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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375098	A. BUILDING ______ B. WING ______	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-MIDWEST CITY	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110

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F 000	INITIAL COMMENTS A recertification/re-licensure survey was conducted from 08/06/13 through 08/09/13. Complaint #OK00042796 was investigated in conjunction with the survey. The following is a list of abbreviations used through out this document. @ - at ADL - activities of daily living ADON - assistant director of nursing CNA - certified nurse aide Dc ' d - discontinued DON - director of nursing HS - hour of sleep I/O - input and output I ' s and O ' s - input and output LPN - licensed practical nurse MAR - medication administration record Mg/ml - milligrams per milliliter Ml - milliliter npo - nothing by mouth peg - percutaneous endoscopic gastrostomy po - by mouth PT/INR - prothrombin time/international normalization ratio q/Q - every R/T - related to rt - right sats - saturation Tabs - tablets	F 000		
F 158 SS=E	483.10(c)(1) RIGHT TO MANAGE OWN FINANCIAL AFFAIRS The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the	F 158		

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

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

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F 158	Continued From page 1	F 158		

facility.

This REQUIREMENT is not met as evidenced by:
Based on trust account ledger review, and interviews, it was determined the facility failed to ensure residents who held their money in the resident trust account had access to their funds at night and on the weekends for three (#5, 11 and #18) of three sampled residents who had their money held in the resident trust account. The business office manager identified seventeen residents whose personal money was held in the resident trust account.

Findings:

A review of the resident trust account ledgers for resident #5, 11 and #18 did not contain documentation the residents' had access to funds at night and on the weekends.

An interview was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident's who held their money in the resident trust account. She stated, "It's in the [Payroll] safe."

She was asked who had access to the funds when resident's requested. She indicated it was herself and [payroll clerk].

She was asked what hours she worked. She stated, "8:00 a.m. through 5:00 p.m."

She was asked how residents' could access funds after 5:00 p.m. and on the weekends. She

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F 158	Continued From page 2 stated, "I don't know I'm not here. She then stated, "They [residents] know to come by before 5:00 p.m." She was asked if there was a system in place to ensure residents had access to their money at night and on the weekends. She stated, "I'm not aware of a system." An interview was conducted on 08/09/13 at 9:19 a.m., with the payroll clerk. She was asked how residents' would access money in the evenings and on the weekends. She stated, "There is no way if [accounts payable] is not here." An interview was conducted on 08/09/13 at 9:55 a.m., with resident #23 regarding accessibility of her money from the trust account. She was asked if money was available at night and on the weekends. She stated, "You are unable to get money when the bookkeeper is not here. You have to let them know ahead of time." An interview was conducted on 08/09/13 at 10:00 a.m., with resident #22 regarding accessibility of her money from the trust account. She was asked if money was available at night and on the weekends. She stated money is not available in the evening and on the weekends.	F 158		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.	F 159		

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F 159	Continued From page 3 The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.	F 159		

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F 159	Continued From page 4	F 159		

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, it was determined the facility failed to ensure residents were informed of balances within two hundred dollars of the resource limit for two (#11 and #18) of three sampled residents currently residing at the facility and had funds greater then the resource limit of $2000.

The business office manager identified seventeen residents whose personal money was held in the resident trust account.

Findings:

The "Resident Trust Fund Authorization" documented, "...If I receive Medicaid benefits, center will notify me when the amount in my account reaches Two Hundred and 00/100 dollars ($200) less than the social security income (SSI) resource limit for one person, and that, if the amount in the account, in addition to the value of my other nonexempt resources, reaches the SSI resource limit for one person, I may lose eligibility for Medicaid and SSI..."

1. A review of the resident trust account ledger for resident #11 documented the resident had a balance of $2,209.70 on 08/01/13.

There was no documentation the facility provided the resident and or their family a notice when they were within $200 of the resource limit.

2. A review of the resident trust account ledger for resident #18 documented the resident had a balance of $2,531.03.

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F 159	Continued From page 5 There was no documentation the facility provided the resident and or their family a notice when they were within $200 of the resource limit. An interview was conducted on 08/09/13 at 9:53 a.m., with the business office manager. She was asked if the facility provided resident #11 and #18 or their family a notice when they were within $200 of the $2,000 resource limit. She stated, "I have not given notices, I didn't know I had to do that."	F 159		
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on resident trust account ledger review and interviews, it was determined the facility failed to convey money held in the resident trust account, within 30 days, for two (#19 and #21) of three sampled residents who had expired and had money held in the trust account. The business office manager identified seventeen residents whose personal money was held in the resident trust account. Findings:	F 160		

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F 160	Continued From page 6 The "Resident Trust Fund Authorization" documented, "...I acknowledge that upon my discharge or death, the balance of my account will be promptly released to the private party or public agency required by law..." An interview was conducted on 08/09/13 at 8:15 a.m., with the business office manager regarding active residents on the trust account. She was asked to identify anyone on the trust account who no longer resided at the facility. She identified residents #19, 20 and #21 as no longer being at the facility. She was asked if they had expired or moved to another facility. She stated they had all expired. She was asked when the residents had expired. She indicated the following dates the residents expired: Resident #19: 06/21/13; Resident #20: 07/19/13; Resident #21: 07/02/13. 1. A review of the resident trust account ledger for resident #19 documented the resident had balance of $1,068.07 on 08/05/13. The resident expired on 06/21/13, 49 days prior to the review of the trust account. 2. A review of the resident trust account ledger for resident #21 documented the resident had balance of $68.43 on 08/01/13. The resident expired on 07/02/13, 39 days prior to the review of the trust account.	F 160		

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F 160	Continued From page 7 A second interview was conducted on 08/09/13 at 9:53 a.m., with the business office manager. She was asked how long the facility had to convey the trust funds to residents' estate. She stated, "Within 30 days." She was asked about residents #19 and #21 account being open still. She stated, "We sent paperwork in, they hadn't been closed out."	F 160		
F 225 SS=E	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. 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.	F 225		

