

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

PRINTED: 02/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
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NAME OF PROVIDER OR SUPPLIER SATURN NURSING REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262
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(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
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F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction.</p> <p>Resident numbers 66 and 8 were both discharged to home on 12/24/12. Appeal rights timeframe have expired for both residents.</p> <p>An audit of residents with Medicare coverage ending was completed as of 2/18/13. Residents with Medicare benefits ending were notified as per the regulation.</p> <p>The Business Office Manager, The Resident Care Director (S.W.) and the Rehabilitation Manager have all been re-educated by the Administrator as of 2/19/13 regarding the need to notify Medicare beneficiaries of their appeal rights.</p> <p>All newly hired BOM's, Social Workers or Therapy Directors will be educated upon hire of the need to notify Medicare beneficiaries of benefits ending and appeal rights.</p>	2/28/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anaela Conrade</i>	TITLE Administrator
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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 30 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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156	<p>The Business Office Manager will audit all Medicare recipients whose coverage ends as those benefits end to ensure that they have been notified of their rights of appeal going forward. The Business Office Manager will report monthly to the QA&A committee the findings of these audits x one year beginning March 2013. The QA&A committee will evaluate the reports to determine if the plan is effective and make changes as necessary.</p>		

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F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview the facility the facility failed to provide Medicare non-coverage notice to 2 of 4 sampled residents (Resident #66 and #8).</p> <p>The findings include: 1. A review of Resident #66's physician orders revealed an order dated 12/19/12 for discharge home on 12/24/12 and an order dated 12/21/12 for discharge from Occupational Therapy (OT). Review of a Physical Therapy discharge summary dated 12/26/12 indicated a discharge date of 12/21/12 and Resident #66 's functional status was indicated with an increase in strength and decrease in fall risk. An OT discharge summary indicated Resident #66 with great progress and no further OT needs. Resident # 66 was discharged from the facility on 12/24/12 to</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>home. There was no record of Resident # 66 being provided an approved Notice of Medicare non-coverage letter that notified her in advance of her Medicare services ending; what the estimated cost of services would be and her right to appeal.</p> <p>On 01/31/13 at 12:40 PM the business office manager reported it was not the practice of the facility to issue a letter of Medicare non-coverage to residents who were returning home prior to their Medicare services ending. The business office manager further explained residents were not given this notification because they were going home and non-coverage letters were only given to residents who would be remaining in the facility and had not exhausted their Medicare days.</p> <p>During an interview with the Administrator on 01/31/13 at 1:50 PM, the Administrator confirmed the business office manager had not been issuing letters of Medicare non-coverage to residents who were being discharged home. The Administrator stated the business office manager should have issued the Medicare non-coverage notice to any resident who no longer required Medicare services regardless of discharge location.</p> <p>2. A review of Resident #8 's physician orders indicated an order dated 12/17/12 for discharge to home on 12/18/12 and to hold discharge until complete blood count (CBC) results were called in and "ok " by the Physician. Laboratory results for a CBC dated 12/22/12 indicated a notation of "good" and "home" with a physician signature. A</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>Physician order dated 12/23/12 indicated Resident #8 may be discharged to home on 12/23/12 or 12/24/12 per resident preference. A social work progress note dated 12/24/12 indicated a discharge note which read resident status post blood transfusion; had been cleared for discharge and was sent home today. Resident #8 was discharged from the facility on 12/24/12 to home. There was no record of Resident # 8 being provided an approved Notice of Medicare non-coverage letter that notified her in advance of her Medicare services ending; what the estimated cost of services would be and her right to appeal.</p> <p>On 01/31/13 at 12:40 PM the business office manager reported it was not the practice of the facility to issue a letter of Medicare non-coverage to residents who were returning home prior to their Medicare services ending. The business office manager further explained residents were not given this notification because they were going home and non-coverage letters were only given to residents who would be remaining in the facility and had not exhausted their Medicare days.</p> <p>Interview with the Administrator on 01/31/13 at 2:30 PM revealed Resident #8 was being covered under Medicare for skilled nursing services due to a recent blood transfusion. The Administrator added Resident #8 was to be discharged after a follow-up lab which was drawn and reported to the Physician on 12/22/12. The Administrator confirmed the business office manager had not been issuing letters of Medicare non-coverage to residents who were being discharged home and should have issued the letter regardless of discharge location.</p>	F 156		
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F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview the facility failed to honor a resident ' s preference (Resident #76) for morning showers for 1 of 3 residents reviewed for choices. (Resident #76).</p> <p>The findings include:</p> <p>Resident #76 was re-admitted on 12/21/12 with diagnoses of chronic obstructive pulmonary disease (COPD) and asthma. A quarterly Minimum Data Set (MDS) dated 12/27/12 documented Resident #76 with no cognitive impairment; requiring assistance with bathing and able to understand and make self understood.</p> <p>During an interview with Resident #76 on 01/29/13 at 8:22 AM, Resident #76 explained showers were given two times a week and he did not believe that the staff would accommodate a change in shower schedule.</p> <p>Review of the shower schedule revealed Resident # 76's showers were scheduled for 3-11 shift on Wednesday and Saturday. Review of</p>	F 242	<p>Resident # 76's shower times were changed per his preference as of 1/31/13.</p> <p>An audit of all residents shower sheets was completed as of 2/19/13. This audit revealed no other residents were refusing showers due to the shower schedule.</p> <p>All nursing staff were re-educated regarding the resident's right to make choices specific to shower times, days as well as an all staff re-education regarding the residents rights to make choices regarding significant aspects of their lives. This re-education was completed as of 2/19/13 by the Administrator.</p> <p>All newly hired nursing staff will be educated regarding the need to honor the resident's rights to choices at the time of hire as well as Resident Rights.</p> <p>The Resident Care Coordinators or the SDC will audit the shower books for all residents each week to ensure that there are no refusals. Residents who have documented refusals will be interviewed to determine the reason for refusals and to ensure that other times, other staff have been offered per the resident's</p>	2/24/13	

