DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDI D SERVICES

45th 17/01/11

PRINTED: 08/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445344	A. BUILDING _____ B. WING _____	08/17/2011

NAME OF PROVIDER OR SUPPLIER: **HOLSTON HEALTH & REHABILITATION CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **3916 BOYDS BRIDGE PIKE, KNOXVILLE, TN 37914**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=E	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make the most recent survey results readily accessible to residents. The findings included: Observation of the front lobby on August 17, 2011, at 8:30 a.m., revealed a posting "...If you would like to see our state survey results, copies are available at the nurse's station...Please ask a staff member if you need assistance..." Interview and observation with the Administrator on August 17, 2011, at 8:48 a.m., confirmed the survey results were located behind the nurse's station at a place not readily accessible to residents.	F 167	Credible allegation of Compliance: F167 1. The State Survey Results Notebook was moved to a desk in the front lobby. 2. The public "posting" was changed to reflect this move. 3. All partners will be in-serviced to location of 'survey results notebook'. 4. The administrator will ensure the most current 'survey results notebook' stays in current place.	8/17/11 8/17/11 9/9/11 8/17/11 And on going
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278	Credible allegation of Compliance: F278 1. MDS Coordinator will submit a corrected 14 and 30 day MDS for resident #2.	9/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K.S. McLeod TITLE: Adm (X6) DATE: 9/2/11

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

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F 278	Continued From page 1 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete an accurate Minimum Data Set (MDS) assessment to reflect resident status for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with	F 278	2. MDS Coordinators will review all current patients with a fall and/or TF for accurate coding. 3. MDS Coordinator will in-service MDS Nurses on accurate coding. 4. MDS Coordinators and ADON will monitor all patients with a fall and/or TF for MDS accuracy.	9/23/11 9/16/11 9/23/11 And on going

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F 278	Continued From page 2 diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, and Muscle Weakness. Medical record review of the MDS dated July 21, and August 5, 2011, revealed resident #2 had one fall since admission or prior assessment and the injuries were addressed as a zero, had a feeding tube, and assessed as extensive assistance for eating. Medical record review of the Nurse's Note dated July 14, 2011, at 1:50 p.m., revealed the resident had a fall and, "Condition...hematoma at R) (right) eyebrow with bleeding noted..." Medical record review of the Post Fall Nursing Assessment dated August 4, 2011, revealed "...no apparent injury..." Medical record review of the Care Area Assessment (CAA) Summary dated July 15, 2011, revealed "...NPO (nothing per mouth) on TF (tube feeding) per chart 7/20..." Observation on August 15, 2011, at 8:32 a.m., in the resident's room revealed the resident lying in bed with the alarm on the feeding pump alarming and connected to a feeding tube in the abdomen. Interview with the MDS Nurses in the MDS Office on August 16, 2011, at 3:40 p.m., confirmed the fall with injury and eating was assessed incorrectly on the MDS.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	Credible allegation of Compliance: F279 1. Care Plan will be updated by RN MDS Coordinator and ADON to	9/16/11

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F 279	Continued From page 3 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to develop a Comprehensive Care Plan for one resident (#2) of seventeen reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, and Muscle Weakness. Medical record review of the Minimum Data Set	F 279	reflect current status of resident #2. 2. ADON will review all current patients who have fallen in the last 90 days to ensure their Care Plan reflects interventions put into place following falls. 3. DON/ADON will in-service nurses to update Care Plan when completing post fall assessment. 4. ADON will review and monitor all post fall assessments to ensure Care Plans are updated. ADON will report results to QA committee quarterly for the next year.	 9/23/11 9/16/11 On going