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F 225	Continued From page 8 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 employee file review and interview, it was determined the facility failed to complete former employer reference checks for 11 of 11 employee files reviewed. This had the potential to affect all 81 residents who resided at the facility. Findings: 1. A review of the employee file for licensed practical nurse #3 documented she was hired on 05/31/13. There was no documentation to indicate the facility completed employer reference checks. 2. A review of the employee file for licensed practical nurse #4 documented she was hired on 05/24/13. There was no documentation to indicate the facility completed employer reference checks. 3. A review of the employee file for licensed practical nurse #5 documented she was hired on 02/25/13.	F 225		

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F 225	Continued From page 9 There was no documentation to indicate the facility completed employer reference checks. 4. A review of the employee file for certified nurse aide #4 documented she was hired on 05/10/13. There was no documentation to indicate the facility completed employer reference checks. 5. A review of the employee file for certified nurse aide #5 documented she was hired on 05/31/13. There was no documentation to indicate the facility completed employer reference checks. 6. A review of the employee file for certified nurse aide #6 documented she was hired on 02/13/13. There was no documentation to indicate the facility completed employer reference checks. 7. A review of the employee file for cook #1 documented he was hired on 03/28/13. There was no documentation to indicate the facility completed employer reference checks. 8. A review of the employee file for cook #2 documented she was hired on 07/26/13. There was no documentation to indicate the facility completed employer reference checks. 9. A review of the employee file for the speech pathologist documented she was hired on	F 225		

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F 225	Continued From page 10 07/19/13. There was no documentation to indicate the facility completed employer reference checks. 10. A review of the employee file for certified medication aide #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed employer reference checks. 11. A review of the employee file for housekeeper #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed employer reference checks. An interview was conducted on 08/07/13 at 9:40 a.m., with the administrator, human resource director and regional human resource director regarding reference checks. They were asked if the facility had completed the reference checks on the new hires listed above. The regional human resource director stated, "That's correct they haven't been done."	F 225		
F 226 SS=E	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	F 226		

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F 226	Continued From page 11 by: Based on employee file review and interview, it was determined the facility failed to implement their abuse policy for completed former employer reference checks for 11 of 11 employee files reviewed. This had the potential to affect all 81 residents who resided at the facility. Findings: The abuse policy and procedure documented, "...Employee screening: The center evaluates a prospective employee's experience in working with patients who have specific conditions and needs, and seeks to identify and verify history of abuse, neglect, or misappropriation of patient property. The center screens prospective employees to reduce the risk that no one is hired who is likely to abuse patients. The center utilizes the employee screening process to identify information from: previous and current employers..." 1. A review of the employee file for licensed practical nurse #3 documented she was hired on 05/31/13. There was no documentation to indicate the facility completed employer reference checks. 2. A review of the employee file for licensed practical nurse #4 documented she was hired on 05/24/13. There was no documentation to indicate the facility completed employer reference checks. 3. A review of the employee file for licensed practical nurse #5 documented she was hired on	F 226		

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F 226	Continued From page 12 02/25/13. There was no documentation to indicate the facility completed employer reference checks. 4. A review of the employee file for certified nurse aide #4 documented she was hired on 05/10/13. There was no documentation to indicate the facility completed employer reference checks. 5. A review of the employee file for certified nurse aide #5 documented she was hired on 05/31/13. There was no documentation to indicate the facility completed employer reference checks. 6. A review of the employee file for certified nurse aide #6 documented she was hired on 02/13/13. There was no documentation to indicate the facility completed employer reference checks. 7. A review of the employee file for cook #1 documented he was hired on 03/28/13. There was no documentation to indicate the facility completed employer reference checks. 8. A review of the employee file for cook #2 documented she was hired on 07/26/13. There was no documentation to indicate the facility completed employer reference checks. 9. A review of the employee file for the speech	F 226		

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F 226	Continued From page 13 pathologist documented she was hired on 07/19/13. There was no documentation to indicate the facility completed employer reference checks. 10. A review of the employee file for certified medication aide #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed employer reference checks. 11. A review of the employee file for housekeeper #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed employer reference checks. An interview was conducted on 08/07/13 at 9:40 a.m., with the administrator, human resource director and regional human resource director regarding reference checks. They were asked if the facility had completed the reference checks on the new hires listed above. The regional human resource director stated, "That's correct they haven't been done." They were asked if their abuse policy and procedure was followed for completing reference checks. The regional director and the human resource director both stated, "No, it was not followed."	F 226		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		

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The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the environment was sanitary and in good repair as evidenced by stained and frayed carpet, stained and torn chairs, stained and torn couches, marked and scuffed end tables and corroded, loose and cracked faucets on two (Halls 100 and 300) of four halls, and one (the lounge area by the dining room) of four public areas. This had the potential to affect seven residents who ambulated independently without assistance and 35 who used a wheel chair or walker without assistance for mobility.

Findings:

On 08/06/13 at 10:30 a.m., an environmental tour was conducted. The following observations were made:

1. On hall 100,
   a. In room 104, the sink faucet was corroded.
   b. In room 114, the sink faucet was loose.

2. On hall 300,
   a. In room 334, the sink faucet was corroded and cracked.

3. In the lounge area by the dining room, there were four gold chairs that were stained throughout and torn with scratches and scuff

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F 252	Continued From page 15 marks on the legs. There were two couches that were stained throughout and torn with scratches and scuff marks on the legs. There were two end tables that were dented and scratched on the table tops and legs of the end tables. The carpet in this area was stained and frayed. On 08/07/13 at 1:30 p.m., the Maintenance supervisor was interviewed. He was shown the findings of the environmental tour. He stated he would take care of it.	F 252		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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Based on observation, record review, and interviews, it was determined the facility failed to address on the care plan a resident's back pain due to compression fractures and the need to use a lumbar corsett for one (#3) of one sampled residents with an order for a lumbar corsett. The director of nursing identified no additional residents who had back pain and an order for a lumbar corsett.

Findings:

Resident #3 was admitted to the facility with diagnoses to include left hip and femur fracture.

A 'Radiology Report" dated 04/25/13, documented, "...Results: T9 modest compression is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/11/13 lumbar spine images which showed an intact T9...conclusion: Unchanged L1 old marked compression fracture with more compressed L3...notify family of somewhat progressed L3 compression fracture..."

