate jeopardy when Resident #6, who was at risk for choking, received a whole hot dog on a bun and Resident #261 received pulled pork, was left alone to eat in his room and chocked to death. Immediate jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON), when they were informed of the immediate jeopardy (IJ) related to choking. The facility provided an acceptable Allegation of Compliance on August 25th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the immediate jeopardy. The immediate jeopardy (IJ) existed from 3/27/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F282 continues at a "D" level citation. The facility is required to submit a Plan of Correction. The findings included: 1. Medical record review for Resident #261 documented an admission date of 6/4/12 with a readmission date of 12/13/12 with diagnoses of	F 282	2. All residents have the potential to be affected by the same practice. • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. 3. What measures will be put into place to insure that this practice does not recur? • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. • A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.	

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F 282	Continued From page 35 Hemiplegia affecting Non Dominant Side, Lack of Coordination, Difficulty in Walking, Oropharyngeal Dysphagia, Aphasia, Dysarthria, Hypertension, Hemiplegia affecting Dominant Side, Muscle Weakness, Cerebral Vascular Accident with Left Sided Weakness, History of Cerebral Vascular Accidents, Diabetes Type 2, Benign Prostatic Hypertrophy, Dementia and Hyperlipidemia. Review of the physician's orders dated 3/1/14 through 3/31/14 and signed by the physician on 3/18/14 documented, "...MECHANICAL SOFT DIET WITH PUREED MEAT..." Review of a quarterly Minimum Data Set (MDS) dated 1/26/14 documented resident was receiving a mechanically altered diet. Review of a care plan dated 5/16/13 and reviewed 2/14 documented a problem that Resident #261 is a nutrition risk due to a swallowing problem related to dysphagia and requires a mechanically altered diet. The interventions to provide the diet as ordered by the physician, monitor the intake and no bread, rice or salad. The care plan documented Resident #261 is to be upright for all meals, staff to feed all meals and aspiration precautions. Review of a nurses note dated 3/28/14 documented, "...cna [certified nursing assistant #30] served resident's [Resident #261] supper. The supper consisted of the following items 4 oz [ounces] of pulled pork... at approximately 5:31 PM the cna [#30] returned to check on him... the cna immediately sought out the nurse at 5:32pm... LPN [licensed practical nurse] #20 immediately responded... noticed that the resident was in ditress [distress] and noted	F 282	• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies. • Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse. • Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.	

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F 282	Continued From page 36 resident's [Resident #261] lips were bluish in color..." Resident #261, who had a swallowing problem related to dysphagia, was served the wrong diet and was left alone in his room to feed himself on 3/27/14. The facility failed to follow the care plan interventions for a therapeutic diet of pureed meat and the resident is to be feed. Review of the autopsy report signed and dated on 5/16/14 documented, "...Date of Autopsy Examination: March 28, 2014... CAUSE OF DEATH: Asphyxia due to choking... INTERNAL EXAMINATION... RESPIRATORY SYSTEM... Non-digested food and mucus partially occlude the upper airway, and pieces of non-digested food occlude the lobar bronchi and some more distal branches... SUMMARY AND INTERPRETATION... Based on the autopsy findings... the cause of death is attributed to asphyxia due to choking..." During an interview in the conference room on 8/14/14 at 5:00 PM, CNA #30 was asked what type of diet was Resident #261 on. CNA #30 stated, "I don't really remember if he was on a regular diet or a pureed diet. It looked like roast beef, it was like stringy. I can't remember what else he had." CNA #30 was asked if the meat was pureed and if it had gravy on it. CNA #30 stated, "It [meat] didn't look like pureed. I don't remember any gravy on it." CNA #30 was asked about Resident #261's choking incident. CNA #30 stated, "I brought his tray in his room... He usually would eat out in the dining room. I left... I went back in to check on him and he seemed like he was in stress, like something was wrong. I asked him if he was okay, and he raised up his hand...	F 282	• Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room. • Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14. 4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? • A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.	

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F 282	Continued From page 37 When black people hold their hand up we know something's wrong. I went immediately and got the nurse..." During an interview in the conference room on 8/18/14 at 3:10 PM, the Dietary Manager (DM) was asked who updated Resident #261's current nutrition care plan. The DM stated, "I did. I wrote that on the care plan from the order dated 12/17/12 [out of bed for all meals spoon feed all meals and upright for all meals]." The facility failed to follow the care plan interventions for a therapeutic diet and assisting with dining resulted in the accidental choking death of Resident #261, which resulted in immediate jeopardy. 2. Medical record review for Resident #6 documented an admission date of 10/8/12 with diagnoses of Seizure Disorder, Paraplegia, Right Above the Knee Amputation, Left Eye Blindness, Dysphagia, Dysarthria, Obesity, Ankle-Foot Deformity, Abnormal Posture, Joint Contractures - Multiple Joints, Muscle Weakness, Cognitive Communicative Deficit and Brain Injury. Review of a quarterly MDS dated 3/14/14 documented Resident #6 received a mechanically altered diet and a therapeutic diet. Review of a telephone physician order dated 3/28/14 documented, "...Mech [mechanical] soft diet, NAS [No Added Salt] diet, (order clarification) no bread... at lunch + [and] supper..." Review of a physician's order dated 8/2/14 documented, "...Diet: NAS; MECHANICAL SOFT; NO BREAD..."	F 282	• A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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Review of a care plan dated 9/25/13 and reviewed 2/14 documented, "...Problem... Resident is a nutrition risk: As evidenced by... NEED FOR MECH ALTERED DIET... NEED FOR THERAPEUTIC DIET... Approach... Provide diet as ordered (see current physician orders)... ASSIST WITH ALL MEALS AS NEEDED... No bread... on trays..."

Review of a tray meal ticket dated 8/22/14 documented, "...DIET: MS [Mechanical Soft], NAS, no bread..."

Observations in Resident #6's room on 8/22/14 at 5:48 PM, revealed Resident #6 received a dinner tray with a regular hot dog on a bun. CNA #32 stated, "Resident is a choke risk and I will have to stay with him until he is finished eating." Further observations revealed CNA #32 cut the hot dog in half and handed one half to the resident. The surveyor stopped the resident from placing the hot dog in his mouth. CNA #32 was asked to look at the meal ticket. CNA #32 stated, "I almost made a big mistake. Thank you for catching it. I just looked at mechanical soft. We forget."

The facility failed to follow the care plan interventions for a therapeutic diet when Resident #6 received a whole hot dog on a bun, which placed Resident #6 at risk for choking, and Immediate Jeopardy.

Validation of the Credible Allegation of Compliance (AOC) was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with nursing, dietary and administrative staff. The surveyors validated

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the corrective actions stated in the AOC were implemented which removed the immediate jeopardy.

The facility provided evidence of in-service training with sign in sheets, for all staff on the tray service to include review of each meal ticket for verification of correct diet served and color coded meal tickets.

The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager.

The facility provided evidence of audits that included physician orders to meal tickets and verified on the care plan. Accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays.

Interviews with CNAs, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets and what a colored meal ticket meant. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery.

Observations in the facility on 8/26/14 and 8/27/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then a second check by the staff member when the tray is delivered to the resident.