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F 242	<p>Continued From page 6</p> <p>Resident #76's shower log revealed an undated entry which indicated " request that his showers be changed to Wednesday and Saturday mornings starting on Wednesday "; the form was signed by an Nurse Aide (NA) and a Nurse who confirmed notification. Further review of the log indicated shower refusals on 3-11 shift for 01/5/13; 01/9/13; 01/19/13; 01/22/13 and 01/30/13. No shower log could be found for the month of December.</p> <p>During an interview with NA #1 on 01/31/13 at 10:18 AM, NA #1 revealed showers were done two times a week on 7-3 and 3-11 shift as per the shower schedule. NA #1 stated residents could request a change in their shower time or day and that would be reported to the nurse, the nurse then would report it to the resident care coordinator (RCC) who would make the changes to the shower schedule per the resident's preference. NA #1 stated she did showers on 7-3 shift and was not aware of Resident #76 wanting a change in his shower time.</p> <p>Review of the 24 hour reports for the month of December 2012 revealed no request for changes to shower schedule documented. Review of the 24 hour reports from 01/01/2013 through 01/30/2013 revealed on 01/23/2013 a notation was made by Resident #76's name to " please change his showers to AM, refuses 3-11 bath!!! "</p> <p>During an interview with Nurse #2, whose function was RCC, on 01/31/13 at 11:20 AM, Nurse #2 revealed communications regarding residents' desires for changes in shower days or times were indicated on the 24 hour report. Nurse #2 explained she became aware of Resident</p>	F 242	<p>preferences to encourage showers and allow for preferences.</p> <p>The Resident Care Coordinators will report their findings from the weekly audits each month to the QA& A committee beginning in March 2013 and continuing for one year.</p> <p>The Resident Care Director (S.W.) will ascertain during care-plans with each resident his/her choice of shower times and days. The Resident Care Director will also re-distribute copies of the Resident Rights during this care-plan.</p> <p>The Resident Care Director (S.W.) will compile a report monthly for the QA&A committee x one year beginning in March of 2013.</p> <p>The QA&A committee will evaluate the effectiveness of the plan and make changes as necessary.</p>	