A care plan dated 01/09/13 and last updated 06/24/13, documented, "Focus: At risk for falls due to history of falls, generalized weakness, use of antidepressant and antianxiety medication...

Goals: minimize risk for injury r/t [due to] falls....

Interventions: Assure the patient wears non skid socks in room...offer frequent toielting- upon rising, before and after meals, and before bed. Provide assist to transfer as needed. Provide assist with frequent toileting...

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F 280	Continued From page 17 The care plan did not address the resident's back problems with compression fractures and the use of a lumbar corsett. A quarterly assessment dated 08/01/13, documented the resident's speech was clear, understood and could be understood and had mild occasional pain. The monthly physician's orders for July 2013, documented, "Lumbar Corsett on when up in wheelchair off when in bed." The order was first written 05/08/13. On 08/06/13 at 10:40 a.m., the resident was observed in her room in a low bed. There was no lumbar corsett visible in the room. On 08/06/13 during the noon and evening meal the resident was observed at the dining room table in her wheelchair chair. The resident did not have a Lumbar Corsett in place at the time of the observation. On 08/07/13 and 08/08/13, the resident was again observed during breakfast and noon meal in the main dining room. The resident was again without the Lumbar Corsett. On 08/08/13 at 9:25 a.m., the director of nursing was asked why the resident required a Lumbar Corsett. She indicated it was for back pain. She was asked what the diagnoses was when the brace was first ordered. She indicated she would have to check with the doctor and see. She was asked where the Lumbar Corsett was located and how often it was placed on the	F 280		

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F 280	Continued From page 18 resident. She left and returned stating, 'I've been told by the certified nurse aides the resident never had it." She then stated, "I don't know why central supply didn't get it." She also stated if the resident used the Lumbar Corsett it would be on the resident's task list. She left and returned providing a task list and stated, "It's not on there." She was asked if the care plan addressed the resident's back pain and the use of a lumbar corsett. She looked through the care plan and stated it had not been addressed. On 08/08/13 at 2:52 p.m., the director of nursing stated the physician had wrote the order for back pain due to the compression fractures.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to ensure a resident had a lumbar corsett in place while up in her wheel chair for one (#3) of one sampled resident with orders for a lumbar corsett due to compression fractures and back pain. The	F 309		

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director of nursing identified no other residents with an order for a lumbar corsett.

Findings:

Resident #3 was admitted to the facility with diagnoses to include left hip and femur fracture.

A 'Radiology Report" dated 04/25/13, documented, "...Results: T9 modest compression is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/11/13 lumbar spine images which showed an intact T9...conclusion: Unchanged L1 old marked compression fracture with more compressed L3...notify family of somewhat progressed L3 compression fracture..."

A quarterly assessment dated 08/01/13, documented the resident's speech was clear, understood and could be understood and had mild occasional pain.

The monthly physician's orders for July 2013, documented, "Lumbar Corsett on when up in wheelchair off when in bed." The order was first written 05/08/13.

During the initial tour of the facility on 08/06/13 the resident was observed in her room in bed. The wheel chair was observed and the room was observed. No lumbar corsett was observed in the room.

On 08/06/13 at 10:40 a.m., the resident was observed in her room in a low bed. There was no lumbar corsett visible in the room.

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On 08/06/13 during the noon and evening meal the resident was observed at the dining room table in her wheelchair chair. The resident did not have a Lumbar Corsett in place at the time of the observation.

On 08/07/13 and 08/08/13, the resident was again observed during breakfast and noon meal in the main dining room. The resident was again without the Lumbar Corsett.

An interview was conducted on 08/08/13 at 8:25 a.m., with certified nurse aide #1. She was asked if the resident wore any braces or supports while up in her wheel chair. She stated, "There are no braces or supports."

Ani interview was conducted on 08/08/13 at 8:40 a.m., with certified nurse aide #2. She was asked where the resident's Lumbar Corsett was located and how often it was placed on the resident. She stated, "No braces, she never had one."

An interview was conducted on 08/08/13 at 9:10 a.m., with the resident. She was asked if she had a back brace she wore. She stated, "I don't wear a back brace."

An interview was conducted on 08/08/13 at 9:25 a.m., with the director of nursing. She was asked why the resident required a Lumbar Corsett. She indicated it was for back pain.

She was asked what the diagnoses was when the brace was first ordered. She indicated she would have to check with the doctor and see.

She was asked where the Lumbar Corsett was located and how often it was placed on the

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F 309	Continued From page 21 resident. She left and returned stating, 'I've been told by the certified nurse aides the resident never had it." She then stated, "I don't know why central supply didn't get it." She also stated if the resident used the Lumbar Corsett it would be on the resident's task list. She left and returned providing a task list and stated, "It's not on there." On 08/08/13 at 2:52 p.m., the director of nursing stated the physician had wrote the order for back pain due to the compression fractures.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews, it was determined the facility failed to assess a resident's incontinence for a toileting program and/or a scheduled bladder program for one (#3) of one sampled residents with urinary incontinence who experienced reoccurring falls while attempting to self toilet. The resident census and condition report, dated 08/06/13,	F 315		

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F 315	Continued From page 22 documented 40 residents were occasionally or frequently incontinent of urine. Findings: Resident #3 was admitted to the facility with diagnoses to include over active bladder, left hip and femur fracture. An incident report, dated 01/06/13 at 10:25 p.m., documented, "pt [patient] found by cna [certified nurse aide] no injuries noted vital signs and nero [sic] checks started...." There was no documentation on the incident report or in the nurse's notes as to what occurred and what the resident had been doing prior to the incident. An incident report, dated 01/09/13 at 5:00 p.m., documented, "Pt was found on the floor in front of bathroom. Pt stated she needed to go to the bathroom. Pt stated she hit her elbow. Skin tear noted to right elbow..." There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet. An incident report, dated 01/25/13 at 8:00 p.m., documented, "Patient found on the floor on the side of the bed, states she was coming from the bathroom and lost balance d/t socks...describe care...routine Lortab given, assessment, and reassurance...." There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet. An incident report, dated 03/07/13 at 9:45 p.m.,	F 315		

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documented, Pt found sitting in floor on bottom in front of bathroom door...assessed and assisted to bed no injuries..."