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F 279	Continued From page 4 (MDS) dated August 5, 2011, revealed the resident had short and long term memory problems, modified independence with decision making, required extensive assistance with all activities of daily living, was always incontinent of bowel and bladder, and had experienced falls. Medical record review of the Nurse's Note dated July 14, 2011, at 1:50 p.m., revealed the resident had a fall from the wheelchair and, "Condition...hematoma at R) (right) eyebrow with bleeding noted..." Medical record review of the Interim Care Plan updated July 15, 2011, revealed, "...personal alarm..." with no indications of when or where the alarm was to be placed. Medical record review of the Comprehensive Care Plan dated July 28, 2011, revealed the resident had a potential for falls, but no documentation for actual falls or interventions placed following falls. Medical record review of the Post Fall Nursing Assessment dated August 4, 2011, revealed the resident had a fall from the wheelchair, "...no apparent injury..." Medical record review of the interim Care Plan updated August 4, 2011, revealed, "...NP eval meds (Nurse Practitioner to evaluate medications) ...". Observation on August 16, 2011, revealed the resident sitting up in bed with left leg hanging over side of the bed.	F 279		

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F 279	Continued From page 5 Interview on August 16, 2011, at 1:28 p.m., with Licensed Practical Nurse #2 outside the resident's room, revealed staff only place the personal alarm on the resident while up in wheelchair. Interview with the ADON (Assistant Director of Nursing) on August 17, 2011 at 8:30 a.m., at East Wing Nurse's Station confirmed the Comprehensive Care Plan had not been updated to reflect the fall preventions on July 14, and August 3, 2011.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to provide personal hygiene care for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, Clostridium difficile, and Muscle Weakness.	F 312	Credible allegation of Compliance: F312 1. DON instructed charge nurses to focus staffing patterns on acuity instead of patient head count to ensure dependent resident receives the necessary services to maintain good nutrition, grooming, personal hygiene and oral hygiene for resident #2. 2. No other residents were identified as being affected. 3. All partners will be in-serviced on the importance of resolving the issue when answering call lights. Care staff who are assigned to residents with higher acuity will be assigned fewer residents. 4. Nursing supervisors will make shift rounds and check 5	8/19/11 8/19/11 9/16/11 On going

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F 312	Continued From page 6 Medical record review of the Minimum Data Set (MDS) dated August 5, 2011, revealed the resident had short and long term memory problems, modified independence with decision making, required extensive assistance with all activities of daily living, and was always incontinent of bowel and bladder. Observation on August 17, 2011, at 9:33 a.m., on the 300 hallway, revealed residents call light was ringing. Further observation revealed Certified Nurse Aide (CNA) Staff Coordinator placed gown, gloves, and shoe covers on and entered the room, exited, went to LPN (Licensed Practical Nurse) #4 and CNA #1, and left the hall. Observation on August 17, 2011, at 10:28 a.m., on the 300 hallway, revealed CNA #1 gathered supplies and entered the resident's room to provide hygiene care. Interview with CNA #1 on August 17, 2011, at 10:33 a.m., outside the resident's room, revealed resident #2 had received pericare at 7:00 a.m., CNA #1 had not been back in the room, and stated, "I have not had a chance." Interview with resident # 2's visitor on August 17, 2011, at 10:42 a.m., in the resident's room, confirmed the resident waited over one hour for assistance from the first time the call light had been turned on until the second time the call light had been answered and CNA #1 entered room to provide incontinence care. Interview with the Wound Care Nurse on August 17, 2011, at 11:25 a.m., outside the resident's room, confirmed the resident needed to be turned	F 312	dependent residents who have urinary and/or bowel incontinence daily for one week and then twice weekly including once on weekends for two months. Findings will be presented to QA committee for further recommendations.	

