

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

PRINTED: 01/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/22/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES-CHERRYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 SELF ST CHERRYVILLE, NC 28021
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F 000	INITIAL COMMENTS	F 000	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and medical record review the facility failed to honor the food preferences for two (2) of five (5) sampled residents. (Residents #7 and #12)  The findings are:  1. Resident #12 was admitted to the facility with diabetes, hypertension and end stage renal disease. The quarterly Minimum Data Set dated 11/18/11 coded Resident #12 as being cognitively intact with no memory problems.  During group interview on 12/21/11 at 11:00 AM, Resident #12 stated she received items listed as dislikes at least weekly. She stated she had received green beans and shrimp which she was not supposed to receive.  On 12/22/11 at 11:05 AM, Resident #12 stated	F 242	For Residents #7 and #12, the computerized nutritional profiles were corrected to reflect all disliked food items on their meal tickets and snack labels.  For all residents in the facility, 100% of all individualized nutritional profiles were audited and corrections implemented for compliance with resident's individual preferences.  As food preferences and dislikes are identified, each individual computerized nutritional profile is updated. Employees preparing the trays are responsible for placing the correct items on the meal trays in accordance with printed items on the tray tickets. The nursing staff/ designee responsible for passing the tray to the resident completes a second check prior to the tray being placed before the resident. Such protocol is followed when preparing and passing bedtime snacks as well. In-service training has been provided to all nursing and dietary staff by the Staff Development Coordinator/ Weekend RN Supervisor regarding tray tickets and taking	12/22/11  1/13/12  1/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Cheryl Mickell* *Administrator* *1/17/12*

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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JAN 19 2012  
BY: *MH*

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F 242	<p>Continued From page 1</p> <p>she was served shrimp last Monday for lunch and that she sent it back and asked for the alternative. She further stated she had received corn, mixed vegetables and green beans which she has told the facility she did not like. She stated she had a dye test in the past and was told at that time she should not eat shellfish.</p> <p>Review of the menus for Monday 12/19/11 revealed popcorn shrimp was on the menu. Review of Resident #12's tray card revealed that her diet included no seafood, no green beans, and no corn.</p> <p>Interview with the nurse aide (NA) #3 on 12/22/11 at 1:05 PM revealed she normally removed the trays from the card, checked the tray cards, checked for preferences and set up the tray. She stated she offered alternatives such as a sandwich and soup if Resident #12 received a dislike. NA #3 stated Resident #12 never received fish.</p> <p>2. Resident #7 was readmitted to the facility with a diagnosis of diabetes mellitus. The most current comprehensive Minimum Data Set (MDS), dated 11/04/11, indicated the resident was cognitively intact, was able to understand verbal instructions, clearly expressed requests and ideas, and was independent in decision making skills. The resident was identified by facility staff as reliable for interview.</p> <p>An observation on 12/20/11 at 12:30 PM revealed Resident #7 was seated on the side of her bed with her lunch tray in front of her on a bedside table. She had received her lunch meal tray with ham, a sweet potato, greens, fruit parfait and a</p>	F 242	<p>the appropriate course of action in the event that a discrepancy is identified on a tray prior to its presentation to the resident.</p> <p>10% of the population will be audited utilizing the Tray Card Accuracy Audit at meal times and the Snack Accuracy Worksheet at snack times three times a week for four weeks, weekly for four weeks, then every other week for four weeks. Results will be reviewed by the District Registered Dietician/ District Manager a minimum of twice per month. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Dietary Manager at the Quality Assurance (QA) Committee meeting.</p>	1/16/12
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F 242	<p>Continued From page 2</p> <p>white roll. A review of Resident #7's tray card for the lunch meal served 12/20/11 revealed the following food preferences: no fried foods, no gravy and no white bread.</p> <p>An interview with Resident #7 on 12/21/11 at 8:15 AM revealed that she had requested no white bread, but was frequently served white bread. Resident #7 stated that she was diabetic and provided a snack before bed time. She stated the snack was usually a sandwich of some type served on white bread.</p> <p>An interview on 12/21/11 at 10:15 a.m. with the Regional Registered Dietician and the District Registered Dietician (DRD) revealed Resident #7 received a white bread roll on 12/20/11 due to dietary aides (DAs) reading the preference for "no white bread" and interpreting that to mean white loaf bread.</p> <p>An interview with Resident #7 on 12/22/11 at 7:06 AM revealed that when she received her evening snack on 12/21/11 the snack was a pimento cheese sandwich served on white bread. Resident #7 stated that she did not eat the white bread, only the crust.</p> <p>A review of the Resident Snack List received from the Dietary Manager revealed Resident #7 was scheduled to receive a sandwich as a bedtime snack.</p> <p>An interview on 12/22/11 at 11:24 a.m. with the DRD revealed she was aware of Resident #7's preference to not receive white bread but the preference was not communicated to the DAs preparing the evening snacks. The DRD stated</p>	F 242		
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F 242	Continued From page 3 that the computer system did not allow all the text entered to show on the print-out the DAs use when preparing scheduled snacks. The DRD stated that Resident #7's preference to not be served white bread needed to be fixed in the computer system and communicated to the DA.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide an activity program as scheduled and care planned to meet the needs of one (1) of eight (8) sampled residents. Resident #6  The findings are:  Resident #6 was admitted to the facility with diagnoses including Alzheimer's Dementia, Parkinson's disease, Adult Failure to Thrive, Dysphagia, and Chronic Kidney Disease. The Activity Department Admission Assessment dated 7/11/11 stated that activities that would be initiated would be "Shirley's Stories + Gilda's Devotions." Activity preferences noted gospel music only.  The admission Minimum Data Set (MDS) dated 7/15/11 coded her with long and short term	F 248	F248  For Resident #6, individual one to one bedside visits have been increased to five times per week and documented accordingly.  The headphones were removed from resident's CD player.  Time frames were established for beginning and changing the CD, communicated to appropriate staff, and the resident care information sheets were updated to reflect resident's bedside activity needs.  For all residents receiving one to one bedside visits, an audit was completed to verify compliance with the appropriate and care planned amount of visits and appropriate documentation and corrections implemented.  Resident care information sheets were updated to reflect resident's bedside activity needs.	12/27/11  12/22/11  1/13/12  12/27/11  1/13/12