There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet.

The resident sustained four falls from 01/06/13 through 03/07/13, while attempting to self toilet.

There was no documentation to show the facility assessed the resident's incontinence for a toileting and or scheduled bladder program.

A care plan, dated 01/09/13 and last updated 06/24/13, documented, "Focus: At risk for falls due to history of falls, generalized weakness, use of antidepressant and antianxiety medication...

Goals...minimize risk for injury r/t falls...

Interventions: Assure the patient wears non skid socks in room...offer frequent toileting- upon rising, before and after meals, and before bed. Provide assist to transfer as needed. Provide assist with frequent toileting...

Focus: Urinary incontinence related to impaired mobility, physical limitations and cognitive impairment...

Goals: will have no complications due to incontinence...

Interventions...provide assistance with toileting..."

A Radiology Report, dated 04/25/13, documented, "...Results: T9 modest compression

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is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/11/13 lumbar spine images which showed an intact T9...conclusion: Unchanged L1 old marked compression fracture with more compressed L3...notify family of somewhat progressed L3 compression fracture..."

A significant change assessment, dated 05/03/13, documented the resident could understand and be understood, and had moderate impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and toilet use and was occasionally incontinent of bladder and was not on a toileting program.

An incident report, dated 07/07/13 at 5:00 a.m., documented, "[Resident] was observed sitting on the floor on her bottom in front of the bathroom-she states she was walking to the bathroom when she fell against the room door, slid down the door and landing on her bottom-denies hitting head-c/o [complains of] soreness to back...describe care...assess for injuries-assist to bathroom and to bed call light pinned to bed and asked her to demo [demonstrate] to use the call light- medicated for pain and soreness of the back..."

A nurse's noted, dated 07/07/13 at 7:29 a.m., documented, "[Resident] was observed scooting on the floor in sitting position- patient states she was walking to the bathroom when she fell- leaning on the door and slid to the floor on her bottom- denies hitting head, does c/o [complains of] sore back-medicated for pain and ask her to demo [demonstrate] the use of call light and at

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the time she states she understands the...purpose of the light..."

An incident report, dated 07/12/13 at 11:00 a.m., documented, "Patient attempting to self transfer without assistance lost balance and slid into floor, fall witnessed by roommate..."

There was no documentation why the resident was attempting to self transfer when she fell.

A quarterly assessment, dated 08/01/13, documented the resident's speech was clear, the resident understood and could be understood and had mild occasional pain. The resident required extensive assistance with transfers, dressing and toilet use. The resident was occasionally incontinent of urine and was not on a toileting program.

The assessment also documented the resident had one fall without injury since the last assessment.

The resident's task list documented, "Bowel and Bladder: provide assistance with toileting. Provide incontinent care as needed."

The resident sustained two additional falls while attempting to self toilet from 03/07/13 through 07/12/13.

There continued to be no documentation the facility assessed the resident's incontinence and placed her on toileting program.

On 08/08/13 at 8:25 a.m., certified nurse aide #1 was asked if the resident was on a toileting schedule or program. She indicated the resident

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was able to make her needs known and would let the staff know.

She was asked if the resident had falls. She indicated the resident had falls while attempting to toilet. She then stated the resident was not on a toileting program.

On 08/08/13 at 8:40 a.m., certified nurse aide #2 was asked if the resident was on a toileting program. She stated, "She can tell us but doesn't always want the help. She was asked if the resident had any falls. She indicated the resident had falls while going to the bathroom.

On 08/08/13 at 9:25 a.m., the director of nursing was asked if there was a pattern with the falls the resident had sustained. She stated, "I do see a pattern, the bathroom."

She was asked if the resident incontinence was assessed and if she was placed on a bladder program. She indicated she would have to look at the resident task list located on the computer. She returned with a copy and stated, "It's not on the task list, she is not."

She was asked if the resident's incontinence had been assessed for a scheduled bladder program. She stated, "No, the resident had not been assessed."

She was asked if the resident would be a good candidate for a toileting program. She stated, "I don't see why she wouldn't be good."

She was asked about the incident report dated 01/06/13 and 07/12/13. She was asked how the falls occurred. She stated the resident had

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F 315	Continued From page 27 attempted to go to the bathroom and fell.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, review of policy/procedures, and resident and staff interviews, it was determined the facility failed to ensure restorative nursing services were provided for one (#9) of four sampled residents who were reviewed for range of motion. This had the potential to affect nine residents identified by the facility who had physician orders for restorative care. Findings: A facility policy, titled Braces/Splints documented, "... Purpose: To maintain functional range of motion, decrease muscle contractures and provide support and alignment for weakened limbs through use of braces and/or splints. Equipment: Orthotic device such as: hand splint, ankle splint or brace.	F 318		

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Procedure: 1. Verify physician's order...9. Follow wearing schedule outlined by therapist or physician..."

Resident #9 was admitted to the facility with diagnoses which included hypertension, chronic obstructive pulmonary disease, hemiplegia, acute respiratory failure, cerebral vascular accident, cognitive deficits and dysphagia.

A care plan, initiated 04/26/13, documented, "...Focus At risk for loss of range of motion r/t immobilization...

Goals Will tolerate application of splint/orthotic device when worn...

Interventions...Apply splint to rt hand as ordered..."

A quarterly assessment, dated 06/08/13, documented the resident was usually understood and understands others. She had modified independence in cognitive skills for daily decision making. She had limited range of motion impairment on one side in both upper and lower extremities. She was frequently incontinent of bowel and bladder.

A monthly physicians order, dated August 2013, documented, "... RESTORATIVE CARE 04/25/13 Hand splint to right hand at 9 am [a.m.] remove at 9 pm [p.m.] to prevent hand contracture..."

On 08/06/13 at 10:30 a.m., the resident was observed in her bed without a hand splint on her right hand.

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The same observation was made at 12:00 p.m., 3:30 p.m. and 4:45 p.m.

On 08/07/13 at 8:00 a.m., the resident was observed in her bed without a hand splint on her right hand.