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F 312	Continued From page 7 and checked for incontinence episodes at least every two hours. Interview with CNA #1 on August 17, 2011, at 11:28 a.m., outside the resident's room, confirmed the resident had been incontinent of stool when pericare had been provided at 10:28 a.m. Interview with the Administrator and the DON (Director of Nursing) on August 17, 2011, at 11:35 a.m., in the Administrator's office, confirmed personal hygiene care had not been provided in a timely manner for the resident.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to perform a comprehensive assessment to include staging, size, and description of a pressure ulcer for one resident (#7) of seventeen residents reviewed. The findings included:	F 314	Credible allegation of Compliance: F314 1. A Nurse will obtain a physician's order and document the stage, size, and description of the pressure ulcer of resident #7. 2. Nurses will complete skin assessments on all current patients to ensure all pressure ulcers have a physician's order and proper documentation. DON will complete wound rounds with wound nurse to ensure all treatments have a physician order. 3. The Wound Care Nurse/treatment nurses have been in-serviced and will obtain a physician order and properly Care Plan all wound treatments. 4. The DON will audit all treatments for Care Plans and physician orders and report the results to the QA committee.	8/19/11 8/19/11 9/16/11 On going

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F 314	Continued From page 8 Resident #7 was admitted to the facility on June 15, 2009, with diagnoses including Alzheimer's Dementia, Adult Failure to Thrive, Generalized Weakness, Chronic Steroid Use, and Malnutrition. Medical record review of the Minimum Data Set (MDS) dated June 15, 2011, revealed the resident had impaired short and long term memory, severely impaired decision making, required extensive assistance with all activities of daily living, and had no pressure ulcers. Medical record review of the Weekly Skin Assessment Record dated July 13, 20, 27, and August 10, 2011, revealed the resident had no alteration in skin integrity (no pressure ulcers). Medical record review of the Weekly Skin Assessment Record dated August 3, 2011, revealed the resident had an area of redness to the buttocks and no other pressure ulcers. Medical record review of the Treatment Records for July 15, through August 16, 2011, revealed the resident was receiving skin prep with a dressing to a left heel blister daily. Medical record review revealed no documentation of an assessment to include staging, measurements, or descriptions of the wound to the left heel. Observation and interview with the facility Wound Care Nurse LPN #3 (Licensed Practical Nurse) on August 17, 2011, at 10:20 a.m., in the resident's room, confirmed the resident had a stage 2 pressure ulcer on the left heel measuring	F 314		

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F 314	Continued From page 9 2.5 cm (centimeters) by 3.0 cm with an open area in the center of the wound measuring 0.7 cm by 0.1 cm. Review of the facility policy Skin Integrity Manual Assessment Guidelines revised January 1, 2006, revealed, "...Wound Assessment includes type, stage, location, measurement of site - (length, width and depth.)...Exudate...Wound bed...Periwound (area surrounding wound) & wound edge appearance to include description and measurement...Weekly Skin and Wound Assessments...includes type, stage, location, measurement of site-length, width and depth..." Interview and medical record review with LPN #3 on August 16, 2011, at 2:38 p.m. at the west nursing station, and on August 17, 2011, at 10:20 a.m., in the resident's room, confirmed the resident had an unavoidable pressure ulcer to the left heel and no initial or weekly comprehensive assessments to include staging, measurements, and description had been completed. Further interview confirmed that the doctor had not been notified.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the 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.	F 315	Credible allegation of Compliance: F315 1. DON has educated the C.N.A. #1 on the "Five Rag Rule" of performing peri-care for resident #2. 2. No other residents were identified as being affected. 3. Nursing Administration will perform in-services to educate all C.N.A.s on .the "Five Rag Rule" of performing peri-care.	8/19/11 8/19/11 9/16/11

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F 315	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide appropriate incontinence care for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, and Muscle Weakness. Medical record review of the Minimum Data Set (MDS) dated August 5, 2011, revealed the resident had short and long term memory problems, modified independence with decision making, required extensive assistance with all activities of daily living, and was always incontinent of bowel and bladder. Observation on August 16, 2011, at 9:05 a.m., in the resident's room, revealed CNA (Certified Nurse Aide) #1 providing incontinence care for the resident who was incontinent of stool. Observation revealed CNA #1 cleanse the resident's perineal area using a wash cloth with soap and water to remove stool; wiped from front to back then folded the wash cloth and went from front to back again, with visible stool on the cloth. Interview with the CNA on August 16, 2011, at 9:30 a.m., in the resident's bathroom, confirmed the CNA had folded the wash cloth, reused the	F 315	4. Charge nurse will audit peri-care 3 times a week for one week then one time a week for the next 2 months to ensure proper incontinence care is given. Infection Control nurse will report the results to the QA committee.	On going

