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| F 276 | Continued From page 20<br>scheduled for January 2011. The record was reviewed January 25, 2011. | F 276 | F276<br>1. The resident assessment was completed and placed in designated areas. A care conference with the resident's family was also held.<br>2. The facility generated a detailed MDS report to identify which assessments for specific resident were listed as out of compliance. The report was analyzed to identify trends that were not in compliance. Data entered assessment identified as due and not completed. Generated a MDS report for subsequent months to determine compliance.<br>3. The facility will utilized the back-up plan of Unit Mangers assisting in completion of MDS on their Respective Units, to keep in compliance if necessary. MDS nurse will report to DON at least weekly to discuss progress of facility towards 100% compliance. Generate MDS Schedule weekly to use as guide to assure compliance. All Nurse Managers and other members of the Interdisciplinary Team will receive a refresher education session on care planning process and completion of the MDS (Discipline Specific).<br>4. Compliance with MDS assessment accuracy and coordination will be reported during weekly Focus QI. Variances and corrections will be reported to the Quality Improvement Committee quarterly.<br>5. Compliance Date | 4/8/2011 |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for eight (8) of 27 sampled residents, and two (2) of 12 supplemental residents, it was determined that | F 278 | | |

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| F 278 | Continued From page 21<br>facility staff failed to accurately code the MDS [Minimum Data Set] for one (1) resident for restraints and splints, four (4) for falls, one (1) resident for hearing impairment, one (1) resident for diagnoses of hypertension, pacemaker, alzheimer's and pressure ulcer, one (1) resident for alzheimer's, urinary tract infection, and pressure ulcer, one (1) resident for allergies, physical behavior, Parkinson and hypertension, one (1) resident for anemia, hyperlipidemia and risk for pressure ulcer, one resident for alzheimer's and two (2) residents for allergies. Residents #2, 4, 5, 15,19, 20, 22, 26, F1 and P1.<br><br>The finding include:<br><br>1. Facility staff failed to code Section J on the quarterly MDS (Minimum Data Set) for data pertaining to falls for Resident #2.<br>A review of the residents " Care Plans " dated November 8, 2010 and November 11, 2010 revealed that the resident sustained a fall on both of the dates mentioned.<br>Review of the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of December 15, 2010 revealed that the facility staff failed to code " Section J 1700 Fall History on Admission; Section J 1800 Any Falls Since Admission or Prior Assessment ... and Section J 1900 Number of falls Since Admission or Prior Assessment ... "<br>Section J1700 Fall History on Admission indicates (complete only if Section A0310A = 01 or A0310E = 1)<br>Review of section A0310E Type of Assessment was coded (1), therefore all of the above mentioned in Section J should have been completed.<br>A face-to-face interview was conducted on | F 278 | F278<br>1. The records cannot be altered retrospectively to the dates of non-compliance. The records of residents #2, #4, #5, #15, #19, # 20, #22, #26, #F1, #P1 were reviewed and the need for consistency in documentation reinforced with staff. Resident #4 record was updated and coded include the merry walker as a restraint.<br><br>2. The MDS staff will continue to audit all residents' records and educate caregivers to ensure accurate coding of residents assessments. The MDS staff has conducted educational sessions with the Nurse Managers reviewing how to accurately code the MDS for restraints & splints, falls, diagnosis, allergies, and pressure ulcers. No residents had any negative effects due to inaccurate coding. The MDS Coordinator audited 10% of the MDS assessment in the medical records on each unit. Where discrepancies were found, on-the-spot education was completed and where possible coding corrected.<br><br>3a. The MDS staff will continue to audit all residents' records and educate caregivers to ensure accurate coding of residents assessments. | |