At 12:00 p.m., the resident was observed in her bed without a hand splint on her right hand.

At 5:00 p.m., the resident was observed in her bed without a hand splint on her right hand.

On 08/08/13 at 6:00 a.m., the resident was observed in her bed without a hand splint on her right hand.

At 8:00 a.m., the resident was observed in her bed without a hand splint on her right hand.

At 9:00 a.m., the resident was observed in her bed without a hand splint on her right hand.

At 9:05 a.m., the DON was asked who applied hand splints when ordered for restorative care. She stated, "The CNA's do restorative." She was then asked if the staff is rotated on the halls. She stated, "No, we have a consistent staffing pattern on the halls."

At 9:09 a.m., CNA #1 was asked if she took care of the resident routinely. She stated, "Yes." She was then asked if the resident had any restorative orders. She stated, "None that I'm aware of. She was doing therapy but they dc'd it. She has an arm brace. It goes on at night and we take it off in the morning. I think they are doing that still."

At 9:12 a.m., CNA #2 was asked if she took care

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F 318	Continued From page 30 of the resident routinely. She stated, "Yes." She was then asked if the resident had any restorative orders. She stated, "No, except moving her legs and arms." She was then asked is she had any restorative care for her right hand. She stated, "A pillow under her arm to elevate it." She was asked if there was a splint to apply to her hand. She stated, "No brace or splint. they were putting one on her right hand." At 9:15 a.m., LPN #1 was asked if the resident had any restorative care ordered. She stated, "She wears a brace at night and off in the morning. I believe the aides took it off this morning." At 9:25 a.m., the DON was asked where in the clinical record it was documented the aides were to perform the application and removal of the splint. She stated, "I'm sure its in the task." At 10:15 a.m., the DON provided the survey team with a Task printout for the resident. The printout documented, "...ADL's/Restorative Care *ADAPTIVE DEVICE: apply splint to rt upper extremity put on at 9pm [9:00 p.m.]..."	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on record review, and interviews, it was determined the facility failed to assess a resident's falls while attempting to self toilet for one (#3) of one sampled residents who experienced reoccurring falls while attempting to self toilet. The resident census and condition report, dated 08/06/13, documented 51 residents required assistance from one or two staff for toilet use.

Findings:

Resident #3 was admitted to the facility with diagnoses to include over active bladder, left hip and femur fracture.

An incident report, dated 01/06/13 at 10:25 p.m., documented, "pt [patient] found by cna [certified nurse aide] no injuries noted vital signs and nero [sic] checks started...."

There was no documentation on the incident report or in the nurse's notes as to what occurred and what the resident had been doing prior to the incident.

An incident report, dated 01/09/13 at 5:00 p.m., documented, "Pt was found on the floor in front of bathroom. Pt stated she needed to go to the bathroom. Pt stated she hit her elbow. Skin tear noted to right elbow..."

There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet.

An incident report, dated 01/25/13 at 8:00 p.m.,

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documented, "Patient found on the floor on the side of the bed, states she was coming from the bathroom and lost balance d/t socks...describe care...routine Lortab given, assessment, and reassurance...."

There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet.

An incident report, dated 03/07/13 at 9:45 p.m., documented, Pt found sitting in floor on bottom in front of bathroom door...assessed and assisted to bed no injuries..."

There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet.

The resident sustained four falls from 01/06/13 through 03/07/13, while attempting to self toilet.

There was no documentation to show the facility assessed the resident's falls and incontinence for a toileting and or scheduled bladder program in attempts to prevent recurrence of falls.

A care plan, dated 01/09/13 and last updated 06/24/13, documented, "Focus: At risk for falls due to history of falls, generalized weakness, use of antidepressant and antianxiety medication...

Goals...minimize risk for injury r/t falls...

Interventions: Assure the patient wears non skid socks in room...offer frequent toileting- upon rising, before and after meals, and before bed. Provide assist to transfer as needed. Provide assist with frequent toileting...

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Focus: Urinary incontinence related to impaired mobility, physical limitations and cognitive impairment...

Goals: will have no complications due to incontinence...

Interventions...provide assistance with toileting..."

A Radiology Report, dated 04/25/13, documented, "...Results: T9 modest compression is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/11/13 lumbar spine images which showed an intact T9...conclusion: Unchanged L1 old marked compression fracture with more compressed L3...notify family of somewhat progressed L3 compression fracture..."

A significant change assessment, dated 05/03/13, documented the resident could understand and be understood, and had moderate impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and toilet use and was occasionally incontinent of bladder and was not on a toileting program.

An incident report, dated 07/07/13 at 5:00 a.m., documented, "[Resident] was observed sitting on the floor on her bottom in front of the bathroom-she states she was walking to the bathroom when she fell against the room door, slid down the door and landing on her bottom-denies hitting head-c/o [complains of] soreness to back...describe care...assess for injuries-assist to bathroom and to bed call light

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pinned to bed and asked her to demo [demonstrate] to use the call light- medicated for pain and soreness of the back..."

A nurse's noted, dated 07/07/13 at 7:29 a.m., documented, "[Resident] was observed scooting on the floor in sitting position- patient states she was walking to the bathroom when she fell- leaning on the door and slid to the floor on her bottom- denies hitting head, does c/o [complains of] sore back-medicated for pain and ask her to demo [demonstrate] the use of call light and at the time she states she understands the...purpose of the light..."

An incident report, dated 07/12/13 at 11:00 a.m., documented, "Patient attempting to self transfer without assistance lost balance and slid into floor, fall witnessed by roommate..."

There was no documentation why the resident was attempting to self transfer when she fell.

A quarterly assessment, dated 08/01/13, documented the resident's speech was clear, the resident understood and could be understood and had mild occasional pain. The resident required extensive assistance with transfers, dressing and toilet use. The resident was occasionally incontinent of urine and was not on a toileting program.

The resident's task list documented, "Bowel and Bladder: provide assistance with toileting. Provide incontinent care as needed."

The resident sustained two additional falls while attempting to self toilet from 03/07/13 through 07/12/13.