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F 248	<p>Continued From page 4</p> <p>memory impairment, being nonambulatory, being nonverbal, being totally dependent on all activities of daily living skills, being fed only by tube, and having range of motion impairment on both sides upper and lower extremities. No changes were noted on the quarterly MDS dated 9/29/11.</p> <p>The most recent Activity Assessment, a quarterly dated 9/27/11, noted that Resident #6's daily preferences and activity preferences were unable to be assessed. The plan included one-on-one activities with Shirley's stories and Gilda's devotions, with independent activities as television and gospel music. Activity notes dated 9/27/11 also included that the resident was unable to make her needs known, and received one-on-one activities in her room. The note stated Resident #6 will at times follow movement with her eyes.</p> <p>A current care plan originally developed on 7/18/11 and reviewed on 9/29/11 identified Resident #6 was dependent on staff and family for social interaction. The goal was "will tolerate others providing socialization daily and cognitive stimulation." Interventions included:                      *encourage staff to bring resident to appropriate activities when offered;                      *one to one bedside visits as tolerated;                      *turn on television/radio/tapes in room if appropriate for stimulation.</p> <p>Review of Resident #6's Activity participation records from 9/1/11 to 12/1/11 revealed Resident #6 received one on one as follows:                      *Gilda's Devotions 5 times in September 2011;                      *Shirley's Stories 1 time in September 2011;                      *Shirley's Stories 3 times in October 2011;</p>	F 248	<p>All other residents who utilize headphones have the ability to play their music on their schedule and to take the headphones on and off themselves. Other residents who listen to music as part of the activity care plan, listen on bedside CD players. Education was provided to the Activities Department personnel and the Nurses Aides by the Staff Development Coordinator/ Weekend RN Supervisor regarding providing an activity program as scheduled and care planned to meet the needs of each resident. Audits will be completed monthly for three months to determine compliance with the activity care plan for those residents receiving one to one visits at the bedside and listening to music at the bedside. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Administrator at the QA Committee meeting.</p>	<p>12/22/11</p> <p>1/13/12</p> <p>1/13/12</p>