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| F 278 | Continued From page 22<br>January 31, 2011 with Employee #19 at 1:45 PM. After review of the MDS, he/she acknowledged the areas that were not coded. The record was reviewed on January 31, 2011.<br>2. Facility staff failed to accurately code Resident #4 for restraints and a splint.<br>A review of Resident #4 ' s quarterly MDS 2.0 [Minimum Data Set] dated September 15, 2010 revealed that facility staff failed to accurately code Section P (3) Nursing rehabilitation/restorative care for splint or brace assistance, P (4) Devices and restraints.<br>According to the 3.0 MDS dated December 6, 2010 revealed Section P (P0100) Physical Restraints was coded " 0 " indicating restraints not used and Section O (O0500) Restorative Nursing Programs coded " 0 " for splint or brace assistance.<br>Resident observed on January 25, 2011 at approximately 9:20 AM in bed with bilateral hand splints. Resident observed at 11:30 AM at the nurse ' s station sitting in a merry walker with belt around waist and a safety bar attached to the chair.<br>A face-to-face interview was conducted on January 25, 2011 at approximately 1:30 PM with Employees #6 and Employee #19. He/she acknowledged that the resident was not coded for restraints and splints. The record was reviewed January 25, 2011.<br><br>3. Facility staff failed to accurately code quarterly MDS for Resident #5 for HTN, Pacemaker, Alzheimer ' s, Pneumonia, and risk for developing ulcer. Resident #5<br><br>A review of Resident #5's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 2, 2010 revealed that facility staff | F 278 | b. The MDS RN Coordinator will review and discuss coding of the MDS with Interdisciplinary team (IDT) members prior to signing.<br><br>c. Diagnosis sheets will updated during monthly POS exchange and quarterly at the time of the IDT assessment.<br><br>d. The MDS Coordinator audited 10% of the MDS assessment in the medical records on each unit. Where discrepancies were found, on-the-spot education was completed and where possible coding corrected.<br><br>4. Compliance with MDS assessment accuracy and coordination will be reported during weekly Focus QI. Variances and corrections will be reported to the Quality Improvement Committee quarterly.<br><br>5. Compliance Date | 4/8/2011 |

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| F 278 | Continued From page 23<br>failed to accurately code for HTN, Pacemaker, Alzheimer ' s, Pneumonia and risk for developing ulcer.<br><br>According to the MDS dated completed on December 2, 2010 the resident was not coded in Section I Active Diagnoses for I0700 (Hypertension), I2000 (Pneumonia), I4200 (Alzheimer ' s Disease), I8000 (Pacemaker) and section M Skin Condition for M0150 (Risk of Pressure Ulcer).<br><br>A face-to-face interview was conducted on January 25, 2011 at approximately 9:30AM with Employee #5. He/she acknowledged the findings. The record was reviewed. January 25, 2011.<br><br>4. Facility staff failed to accurately code quarterly MDS for Resident #15 for Alzheimer ' s, UTI and risk for developing ulcer. Resident #15<br><br>A review of Resident #15's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 7, 2010 revealed that facility staff failed to accurately code for Alzheimer ' s, UTI and risk for developing ulcer.<br><br>According to the MDS dated completed on December 7, 2010 the resident was not coded in Section I Active Diagnoses for I2300 (UTI), I4200 (Alzheimer ' s Disease) and section M Skin Condition for M0150 (Risk of Pressure Ulcer).<br><br>A face-to-face interview was conducted on January 31, 2011 at approximately 9:30AM with Employee #7. He/she acknowledged the findings. The record was reviewed January 31, 2011. | F 278 | | |

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| F 278 | Continued From page 24<br>5. Facility staff failed to code Resident #19 for restraints.<br><br>A review of the "Physician's Order Form" dated and signed January 2, 2011 indicated "patient to use merry walker for safe ambulation."<br><br>An observation was made on January 28, 2011 at approximately 10:35 AM. Resident #19 was observed sitting in the merry walker, attempting to reach for an object and pulling at the seat cushion. A trunk restraint was observed to be in place to secure the resident to the merry walker in order to prevent he/she from falling out during ambulation.<br><br>" Review of the residents annual MDS [Minimum Data Set) with an ARD (Assessment Reference Date) of November 29, 2010 in Section P: titled Restraints, lacked evidence that the resident was coded for "using a trunk restraint" while in a chair,<br><br>A face-to-face interview was conducted on January 28, 2011 at 10:30 AM with Employee #4. After review of the MDS and the definition of restraint he/she acknowledged the above findings. The record was reviewed on January 28, 2011.<br><br>6a. Facility staff failed to code Section J on the quarterly MDS (Minimum Data Set) for data pertaining to falls for Resident #20.<br>A review of the residents " Care Plan Face Sheet " dated December 21, 2010 revealed that the resident sustained a fall on October 15, 2010.<br>Review of the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of December 13, 2010 revealed that the facility staff | F 278 | | |