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There continued to be no documentation the facility assessed the resident's incontinence and placed her on toileting program to prevent recurrence of falls.

On 08/08/13 at 8:25 a.m., certified nurse aide #1 was asked if the resident was on a toileting schedule or program. She indicated the resident was able to make her needs known and would let the staff know.

She was asked if the resident had falls. She indicated the resident had falls while attempting to toilet. She then stated the resident was not on a toileting program.

On 08/08/13 at 8:40 a.m., certified nurse aide #2 was asked if the resident was on a toileting program. She stated, "She can tell us but doesn't always want the help.

She was asked if the resident had any falls. She indicated the resident had falls while going to the bathroom.

On 08/08/13 at 9:25 a.m., the director of nursing was asked if there was a pattern with the falls the resident had sustained. She stated, "I do see a pattern, the bathroom."

She was asked if the resident incontinence was assessed and if she was placed on a bladder program to aide in the prevention of recurrnce of falls. She indicated she would have to look at the resident task list located on the computer. She returned with a copy and stated, "It's not on the task list, she is not."

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F 323	Continued From page 36 She was asked if the resident's incontinence had been assessed for a scheduled bladder program. She stated, "No, the resident had not been assessed." She was asked about the incident report dated 01/06/13 and 07/12/13. She was asked how the falls occurred. She stated the resident had attempted to go to the bathroom and fell.	F 323		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to ensure the pureed meal was prepared and served in accordance with the menu for one (the noon meal on 08/06/13) of two meals observed. The dietary manager identified eleven residents who received pureed meals. Findings: The "Menu Overview" documented, "...repetition of the same or nearly same menu helps standardize preparation procedures and gives the employees an opportunity to become more efficient through repeated use of familiar recipes... The pureed menu extension documented the	F 363		

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resident was to recieve the following items:

one pureed shaped ham,
#40 scoop of pineapple,
#8 scoop of Au Gratin potatoes,
#8 scoop of greens,
#16 scoop of bread and
ice cream.

A review of the menu for Tuesday 08/06/13, noon meal documented the resident's were to be served the following items: slice of ham with pineapple rings, greens, Au Gratin potatoes, ice cream and bread of choice.

The recipe for pureed Ham with Pineapple Ring documented, "...Pureed pineapple: place number of pineapple slices or equivalent of crushed pineapple in processor and blend...Serve #40 scoop of pureed pineapple with pureed ham."

During the noon meal service on 08/06/13 from 11:35 a.m. through 12:20 p.m., cook #3 was observed serving the meal.

The cook was observed serving the pureed meal with the following menu items:

one pureed shaped ham,
#8 scoop of Au Gratin potatoes,
#8 scoop of greens,
ice cream.

The cook did not serve any pureed bread and pineapple to the residents. He was observed serving all eleven pureed plates with the same.

The eleven residents who received pureed meals was observed consuming their meal without the

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F 363	Continued From page 38 bread and pineapple. An interview was conducted on 08/07/13 at 1:35 p.m., with cook #3. He was asked about the pureed bread and pineapple not being served to the residents. He stated, "The pureed bread is to be put on the tray by someone else." He was asked about serving the pureed pineapple. He stated, "I didn't do that. I didn't realize I had to" He was asked if the pureed menu was served according to the menu. He indicated it had not.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, it was determined the facility failed to ensure the kitchen food storage and preparation was maintained in a sanitary manner as evidenced by exposed food in the freezer, unlabeled sliced tomatoes, dirty grimy can opener, unclean microwave and workers with facial hair who had no guards on. This had the	F 371		

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potential to affect 77 of 81 residents who received meals from the kitchen.

Findings:

The "Cleaning Procedure- Microwave Oven" documented, "...wipe up all spills as they occur..."

The "Cleaning Procedure- Can Opener, Manual Bench Type" documented, "...remove the opener by lifting the shaft out of the base...wash in detergent solution, rinse and sanitize...the shaft may be sanitized by running through the dish machine..."

The "Cleaning Procedure- Pots and Pans" documented, "...air dry...stacked once completely dry..."

During the initial tour of the kitchen on 08/06/13 at 8:40 a.m., the following observations were made:

Two male workers were observed working in the food preparation area with facial hair. The workers did not have a guard on.

A package of waffles was open in the small upright freezer exposing the food to ice and cold temperature.

A small plastic bag with french toast was open and exposed. The french toast was freezer burnt.

A container of sliced tomatoes was in the refrigerator undated and labeled.

A package of lettuce was brown in the refrigerator.

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Ten cases of thickened liquids from Sysco was stored on the floor of the dry storage room.

Twenty eight desert cups were stacked wet. Three of them were still soiled.

The microwave had dried brown substance on the inside tray and walls.

A bag of vanilla wafers were open and exposed to the air.

The can opener had a build up of dried food and grime.

During the noon meal service on 08/06/13 from 11:35 a.m. through 12:20 p.m., cook #3 was observed serving the meal. The cook was observed placing cooked greens into three soiled desert cups and serving them to the residents. The cook had facial hair which was not covered during the meal service.

An interview was conducted on 08/06/13 at 3:05 p.m., with the dietary manager regarding the observations listed above. She was asked about the exposed food in the freezers. She stated they should be in sealed plastic bags.

She was asked about the cases of thickened liquids stored on the floor. She stated, "They are suppose to be up on milk crates."

She was made aware of the stacked wet desert cups, microwave, and can opener. She acknowledged all the observations and stated she identified a lot of them when she walked in after the initial tour.

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F 371	Continued From page 41 She was asked about the workers wearing guards when they have facial hair. She stated, "I know it's a problem."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		

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Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, it was determined the facility failed to ensure:

~ incontinent care was provided in a manner to prevent cross contamination for one (#9) of three sampled residents observed during incontinent care. This had the potential to affect 40 residents identified by the facility census and condition report as being incontinent of bowel and/or bladder; and

~ tuberculosis skin tests were performed on hire for 11 (LPN#3, LPN #4, LPN #5, CNA #4, CNA #5, CNA #6, Cook #1, Cook #2, Speech Pathologist #1, CMA #1 and housekeeper #1) of 11 employees whose personnel files were reviewed. This had the potential to affect all 81 residents who resided in the facility.