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F 248	<p>Continued From page 5</p> <p>*Shirley's Stories 3 times in November 2011; and *Shirley's Stories 1 time in December 2011.</p> <p>Observations revealed the following while Resident #6 was in bed, eyes open, nonverbal and could not independently move, gesture or indicate understanding: *On 12/20/11 at 12:03 PM and 12:46 PM, resident had head phone on connected to compact disc (CD) player, but CD player was not running; *On 12/20/11 at 3:10 PM, 3:50 PM, and 4:55 PM, the resident's head phones were on but not connected to the CD player. *On 12/21/11 at 11:03 AM, 12:20 PM, 3:05 PM and 4:40 PM, the resident's head phones were on and connected to the CD player which was not running.</p> <p>On 12/22/11 at 8:50 AM the activity calendar was reviewed with the Activity Director (AD). The activity calendar revealed that Gilda's Devotions occurred every Monday, Wednesday and Friday and Shirley Stories occurred every Tuesday and Thursday. Per the AD, these activities involved volunteers who had a list of all bedfast residents and they were to visit each of the bedfast residents every visit and read to them and apply lotion, etc. Afterwards they turned in a list of all residents they visited and that was entered into the activity participation record. The AD stated Resident #6 was a bedfast resident who never came out of her room and only got up in a gerichair about one to two times a week. Per the AD, Resident #6 should receive one-on-one visits five days a week via Shirley's Stories and Gilda's Devotions. The AD further stated that she had purchased compact discs (CDs) for the CD player</p>	F 248			

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F 248	Continued From page 6 in Resident #6's room with head phones so she could listen to classical music. The AD stated that either she or the nurse aides on the floor would put a CD in the CD player. The AD stated she would stop in and check since she knew the CDs lasted about one hour and she could replay them. She further stated that she could not recall if she put the CD on for Resident #6 on Tuesday 12/20/11 but did put it on one time 12/21/11. There was no set schedule or plan as to when the CDs should play. When asked what was expected relating to the care plan indicating tapes "if appropriate" the AD stated if no visitors were present or care being done.  Interview with Nurse Aide (NA) #1 on 12/22/11 at 1:40 pm revealed she was responsible for Resident #6 on 12/21/11. NA #1 stated that after care, nurse aides were to set up Resident #6 with the CDs and headphones. She stated she did not put the headphones on yesterday but she should check during rounds to make sure the CDs were playing. She further stated there was no set plan for playing the CDs.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interview, the facility failed to	F 250	F250 For Resident #8, an assistive hearing device was put into place consisting of an amplifier box and headphones. For resident #8, a dental appointment was scheduled for resident for a denture adjustment/ fitting on January 3 and January 16, both of which resident has refused consultation and appointments have been cancelled and re-scheduled.	12/22/11  12/22/11

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F 250	<p>Continued From page 7</p> <p>provide social services to provide one (1) of one (1) sampled residents with a recommended hearing device and needed dental care. Resident #8.</p> <p>The findings are:</p> <p>1. Resident #8 was admitted with diagnoses of Paraplegia, Diabetes, and Dysphagia.</p> <p>A physician's progress noted dated 5/11/11 noted that the visit was for evaluation of the resident's hearing deficit. The note stated that upon speaking with nursing staff, the resident was noted to have decreased hearing. Staff reported that the resident frequently listened to her television quite loudly. The progress note included the plan to refer Resident #8 for evaluation and treatment.</p> <p>The consultation report from the hearing evaluation dated 5/23/11 noted Resident #8 had bilateral hearing loss. Recommendations were "Assistive listening device and/or hearing aids. To be determined what is most appropriate for her needs at (facility name)." There was no evidence in the medical record of follow up.</p> <p>The annual Minimum Data Set (MDS) dated 8/24/11 coded Resident #8 as being cognitively intact with no memory impairments, being totally dependent on staff for all activities of daily living skills (ADLS) except eating and having moderate hearing loss.</p> <p>The Care Area Assessment (CAA) for communication dated 8/24/11 stated Resident #8</p>	F 250	<p>For all residents in the facility, 100% of the residents' medical records were audited for consultation follow-up and corrections implemented for compliance with providing medically related social services.</p> <p>A Communication Form for Medically Related Social Services was created in order for nurses to effectively communicate with the appropriate department head when there is a need for a medically related social service consult or device. Education was provided to all department heads and nurses by the Staff Development Coordinator/ Weekend RN Supervisor regarding the utilization of the Communication Form and providing medically related social service needs.</p> <p>Audits of 100% of all residents' medical records will be completed monthly for three months to determine compliance with providing medically related social service needs and the appropriate follow-up to consultations. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Administrator at the QA Committee meeting.</p>	<p>1/13/12</p> <p>1/13/12</p> <p>1/13/12</p>