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| F 278 | Continued From page 25<br>failed to code " Section J 1700 Fall History on Admission; Section J 1800 Any Falls Since Admission or Prior Assessment ... and Section J 1900 Number of falls Since Admission or Prior Assessment ... "<br>Section J1700 Fall History on Admission indicates (complete only if Section A0310A = 01 or A0310E = 1)<br>Review of section A0310E Type of Assessment was coded (1), therefore all of the above mentioned in Section J should have been completed.<br>A face-to-face interview was conducted on January 31, 2011 with Employee #19 at 1:45 PM. After review of the MDS, he/she acknowledged the areas that were not coded. The record was reviewed on January 31, 2011.<br>6b. Facility staff failed to code Resident #20 for restraints. A review of the " Physician ' s Order Form " dated and signed January 2, 2011 indicated " merry walker for safe ambulation " . An observation was made on January 28, 2011 at approximately 11:35 AM Resident #20 was observed sitting in the merry walker with seat belt attached.<br>Review of the residents annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of November 29, 2010 in Section P: titled Restraints, lacked evidence that the resident was coded for " using a trunk restraint " while in a chair, the trunk restraint was observed to be in place to secure the resident to the merry walker in order to prevent he/she from falling out during ambulation. "<br>A face -to face interview was conducted on January 28, 2011 at 10:30 AM with Employee #4. After review of the MDS and the definition of restraint he/she acknowledged the findings.<br>The record was reviewed January 31, 2011 | F 278 | | |

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7. Facility staff failed to code the MDS for Allergies, Physical behavior, Parkinson and HTN #22
Facility staff failed to accurately code quarterly MDS for Allergies, Physical behavior, Parkinson and HTN. Resident #22

A review of Resident #22's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 23, 2010 revealed that facility staff failed to accurately code for Allergies, Physical behavior, Parkinson and HTN.

According to the MDS dated completed on December 30, 2010 the resident was not coded in Section I Active Diagnoses for I0700 (Hypertension), I5300 (Parkinson Disease), I8000 (Allergies) and section E Behaviors 0200 (Physical Behavior).

8. Facility staff failed to code admission MDS for Anemia, hyperlipidemia and accurately code for risk of pressure ulcer Resident #26.

A review of Resident #26's admission MDS [Minimum Data Set] with Assessment Reference Dated of November 30, 2010 revealed that facility staff failed to code for Anemia, hyperlipidemia and accurately code for risk of pressure ulcer.

According to the MDS dated completed on December 4, 2010 the resident was not coded in Section I Active Diagnoses for I0200 (Anemia), I3300 (Hyperlipidemia), and section M Skin Condition for M0150 (Risk of Pressure Ulcer) resident was coded 0 (No) instead of 1 (yes).

A face-to-face interview was conducted on

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January 28, 2011 at approximately 9:30AM with Employee #3. He/she acknowledged the findings. The record was reviewed. January 28, 2011.

9. Facility staff failed to code the Admissions MDS 3.0 dated November 22, 2010 for "Hearing Impairment" under Section I [Additional Active Diagnosis] for Resident #F1.

A review of the Physical Examination conducted by the physician and signed on November 17, 2010 revealed that Resident #F1 had a diagnosis of " Deaf " .

The Physician ' s Order Form dated January 2011 and signed by the physician on January 10, 2011 revealed a diagnosis of " Hearing Impaired-Deaf " .

A review of the Admission MDS 3.0 with a completion date of November 22, 2010 revealed that " Hearing Impairment " was not coded in Section I 1800 [Additional Active Diagnosis].

A face-to-face interview was conducted with Employee #6 on February 1, 2011 at 11:30 AM. After review of the documents he/she acknowledged that " Hearing Impairment " was not coded on the admission MDS 3.0.

Facility staff failed to code the Admissions MDS for "Hearing Impairment ". The record was reviewed February 1, 2011.