Findings:

1. Resident #9 was admitted to the facility with diagnoses which included hypertension, chronic obstructive pulmonary disease, hemiplegia, acute respiratory failure, cerebral vascular accident, cognitive deficits and dysphagia.

A quarterly assessment, dated 06/08/13, documented the resident was usually understood and understands others. She was modified

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independent in cognitive skills for daily decision making. The resident required extensive assistance from staff with bed mobility, transfers, toilet use and bathing. She was totally dependent on staff for locomotion on and off the unit, dressing, eating and hygiene. She had limited range of motion impairment on one side in both upper and lower extremities. She was frequently incontinent of bowel and bladder.

A care plan, initiated 04/01/13, documented,

"...Focus Urinary incontinence related to disease process CVA, impaired mobility, physical limitations...

Goals Will have no complications due to incontinence...

Interventions...Provide incontinent care as needed..."

On 08/07/13 at 1:30 p.m., the following observations were observed as the resident was provided incontinent care.

CNA #2 and CNA #3 sanitized their hands with soap and water and then donned gloves.

CNA #2 provided peri care to the resident and then rolled her over onto her side. Without changing her soiled cloves she then cleansed her buttocks and rectal area. She then tucked the soiled brief under the resident and rolled a clean brief under the resident. The resident was then rolled onto her back.

CNA #3 then removed the soiled brief from under the resident. CNA #3 then removed her gloves

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and donned new gloves without sanitizing her hands and replaced the resident's sheet.

At 2:00 p.m., CNA #2 was asked if she would have done anything differently to prevent cross contamination during the provision of care. She stated, "I would have changed my gloves more, after every two or three wipes. I was nervous."

TB test:

The "Infection Control Manual Chapter 9-Screening and Immunization Tuberculosis Screening" page 146 documented, "...Employee Screening Guideline: Healthcare workers face an increasing risk of occupational exposure to tuberculosis...Initial screening procedures; Employees receive baseline tuberculosis screening upon hire..."

1. A review of the employee file for licensed practical nurse #3 documented she was hired on 05/31/13.

There was no documentation to indicate the facility completed TB (Tuberculosis Screening) skin test upon hire.

2. A review of the employee file for licensed practical nurse #4 documented she was hired on 05/24/13.

There was no documentation to indicate the facility completed TB skin test upon hire.

3. A review of the employee file for licensed practical nurse #5 documented she was hired on 02/25/13.

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F 441	Continued From page 45 There was no documentation to indicate the facility completed TB skin test upon hire. 4. A review of the employee file for certified nurse aide #4 documented she was hired on 05/10/13. There was no documentation to indicate the facility completed TB skin test upon hire. 5. A review of the employee file for certified nurse aide #5 documented she was hired on 05/31/13. There was no documentation to indicate the facility completed TB skin test upon hire. 6. A review of the employee file for certified nurse aide #6 documented she was hired on 02/13/13. There was no documentation to indicate the facility completed TB skin test upon hire. 7. A review of the employee file for cook #1 documented he was hired on 03/28/13. There was no documentation to indicate the facility completed TB skin test upon hire. 8. A review of the employee file for cook #2 documented she was hired on 07/26/13. There was no documentation to indicate the facility completed TB skin test upon hire. 9. A review of the employee file for the speech pathologist documented she was hired on 07/19/13.	F 441		

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F 441	Continued From page 46 There was no documentation to indicate the facility completed TB skin test upon hire. 10. A review of the employee file for certified medication aide #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed TB skin test upon hire. 11. A review of the employee file for housekeeper #1 documented she was hired on 07/15/13. There was no documentation to indicate the facility completed TB skin test upon hire. An interview was conducted on 08/07/13 at 9:40 a.m., with the administrator, human resource director and regional human resource director regarding TB skin test upon hire. They were asked if employees were being administered the TB skin test upon hire. The administrator stated, "We have not been doing TB test." The regional human resource director and human resource director both stated, "They haven't been done, we have identified that as a problem."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain the exterior grounds free of debris, cigarette butts, large trash bags, old pallets, an old fan base, trash, debris, a used nursing glove, an old recliner, an old wheelchair, old gate panels, an old table and an old bedside table.

This had the potential to affect 15 of 81 residents identified by the facility who were independent with ambulation and wheelchair mobility.

Findings:

An exterior environmental tour was conducted on 08/07/13 at 8:00 a.m., the following was observed:

1. Numerous cigarette butts were lying on the southeast patio.

2. On the northeast side of the building there were 11 large trash bags lying by the dumpster.

3. There were seven old pallets lying on the ground.

4. There was an old fan base on the ground.

5. On the southwest corner of the building there was a used nursing glove, trash and debris.

6. There was an old recliner, wheelchair, three gate panels, table and bedside table on the grounds.

On 08/07/13 at 1:30 p.m., an interview was

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F 465	Continued From page 48 conducted with a the Maintenance Supervisor. He was asked how often rounds were completed on the exterior building grounds for trash, debris, non-working equipment and equipment that is no longer being used. He stated the grounds were checked twice a day. He stated he would take care of it.	F 465		
F 502 SS=E	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide laboratory services as ordered by the physician for one (#2) of one resident who had orders for daily PT INR and one (#1) of ten sampled residents who had a telephone and or routine orders for laboratory draws. Resident #2 had 17 PT INR laboratory draws missed and #1 had one laboratory draw missed. The director of nursing identified 81 of 81 residents who resided in the facility had laboratory draws ordered from 05/01/13 through 08/09/13. Findings: 1. Resident #1 had diagnoses which included neuropathy, renal failure, and acute kidney failure. A physician's telephone order dated 07/18/13, documented, "[check] UA [urinalysis] c [with] C &	F 502		