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F 242	<p>Continued From page 7</p> <p>#76's desire to change his shower times on 01/24/13 via the 24 hour report but was too busy and did not attempt to communicate with the resident or make any changes to his shower schedule. Nurse #2 confirmed she was responsible for making the necessary changes to the shower schedule per resident request and preference.</p> <p>During an interview with Resident #76 on 01/31/13 at 11:54 AM, Resident #76 stated he had requested a change in his shower time from evenings to mornings sometime in late December but the staff did not follow up with him and he began to refuse his evening showers because he wanted them in the morning. Resident #76 further explained he had requested the change due to his COPD and history of pneumonia and felt in his condition showering at night would be bad for his health.</p> <p>Interview with NA #2 on 01/31/13 at 3:26 PM revealed she reported Resident #76's request for change in shower times and refusals to the nurse as well as documented it on the Resident's shower log, which the shift nurse signed to acknowledge being notified. The NA added she thought the nurse would have taken care of the Resident's request but for the rest of the month when she would offer Resident #76 a shower, he would refuse.</p> <p>Interview with the Director of Nursing (DON) on 01/31/13 at 4:16 PM revealed she would have expected the showers to have been changed per resident preference; the Nurse to have indicated it on the 24 hour report on the day it was requested and the RCC to have follow-up with the</p>	F 242			

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F 242	Continued From page 8	F 242	Resident # 117's environment was	2/28/13	
F 323 SS=D	Resident immediately after being made aware. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to position a fall mat next to the bed and failed to provide a hazard free environment by placing an over bed table and chair on a fall mat for 1 of 3 residents at risk for accidents. (Resident #117). The findings included: Resident #117 was admitted to the facility on 08/18/12 with diagnoses which included difficulty walking, brittle bones, Alzheimer's disease and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/03/13 indicated Resident #117 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #117 required extensive assistance with 2 or more staff for transfers. A review of a care plan that was updated on	F 323 Resident # 117's environment was evaluated on the date of the survey and hazards were removed at that time. An audit of all resident's rooms was completed as of 2/22/13 by the Department Managers assigned to Customer Service Ambassador rounds. At that time, the environment was evaluated for hazards and removed if found. All staff were re-educated regarding the need to maintain an accident/hazard free environment as of 2/19/13 by the Administrator and the DON. All newly hired staff will be educated at the time of hire regarding the importance of maintaining an accident and hazard free environment. Department Managers will audit rooms each week for hazards during the Customer Service Ambassador rounds. Identified hazards will be resolved at the time identified if possible and a report will be made to the appropriate Department Manager and the Administrator.			

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F 323	<p>Continued From page 9</p> <p>11/05/12 indicated Resident #117 had poor balance and had a potential for falls and fall related injuries. The approaches indicated in part to keep the bed in low position for safe transfers with floor mats on each side of the bed at all times.</p> <p>A review of an incident/accident report dated 01/04/13 with a time of 7:15 AM indicated Resident #117 was found on the floor mat next to her bed. The report further indicated the resident was alert but confused and no new fall precautions were implemented.</p> <p>A review of a facility document titled "Interdisciplinary Post-Fall Assessment" dated 01/04/13 indicated the possible cause of the fall was Resident #117 apparently tried to transfer unassisted and sat down on the fall mat beside the bed.</p> <p>During an observation on 01/30/13 at 8:29 AM, Resident #117 was in bed with a fall mat on the floor next to the right (R) and left (L) side of her bed. The fall mat on the (L) side of the bed was located next to the side of the bed but the mat on the (R) side of the bed was not located next to the bed and there was a 10 inch gap where the bare floor was exposed. An over bed table with a large metal base with wheels was sitting on top of the fall mat on the (R) side of the resident's bed and a chair was sitting next to the over bed table with all 4 of its wooden legs on top of the fall mat.</p> <p>During an observation on 01/30/13 at 2:46 PM, Resident #117 was lying in bed and turned on her (R) side. The fall mat on the (L) side of the bed was next to the bed but the fall mat on the (R)</p>	F 323	<p>The Administator will evaluate the findings from the Customer Service Ambassador rounds and report to the QA& A committte monthly x one year beginning in March 2013.</p> <p>The QA& A committee will evaluate the effectiveness of this plan and make changes as necessary.</p>		

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F 323	<p>Continued From page 10</p> <p>side was not next to the bed and the bare floor was exposed. The over bed table and the chair were still sitting on top of the fall mat on the (R) side of the bed.</p> <p>During an interview on 01/30/13 at 3:47 PM, Nurse Aide (NA) #3 stated she had provided care of Resident #117 and the resident was at risk for falls. She further stated the fall mats were supposed to be next to her bed to protect her if she rolled out of bed or fell while trying to get out of bed and the bare floor should not be exposed. She further stated there was not supposed to be anything sitting on the fall mats that might cause an injury to the resident.</p> <p>During an observation on 01/31/13 at 3:11 PM, Resident #117 was lying in bed and was turned to her (R) side. The fall mat on the (L) side of the bed was next to the bed but the fall mat on the (R) side was not next to the bed and the bare floor was exposed. The over bed table and the chair were sitting on top of the fall mat on the (R) side of bed.</p> <p>During an interview on 01/31/13 at 3:17 PM, Nurse #4 stated she was Resident #117's nurse. She confirmed the over bed table and the chair were sitting on top of the fall mat on the (R) side of the resident's bed and the fall mat was pushed away from the side of the bed with the bare floor exposed. She stated the fall mat should have been placed next to the resident's bed without the bare floor exposed so that if Resident #117 fell out of bed she would fall on the mat and not the floor. She also stated the chair and over bed table should not have been placed on top of the fall mat.</p>	F 323			

