

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/15/2012
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NAME OF PROVIDER OR SUPPLIER  MOUNT VERNON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: May 7-11, 14, 15, 2012</p> <p>Facility number: 000234 Provider number: 155342 AIM number: 100273490</p> <p>Survey team: Diane Hancock, RN, TC Amy Wininger, RN Barbara Fowler, RN Vickie Ellis, RN Jodi Meyer, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 57 Total: 64</p> <p>Census payor type: Medicare: 8 Medicaid: 46 Other: 10 Total: 64</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/23/12 by Suzanne</p>	F0000	<p>The preparation and/or execution of this plan of correction does not constitute agreement or admission by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	Williams, RN			

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F0156 SS=C	<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>						

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	<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</p>			

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	<p>individual's option, formulate an advance directive. This 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>Based on observation, interview and record review, the facility failed to ensure toll free phone numbers were available to contact the state agency, and failed to ensure 2 of 2 residents interviewed regarding location of contact information were knowledgeable of where to find information. This deficient practice had the potential to affect all 64 residents residing in the facility. (Residents #54, #57)</p> <p>Findings include:</p> <p>1. In an interview on 05/10/12 at 3 p.m. with Resident #54 (the resident council president), the resident council president indicated no knowledge of the ability to contact the Indiana State Department of Health in</p>	F0156	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to provide all residents toll free numbers to include 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. This alleged deficit practice has the potential to affect all residents. There was no negative outcome. Toll free numbers have been added to the current listing of State client advocacy groups and the posting will remain in the lobby as well as posted at the residents' phone in the main dining room. Resident Council president, vice president and participating residents will be in-serviced on contacting the ISDH regarding a complaint involving the facility. Information</p>	06/15/2012

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	<p>the event of a complaint involving the facility.</p> <p>2. In an interview on 05/10/12 at 3:45 p.m. with Resident #57 (the resident council vice-president), the resident council vice-president indicated no knowledge of the ability to contact the Indiana Department of Health regarding a complaint involving the facility</p> <p>3. In an interview on 05/10/12 at 3:55 p.m. with the Social Worker, she indicated she did not know if the residents of the facility had been educated about notifying the state in the event of a complaint, because the Activity Director, who assisted with the resident council meetings, was no longer employed at the facility.</p> <p>4. An observation was made on 05/10/12 at 3:50 p.m. of the facility postings of the state complaint phone numbers along with the Ombudsman phone numbers in the entryway of the facility. The phone numbers did not include the toll free stage agency complaint line phone number.</p> <p>5. On 5/11/12 at 9:30 a.m., an interview with the Administrator indicated the admission packet contained the resident's right to make</p>		<p>will be provided at each council meeting to further communicate the posting and toll free number. The toll free numbers were added to the current information included in the admission packet. Resident Council minutes will be reviewed by the QA committee monthly for 6 months to assure compliance.</p>				

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	<p>a complaint to the state and have an advocate represent the resident.</p> <p>6. A review of an admission packet, provided by the Administrator on 5/11/12 at 9:00 a.m., indicated the residents had been given resident rights on admission, which included a statement indicating the residents had the right to contact the state in the event of a complaint involving the facility. Not included in this statement was the phone number to call.</p> <p>7. A review on 05/12/12 at 11:30 a.m. of the resident council minutes, provided by the Assistant Activity Director, indicated no education of the right to contact the state or the ombudsman in the event of a complaint involving the facility.</p> <p>8. On 5/11/12 9:20 a.m. during a tour of general environment, no statement that a resident may file a complaint with the survey agency was observed. The toll free state complaint number was not posted, only a toll number was posted at the front of the building.</p> <p>3.1-4(j)(3)</p>						

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, the facility failed to ensure the residents were served their meals in a manner to enhance their dignity and/or individuality during 2 of 2 meals observed (5/7/12 lunch, 5/10/12 breakfast). Eight (8) of 8 residents observed needing assistance with eating were observed to wait with food in front of them when staff weren't available to feed them and/or were observed to be fed by staff standing above them and/or were left to sleep for several minutes while food sat in front of them. (Residents #18, #34, #26, #13, #21, #28, #10, #59)</p> <p>Findings include:</p> <p>1. Lunch was observed on May 7, 2012 in the Main Dining room. Resident #18's lunch tray was served at 12:15 p.m. The resident's table mate was being fed by a family member at that time. The cover of the food was not removed and/or opened until 12:21 p.m. The Director</p>	F0241	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to ensure the residents are served their meals in a manner to enhance their dignity and/or individuality. Residents #'s 18, 34, 26, 13, 21, 28, 10 and 59 were affected. There were no negative psychosocial effects. The dining room seating has been assessed and modifications have been implemented to promote dignity and respect for residents during mealtimes. Residents requiring assistance with meals have been offered seating to enhance staff assistance and individual preferences. Department Leaders have been in-serviced on "All Hands Dining" approach and schedules revised to better accomodate residents' needs. DON/designee will observe random meal 5x's per week for 4 weeks; 2x's per week for 4 weeks; and, random meals as indicated for 6 months. Observation reviews will be presented monthly to the QA committee with updates as indicated and forwarded for 6 months.</p>	06/15/2012