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F 250	<p>Continued From page 8</p> <p>had impaired communication related to being hard of hearing and impaired voice production. The CAA stated that a care plan would be developed to minimize the resident's risk for decline in communication.</p> <p>Nursing notes dated 9/9/11 at 1:20 PM noted she complained about not hearing the television.</p> <p>The quarterly MDS dated 10/13/11 coded Resident #8 as being cognitively intact, totally dependent for all ADLS except eating and having adequate hearing.</p> <p>The communication care plan last updated 10/18/11 addressed her verbal communication difficulties.</p> <p>The Social Service notes in the medical record recorded entries on 4/11/11, 6/16/11, 8/22/11, 10/12/11 and 10/25/11. There was nothing in any of these notes related to follow up of hearing devices.</p> <p>Resident #8 was observed in her room watching television without any hearing devices on: *12/20/11 at 12:07 PM, 12:40 PM, 2:15 PM, at 4:30 PM; *12/21/11 at 8:06 AM, 11:05 AM, 12:23 PM; and *12/22/11 at 7:12 AM.</p> <p>On 12/21/11 at 12:23 PM Resident #8 stated that she had failed to mention something to the surveyor during her individual resident interview. She then stated that she was assessed as having "significant" hearing loss and needed hearing aides. She stated she did not have any.</p>	F 250			

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F 250	<p>Continued From page 9</p> <p>On 12/22/11 at 10:59 AM, the Social Worker was observed setting her up with a hearing device consisting of an amplifier box and hear plugs. On 12/22/11 at 11:00 AM Resident #8 stated she had just received the hearing device from the Social Worker. She further stated she had never been offered or tried any type of device until this time.</p> <p>Interview with the Social Worker on 12/22/11 at 11:35 PM revealed she did not think medicaid would cover the hearing aides and the family could most likely not afford hearing aides so she provided Resident #8 with the hearing device this date. She further stated they were waiting to hear from medicaid about hearing aides. She confirmed no other device had been tried while waiting to hear about medicaid eligibility and was able to give no reason why it took almost seven months to try an amplifier.</p> <p>Follow up interview with the social worker on 12/22/11 at 2:10 PM revealed that usually the place that completed the hearing evaluation applied to medicaid about eligibility for hearing aides. She stated that follow up in the facility was a "team" effort. She stated there was no evidence of any follow up with the hearing evaluation consultants by the facility since the 5/23/11 evaluation.</p> <p>2. Resident #8 was admitted with diagnoses of Paraplegia, Diabetes, and Dysphagia. The annual Minimum Data Set (MDS) dated 8/24/11 coded Resident #8 as being cognitively intact with no memory impairments, being totally dependent on staff for all activities of daily living skills (ADLS) except eating and having no natural teeth.</p>	F 250		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/22/2011	
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES-CHERRYVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 SELF ST CHERRYVILLE, NC 28021		
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F 250	<p>Continued From page 10</p> <p>Review of the medical record revealed Resident #8 was seen by the dentist on 8/24/11 with no treatment needed.</p> <p>Nursing notes dated 9/9/11 at 1:20 PM revealed Resident #8 complained she was not wearing her upper dentures because wearing her upper dentures caused her lower dentures to bother her.</p> <p>The Social Service notes in the medical record recorded entries on 10/12/11 and 10/25/11. There was nothing in any of these notes related to follow up of dental concerns.</p> <p>The undated Resident Care Sheet, used by nurse aides for individual care needs, noted that Resident #8 needed assistance with upper and lower dentures.</p> <p>Resident #8 was observed wearing only her upper dentures on 12/20/11 at 12:07 PM. The lower dentures were in the denture cup. She stated at this time that her bottom dentures bothered her gums. She was observed to wear only her top dentures on 12/20/11 at 12:40 PM, 12:59 PM, 2:15 PM, and 4:30 PM and on 12/21/11 at 11:05 AM and 12:23 PM.</p> <p>Nurse aide #2 stated on 12/21/11 at 10:00 AM that Resident #8 put her own dentures in and she did not wear the lower ones.</p> <p>Interview with the Social Worker on 12/22/11 at 11:35 AM revealed that she and the Activity Director were currently responsible for ensuring dental services were provided. When asked</p>	F 250		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 250	Continued From page 11 about the nursing note dated 9/9/11 which indicated a concern with her dentures, the Social Worker stated the charge nurse should follow up.  Interview on 12/22/11 at 1:55 PM with the charge nurse revealed that she wrote the 9/9/11 nursing note about Resident #8's complaint. She stated she was responsible for letting staff know that the resident needed a dental appointment. When asked about follow up she stated apparently the dentist did not come to see her.  Follow up on 12/22/11 at 2:10 PM with the Social Worker revealed the dentist comes to the facility as does the hygienist. She further stated that there was an administrative support person who would follow up on dental needs. The administrative support person was no longer in the facility. The social worker could not provide any evidence of follow up for resident #8's lower denture concerns.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	F272 For Residents #6, #8, and #12, the Care Area Assessments were reviewed and additional contributing factors related to the care areas with further analysis were documented. For all residents with annual assessments, significant change assessments, and admission assessments in the last three months, the Care Area Assessments will be reviewed and additional contributing factors related to the care areas with further analysis documented.	1/11/12  1/19/12