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F 315	Continued From page 11 cloth and cleaned the resident again with visible stool on the cloth. Interview with ADON (Assistant Director of Nursing) on August 17, 2011, at 8:30 a.m., at West Wing Nurse's Station, confirmed reusing the wash cloth with stool present was not according to the facility's procedure for incontinence care.	F 315		
F 318 SS=D	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 and interview the facility failed to provide appropriate treatment and services to prevent further decrease in Range of Motion (ROM) for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, and Muscle Weakness. Observation on August 15, 2011, at 8:32 a.m.,	F 318	Credible allegation of Compliance: F318 1. The facility will ensure treatments are assessed, ordered, and Care Planned for resident #2. 2. The facility's Rehab partners will audit their case load to ensure all patients are receiving required treatment and services to prevent further decrease in ROM. 3. Licensed Rehab partners will be in-serviced to obtain a physician order and properly Care Plan all patients who require treatment and services to prevent further decrease in ROM. C.N.A.s will be in-serviced as to the proper application and the importance of using the devices to prevent further decrease in ROM. 4. Director of Rehabilitation will monitor patients who require treatment and services to prevent further decrease in	8/18/11 9/9/11 8/23/11 On going

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F 318	Continued From page 12 the resident was in the bed with no palm guard on the right hand. Further observation revealed the palm guard on the bedside table. A sign over the head of the bed revealed the palm guard was to be placed in the right hand at all times. Observation on August 16, 2011, at 9:35 a.m., revealed the resident lying in bed dressed and the palm guard lying on the bedside table. Interview on August 16, 2011, at 9:35 a.m., in the hallway outside room 307, with the CNA #1, confirmed am care was complete, the palm guard had not been placed on the resident's right hand and it was supposed to be in place at all times. Interview on August 16, 2011, at 8:55 a.m. at the nurse's station on East Wing with OT (occupational therapy), confirmed all staff are to place the palm guard on the residents right hand and "the hand is already getting contracted."	F 318	ROM. DOR will report results to QA committee.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353	Credible allegation of Compliance: F353 1. DON instructed charge nurses to focus staffing patterns on acuity instead of patient head count. This will ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psycho-social wellbeing of each resident, as determined by resident	8/19/11

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	445344		08/17/2011

NAME OF PROVIDER OR SUPPLIER: HOLSTON HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3916 BOYDS BRIDGE PIKE, KNOXVILLE, TN 37914

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F 353	Continued From page 13 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide sufficient staffing to meet the resident's needs for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, and Muscle Weakness. Observations on August 17, 2011, from 9:33 a.m., until 10:41 a.m., on the 300 hallway, revealed the following: 9:33 a.m., call light ringing for room 307, Certified Nurse Aide (CNA) Staff Coordinator placed gown, gloves, and shoe covers on, entered room, exited, went to LPN (Licensed Practical Nurse) #4 and CNA #1, and left the hall; 9:55 a.m., call light ringing for room 305, Activity Staff answered the light and explained to resident #17 the CNA will be right in and left the hall; 9:58 a.m., call light ringing for room 308, the Treatment Nurse entered the room, informed the resident CNA #1 would be notified of needs, and spoke to CNA #1 in	F 353	assessments and individual plans of care for resident #2. 2. No other residents were identified as being affected. 3. All partners will be in-serviced on the importance of resolving the issue when answering call lights. Care staff who are assigned to higher acuity residents will be assigned less residents. 4. Nursing supervisors will make shift rounds and check 5 dependent residents three times a week for one week, once a week for three weeks, and monthly for two months to ensure resident's needs are met. The results will be given to DON who will report them to the QA committee.	8/19/11 9/16/11 On going