The facility will remain out of compliance at a

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F 282	Continued From page 40 scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 282		
F 309 SS=J	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 review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, medical record review, review of the investigator's report, review of an autopsy, review of a tray card, observation and interview, it was determined the facility failed to provide care and services necessary to maintain the highest practicable physical, mental, and psychosocial well-being of residents when staff failed to follow physician orders for therapeutic diets for 2 of 39 (Residents #261 and 6) sampled residents included in the stage 2 review. The facility failed to follow therapeutic diets when Resident #6, who was at risk for choking, received a plate that included a whole hot dog on a bun and Resident #261 received a plate that included pulled pork instead of pureed meat. The facility failed to	F 309	1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. Resident #6 was given a correct diet on 8/22/14. CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14 CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14. Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager on 8/28/14. 2. All residents have the potential to be affected by the same practice. • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.	9/25/14

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F 309	Continued From page 41 monitor Resident #261 during dining and staff failed to perform the Heimlich maneuver (action to remove what is blocking the airway) to prevent choking and suffocation which resulted in the accidental choking death of Resident #261. These incidents resulted in an immediate jeopardy which is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The immediate jeopardy for F309 constitutes substandard quality of care. An extended survey was completed on 8/26/14 and 8/27/14. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) when they were informed of the immediate jeopardy (IJ). The facility provided an acceptable Allegation of Compliance on August 25th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the immediate jeopardy. The immediate jeopardy (IJ) existed from 3/27/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F309 continues at a "D" level citation. The facility is required to submit a plan of correction. The findings included:	F 309	3. What measures will be put into place to insure that this practice does not recur? • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. • A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies. • Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.	

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F 309	Continued From page 42 1. Review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, third edition, page 576, management of obstructed airway, documented, "The two techniques for relieving foreign body airway obstruction are manual chest and abdominal thrusts (Heimlich maneuver) and finger sweeps." Medical record review for Resident #261 documented an admission date of 6/4/12 with a readmission date of 12/13/12 with diagnoses of Hemiplegia affecting Non Dominant Side, Lack of Coordination, Difficulty in Walking, Oropharyngeal Dysphagia, Aphasia, Dysarthria, Hypertension, Hemiplegia affecting Dominant Side, Muscle Weakness, Cerebral Vascular Accident with Left Sided Weakness, History of Cerebral Vascular Accidents, Diabetes Type 2, Benign Prostatic Hypertrophy, Dementia and Hyperlipidemia. Review of the physician's orders dated 3/1/14 through 3/31/14 and signed by the physician on 3/18/14 documented, "...MECHANICAL SOFT DIET WITH PUREED MEAT..." Review of a quarterly Minimum Data Set (MDS) dated 1/26/14 documented Resident #261 received a mechanically altered diet. Review of a care plan dated 5/16/13 and reviewed 2/14 documented a problem that Resident #261 is a nutrition risk due to a swallowing problem related to dysphagia and requires a mechanically altered diet. The interventions to provide the diet as ordered by the physician, monitor the intake and no bread. The care plan documented Resident #261 is to be upright for all meals, staff to feed all meals and aspiration precautions.	F 309	• Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations. • Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room. • Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14	

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F 309	Continued From page 43 Review of a nurses note dated 3/28/14 documented, "...cna [certified nursing assistant #30] served resident's [Resident #261] supper. The supper consisted of the following items 4 oz [ounces] of pulled pork... at approximately 5:31 PM the cna [#30] returned to check on him... the cna immediately sought out the nurse at 5:32pm... LPN [licensed practical nurse] #20 immediately responded... noticed that the resident was in ditress [distress] and noted resident's [Resident #261] lips were bluish in color... the resident was still breathing at this time. The LPN [#20] stimulated the resident with cardiac massage... a code blue was called... compressions were commenced until EMT's [Emergency Medical Technicians] arrived. Breaths were administered between compressions... EMT arrived at 5:45pm... The EMT's and the first responder hooked him up to a monitor... stopped the code at approximately 5:55pm..." There was no documentation the facility staff performed the Heimlich maneuver. Review of the investigator's report signed and dated on 3/27/14 documented, "...[Named Rescue Team] arrived on the scene and cleared his [Resident #261] airway but asystole [no heart beat] was confirmed at 1755 [5:55 PM] by paramedics... [Named Officer] advised the following: this black male was eating dinner and began choking on his food... Fire department paramedics removed the food from his airway and staff threw it away. Due to this accident jurisdiction was accepted and this black male was transported to the [Named] forensic center for further examination [autopsy]..." Review of the autopsy report signed and dated on	F 309	4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? • A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained. • A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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5/16/14 documented, "...Date of Autopsy Examination: March 28, 2014... CAUSE OF DEATH: Asphyxia due to choking... INTERNAL EXAMINATION... RESPIRATORY SYSTEM... Non-digested food and mucus partially occlude the upper airway, and pieces of non-digested food occlude the lobar bronchi and some more distal branches... SUMMARY AND INTERPRETATION... Based on the autopsy findings... the cause of death is attributed to asphyxia due to choking..."

During an interview in the conference room on 8/14/14 at 4:30 PM, the DON was asked what Resident #261 choked on. The DON stated, "I believe it was pulled pork or roast beef."

During an interview in the conference room on 8/14/14 at 5:00 PM, CNA #30 was asked if she was present during Resident #261's choking incident. CNA #30 stated, "I brought his tray in his room... He usually would eat out in the dining room... I went back in to check on him and he seemed like he was in stress, like something was wrong. I asked him if he was okay, and he raised up his hand... I went immediately and got the nurse..." CNA #30 was then asked what type of diet was Resident #261 on. CNA #30 stated, "I don't really remember if he was on a regular diet or a pureed diet. It looked like roast beef, it was like stringy. I can't remember what else he had." CNA #30 was asked if the meat was pureed and if it had gravy on it. CNA #30 stated, "It [meat] didn't look like pureed. I don't remember any gravy on it."

During an interview in the conference room on 8/18/14 at 3:10 PM, the Dietary Manager (DM) was asked about Resident #261's order for the

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therapeutic diet and who updated Resident #261's current nutrition care plan. The DM stated, "I did. I wrote that on the care plan from the order dated 12/17/12 [out of bed for all meals spoon feed all meals and upright for all meals]."

During a telephone interview on 8/18/14 at 3:50 PM, the Registered Dietician (RD) was asked about Resident #261's diet orders and need for assistance. The RD stated, "His diet order changed a lot. He was at high risk of choking. There was other food he couldn't have. As far as I know he was supposed to be fed." The RD was asked if he should have been left alone in his room to eat. The RD stated, "I don't think so [this was stated with emphasis]."

The facility failed to ensure Resident #261 received the proper therapeutic diet, failed to monitor Resident #261 during dining and failed to perform the Heimlich maneuver when Resident #261 was noted to be in distress, and subsequently choked to death, which resulted in an immediate jeopardy.

2. Medical record review for Resident #6 documented an admission date of 10/18/12 with diagnoses of Obesity, Paraplegia, Hypertension, Joint Contracture, Muscle Weakness, Ankle-Foot Deformity, Convulsions, Abnormal Posture, Cognitive Communicative Deficit, Brain Injury, Amputee Right Above The Knee, Head Injury, Dysphagia, Dysarthria and Left Eye Blindness.

Review of an admission MDS dated 3/14/14 documented Resident #6 received a therapeutic, mechanically altered diet.

Review of a care plan dated 9/25/13 and

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reviewed 2/14 documented, "...Problem... Resident is at nutrition risk: As evidenced by... NEED FOR MECH [mechanical] ALTERED... THERAPEUTIC DIET... Approach... Provide diet as ordered (see current physician orders)... ASSIST WITH ALL MEALS AS NEEDED..."

Review of a physician's order signed and dated 8/2/14 documented, "...Diet ...MECHANICAL SOFT... NO BREAD..."

Review of a supper tray card dated 8/22/14 documented, "...DIET: MS [Mechanical Soft], NAS [No Added Salt], no bread..."