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F 323	Continued From page 11 During an interview on 01/31/13 at 3:29 PM, the Director of Nursing (DON) stated it was her expectation for fall mats to be placed next to Resident #117's bed on both sides and the floor should not be exposed. She further stated it was her expectation for staff to keep resident's safe and they should not put furniture or equipment on the fall mats that could cause a potential injury to the resident.	F 323			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer Senna (laxative) 2 tablets twice daily for the months of April, May, June, July and October 2012 and January 2013 for 1 of 10 residents reviewed for unnecessary medications. (Resident #74) Resident #74 was re-admitted to the facility on 02/25/2011 with diagnoses of hypertension, rheumatoid arthritis and constipation. A physician order dated 01/05/12 indicated to increase Senna-S to 2 tablets orally twice a day (BID). A review of Resident #74's Medication administration record (MAR) from January 2012 to January 2013 revealed Senna plus 2 tablets by mouth twice daily for constipation was only	F 333	Resident # 74's order for Senna 2 tablets twice daily has been corrected on the Medication Administration Record and resident is receiving per physician's order. An audit of MARS was completed by the Administrative nurses as of 2/1/13. The audit included looking at original physicians orders and correcting the MAR as needed. All nurses were re-educated as of 2/19/13 by the DON regarding the importance of the MAR checks and the importance of verifying the order if there is a change in a medication on the MAR.	2/28/13	

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F 333	<p>Continued From page 12</p> <p>administered at 9 PM for the months of April, May, June, July and October of 2012 and for the month of January 2013. A review of the Physician's order sheets from February 2012 to January 2013 revealed the order for Senna plus to take 2 tablets by mouth twice daily for constipation, had only 9 PM as the pre-printed timeframe.</p> <p>A review of Resident #74's bowel record for October 2012 and January 2013 indicated bowel movements daily or every other day. A review of the MARs from February 2012 to January 2013 revealed the physician's standing order for milk of magnesia (MOM) 30 cubic centimeters (cc) orally every day as needed for constipation for 2 days was not initiated.</p> <p>During an interview with Nurse #3 on 1/30/13 at 11:59 AM, Nurse # 3 explained the MAR conversion is done by the administrative nurses. She added the 1st and 2nd checks were completed by the supervisory nurses and the 3rd shift nurse was responsible for placing the MAR in the medication administration book. Nurse #3 also added that the nurses passing the medication were the 3rd set of eyes to ensure the medications on the MAR were correct. After reviewing the MAR for Resident #74 with Nurse #3 at 2:49 PM Nurse #3 stated she was not aware Resident #74 should have been receiving a 9 AM dose of Senna plus 2 tablets. She added she must have overlooked it because she typically looked at the medication, the pre-printed time on the MAR and did not read the entire order.</p> <p>Interview with the MDS nurse on 01/30/13 at 3:03</p>	F 333	<p>All newly hired nurses will be educated about the importance of the Medication Administration Record change-over and the importance of verifying the order if there is a change in a medication on the MAR.</p> <p>The Director of Nurses or the Staff Development Coordinator will audit three charts weekly for medication errors.</p> <p>The Director of Nurses or the Staff Development Coordinator will report monthly to the QA& A committee beginning in March 2013 for one year.</p> <p>The QA&A committee will evaluate the effectiveness of the plan and make changes as necessary.</p>		