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F 272	Continued From page 12 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessments for three (3) of twelve (12) sampled residents. Residents #6, #8 and #12's comprehensive assessments did not include the registered nurse's analysis of the resident's individual strengths and weaknesses and factors which contributed to the problem and conclusions drawn from this analysis.  The findings are:	F 272	One to one education was provided to the MDS Coordinator by the Administrative RN regarding the CAA process providing a framework for guiding the review of triggered areas and clarification of a resident's functional status and related causes of impairments.  Audits of 100% of all residents' future annual assessments, significant changes, and admission assessments will be completed over the following six months. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Director of Nursing at the QA Committee meeting.	12/22/11  1/19/12

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F 272	<p>Continued From page 13</p> <p>1. Resident #6 was admitted to the facility with diagnoses including congestive heart failure, adult failure to thrive, dysphagia, chronic kidney disease, Parkinson's Disease, and feeding tube placement.</p> <p>The admission Minimum Data Set (MDS) dated 7/15/11 coded her with long and short term memory impairment, being nonambulatory, requiring total assistance with all activities of daily living skills (ADLs), having a stage III pressure ulcer and being totally incontinent.</p> <p>Review of the Care Area Assessments (CAAs) dated 7/18/11 for the triggered areas revealed there was no analysis of findings, descriptions of the problems, causes and contributing factors and risk factors related to the care areas. The form included a checkbox form but no individual description. The analysis of findings were noted as follows:</p> <ul style="list-style-type: none"> <li>*cognitive loss: advanced Alzheimer's Disease, impaired communication, Adult failure to thrive;</li> <li>*visual function: decreased visual acuity;</li> <li>*communication: Advanced Alzheimer's Disease, Non-verbal;</li> <li>*ADLs: Advanced Alzheimer's Disease, Contractures, Adult failure to thrive;</li> <li>*urinary incontinence: End stage Parkinson's, Advanced Alzheimer's, Contractures, non-ambulatory;</li> <li>*psychosocial well-being: Advanced Alzheimer's, Nonverbal, End-stage Parkinson's;</li> <li>*activities: Advanced Alzheimer's, End-stage Parkinson's, Non-verbal, Non-ambulatory;</li> <li>*nutritional status: Unable to swallow, Requires a feeding tube, Advanced Alzheimer's, End-stage Parkinson's;</li> </ul>	F 272		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 14</p> <p>*feeding tubes: Adult failure to thrive, impaired swallowing, Advance Alzheimer's, End-stage Parkinson's;</p> <p>*dehydration/fluid maintenance: Advanced Alzheimer's, End-stage Parkinson's, Swallowing issues, Recent PEG tube placement;</p> <p>*dental: Advanced Alzheimer's, End-stage Parkinson's, Decreased ADL function and mobility;</p> <p>*pressure ulcers: Impaired monility (sic), End-stage Parkinson's, Advanced Alzheimer's, Incontinence, Stage III present upon admission.</p> <p>On 12/22/11 at 9:15 AM interview with the MDS coordinator who completed the CAAs revealed the CAAs were completed from a computer program that allowed checks to be placed in pertinent categories. Regarding the analysis of the information, the MDS coordinator was trained to list the problems and then decide if there would be care plan developed. She further stated she was not trained to write a summary of her analysis or conclusions.</p> <p>2. Resident #8 was admitted with diagnoses including bipolar disorder, diabetes, and paraplegia.</p> <p>The annual Minimum Data Set (MDS) dated 8/24/11 coded her with no memory problems, requiring total assistance with all activities of daily living skills (ADLs) except eating, having constant pain and pressure sores.</p> <p>Review of the Care Area Assessments (CAAs) dated 8/24/11 for the triggered areas revealed there was no analysis of findings, descriptions of the problems, causes and contributing factors</p>	F 272			