Observations on the 4th floor north hall on 8/22/14 at 5:48 PM, CNA #32 delivered a tray to Resident #6's room. The meal was a regular hot dog on a bun with french fries. CNA #32 stated, "He is a choke risk and I will have to stay with him until he is finished eating" CNA #32 cut the hot dog in half and handed it to Resident #6. The surveyor stopped the resident from placing the hot dog in his mouth. CNA #32 was asked to look at the meal ticket. CNA #32 stated, "I almost made a big mistake. I just looked at mechanical soft. We forget."

During an interview at the 4th floor nurses' desk on 8/23/14 at 7:40 AM, the DM was asked about Resident #6 receiving the wrong diet on the 8/22/14 dinner tray which was a regular hot dog on a bun. The DM stated, "The person at the end of the line didn't catch it. Two people looked at it and didn't catch it, didn't pay enough attention, will be clarified today... anybody on mechanical soft diet is at risk for choking. My department missed it. I own it."

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F 309	Continued From page 47 The facility failed to follow the physician order for a therapeutic diet when Resident #6 received a whole hot dog on a bun, which placed Resident #6 at risk for choking and in immediate jeopardy. Validation of the Credible Allegation of Compliance was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with nursing, dietary and administrative staff. The facility provided evidence of in-service training with sign in sheets, for all staff on the Heimlich maneuver, tray service to include review of each meal ticket for verification of correct diet served and color coded meal tickets. The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager. The facility provided evidence of audits that included physician orders to meal tickets and verified on the care plan. Accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays. Interviews with CNAs, dietary staff, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery.	F 309		

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F 309	Continued From page 48 Observations in the facility on 8/26/14 and 8/27/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then a second check by the staff member when the tray is delivered to the resident. The facility will remain out of compliance at a scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 309		
F 365 SS=J	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on review of an autopsy report, review of meal tray card, medical record review, observation and interview, it was determined the facility failed to provide the correct therapeutic diet for 2 of 39 (Residents #261 and 6) sampled residents of the 39 residents included in the stage 2 review. The facility failed to follow therapeutic diets when Resident #6, who was at risk for choking, received a plate that included a whole hot dog on a bun and Resident #261 received a plate of pulled pork instead of pureed meat and subsequently choked to death. These incidents resulted in immediate jeopardy, a situation in	F 365	1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. Resident #6 was given a correct diet on 8/22/14. CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14 CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14. Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager on 8/28/14.	9/25/14

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F 365	Continued From page 49 which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON), when they were informed of the Immediate Jeopardy (IJ) related to choking. The facility provided an acceptable Allegation of Compliance on August 25th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25, 2014, had removed the immediate jeopardy. The immediate jeopardy (IJ) existed from 3/27/14 through 8/24/14. The IJ was removed on 8/25/14. Noncompliance for F365 continues at a "D" level citation. The facility is required to submit a plan of correction. The findings included: 1. Medical record review for Resident #261 documented an admission date of 6/4/12 with a readmission date of 12/13/12 with diagnoses of Hemiplegia affecting Non Dominant Side, Lack of Coordination, Difficulty in Walking, Oropharyngeal Dysphagia, Aphasia, Dysarthria, Hypertension, Hemiplegia affecting Dominant Side, Muscle Weakness, Cerebral Vascular Accident with Left Sided Weakness, History of Cerebral Vascular Accidents, Diabetes Type 2, Benign Prostatic Hypertrophy, Dementia and Hyperlipidemia. Review of the physician's orders dated 3/1/14	F 365	2. All residents have the potential to be affected by the same practice. • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. 3. What measures will be put into place to insure that this practice does not recur? • A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR. • A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.	

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F 365	Continued From page 50 thru 3/31/14 and signed by the physician on 3/18/14 documented, "...HONEY THICKENED LIQUIDS... MECHANICAL SOFT DIET WITH PUREED MEAT..." Review of a nurses note dated 3/28/14 documented, "...CNAs [certified nursing assistant #30] served resident's [Resident #261] supper. The supper consisted of the following items 4 oz [ounces] of pulled pork..." Review of the autopsy report signed and dated on 5/16/14 documented, "...Date of Autopsy Examination: March 28, 2014... CAUSE OF DEATH: Asphyxia due to choking... Based on the autopsy findings... the cause of death is attributed to asphyxia due to choking..." During an interview in the conference room on 8/14/14 at 4:30 PM, the Director of Nursing (DON) was asked what Resident #261 choked on. The DON stated, "I believe it was pulled pork or roast beef." During an interview in the conference room on 8/14/14 at 5:00 PM, CNAs #30 was asked what type of diet was Resident #261 on. CNAs #30 stated, "I don't really remember if he was on a regular diet or a pureed diet. It looked like roast beef, it was like stringy. I can't remember what else he had." CNAs #30 was asked if the meat was pureed and if it had gravy on it. CNAs #30 stated, "It [meat] didn't look like pureed. I don't remember any gravy on it." During a telephone interview on 8/18/14 at 3:50 PM, the Registered Dietician (RD) was asked about Resident #261's diet orders. The RD stated, "His diet order changed a lot. He was at	F 365	• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies. • Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse. • Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.	

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F 365	Continued From page 51 high risk of choking. There was other food he couldn't have..." The facility failed to ensure Resident #261 received the proper therapeutic diet which resulted in an immediate jeopardy when the resident subsequently choked to death. 2. Medical record review for Resident #6 documented an admission date of 10/18/12 with diagnoses of Obesity, Paraplegia, Hypertension, Joint Contracture, Muscle Weakness, Ankle-Foot Deformity, Convulsions, Abnormal Posture, Cognitive Communicative Deficit, Brain Injury, Amputee Right Above The Knee, Head Injury, Dysphagia, Dysarthria and Left Eye Blindness. Review of an admission Minimum Data Set (MDS) dated 3/14/14 documented Resident #6 received a mechanically altered diet and a therapeutic diet. Review of a physician's order signed and dated 8/2/14 documented, "...Diet ...MECHANICAL SOFT... NO BREAD..." Review of a supper tray card dated 8/22/14 documented, "...DIET: MS [Mechanical Soft], NAS [No Added Salt], no bread..." Observations on the 4th floor north hall on 8/22/14 at 5:48 PM, CNAs #32 delivered a tray to Resident #6's room. The meal was a regular hot dog on a bun with french fries. CNAs #32 stated, "He is a choke risk and I will have to stay with him until he is finished eating" CNAs #32 cut the hot dog in half and handed it to Resident #6. The surveyor stopped the resident from placing the hot dog in his mouth. CNAs #32 was asked to look at the tray card. CNAs #32 stated, "I almost	F 365	• Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room. • Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14. 4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? • A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing. • On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.	

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F 365	Continued From page 52 made a big mistake. I just looked at mechanical soft. We forget." During an interview at the 4th floor nurses' desk on 8/23/14 at 7:40 AM, the Dietary Manager (DM) was asked about Resident #6 receiving the wrong diet on the 8/22/14 dinner tray which was the regular hot dog on a bun. The DM stated, "The person at the end of the line didn't catch it. Two people looked at it and didn't catch it, didn't pay enough attention, will be clarified today... anybody on mechanical soft diet is at risk for choking. My department missed it. I own it." The facility failed to follow the physician order for a therapeutic diet when Resident #6 received a whole hot dog on a bun, which placed Resident #6 at risk for choking, resulting in immediate jeopardy. Validation of the Credible Allegation of Compliance was accomplished on-site August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with nursing, dietary and administrative staff. The facility provided evidence of in-service training with sign in sheets, for all staff on tray service to include review of each meal ticket for verification of correct diet served and color coded meal tickets. The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager.	F 365	• A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months. • A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.	