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F 353	Continued From page 14 another room; 10:00 a.m., CNA #1 entered and exited room 310 then entered room 308 at 10:02 a.m., and closed the door; 10:05 a.m., CNA #1 entered and exited room 309 and then entered 311 and stated "me again" and closed the door; 10:12 a.m., call light ringing in room 305 and staff entered the room; 10:13 a.m., a visitor in the hallway looked up and down the hall, then went to the Nurse's Station and requested CNA #1; 10:26 a.m., resident in room 310 yelled, "nurse, nurse"; 10:28 a.m., CNA #1 entered room 307 (55 minutes after 307 had requested assistance); 10:29 a.m., the resident in room 310 yelled, "nurse, nurse"; 10:41 a.m., the resident yelled, "Hey, Hey", the Floor Tech stopped, went in to room 310, and wheeled the resident in to the hallway. Interview with CNA #1 on August 17, 2011, at 10:33 a.m., in the 300 hallway, revealed resident #2 had received care at 7:00 a.m., CNA #1 had not been back in the room, and stated, "I have not had a chance." Interview with resident #2's visitor on August 17, 2011, at 10:42 a.m., in the resident's room, confirmed resident #2 waited over one hour for assistance from the first time the call light had been turned on until the second time the call light had been answered and CNA #1 entered the room to provide care. Interview with the Wound Care Nurse on August 17, 2011, at 11:25 a.m., outside resident #2's room, confirmed resident #2 needed to be turned at the least every two hours. Interview with CNA #1 on August 17, 2011, at	F 353		

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F 353	Continued From page 15 11:28 a.m., outside resident #2's room, confirmed resident #2 had been incontinent of stool when pericare had been provided at 10:28 a.m. Interview with the Administrator and the DON (Director of Nursing) on August 17, 2011, at 11:35 a.m., in the Administrator's office, confirmed staff had not provided care in a timely manner for resident #2 and on the 300 hallway.	F 353		
F 441 SS=D	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	F 441	Credible allegation of Compliance: F441 1. The DON/ADON will educate all care staff and all Rehab partners on the proper isolation procedures for resident #2. 2. Only one other resident was identified as in isolation and was not affected. 3. Nursing Administration will perform in-services for all care staff and Rehab partners on all isolation procedures of current patients. 4. Infection Control nurse will audit isolation room 3 times for one week, then once a week for three weeks, and then monthly for two months to ensure proper infection control practices are followed. Infection Control nurse will report the results to the QA committee.	9/16/11 8/19/11 9/16/11 On going

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F 441	Continued From page 16 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of facility policy, the facility failed to follow the infection control policy for two staff members and one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted on July 8, 2011, with diagnoses of Right Hemiparesis, Dysphagia (difficulty swallowing), Cerebral Vascular Accident (CVA), Lack of Coordination, Abnormal Posturing, Clostridium difficile, and Muscle Weakness. Medical record review of the physician's telephone orders revealed an order dated July 22, 2011, "...stool for c-diff (Clostridium Difficile)..." and an order dated July 28, 2011, to place the resident in Contact Isolation. Medical Record review of a Nurse's Note dated July 27, 2011, "...positive c-diff results, informed supervisor, resident in isolation...".	F 441		