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F 502	Continued From page 49 S [culture and sensitivity] if ind [indicated]..." A review of the laboratory results were conducted. There were no laboratory results for a urinalysis completed on 07/18/13. On 08/06/13 at 3:45 p.m., the ADON was asked about the lab results for the urinalysis. She stated it appeared that it had not been done. 2. Resident # 2 was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease, hypertension, chronic pain, anxiety, depression and gastroesophageal reflux disease. A physicians' order, dated 06/23/13, documented, "...PT/INR every day..." A review of the laboratory results was conducted. There were no laboratory results for a PT/INR completed on 06/26/13, 07/01/13, 07/03/13, 07/04/13, 07/05/13, 07/06/13, 07/07/13, 07/08/, 07/10/13, 07/19/13, 07/20/13, 07/21/13, 07/24/13, 07/27/13, 07/28/13, 07/29/13 and 08/03/13. On 08/07/13 at 8:30 a.m., the DON was asked if there were any other lab results for the resident. She stated, "We just missed those labs. There are no results."	F 502		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		

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systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to maintain complete and accurate clinical records for three (#3, 9 and #10) of 14 sampled residents whose clinical records were reviewed. The resident census and conditions report documented 81 residents resided in the facility. Findings:

A facility policy, titled Ongoing Management Strategies documented, "...Skin Evaluations

Patients at risk for skin breakdown have a head-to-toe skin evaluation weekly by a licensed nurse...Documentation of the evaluation is located in the Treatment Administration Record or progress note..."

1. Resident #9 was admitted to the facility with diagnoses which included hypertension, chronic obstructive pulmonary disease, hemiplegia, acute respiratory failure, cerebral vascular accident, cognitive deficits and dysphagia.

A monthly intake and output flow sheet, dated April 2013 documented, seven of the 33 input and output opportunities were blank.

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F 514	Continued From page 51 A MAR, dated April 2013 documented, four of four skin assessment updates were blank. A monthly intake and output flow sheet, dated May 2013 documented, 21 of the 36 input and output opportunities were blank. A MAR, dated May 2013 documented, two of four skin assessment updates were blank. A monthly intake and output flow sheet, dated June 2013 documented, 12 of the 33 input and output opportunities were blank. A MAR, dated June 2013 documented, two of four skin assessment updates were blank. A monthly intake and output flow sheet, dated July 2013 documented, 22 of the 36 input and output opportunities were blank. A MAR, dated July 2013 documented, one of four skin assessment updates were blank and six of 33 oxygen saturations were blank. A monthly intake and output flow sheet, dated August 2013 documented, six of the 18 input and output opportunities were blank. A MAR, dated August 2013 documented, one of one skin assessment updates were blank and three of 18 oxygen saturations were blank. A monthly physicians order, dated August 2013 documented, "...03/31/13 NPO - tube feeder...03/31/13 update skin sheets weekly on Sunday...07/14/13 check 02 sats every shift..." On 08/08/13 at 9:15 a.m., LPN #1 was asked who	F 514		

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documented the input,output and oxygen saturations. She stated, "I do mine. I document it in the MAR."

On 08/09/13 at 8:30 a.m., LPN #2 was asked which residents required input and output to be recorded in the clinical record. She stated, "Everyone with a PEG is on I's and O's. She was then asked who was responsible for documenting the input, output and oxygen saturations. She stated, "Nurses." She was then shown the gaps in the input, output and oxygen saturations and asked if there were any reasons for the gaps in documentation. She stated, "There's no reason why not documented."

At 8:40 a.m., the DON was asked which residents had input and output recordings in the clinical record. She stated, any residents with an indwelling urinary catheter, peg tube, IV (intravenous) or a fluid restriction. She was then asked who was responsible for documenting the input, output and oxygen saturations. She stated, the nurses.

2. Resident #10 was admitted to the facility with diagnoses which included, congestive heart failure, diabetes mellitus type II, Alzheimer's disease and hyperlipidemia.

A nurse's note, dated 08/07/13 at 3:23 p.m., documented, "...Patient has a new order for Megace 40 mg/ml take 10 ml daily. MAR updated to new order..."

A physician's order, dated 08/07/13 at 3:45 p.m., documented, "... Remeron 30 mg [1] po @ HS may give 2 15 mg tabs until 15 mg tabs are gone...Indication - DX appetite stimulant..."

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A MAR, dated August 2013 documented, "...Remeron 30 mg po @ HS may give 2 15mg to = 30mg until 15mg tabs are gone 8/7/13 9pm [p.m.]..."

On 08/08/13 at 11:55 a.m., RN #1 was shown the clinical record and asked where the order was located. She stated, "That's a mistake, I will find out."

At 12:09 p.m., RN #1 stated, "OK, it was not Megace, it was Remeron. The Megace order is a mistake. I called the staff who wrote it."

3. Resident #3 was admitted to the facility with diagnoses to include over active bladder, left hip and femur fracture.

An incident report dated 01/06/13 at 10:25 p.m., documented, "pt [patient] found by cna [certified nurse aide] no injuries noted vital signs and nero [sic] checks started...."

There was no documentation on the incident report or in the nurse's as to what occurred and what the resident had been doing prior to the incident.

An incident report dated 01/09/13 at 5:00 p.m., documented, "Pt was found on he floor in front of bathroom. Pt stated she needed to go to the bathroom. Pt stated she hit her elbow. Skin tear noted to right elbow...".

There was no documentation in the nurse's notes about the resident's fall while attempting to self toilet.

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An incident report dated 01/25/13 at 8:00 p.m., documented, "Patient found on the floor on the side of the bed, states she was coming from the bathroom and lost balance d/t socks...describe care...routine Lortab given, assessment, and reassurance...."

There was no documentation in the nurse's notes about the resident's fall while attempting to self toilet.

An incident report dated 03/07/13 at 9:45 p.m., documented, Pt found sitting in floor on bottom in front of bathroom door....assessed and assisted to bed no injuries...."

There was no documentation in the nurse's notes about the resident's fall while attempting to self toilet.

An incident report dated 07/12/13 at 11:00 a.m., documented, "Patient attempting to self transfer without assistance lost balance and slid into floor, fall witnessed by roommate..."

There was no documentation why the resident was attempting to self transfer when she fell on the incident report and in the nurse's notes.

An interview was conducted on 08/08/13 at 9:25 a.m., with the director of nursing. She was asked if the resident's incident reports and nurse's accurately reelected what happened. She stated, "It's not accurate."