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F 365	Continued From page 53 The facility provided evidence of audits that included physician orders to meal tickets. Accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays. Interviews with CNAs, dietary staff, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery. Observations in the kitchen on 8/2614 and 8/27/14 revealed staff physically checking the meal tickets to the food tray before being placed on the cart. Observations in the facility on 8/2614 and 8/27/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then again by the staff member when the tray was delivered to the resident. The facility will remain out of compliance at a scope and severity level "D" an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 365		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and	F 490	The facility will administer in a manner that enables it use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	9/25/14

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F 490	Continued From page 54 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 policy review, review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, review of a time detail sheet, review of a suspension form, review of an investigator's report, review of an autopsy report, review of a meal tray card, medical record review, observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use it's resources effectively and efficiently to maintain the highest practicable physical and psychosocial well-being of the residents as evidenced by: failing to ensure residents were protected from potential staff to resident abuse, to ensure the abuse policy was implemented to ensure allegations of abuse and neglect were thoroughly investigated and reported to administration for 2 of 15 (Residents #130 and 261) residents; failing to ensure adherence to current medical standards of practice related to emergency services for choking for 1 of 39 (Resident #261) residents; failing to ensure staff followed current plans of care and physician orders for the residents related to therapeutic diets for 2 of 39 (Residents #6 and 261) residents; failing to provide properly functioning medical equipment for a resident with a tracheostomy for 1 of 2 (Resident #193) residents with a tracheostomy; failing to ensure residents were free from unnecessary medications related to the use of anticoagulant medications and failing to ensure timely physician notification of abnormal lab results for 2 of 15	F 490	2. All residents have the potential to be affected by the same practice.	

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F 490	Continued From page 55	F 490		

(Residents 25 and 205) residents receiving coumadin; and failure to ensure the quality assurance program was effective in identifying issues and concerns related to the noncompliance identified above. The incidents noted above resulted in immediate jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON) at which time they were informed of the IJ related to abuse and choking.

A meeting was conducted in the conference room on 8/20/14 at 12:15 PM, with the Administrator and the DON, at which time they were informed of the IJ related to timely lab result notification.

A meeting was conducted in the conference room on 8/21/14 at 12:46 PM, with the Administrator and the DON, at which time they were informed of the IJ related to malfunctioning suction equipment which resulted in improper tracheostomy care.

The facility provided two acceptable Allegation of Compliance on August 25th, 2014 and one on August 26th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25 and 26, 2014, removed the IJ.

The immediate jeopardy (IJ) existed from 2/14/14 through 8/25/14. The IJ was removed on 8/26/14.

Noncompliance for F490 continues at a "D" level

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F 490	Continued From page 56 citation. The facility is required to submit a plan of correction. The findings included: 1. The administration failed to ensure residents were protected from potential staff to resident abuse during investigation of an abuse allegation, and failed to ensure the abuse and neglect policies were implemented to ensure allegations of abuse were thoroughly investigated and reported to administration, placing Resident #130 in immediate jeopardy; and neglected to ensure physician orders were followed for a therapeutic diet, neglected to provide dining assistance for a resident, and failed to perform the Heimlich maneuver (action to remove what is blocking the airway) for a resident that was choking, placed Resident #261 in IJ and resulted in the choking death of Resident #261. Refer to F224, F225 and F226. 2. The administration failed to ensure staff adhered to current medical standards of practice related to emergency services for choking, when staff failed to perform the Heimlich maneuver when Resident #261 choked to death which placed Resident #261 in IJ. Refer to F281. 3. The administration failed to ensure the staff followed the care plan interventions and physician orders to provide the correct therapeutic diets and dining assistance for Residents #6 and 261. Resident #6 received a whole hot dog on a bun instead of a mechanical soft diet as ordered and Resident #261 received pulled pork instead of	F 490	Please refer to attachment for Tags F224, F225 and F226. 2. Please refer to attachment for tag F281 3. Please refer to attachment for tags F282, F309, and F365.	

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F 490	Continued From page 57 pureed meat and was left alone to eat in his room and choked to death. Theses incidents resulted in an IJ. Refer to F282, F309 and F365. 4. The administration failed to ensure that suction equipment was readily available and functional for Resident #193 to ensure proper tracheostomy care was provided, which placed Resident #193 in IJ. Refer to F328 and F456. 5. The administration failed to ensure proper drug monitoring and ensure timely reporting of anticoagulant lab values to the physician placed Residents #25 and 205 in IJ. Refer to F329 and F505. 6. The administration failed to ensure the Quality Assessment and Assurance (QAA) committee established and implemented an effective quality assurance program that thoroughly and systematically identified and addressed concerns and noncompliance within the facility. Refer to F520. Validation of the Credible Allegation of Compliance (AOC) was accomplished on August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with dietary, suction machine company supervisors, nursing, dietary staff and administrative staff administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the	F 490	4. Please refer to attachment for tags F328 and F456. 5. Please refer to attachment for tags F329 and F505. 6. Please refer to attachment for tags F520	

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F 490	Continued From page 58 immediate jeopardy. The facility provided evidence that all staff received an abuse in-service and an abuse questionnaire, on which they were required to answer 100 percent correctly. Review of 5 of 5 new hire personnel files were reviewed and contained evidence of background and abuse registry checks before hire. The facility provided evidence of in-service training with sign in sheets, for all staff on the Heimlich Maneuver, tray service to include review of each meal ticket for verification of correct diet served and color coded meal tickets for therapeutic diets. The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager. The facility provided evidence of in-service training with sign in sheets for licensed nurses on proper suctioning, tracheostomy care, availability of suction machines, suction supplies and facility process for non-functioning equipment. The facility provided evidence of Lab/Lab Values in-service training with sign in sheets for all nursing staff. The facility provided evidence of audits that included physician orders to meal tickets and verified on the care plan. Accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays.	F 490		

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F 490	Continued From page 59 Observations in the kitchen on 8/26/14 revealed the meal ticket being checked at each station, the condiments and fluid station, the entree station and at the bread and dessert station the entire meal tray was reviewed by that staff member to ensure the tray was correct. Observations in the facility on 8/26/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then a second check by the staff member when the tray is delivered to the resident. Observations on 8/26/14 of the new suction machines delivered revealed all machines serviced by the suction machine company and were in working order. Interviews on 8/26/14 were completed with nursing and administrative staff to ensure staff were knowledgeable of proper procedures regarding the reporting of abuse and protection of the residents. An interview was conducted with the Abuse Prevention Coordinator, in which she stated that weekly Performance Improvement meetings have been scheduled. Interviews on 8/26/14 with CNAs, dietary staff, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets, what a colored meal ticket means, and how to do the Heimlich maneuver. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery. Interviews on 8/26/14 with the suction company's operations manager and director of accounts, it	F 490		

Tag F490

1. 1. Resident #261expired 3/27/14. LPN# 20 and CAN #30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14.

2. All residents have the potential to be affected by the same practice.

• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.
3. What measures will be put into place to insure that this practice does not recur?
• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to effect correct diets on the MAR.
•A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.
• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14
for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies.
• Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.
• Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.
• Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room.
• Color coded meal ticket initiated on 4/4/14 for
residents on altered diet. All staff were
educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14

F225

1. The allegation of abuse was reported to the State of Tennessee on 2/21/14 on Resident #130 by the Director of Nursing. Resident #130 full body assessment was completed on 2/17/14 by a licensed nurse and 2/18/14 by the nurse practitioner and no physical signs of injuries were noted. Resident #130 was seen by the psychiatrist on 3/16/14 and no recommendation or medication changes were made. CNA#34 was suspended on 2/17/14 and resigned 2/21/14. Nurse #22 resigned on 2/21/14.