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F 441	Continued From page 17 Observation on August 15, 2011, at 2:45 p.m., in the 300 hallway, revealed Certified Nurse Aide (CNA) #1 exited a resident's room, took off gloves, placed in a trash bag in the hallway, went to the clean linen cart, collected a blue pad and reentered the resident's room, without washing the hands. Interview on August 15, 2011, at 2:50 p.m., on 300 hallway, with CNA #1 confirmed the CNA did not wash the hands after removing the gloves. Observation on August 16, 2011, at 8:28 a.m., on the 300 hallway, revealed CNA #1 entered resident #2's room, with a contact isolation sign indicating, "...gown, gloves, and shoe covers required...". Observation revealed the CNA did not don gown, gloves, or shoe covers, placed linen in a chair, then went to the clean linen cart, retrieved linen, and went into another resident's room without washing the hands. Interview on August 16, 2011, at 8:30 a.m., on the 300 hallway, with CNA #1 confirmed the CNA entered the isolation room without gown, gloves, or shoe covers and did not wash the hands when exiting. Observation on August 16, 2011, at 3:22 p.m., on the 300 hallway, revealed PTA (Physical Therapy Assistant) #1 exited the isolation room with gown and shoe covers, reached in the glove box on the isolation cart in the hallway and reentered the isolation room. Interview on August 16, 2011, on the 300 hallway, with PTA #1, confirmed the PTA exited the isolation room with gown and shoe covers on, to	F 441		

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F 441	Continued From page 18 retrieve gloves and reentered the room. Continued interview confirmed the gown and shoe covers were to be removed before exiting the isolation room. Observation on August 17, 2011, at 10:42 a.m., on the 300 hallway, revealed a pair of soiled gloves on top of the isolation cart turned inside out. Interview on August 17, 2011, at 10:42 a.m., on 300 hallway, with Licensed Practical Nurse (LPN) #4, confirmed the gloves were soiled and were not disposed of properly. Review of facility's policy Handwashing/Hand Hygiene (no policy date or number) revealed, "...handwashing after removal of gloves and when there is likely exposure to spores (C. difficile)...". Interview with the Infection Control Nurse on August 17, 2011, at 9:18 a.m., at West Wing Nurse's Station, confirmed contact isolation was gown, gloves, and shoe covers, when entering the room, remove gown, gloves, and shoe covers, and wash hands before exiting an isolation room. Continued interview confirmed all residents suspected of c-diff were to be placed in contact isolation until results were reported and wash hands with soap and water after removing gloves and before exiting the room. Continued interview confirmed the facility's policies for infection control were not followed.	F 441		
F 502 SS=D	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	F 502	Credible allegation of Compliance: F502 1. The facility's Medical Director reviewed lab results of resident #7 to ensure proper care was given.	8/18/11

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F 502	Continued From page 19 of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a urinalysis in a timely manner for one resident (#7) of seventeen residents reviewed. The findings included: Resident #7 was admitted to the facility on June 15, 2009, with diagnoses including Alzheimer's Dementia, Adult Failure to Thrive, Generalized Weakness, history of Cerebral Vascular Accident (stroke), and Degenerative Joint Disease. Medical record review of the Minimum Data Set (MDS) dated June 15, 2011, revealed the resident had impaired short and long term memory, severely impaired decision making, required extensive assistance with all activities of daily living, and was incontinent of bladder. Medical record review of a physician's order dated June 16, 2011, revealed,"...In & out cath U/A (with) micro C&S (straight catheterization for urinalysis and culture and sensitivity)..." Medical record review of the urinalysis results revealed the urine specimen was received by the lab on June 20, 2011, (4 days after physician order). Interview with the DON (Director of Nursing) on August 16, 2011, at 10:00 a.m. in the DON's office, confirmed the urinalysis was not obtained	F 502	2. All orders for UA will be audited by RN House Supervisors to ensure timeliness of obtaining and picking up of samples. 3. DON/ADON will in-service nurses regarding procedure for obtaining specimen and ensuring timely lab pick up. 4. All orders for UA will be audited by RN House Supervisors 3 times a week for one week, then once a week for three weeks, and then monthly for two months to ensure timeliness of obtaining and picking up of samples. DON will report results to QA committee.	9/16/11 9/16/11 On going

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F 502	Continued From page 20 in a timely manner.	F 502		

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