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F 333	Continued From page 13 PM, the MDS nurse explained she was responsible for the initial check of Resident # 74's MAR and did not notice the Senna was ordered BID. Interview with Nurse #4 on 01/30/13 at 3:19 PM revealed she was responsible for the 2nd check of Resident #74's MAR and did not notice that the Senna was missing the AM dose time. She added she usually read the order and if the time was not pre-printed on the MAR by pharmacy she would enter the times onto the MAR but she must have missed the Senna. During an interview with the Director of Nursing (DON) on 01/30/13 at 5:46 PM, the DON stated she expected the nurses to read the orders and she would have expected either the nurse who did the 1st check or the 2nd check to have caught the mistake and faxed it to the pharmacy so the MAR could have been corrected.	F 333			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff the facility failed to prepare frozen collard greens and frozen carrot coins to conserve nutritional value. The findings include:	F 364	All residents had the potential to be affected by the alleged deficient practice. All dietary cooks as well as the Dietary Manager and the Assistant Dietary Manager were re-educated as of 2/15/13 regarding the importance of maintaining the nutritive value/ appearance of foods. In particular cook times and amounts of liquids.	2/28/13	

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F 364	<p>Continued From page 14</p> <p>During the initial kitchen observation on 1/28/13 at 9:45 AM, review of the menu revealed glazed carrots would be served for the lunch meal. The stove top was observed with a large pot filled approximately half full of carrot coins and approximately three-fourths full of water. The temperature was set to medium/high heat and the water and carrots were rapidly boiling. Dietary staff #1 stated during the observation that she started preparing the vegetables that morning for the lunch meal between 8:30 - 9:00 AM. Dietary staff #1 further stated that she would place the carrots on the steam table around 11:00 AM and begin serving lunch around 11:30 AM.</p> <p>During an observation of restorative dining on 1/28/13 at 11:44 AM residents who received a mechanical soft or regular diet received glazed carrots served as broken carrot pieces.</p> <p>On 1/31/13 review of the lunch menu revealed collard greens would be served for lunch. A continuous observation from 7:16 AM to 7:48 AM revealed a large pot three-fourths filled with water and frozen collard greens was observed with the temperature set to high heat. The water and some of the collard greens were boiling rapidly while approximately six large blocks of collards greens were still frozen. At 7:48 AM approximately four large blocks of collard greens were frozen while the remaining collard greens were boiling rapidly in the water.</p> <p>The lunch meal tray line was observed on 1/31/13 at 11:40 AM. Collard greens were observed on the tray line with a dark green color and mushy texture. During an interview on 1/31/13 at 11:45</p>	F 364	<p>All newly hired dietary cooks will be educated at the time of hire on the importance of maintaining the nutritive value/appearance of foods. In particular cook times and amount of liquids.</p> <p>The Dietary Manager will audit cook times as well as the amounts of liquid used in cooking for one meal per day to include a minimum of one breakfast, one lunch and one dinner per week for one month, then monthly x one year.</p> <p>The Dietary Manager will report to the QA&A committee monthly x one year the findings of the audits.</p> <p>The QA&A committee will evaluate the plan for effectiveness.</p>	

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F 364	<p>Continued From page 15</p> <p>AM, dietary staff #2 stated that she started cooking the frozen collard greens that morning at 7:00 AM for the lunch meal. Dietary staff #2 stated she placed seven packages of frozen collard greens in a large pot of water, seasoned them according to the recipe and cooked the collard greens on high heat until 10:45 AM. Dietary staff #2 stated she allowed the collard greens to boil continuously so that the vegetables would be tender. Dietary staff #2 stated she was not sure how long it took for the collard greens to become tender; she just left them boiling on the stove until she set up the lunch tray line around 11:00 AM. Dietary staff #2 stated that "a while ago" residents complained that greens were not cooked and they wanted greens cooked longer, so since then she cooked frozen collards for a long time so that the vegetables would be soft.</p> <p>Review of the facility's recipes revealed frozen carrot coins and frozen collard greens were to be cooked until tender and then held at 140 degrees Fahrenheit or higher until service.</p> <p>An interview with the food service director (FSD) on 1/31/13 at 12:10 PM revealed she had not monitored the start time of meal preparation for the lunch meal. The FSD stated she checked to ensure the cooks had all the items needed to prepare each meal and then started her clinical responsibilities. The FSD stated that the time necessary to cook foods varied and depended on how much food needed to be cooked. The FSD stated that rather than cooking all the frozen vegetables in one pot, staff should separate them into smaller portions in order to reduce the cooking time and preserve the nutritional value. The FSD stated she was not aware that staff</p>	F 364			