2. All residents are at risk for mistreatment, neglect, abuse, injuries of unknown injuries or unknown source and misappropriation of resident property. The facility plans to protect the residents by:
a. Reporting abuse allegations immediately to the Abuse Coordinator.
b. Suspending the perpetrator immediately.
c. All allegation of abuse must be reported to the police, APS, Ombudsman, and State of Tennessee.
d. Transfer all residents with an allegation of rape to the ER for examination by a physician.
e. All alleged violations will be thoroughly investigated and prevent further potential abuse while the investigation is in progress.

3. What measures will be put into place to insure that this practice does not recur?
• All residents on 8/20/14 were interviewed related to abuse and neglect. And all residents that are non-interviewable were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident's POA were attempted to be contacted to question on any abuse/neglect concerns on 8/20/14. A total of 70 POA contacted and interviewed on 8/29/14. Abuse audits, assessments, interviews and questionnaires were reviewed by the Administrator, Director of Nursing and Social Services Director on 8/19/14 for any indications of abuse/neglect concerns. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Social Services Director.
• 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation.
• Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14.
• 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation.
• Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14.
4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put in place.
• A staff questionnaire regarding abuse is being administered by Administrator, DON, ADONs, MDSC, Activities director, Chaplain, Dietary manager, Chaplain, Marketing, Admissions/Marketing, Rehab Manager, Medical Records, HR director to staff members beginning 8/19/2014 with 20 staff members per week for one month, then 15 staff members per week for one month, then 10 staff members per week for one month, then 5 staff members per week for one month, then weekly random audit for 3 months. If less than 100% was met on the questionnaire a re-education will be conducted until 100% is met.
• Elder Justice Act signs have been moved and made more visible in the facility.
• HR completed an audit on 8/23/14 of all active employees related to background checks. Audit

revealed that all active employees have a background check with no issues.
• The Administrator, Social Services Director, Director of Nursing or Weekend Supervisor will review the grievances, incidents and accidents reports daily beginning 8/23/14 to determine if there are reportable allegations that have not been identified. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Administrator, Director of Nursing and Social Services Director. The Director of Nursing will report any allegations of abuse, neglect or misappropriation to the outside agency
• A resident council meeting held on 8/27/14 with Activities Director going over Resident's Rights and Abuse.
• A family council meeting scheduled for 9/25/14 with Social Services Director to go over Resident's rights and Abuse.
• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluation of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.

F226
1. The allegation of abuse was reported to the State of Tennessee on 2/21/14 on Resident #130 by the Director of Nursing. Resident #130 full body assessment was completed on 2/17/14 by a licensed nurse and 2/18/14 by the nurse practitioner and no physical signs of injuries were noted. Resident #130 was seen by the psychiatrist on 3/16/14 and no recommendation or medication changes were made. CNA#34 was suspended on 2/17/14 and resigned 2/21/14. Nurse #22 resigned on 2/21/14.

2. All residents are at risk for mistreatment, neglect, abuse, injuries of unknown injuries or unknown source and misappropriation of resident property. The facility plans to protect the residents by:
a. Reporting abuse allegations immediately to the Abuse Coordinator.
b. Suspending the perpetrator immediately.
c. All allegation of abuse must be reported to the Police, APS, Ombudsman, and State of Tennessee.
d. Transfer all residents with an allegation of rape to the ER for examination by a physician.
e. All alleged violations will be thoroughly investigated and prevent further potential abuse while the investigation is in progress.
3. What measures will be put into place to insure that this practice does not recur?
• All residents on 8/20/14 were interviewed related to abuse and neglect. And all residents that are non-interviewable were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident's POA were attempted to be contacted to question on any abuse/neglect concerns on 8/20/14. A total of 70 POA contacted and interviewed on 8/29/14. Abuse audits, assessments, interviews and questionnaires were reviewed by the Administrator,
Director of Nursing and Social Services Director on 8/19/14 for any indications of abuse/neglect concerns. All grievances and abuse concerns identified were investigated, addressed, reported and resolved by the Social Services Director.
• 100% of all staff were in-serviced regarding facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements using Care2learn as of 9/1/14. All new hires will complete abuse training during orientation.
• Education on facility's abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements with all the department heads by the Regional Social Services Director on 9/18/14.

Tag F281

1. Resident #261expired 3/27/14. LPN# 20 and 9/25/14 CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14.

2. All residents have the potential to be affected by the same practice.

• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.

3. What measures will be put into place to insure that this practice does not recur?

• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager.
Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.

• A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.

• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager.
All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies.

• Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.

• Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.

• Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room.

• Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14.

4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?

• A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.

• On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week

for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.
• A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months.
• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.

F282
1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14.
Resident #6 was given a correct diet on 8/22/14.
CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14 CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14. Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager by 8/28/14.
2. All residents have the potential to be affected by the same practice.
• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.
3. What measures will be put into place to insure that this practice does not recur?
• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.
• A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed

each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.

- Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies.
- Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.
- Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.
- Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room.
- Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14.

4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?

- A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6

meal audits for 2 months, then 2 meal audit for a month, and ongoing.

- On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.
- A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months.
- A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.

F309

1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14.
Resident #6 was given a correct diet on 8/22/14. CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14 CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14. Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager on 8/28/14.
2. All residents have the potential to be affected by the same practice.

- A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.

3. What measures will be put into place to insure that this practice does not recur?

• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.

• A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.

• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff on choking hazards, different type of diets, and the different types of liquid consistencies.

• Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.

• Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.

• Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room.

• Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14.

4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?

• A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.

• On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.

• A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months.

• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.

F365

1. Resident #261expired 3/27/14. LPN# 20 and CNA#30 received training on identification of correct diet, consistency of fluid, color coded tickets, and Heimlich maneuver by the Staff Development Coordinator on 4/2/14 and 4/4/14. 9/25/14
Resident #6 was given a correct diet on 8/22/14.
CNA#32 was coached and counseled by the DON on 8/26/14. Dietary staff was coached and counseled by the Certified Dietary Manager on 8/24/14
CNA #32 was educated by Staff Development Coordinator on color coded tickets on 8/30/14.
Dietary staff was educated on identification of correct diet and preparation of all types of diet by the Certified Dietary Manager on 8/28/14.
2. All residents have the potential to be affected by the same practice.
• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.
3. What measures will be put into place to insure that this practice does not recur?
• A 100% audit of physician orders against diet cards and verified on care plan on all three floors completed on 3/28/2014 by Certified Dietary Manager. Clarification orders were written and referral to speech therapist as needed. Another 100% audit was completed on 8/17/14 and all diets match the tray cards. Clarification orders were written on 10 residents to reflect correct diets on the MAR.
• A daily audit of meal tray cards served for accuracy with plans of care and physician orders was completed each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.
• Education and training conducted on 3/28/14 with all dietary staff regarding identification and preparation of all type of diets, competencies for food preparation, and thickened liquids by the Certified Dietary Manager. All competencies regarding this were completed on 4/12/14 for all dietary staff. On 8/4/14, 8/19/14, 8/24/14, and 8/28/14 the Certified Dietary Manager did an in-service with all dietary staff

on choking hazards, different type of diets, and the different types of liquid consistencies.

- Education and training on 3/28/14 with all nursing staff conducted regarding meal service focused on checking accuracy of diet serve, thickened liquids, signs and symptoms of choking and aspiration by the Staff Development Nurse.
- Education and training regarding how to perform the Heimlich maneuver was conducted with all staff except dietary on 3/28/14. On 4/2/14 EMHC performed training and education on Heimlich maneuver and signs and symptoms of ineffective breathing with all staff except dietary. Education and training was completed on Heimlich maneuver for all new hires as of 3/27/14 including all dietary staff as well on 8/19/14. A 100% training on Heimlich maneuver with all licensed nurses, CNAs, dietary staff, activity staff, and therapist except for 2 prn therapists completed by 8/30/14 The 2 prn therapists were issued a letter with return receipt noting that they have to go through training before they're allowed to work. Heimlich maneuver training will be done on all new hires during orientations.
- Heimlich posters with pictures and instructions were placed on every dining room, 2nd floor, 3rd floor, 4th floor, and main dining room.
- Color coded meal ticket initiated on 4/4/14 for residents on altered diet. All staff were educated on the color code meal ticket 4/14/14 by the Staff Dev. Coordinator. A 100% in-service with all staff on color coded tickets completed by the Staff Development Coordinator on 8/30/14.