10. Facility staff failed to accurately code Resident P1 ' s quarterly Minimum Data Set (MDS) for falls.

A review of Section J1800 of the quarterly MDS

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| F 278 | Continued From page 28<br>with a completion date of October 4, 2010 revealed that the resident was coded with a zero [0], which indicated that he/she had no falls during the required assessment period. The assessment asked the following question; " Has the resident had any falls since admission or the prior assessment? " The facility staff responded " no " .<br><br>A review of the nursing documentation in the resident ' s clinical record revealed the following note, dated August 3, 2010. " Resident was observed on floor today at 10:00AM by therapy aide. "<br><br>A face-to-face interview was conducted with Employee #18 at approximately 9:45AM on February 2, 2011. The employee stated I don ' t know why it was missed. I 'll have to research it and get back to you. " The employee returned to this surveyor approximately 15 minutes later with a corrected copy of Section J [fall] of the MDS. He/she stated, " I don ' t know how I missed it. I checked my notes and found that he/she [the resident] did have a fall. " The record was reviewed on January 28, 2011.<br><br>Facility staff failed to accurately code Resident P1 ' s quarterly Minimum Data Set (MDS) for falls. | F 278 | | |
| F 279 SS=E | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's | F 279 | | |

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| F 279 | Continued From page 29<br>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for four (4) of 27 sampled residents and one (1) of 12 supplemental residents reviewed, it was determined that facility staff failed to develop care plans two (2) resident with allergies, one (1) resident on anticoagulation therapy, one (1) resident who utilized side rails for bed mobility, with hearing aids, and medications at the bedside and one (1) resident with a venous access device, falls, incontinence, dental care and medications at the bedside. Residents # 4, 7, 17, 18, and F1.<br><br>The findings include:<br><br>1. Facility staff failed to develop a care plan for allergies for Resident #4.<br><br>The physician ' s order sheet signed and dated January 11, 2011 revealed, " Allergies: Benadryl, Periactin. " | F 279 | | |

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| F 279 | Continued From page 30<br>A review of Resident #4 ' s clinical record revealed that there was no care plan to address the resident ' s allergy to Benadryl.<br><br>There was no evidence that facility staff initiated a care plan with goals and approaches to address the resident's allergy to Benadryl.<br><br>A face-to-face interview was conducted with Employee #6 on January 25, 2011 at approximately 12:30 PM. He/she acknowledged that there was no care plan initiated for the resident's allergy to Benadryl. The record was reviewed on January 25, 2011.<br>.<br><br>2. Facility staff failed to develop a care plan for allergies for Resident #7.<br>Review of the December 2010 Physician ' s Orders revealed that the resident had allergies to Penicillins and Cephalosporins.<br>Review of the care plans last updated December 9, 2010 lacked evidence of a care plan for allergies to Penicillins and Cephalosporins for Resident #7.<br>A face-to-face interview was conducted on February 1, 2011 at 11:25 AM with Employee #3. After review of the care plans he/she acknowledged the findings. The record was reviewed on February 1, 2011.<br><br>3. A review of the clinical record for Resident #17 revealed that facility staff failed to develop a care plan for the potential adverse effects related to the use of anticoagulation therapy.<br><br>The history and physical examination dated March 16, 2010 revealed Resident #17's diagnoses included Anemia, Hypertensive | F 279 | F279<br>1. Resident #4, #7—an allergies care plan has been added to the medical record<br><br>Resident #17—anticoagulant care plan has been added to the medical record<br><br>Resident # 18—hearing aide & self administration of medications care plans has been added to the medical record. Care plan also added to reflect use of side rails for mobility by resident.<br><br>Resident #F1—care plan added to medical record for self administration of medications. Care plan initiated and added to medical record for care of a Mediport. Care plans initiated and added to the medical record for urinary incontinence, falls and dental care.<br><br>2. By April 8, 2011 Unit Nurse Managers will conduct a side by side audit of CAA (Care Assessment Areas) & CAT (Care Assessment Triggers) to match with resident care plans. Negative trends will be corrected at the time of the audit. Nurse managers will be given a training session on how to use the CAAs & CATs to enhance the resident care planning process. | |