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F 272	<p>Continued From page 15</p> <p>and risk factors related to the care areas. The form included a checkbox form but no individual description. The analysis of findings were noted as follows:</p> <ul style="list-style-type: none"> <li>*visual: poor vision and required glasses;</li> <li>*communication: hard of hearing and impaired voice production;</li> <li>*ADLs: paraplegia, pain, contractures, use of anti-psychotic meds;</li> <li>*incontinence: neurogenic bladder, paraplegia, use of anti-psychotic and narcotic meds, pain;</li> <li>*psychosocial well-being: resident has issues with some staff, paraplegia, communication deficits, vision deficits, use of psychoactive and narcotic meds, pain;</li> <li>*mood: depression, impaired communication, impaired mobility, pain, use of anti-psychotic and narcotic meds.</li> </ul> <p>On 12/22/11 at 9:15 AM interview with the MDS coordinator who completed the CAAs revealed the CAAs were completed from a computer program that allowed checks to be placed in pertinent categories. Regarding the analysis of the information, the MDS coordinator was trained to list the problems and then decide if there would be care plan developed. She further stated she was not trained to write a summary of her analysis or conclusions.</p> <p>3. Resident #12 was admitted to the facility with diagnoses including pressure ulcers, diabetes, hypertension, and end stage renal disease.</p> <p>The annual Minimum Data Set (MDS) dated 9/2/11 coded her with having intact cognition, requiring limited assistance with dressing,</p>	F 272			



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F 272	<p>Continued From page 16 hygiene and bathing.</p> <p>Review of the Care Area Assessments (CAAs) dated 9/02/11 for the triggered areas revealed there was no analysis of findings nor descriptions of the problems, causes and contributing factors and risk factors related to the care areas. The CAA included a checkbox form but no individual description. The analysis of findings were noted as follows:</p> <ul style="list-style-type: none"> <li>*delirium: BIMS (brief interview for mental status), mood, pain, decreased visual acuity;</li> <li>*vision: decreased visual acuity;</li> <li>*ADLs: pain, cardiovascular issues, decreased visual acuity;</li> <li>*mood: cardiovascular meds, narcotic meds, pain;</li> <li>*nutrition: diabetes, cardiovascular issues, pain, decreased visual acuity, requires a mechanically altered diet;</li> <li>*pressure: diabetes, pain, use of narcotics.</li> </ul> <p>During an interview on 12/22/11 at 9:15 a.m. the MDS coordinator who completed the CAAs revealed the CAAs were completed from a computer program that allowed checks to be placed in pertinent categories. Regarding the analysis of the information, the MDS coordinator stated she was trained to list the problems and then decide if there would be care plan developed. She further stated she was not trained to write a summary of her analysis or conclusions.</p>	F 272			