4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?

- A daily audit of meal tray cards served for accuracy with plans of care and MD orders was completed for each meal for 30 days beginning 3/31/14, then 4-6 meal audits for 2 months, then 2 meal audit for a month, and ongoing.
- On 8/19/14 the nursing staff was audited and monitored by ADON and Department heads during meal time in regards to checking accuracy of meals served to patients, then will monitor 20 staff members per week for 1 month, 10 staff members per week for 1 month, and 5 staff members per week for 1 month, then random audit weekly x 3 months. Staff that failed to follow the plan will be re-educated and trained.

• A weekly audit of all resident's diet against the meal tray ticket, physician's orders, and care plan will be done by the Registered Dietitian started 9/8/14 for 1 month and then random weekly audit for 3 months.
• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluated of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the well-being of the residents.

F328
1. Nurse# 7 was educated on tracheostomy care and proper suctioning on 8/21/14 by the Staff Development Coordinator. Nurse#7 completed and successfully demonstrated a competency training regarding tracheostomy care and proper suctioning on 8/21/14. The suction machine in Resident#193 was serviced by Recover care on 8/21/14 and was noted to be functioning properly. CSM & Rehab Manager was educated by Regional Nurse Consultant regarding processing non-functioning equipment i.e. suction machine Resident #102 went to the hospital on 9/16/14. CNA#12 and Nurse#6 coached and counseled by the DON on 9/17/14 and educated on handling of ostomy and indwelling catheter and infection control policy by the Staff Development Coordinator on 9/18/14.
2. All residents have the potential of being affected by the deficient practice.
a. All suction machines in use by a patient, crash carts on 2nd, 3rd, 4th floor, therapy gym, and dining room were serviced by Recover care by 8/22/14 and were noted to be functioning properly. Central Supply person and Weekend supervisor will check daily for suction machine and supplies availability and par level.
b. An audit of all residents with ostomy adaptive devices and indwelling catheter for proper functiontining.
3. How will corrective action be monitored to ensure 9/25/14 the practice does not recur and what QA monitoring will be put into place?
• A 100% training and return demonstration for all licensed nurses on tracheostomy care and proper suctioning completed on 9/16/14. All new hires will be educated and should successfully demonstrate competency training regarding tracheostomy care

and proper suctioning during orientation.
• Central Supply and Supervisor will perform an inventory of all suction machines daily.
• Recover care will perform a preventative maintenance on all suction machines according to preventive maintenance schedule.
• Licensed Nurses received education by the Nurse Consultant and SDC regarding availability of suction machine, suction machine supplies, and facility's procedure for processing non- functioning equipment completed on 8/26/14. All new hires will be educated regarding the facility's procedure for processing non-functioning equipment. The licensed nurses that are currently on leave of absence, vacation or per diem were sent a letter indicating that training regarding the facility's procedure for processing non-functioning equipment must be completed prior to returning for next scheduled shift.
• All licensed nurses and CNAS will be educated by the Staff Development Coordinator on proper handling of all ostomy adaptive devices and indwelling catheter for proper functioning and infection.

F456
1 Nurse# 7 was educated on tracheostomy care 9/25/14 and proper suctioning on 8/21/14 by the Staff Development Coordinator. Nurse#7 completed and successfully demonstrated a competency training regarding tracheostomy care and proper suctioning on 8/21/14. The suction machine in Resident#193 was serviced by Recover care on 8/21/14 and was noted to be functioning properly. CSM & Rehab Manager was educated by Regional Nurse Consultant regarding processing non-functioning equipment i.e. suction machine
2. All residents have the potential of being affected by the deficient practice.
a. All suction machines in use by a patient, crash carts on 2nd, 3rd, 4th floor, therapy gym, and dining room were serviced by Recover care by 8/22/14 and were noted to be functioning properly. Central Supply person and Weekend supervisor will check daily for suction machine and supplies availability and par level.
3. How will corrective action be monitored to ensure the practice does not recur and what QA monitoring will be put into place? 9/25/14
• A 100% training and return demonstration for

all licensed nurses on tracheostomy care and proper suctioning completed on 9/16/14. All new hires will be educated and should successfully demonstrate competency training regarding tracheostomy care and proper suctioning during orientation.

- Central Supply and Supervisor will perform an inventory of all suction machines daily.
- Recover care will perform a preventative maintenance on all suction machines according to preventive maintenance schedule.
- Licensed Nurses received education by the Nurse Consultant and SDC regarding availability of suction machine, suction machine supplies, and facility's procedure for processing non-functioning equipment completed on 8/26/14. All new hires will be educated regarding the facility's procedure for processing non-functioning equipment. The licensed nurses that are currently on leave of absence, vacation or per diem were sent a letter indicating that training regarding the facility's procedure for processing non-functioning equipment must be completed prior to returning for next scheduled shift.

4. How will corrective action be monitored to ensure the practice does not recur and what QA monitoring will be put in place.

- DON, ADON, & SDC will do random audits weekly with licensed nurses on tracheostomy care for 3 months.
- CSM and ADON/Supervisor will perform audit on the suction machines for proper functioning twice a week for 3 months.
- Recover Care performs a monthly preventative maintenance on all suction machines.
- A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/28/14 and then monthly for findings, recommendations, and follow-up regarding the above plan. At that time based upon evaluation of the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet

F329

1. Resident #25 Coumadin was discontinued on 7/17/14 and stat INR done on 7/17/14 showing INR of 1.6 and is within normal limits. Resident did not have any adverse drug reactions. Medication error report completed on 8/20/14 DON conducted coaching and counseling with Nurse #18 on 8/21/14. Medication Error training thru Care2Learn was completed on 8/21/14 by Nurse #18.

Resident #205 PT & INR done on 7/31/14 showing PT 20.6 and INR of 2.7 and new order for Coumadin 3mg Tuesday, Thursday, Saturday, & Sunday alternating Coumadin 2mg Monday, Wednesday, & Friday. Resident#205 did not have any adverse drug reactions. Medication error completed 9/16/14.

Resident #35 Aims testing completed 9/16/14 and Behavior monitoring flow sheet initiated on 9/1/14

Resident #47 MDS was corrected on 9/16/14 with Abilify, anti-psychotic medication coded on Section N0410A. Aims testing completed on 8/22/14 and anti-psychotic care plan completed on 9/16/14

Resident #219 Aims testing was completed on 9/16/14 and Behavior monitoring flow sheet initiated on 9/11/14

2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 9/25/14

a. All residents have the potential to be affected by the same practice. All critical lab values from 7/10/14 until 8/20/14 were reviewed by the ADON and MDS Coordinator on 8/20/14 to ensure that the physician/nurse practitioner were notified of any critical lab values. A complete audit of all current residents receiving Coumadin therapy was completed by ADON & MDSC on 8/20/14 for correct dosage and frequency in the physician order and present on MAR, as well as, ensuring that physician/nurse practitioner were notified of any critical lab values and a care plan is present for those receiving the Coumadin therapy.