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| F 279 | Continued From page 31<br>Cardiovascular Disease, Hypothyroidism, Diabetes Mellitus, Depression and Status-Post Cerebrovascular Accident.<br><br>Physician's orders dated December 1, 2010 revealed the resident's medication regimen included Aspirin 81mg daily for prophylaxis.<br><br>The comprehensive care plan, most recently updated December 16, 2010 lacked evidence of problem identification, approaches and interventions for the use of anticoagulant therapy (Aspirin).<br><br>A face to face interview was conducted with Employee #3 on January 24, 2011. He/she acknowledged that the care plan lacked identification, approaches and interventions for Aspirin. The clinical record was reviewed January 24, 2011.<br><br>4. Facility staff failed to initiate a care plan with appropriate goals and approaches for the use of a hearing aid and for self administration of medication for Resident #18.<br><br>4a. A review of the clinical record for Resident #18 revealed that facility staff failed to develop a care plan for the use of a hearing aide.<br>According to the MDS [Minimum Data Set] 3.0 dated November 30, 2010 revealed in Section B (Hearing, Speech, and Vision) /B0300 (Hearing) was coded " 1 " indicating ability to hear(with hearing aid or hearing appliances if normally used) with minimal difficulty.<br>A review of the " Nursing Monthly Summary " for November 2010 and December 2010 revealed " Hearing: check was in front of the space for | F 279 | 3. Once per month nursing unit managers will audit 10% of resident records to ensure IDT care plans and MDS documentation match. A chart audit tool will be created for usage by the nurse managers: nurse managers prior to using tool will receive training to use the tool.<br><br>4. Unit Nurse Managers will forward monthly chart audits to the QI for identification of trends and corrections. Outcomes will be reported to the Quality Improvement Committee quarterly.<br><br>5. Compliance Date | 4/8/2011 |

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| | 095005 | A. BUILDING _____ B. WING _____ | 02/02/2011 |

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| F 279 | Continued From page 32<br>hearing aid. "<br>The comprehensive care plan, most recently updated November 2, 2010 lacked evidence of problem identification, approaches and interventions for the use of a hearing aid. The chart was reviewed January 31, 2011.<br><br>4b. Physician ' s orders dated and signed January 11, 2011 directed " Ciloxan Ophthalmic 0.3% ointment, apply to right eye twice daily for chronic conjunctivitis (indefinitely). "<br><br>An observation of Resident #18 on January 24, 2011 revealed medication was stored in resident ' s bedside table proximal to the resident ' s bed. Facility staff acknowledged that the resident self-administered his/her eye drops in accordance with physician ' s orders.<br><br>A review of the plan of care for Resident #18 lacked problem identification, objectives and approaches for self administration of eye drops.<br><br>A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for self administration of eye drops. The record was reviewed on January 24, 2011.<br><br>4c. According to a physician ' s " interim order " dated January 23, 2011 at 8:00 PM revealed, " May use ½ [half] side rails when in bed for functional mobility.<br><br>During the orientation tour of the facility on January 24, 2011 at approximately 9:20 AM, Resident #18 was observed lying in bed with both | F 279 | | |

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| F 279 | Continued From page 33<br>upper side rails up.<br><br>A review of the care plan lacked problem identification, objectives and approaches for side rails for bed mobility.<br><br>A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 10:00AM. He/she acknowledge that the record lacked a care plan for the use of side rails for bed mobility. The record was reviewed January 24, 2011.<br><br>5a. .Facility staff failed to develop a care plan with goals and approaches for Resident #F1 to keep medication at the bedside.<br><br>On January 26, 2011 at 3:00 PM a tour of Resident F1 ' s room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the medication was on the resident night stand. Employee #16 stated, " [He/she] self administers the spray to his/her throat. "<br><br>Additionally, Resident F1 wrote the following on his/her communication board, " I spray it in my mouth. "<br><br>The Physician Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Cetacaine Spray 2 sprays every 3 hours as needed for pain-may keep at bedside to use as needed. "<br><br>A review of plan of care /care plan section of Resident # F1 ' s current clinical record revealed | F 279 | | |