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F 364	Continued From page 16 started cooking frozen vegetables before the breakfast tray line and did not think it would be necessary to do so in order for the vegetables to be tender.	F 364			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to complete admission assessment documents in the medical record for 1 of 3 newly admitted residents. (Resident #142). The findings included: Resident #142 was admitted to facility on 01/24/13 with diagnoses which included difficulty with walking, Alzheimer's disease, dementia and a stroke. There was no Minimum Data Set (MDS) available but a nurse's progress note dated 01/26/13	F 514	Resident # 142's chart was audited to ensure that all assessments were complete as well as appropriate for this resident as of 2/19/13. An audit of all newly admitted residents was completed as of 2/19/13 by Administrative nurses to ensure that all appropriate forms were completed upon admission. All nurses were re-educated as of 2/19/13 regarding the importance of completing all forms. All nurse's were re-educated regarding the need to eliminate unnecessary forms if not relevant to a specific resident by the Director of Nurses and the Resident Care Coordinator. All newly hired nurses will be educated regarding the importance of completing all forms. New hires will also be educated regarding the need to eliminate unnecessary forms if not relevant to a specific resident.	2/28/13	

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F 514	<p>Continued From page 17</p> <p>indicated Resident #142 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The nurse's progress notes further indicated Resident #142 required extensive assistance by staff for transfers and activities of daily living.</p> <p>A review of a facility document titled "Braden Scale - For Predicting Pressure Sore Risk" and dated 01/24/13 indicated to evaluate the resident's risk factors to determine the resident's risk for pressure sores. The document indicated Resident #142's risk factors included the following:</p> <p>Sensory Perception - (slightly limited) with a numerical score of 3 to indicate the resident responded to verbal commands but could not always communicate discomfort or the need to be turned or limited ability to feel pain or discomfort in 1 or 2 extremities.</p> <p>Moisture - (occasionally moist) with a numerical score of 3 to indicate the resident's skin was occasionally moist, and required an extra linen change at least once a day.</p> <p>Activity - (Chair Fast) with a numerical score of 2 to indicate the resident's ability to walk was severely limited, could not bear weight and/or must be assisted into chair or wheelchair).</p> <p>Mobility - (slightly limited) with a numerical score of 3 to indicate the resident made slight changes in body or extremity position independently.</p> <p>Nutrition - did not indicate an answer and had no numerical score.</p> <p>Friction and Shear - (potential problem) with a numerical score of 2 to indicate the resident moved feebly or required minimum assistance and during a move the resident's skin slid to some extent against sheets, chair or other</p>	F 514	<p>At the time of admission all newly admitted residents charts will be audited by the DON, The Weekend Supervisor, MDS or the RCC to ensure that all assessments have been completed and are appropriate for the resident.</p> <p>The Director of Nurses will perform two audits per week of newly admitted residents charts and report to the QA&A committee monthly x one year.</p> <p>The QA &A committee will evaluate the audits and reports to determine the effectiveness of the plan and make changes as needed.</p>		

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F 514	<p>Continued From page 18 devices.</p> <p>A section at the bottom of the document indicated a total score of 12 or less represented high risk for pressure sores but there was no total score documented.</p> <p>A review of a facility document titled Physical Restraint Elimination Assessment dated 01/24/13 revealed a section labeled "instructions" and indicated for each category listed below, assess the resident by circling the corresponding score(s) that best describe his/her current status in the appropriate assessment column. Add the column of numbers to obtain the total score. There were 2 sections of the form titled Activity Participation and Medication Therapy that had not been completed. At the bottom of the form the document indicated to "record total score here" but there was no total score on the bottom of the form.</p> <p>During an interview on 01/31/13 at 8:35 AM, Nurse #5 stated it was her understanding that admission assessments should be completed with all of the questions on the forms answered within 24 hours after a resident was admitted.</p> <p>During an interview on 01/31/13 at 9:29 AM, Nurse #6 stated it was her understanding that nurses were expected to complete all questions, spaces and boxes on the assessment forms. She explained the forms such as the Braden Scale and the Physical Restraint Elimination Assessment forms should have the scoring documented with the total score at the bottom so staff would know what care to provide the resident.</p>	F 514			

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F 514	<p>Continued From page 19</p> <p>During an interview on 1/31/13 at 10:43 AM the Director of Nursing (DON) she stated it was her expectation that if a nurse completed part of an admission assessment form then they should complete all of it.</p> <p>During a follow up interview on 1/31/13 at 3:45 PM she stated it was her expectation that admission assessment documents in the medical record should be completed fully and there should be no blank spaces on the documents.</p>	F 514		
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