A complete Laboratory audit was completed by Nursing on 8/23/2014 to ensure Lab was performed according to physicians order and physician notified when abnormal results are obtained.

b. An audit of all residents on psychotropic medication to ensure that there is a behavior monitoring flow sheet in place by 9/23/14. All residents on anti-psychotic medication will have

Aims testing completed, psychotropic meds coded on MDS accurately and all psychotropic medications have care plan in place by 9/23/14

c. Pharmacy Consultant completed a medication regimen review on all residents on 9/12/14 with recommendations.

3. How will corrective action be monitored to ensure the practice does not recur and what QA will be put in place.

• Education and training with all licensed nursing staff by the Staff Development Coordinator regarding facility's policy on reporting critical lab results to the physician/nurse practitioner timely, as well as, policy regarding anti-coagulant therapy ensuring residents prescribed anti-coagulant therapy receive the medication in a safe and therapeutic manner on 8/20/14, 8/24/14, 9/8/14, & 9/9/14.

• Education and training on Antibiotic-Coumadin potential drug interaction, Unnecessary drugs, Anti-psychotic usage with appropriate diagnosis, use of behavior monitoring sheets, and Aims testing to all licensed nurses by the Pharmacy Consultant on 9/9/14 & 9/10/14.

• Education and training with all licensed nurses on how to utilize the lab tracking tool by the Regional Nurse Consultant on 8/24/14, 8/25/14, 8/26/14, 8/28/14.

4. How will corrective action be monitored to ensure the practice does not recur and what QA monitoring will be put into place?

• DON, ADON or Weekend Supervisor will review all lab results including abnormal/critical values daily using the lab tracking tool to ensure the physician /nurse practitioner are notified timely. 9/25/14

• DON, ADON, or Weekend Supervisor will continue to audit all current residents receiving Coumadin therapy daily for correct dosage and frequency on the physician's order and MARS.

• DON & ADON will audit resident's on psychotropic medications for behavior monitoring flow sheet

• DON, ADON or weekend supervisor will review telephone orders daily for any new order/changes on resident's psychotropic medications to ensure Aims testing is completed, behavior monitoring flow initiated, and care plan initiated for use of psychotropic medication.

• A psychotropic drug meeting with the psychiatrist and the interdisciplinary team members will be held on 9/18/14 to review residents on

psychotropic medication to attempt gradual dose reduction. A psychotropic drug meeting will be conducted monthly thereafter.
• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan.

F505
1. Resident #25 Coumadin was discontinued on 7/17/14 and stat INR done on 7/17/14 showing INR of 1.6 and is within normal limits. Resident did not have any adverse drug reactions. Medication error report completed on 8/20/14 DON conducted coaching and counseling with Nurse #18 on 8/21/14. Medication Error training thru Care2Learn was completed on 8/21/14 by Nurse #18. Resident #205 PT & INR done on 7/31/14 showing PT 20.6 and INR of 2.7 and new order for Coumadin 3mg Tuesday, Thursday, Saturday, & Sunday alternating Coumadin 2mg Monday, Wednesday, & Friday. Resident#205 did not have any adverse drug reactions.
Medication error completed 9/16/14.
Resident #35 Aims testing completed 9/16/14 and Behavior monitoring flow sheet initiated on 9/1/14
Resident #47 MDS was corrected on 9/16/14 with A bilify, anti-psychotic medication coded on Section N0410A. Aims testing completed on 8/22/14 and anti-psychotic care plan completed on 9/16/14
Resident #219 Aims testing was completed on 9/16/14 and Behavior monitoring flow sheet initiated on 9/11/14.
2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?
a. All residents have the potential to be affected by the same practice. All critical lab values from 7/10/14 until 8/20/14 were reviewed by the ADON and MDS Coordinator on 8/20/14 to ensure that the physician/nurse practitioner were notified of any critical lab values.
A complete audit of all current residents receiving Coumadin therapy was completed by ADON & MDSC on 8/20/14 for correct dosage and frequency in the physician order and present on MAR, as well as, ensuring that physician/nurse practitioner were notified of any critical lab values and a care plan is present for those receiving the Coumadin therapy. A complete Laboratory audit was completed by Nursing on 8/23/2014 to ensure Lab was performed according to

physicians order and physician notified when abnormal results are obtained.
b. An audit of all residents on psychotropic medication to ensure that there is a behavior monitoring flow sheet in place by 9/23/14. All residents on anti-psychotic medication will have Aims testing completed, psychotropic meds coded on MDS accurately and all psychotropic medications have care plan in place by 9/23/14
c. Pharmacy Consultant completed a medication regimen review on all residents on 9/12/14 with recommendations.
3. How will corrective action be monitored to ensure the practice does not recur and what QA will be put in place.
• Education and training with all licensed nursing staff by the Staff Development Coordinator regarding facility's policy on reporting critical lab results to the physician/nurse practitioner timely, as well as, policy regarding anti-coagulant therapy ensuring residents prescribed anti-coagulant therapy receive the medication in a safe and therapeutic manner on 8/20/14, 8/24/14, 9/8/14, & 9/9/14.
• Education and training on Antibiotic-Coumadin potential drug interaction, Unnecessary drugs, Anti-psychotic usage with appropriate diagnosis, use of behavior monitoring sheets, and Aims testing to all licensed nurses by the Pharmacy Consultant on 9/9/14 & 9/10/14.
• Education and training with all licensed nurses on how to utilize the lab tracking tool by the Regional Nurse Consultant on 8/24/14, 8/25/14, 8/26/14, 8/28/14.
4. How will corrective action be monitored to ensure the practice does not recur and what QA monitoring will be put into place?
• DON, ADON or Weekend Supervisor will review all lab results including abnormal/critical values daily using the lab tracking tool to ensure the physician/nurse practitioner are notified timely.
• DON, ADON, or Weekend Supervisor will continue to audit all current residents receiving Coumadin therapy daily for correct dosage and frequency on the physician's order and MARS.
• DON & ADON will audit resident's on psychotropic medications for behavior monitoring flow sheet
• DON, ADON or weekend supervisor will review telephone orders daily for any new order/changes on resident's psychotropic medications to ensure Aims testing is completed, behavior monitoring flow initiated, and care plan initiated for use of psychotropic medication.
• A psychotropic drug meeting with the psychiatrist and the interdisciplinary team members will be held on 9/18/14 to review residents on psychotropic medication to attempt gradual dose reduction.
A psychotropic drug meeting will be conducted

monthly thereafter.
• A Quality Assurance meeting will be held weekly for 4 weeks beginning 8/23/14 and then monthly for findings, recommendations, and follow-up regarding the above plan.

F520
Social Services Director/Quality Assurance Chairperson was educated on the facilities immediate measures taken to ensure that the highest quality of care were implemented in all areas in particular dietary, nursing, clinical & equipment.
The facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee will meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

The facility's Quality Assessment and Assurance (QAA) committee will continue to ensure corrective actions are consistently monitored to ensure the staff follow physician orders for therapeutic diets and interventions on the care plans related to assisting with dining with residents and ensure functioning medical equipment to immediately perform tracheal suctioning for residents with a tracheostomy. The committee will also ensure residents are protected from potential staff to resident abuse. The committee will ensure the abuse policy is followed to ensure allegations of abuse and neglect are thoroughly investigated and reported to administration for all residents. The committee will also ensure adherence to current medical standards of practice related to emergency services for choking as well as ensure residents are free from unnecessary medications related to the use of anticoagulant medications and ensure timely physician notification of abnormal lab results.

Weekly Performance Improvement meetings began on 8/23/14 and will be held weekly for four weeks, then monthly for findings, recommendations and follow up related to the plan. The administrator will have oversight to ensure an effective plan is in place and being followed.