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| F 279 | Continued From page 34<br>that a care plan did not exist for self administers medication (Cetacaine).<br><br>There was no evidence that a plan of care was initiated with goals and approaches for Resident #F1 to self administer the Cetacaine.<br><br>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that there was no plan of care initiated with goals and approaches for Resident F1 to self administer the Cetacaine. The record was reviewed on February 1, 2011.<br><br>5b. Facility staff failed to develop a care plan with goals and approaches for the use of the Mediport for Resident #F1.<br><br>The Interim Order Form dated January 12, 2011 at 12:15 PM and signed by the physician on January 13, 2011 directed, " Use Emla cream or generic brand 30 minutes before every month Mediport flush. "<br><br>A review of plan of care /care plan section of Resident # F1 ' s current clinical record revealed that a care plan did not exist for goals and approaches for the care of the Mediport.<br><br>There was no evidence that a plan of care was initiated with goals and approaches for the care of the Mediport for Resident #F1.<br><br>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that there was no plan of care initiated with goals and approaches for the care of the Mediport for Resident F1. The record was reviewed on February 1, 2011. | F 279 | | |

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| F 279 | Continued From page 35<br><br>5c. Facility staff failed to develop a care plan with goals and approaches for dental care, falls and incontinence for Resident #F1.<br><br>A review of the Care Assessment Area (CAA) Summary completed November 22, 2010 revealed that urinary incontinence, falls, and dental care was check in the , " Care Area Triggered " column and urinary incontinence, falls, and dental care was checked in the Addressed in care plan column.<br><br>A review of plan of care /care plan section of Resident # F1 ' s current clinical record revealed that a care plan did not exist for goals and approaches for urinary incontinence, falls, and dental care.<br><br>There was no evidence that a plan of care was initiated with goals and approaches for urinary incontinence, falls, and dental care for Resident #F1.<br><br>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that there was no plan of care initiated with goals and approaches for urinary incontinence, falls, and dental care for Resident F1. The record was reviewed on February 1, 2011. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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. | F 280 | | |

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| F 280 | Continued From page 36<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review and interview for two (2) of 12 supplemental residents, it was determined that facility staff failed to review and revise care plans for one resident with a functional decline, and one (1) resident with impaired skin integrity. Residents # K1 and M1.<br><br>The findings Include:<br><br>1. A review of the clinical record for Resident #K2 revealed facility staff failed to amend the care plan when it was determined the resident ' s self-feeding ability declined.<br><br>A review of Section G, Functional Status, of the Minimum Data Set [MDS] signed January 8, 2011 revealed Resident #K1 required limited assistance of one person for meal consumption. An occupational therapy discharge summary | F 280 | | |

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| F 280 | Continued From page 37<br>dated December 10, 2010 revealed the resident required minimal assistance for feeding.<br><br>Dining observations of the breakfast and lunch meal on January 25, 2011 revealed Resident #K1 demonstrated impaired dexterity/mobility of upper extremities and was provided total staff assistance for meal consumption.<br><br>A review of the nutrition care plan, most recently updated January 13, 2011 lacked evidence of approaches and interventions related to the resident ' s eating ability.<br><br>A face-to-face interview conducted with Employee #20 on January 25, 2011 at approximately 1:00 PM revealed the resident ' s functional eating ability had declined " over the past few weeks. " Employee #3 identified the nutrition care plan as the component of the care plan that would address the resident ' s functional eating ability. It was acknowledged that the nutrition care plan lacked evidence of approaches and interventions to address the resident ' s eating abilities. The record was reviewed January 25, 2011.<br><br>2. Facility staff failed to revise and review Resident #M1's care plan with appropriate goals and approaches for skin impairment. Resident #M1<br><br>A review of the Nurse practitioner monthly notes signed and dated January 19, 2011 revealed, " Ulcer on left buttocks reopened. Hydrogel and tegaderm to left buttock wound twice a day. Reposition routinely " .<br><br>A review of Resident #M1's "Physicians Order Sheet" revealed orders signed and dated January | F 280 | F280<br>1. Resident #K1 – The Nutritionist, in collaboration with IDT, will discuss updated care plan to reflect decline in level of assistance needed for feeding of resident. Documentation of IDT will be in the medical record.<br><br>2. By April 8, 2011 Nurse Managers will audit medical record of residents identified as needing minimal, extensive, or total assistance with feeding and will collaborate with the Nutritionist as needed, if revisions must be made.<br><br>3. A chart audit tool will be created for use by the nurse managers: nurse managers will receive training as to how to use the audit. Once per month nursing unit managers will audit 10% of resident records to ensure IDT care plans and MDS documentation match. Audits are to be forwarded to the Quality Improvement Nurse.<br><br>4. Unit Nurse Managers will forward monthly chart audits to the QI and the Nutritionist, who will report variances and corrections to the Quality Improvement Committee quarterly.<br><br>5. Compliance Date | 4/8/201 |