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F 490	Continued From page 60 was verified the preventive maintenance schedule is ongoing for all new machines delivered. Interviews on 8/26/14 with staff verified the use of coumadin flow sheets at each nursing desk that will be taken daily to the clinical meetings for review and follow up. Interviews with nursing staff revealed nursing staff were aware of lab policy and when to notify physician of lab value results. Interview on 8/27/14 the Quality Assurance (QA) Coordinator stated that weekly performance Improvement meetings began on 8/23/14 and will be held weekly for four weeks and then monthly. The administrator will have oversight to ensure an effective plan is in place. The facility will remain out of compliance at a scope and severity level of "D", an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	Social Services Director/Quality Assurance Chairperson was educated on the facilities immediate measures taken to ensure that the highest quality of care were implemented in all areas in particular dietary, nursing, clinical & equipment.	9/25/14

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F 520	Continued From page 61 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Sorensen and Luckmann's Basic Nursing a Psychophysiologic Approach, policy review, review of the investigator's report, review of an autopsy report, review of a meal tray card, medical record review, observation and interview, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to ensure corrective actions were consistently monitored to ensure the staff followed physician orders for therapeutic diets and interventions on the care plans related to assisting with dining for 2 of 39 (Residents #261 and 6) residents and failed to ensure functioning medical equipment to immediately perform tracheal suctioning for 1 of 2 (Resident #193) residents with a tracheostomy. The incidents noted above resulted in immediate jeopardy (IJ), a situation in which the provider's	F 520	The facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee will meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. The facility's Quality Assessment and Assurance (QAA) committee will continue to ensure corrective actions are consistently monitored to ensure the staff follow physician orders for therapeutic diets and interventions on the care plans related to assisting with dining with residents and ensure functioning medical equipment to immediately perform tracheal suctioning for residents with a tracheostomy. The committee will also ensure residents are protected from	9/25/14

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F 520	Continued From page 62 noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. A meeting was conducted in the conference room on 8/18/14 at 4:52 PM, with the Administrator and the Director of Nursing (DON) at which time they were informed of the IJ related to choking. A meeting was conducted in the conference room on 8/21/14 at 12:46 PM, with the Administrator and the DON, at which time they were informed of the IJ related to malfunctioning suction equipment for tracheostomy care. The facility provided acceptable Allegations of Compliance (AOC) on August 25th, 2014 and an AOC on August 26th, 2014. It was determined on August 26, 2014 the corrective actions implemented on August 25th and 26th, 2014, removed the IJ. The immediate jeopardy (IJ) existed from 2/14/14 through 8/25/14. The IJ was removed on 8/26/14. Noncompliance for F520 continues at a "D" level citation. The facility is required to submit a Plan of Correction. The findings included: 1. The quality assurance (QA) committee identified the problem in which residents may receive an incorrect diet after the accidental choking death of Resident #261 in March, 2014. Inservices began for the dietary staff and the nursing staff related to proper diet delivery, identification of therapeutic diets and proper set	F 520	potential staff to resident abuse. The committee will ensure the abuse policy is followed to ensure allegations of abuse and neglect are thoroughly investigated and reported to administration for all residents. The committee will also ensure adherence to current medical standards of practice related to emergency services for choking as well as ensure residents are free from unnecessary medications related to the use of anticoagulant medications and ensure timely physician notification of abnormal lab results. Weekly Performance Improvement meetings began on 823/14 and will be held weekly for four weeks, then monthly for findings, recommendations and follow up related to the plan. The administrator will have oversight to ensure an effective plan is in place and being followed.	

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F 520	Continued From page 63	F 520		

up. Documentation for cook skills checklists dated during April 2014 and facilitated by the Dietary manager, documented training objectives to include pureed foods and mechanical soft foods. All staff disciplines received inservicing beginning on 3/28/14 that included: The difference between pureed foods, mechanical soft, honey thick liquids and nectar thick liquids. Comparing the actual meal to the tray ticket. How to read a tray ticket. Tray tickets are highlighted for residents that at risk for choking, which includes all residents on mechanical soft or pureed diets and those with thickened liquids. The proper position for residents at risk for choking. All of these inservice sheets were reviewed and verified.

The Quality Assessment and Assurance (QAA) Committee had implemented corrective actions related to the dietary issues following the choking death of Resident #261.

The QA committee failed to continuously identify and failed to sustain performance improvement initiatives related to meal delivery and training on correct diet identification and meal tray delivery as evidenced by an observation on 8/22/14 when Resident #6 received a regular hot dog on a bun when a mechanical soft diet with no bread was ordered by the physician.

There was no system in place to monitor staff performance related to checking the meal trays to ensure the correct diet was delivered to the residents.

Refer to F282, F309 and F365.

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F 520	Continued From page 64 2. The facility failed to ensure suction equipment was readily available and functional for proper tracheostomy care for Resident #193. Nurse #7, the Rehab Director and the Central Supply Manager verified the facility had issues with the suctions machines not always functioning properly. Refer to F328 and F456. 3. During an interview in the Director of Social Services (DSS) office on 8/27/14 at 11:45 AM, the DSS stated, the Quality Assessment and Assurance (QAA) Committee had not implemented plans of corrective action related to the dietary issues resulting in Resident #261's choking death. The DSS's statement is not accurate, in that the surveyors verified that initial corrective actions had actually been implemented following the choking of Resident #261. 4. Validation of the Credible Allegation of Compliance (AOC) was accomplished on August 26, 2014, through review of facility documents, audits, review of in-service records, observations and interviews with dietary, suction machine company supervisors, nursing, dietary staff and administrative staff administrative staff. The surveyors validated the corrective actions stated in the AOC were implemented which removed the IJ. The facility provided evidence of in-service training with sign in sheets, for all staff tray service to include review of each meal ticket for verification of correct diet served and color coded	F 520		

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F 520	Continued From page 65 meal tickets for therapeutic diets. The facility provided evidence of in-service training for all dietary personnel regarding identification and preparation of diets, competencies for food preparation and thickened liquids by the certified dietary manager and registered dietician. The facility provided evidence of in-service training with sign in sheets for licensed nurses on proper suctioning, tracheostomy care, availability of suction machines, suction supplies and facility process for non-functioning equipment. The facility provided evidence of audits that included physician orders to meal tickets and verified on the care plan. Accuracy of meals served to residents to include trays from the kitchen to the floors and tray tickets verified with meals on the trays. Observations in the kitchen on 8/26/14 revealed the meal ticket being checked at each station, the condiments and fluid station, the entree station and at the bread and dessert station the entire meal tray was reviewed by that staff member to ensure the tray was correct. Observations in the facility on 8/26/14 revealed staff physically checking the meal tickets to the food tray when the cart was delivered to the halls, and then a second check by the staff member when the tray is delivered to the resident. Observations on 8/26/14 of the new suction machines delivered revealed all machines serviced by the suction machine company and were in working order.	F 520		

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F 520	Continued From page 66 Interviews on 8/26/14 with CNAs, dietary staff, nurse managers, charge nurses conducted in the facility, staff verbalized how to properly check for proper diets and matching the tray tickets, what a colored meal ticket means, and how to do the Heimlich maneuver. Nurse managers verbalized how they would continue to monitor and audit the accuracy of the meal delivery. Interviews on 8/26/14 with the suction company's operations manager and director of accounts, it was verified the preventive maintenance schedule is ongoing for all new machines delivered. Interview on 8/27/14 the Quality Assurance (QA) Coordinator stated that weekly performance Improvement meetings began on 8/23/14 and will be held weekly for four weeks and then monthly. The administrator will have oversight to ensure an effective plan is in place. The facility will remain out of compliance at a scope and severity level of "D", an isolated deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is required to submit a plan of correction.	F 520		