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| F 280 | Continued From page 38<br>19, 2011 directed, "Hydrogel to left buttock ulcer covered with tegaderm BID or PRN if soiled or dressing becomes loose times 7 days."<br><br>A review of the "Skin Impairment" care plan that was last updated on October 26, 2010, lacked evidence that the care plan was reviewed and revised with goals and approaches for skin impairment.<br><br>There was no skin impairment care plan dated January 19, 2011 on resident record for reopened left buttocks ulcer.<br><br>A face-to-face interview was conducted on January 31, 2011 at approximately 9:30 AM with Employee #. He/she acknowledged the findings on the " skin impairment" care plan. The record was reviewed on January 31, 2011. | F 280 | 1. Resident #M1 – The care plan updated to reflect re-opened area on left buttocks.<br><br>2. During weekly wound rounds the Nurse Manager will initiate and/or update skin impairment plans of care for all residents with skin impairments.<br><br>3. A chart audit tool will be created for use by the nurse managers: nurse managers will receive training as to how to use the audit. Once per month nursing unit managers will audit 10% of resident records to ensure IDT care plans and documentation is revised to reflect changes in resident care. | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview for three (3) of 27 records reviewed, it was determined that facility staff failed to meet professional standards of quality during the administration of eye drops for two (2) residents and a failure to fully assess one resident prior to medication administration. Resident ' s #10, 17 and 18<br><br>The findings include: | F 281 | 4. Unit Nurse Managers will forward monthly chart audits to QI, who will report outcomes and corrections to the Quality Improvement Committee monthly.<br><br>5. Compliance Date | 4/8/2011 |

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| F 281 | Continued From page 39<br>1. A review of the clinical record for Resident #10 revealed facility staff failed to administer resident ' s eye drop for glaucoma properly according to professional standards.<br><br>Physician ' s orders dated January 7, 2100 directed the administration of Cosopt Ocumeter Plus instill one (1) drop in left eye every 12 hours for glaucoma.<br>According to the " 2006 Lippincott ' s Nursing Procedure Manual, page 283 under " Medication Administration, to instill eye drops...pull the lower lid down to expose the conjunctival sac, have the patient look up and away, then squeezed the prescribed number of drops into the sac. "<br><br>During a medication pass conducted with Employee #15 on January 24, 2011 at approximately 10:00 AM,. observed eye drop being instilled in left eye, the eye drop did not make full contact with the conjunctival sac, medication observed running down resident ' s cheek. The observation was made on January 24, 2011.<br>Cross over to §483.25<br><br>2. A review of the clinical record for Resident #17 revealed facility staff failed to assess the resident ' s blood pressure prior to the administration of an anti-hypertensive medication. The prescription included parameters of administration.<br><br>Physician ' s orders dated December 1, 2010 directed the administration of Diovan 160mg one (1) tablet daily for blood pressure, hold for systolic blood pressure less than 110 or heart rate less than 60.<br><br>A review of the Medication Administration Record | F 281 | F281<br>1. Resident #10, #18 - Nurse administering eye drops was given one on one education—technique for administering eye drops.<br><br>2. Follow up random medication administration observation conducted with same nurse as nurse administered eye drops. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with at least one nurse on their units.<br>3. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse managers have received training through our pharmacy on how to conduct Medication Administration Observation rounds.<br>4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the Quality Improvement Committee quarterly.<br><br>5. Compliance Date | 4/8/2011 |