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	<p>of Nurses [DoN] set up the tray, gave the resident one spoon full of food, standing over her. The DoN then turned to Resident #34 at an adjacent table, set up her tray, gave her one bite of food; Resident #18 grunted/moaned. A second spoon full was given by the DoN to Resident #18, then the DoN returned to Resident #34. The Assistant Director of Nurses [ADON] sat down with the resident and began feeding Resident #18 at 12:23 p.m.</p> <p>On May 7, 2012 at 12:13 p.m., Resident #26 had her lunch tray placed in front of her; the food was not uncovered until 12:21 p.m. A CNA began feeding the resident at that time.</p> <p>2. On 5/10/12 at 7:20 a.m., the main dining room was delivered the breakfast meal and trays were passed to the residents. Three staff members were observed to be in the main dining room to feed residents. Resident #13, Resident #21, Resident #26 , and Resident #28 were observed to be sitting at their tables, plates in front of them on their tables, waiting to be fed.</p> <p>At 7:25 a.m., Resident #10 and Resident #59 were observed to be sleeping in their chairs at the main</p>			

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	<p>dining room tables with their plates uncovered. No attempts were made by staff to wake the residents, who were sleeping.</p> <p>At 7:35 a.m. on 5/10/12, Resident #10 and Resident #59 continued to be asleep in their chairs at their dining room tables with their plates uncovered in front of them. On 5/10/12 at 7:35 a.m., Resident #10 was awakened by staff to eat, and at 7:37 a.m., Resident #59 was awakened by staff to eat.</p> <p>3.1-3(t)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure social services were provided to 2 of 3 residents reviewed for behaviors, in a sample of 11 residents who met the criteria for behaviors and/or pain, in that residents exhibiting resistance to care, physical and verbal abusive behaviors towards staff, and potential signs and symptoms of pain were not thoroughly assessed and interventions were not evaluated for their effectiveness to determine if new interventions needed attempted. (Residents #72, #21)</p> <p>Findings include:</p> <p>1. Resident #72 was observed crying for her son and saying his name on 5/7/12 at 12:39 p.m. LPN #1 told Resident #72 her son was at work. Resident #72 continued to cry for her son. CNA #1 tried to comfort the resident and offered the resident a drink. Resident #72 refused. Resident #72 stopped crying for a minute and then resumed crying for</p>	F0250	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. Residents #'s 72 and 21 of the survey sample have been assessed to identify any new on-set behaviors and to assure that current identified behaviors are care planned with effective interventions. Social Service Director will review the Mood and Behavior policy and provide re-education to all staff related to documentation and reporting behaviors and effectiveness of intervention. SSD will complete a one time, 100% medical record review of all residents to identify those with aggressive or inappropriate behaviors to assure that interventions currently in place are appropriate to the identified resident. Ineffective interventions or new on-set behaviors that have the potential to affect the psychosocial well being of other residents will be referred to the attending MD and/or Psychiatric services for review and assessment. SSD will complete a one time interview of</p>	06/15/2012			

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	<p>her son stating his name repeatedly. LPN #1 stood nearby and appeared to not pay attention to the resident. No pain assessment or intervention was observed.</p> <p>An observation was made continuously on 05/09/12 from 1:55 p.m. until 3:00 p.m., of Resident #72 in her room, lying in bed squirming and grabbing at anything in reach. Resident #72 was moaning her son's name repeatedly. The Assistant Director of Nursing [ADoN] was observed in the room trying to redirect Resident #72 by offering a back rub, food, and drink to Resident #72. Resident #72 was saying "ouch" repeatedly. The ADoN asked RN #1 to check on pain medication for Resident #72. CNA #4 asked Resident #72 if she wished to get up and get cleaned up. Resident #72 agreed, but continued to moan son's name and say "ouch" repeatedly. Resident #72 smacked at CNA #4, and CNA #4 tried to redirect Resident #72 by asking her if she wanted to use the restroom. Resident #72 indicated the need to use the restroom. Resident #72 indicated her finger hurt and was pulling on the covers while sitting on the side of the bed. Resident #72 stated, "don't hurt me" and "please." Resident #72</p>		<p>all staff to assure they can identify inappropriate behaviors. SSD will communicate behavioral interventions to staff initially and as required and maintained via CNA assignment sheets. SSD will monitor behavior tracking reports 5 days per week as indicated. SSD will provide behavior tracking reports from Caretracker for review by the Clinical Team, 5 days per week for 4 weeks; 2 days per week or 4 weeks and as indicated thereafter. Information will be presented to the QA committee monthly, for 6 months, for review with updates as indicated.</p>	

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	<p>indicated her stomach hurt. RN#1 redirected Resident #72 to use the restroom and tried to give Resident #72 pain medication. Resident #72 refused pain medication. Resident #72 was assisted to the restroom by RN#1 and CNA #4. Resident #72 continued to say son's name and stated "my god my god my god." RN #2 and RN#1 assisted Resident #72 to her wheelchair. Resident #72 continued saying son's name repeatedly. Resident #72 cried and RN #2 wiped tears from the resident's eyes. Resident # 72 said "ouch ouch" when her tears were being wiped. RN#2 redirected the resident to her pain medication and Resident #72 took the pain medication. Resident #72 was redirected by RN #2 to look out the window and Resident #72 calmed down and no longer was crying or saying son's name.</p> <p>Resident #72 was observed refusing pain medications administered by RN#1, on 5/10/12 at 9:30 a.m. The resident was in her room crying and saying "no no" and repeating her son's name over and over. RN #1 tried to redirect the resident, asking if she would like a milkshake.</p> <p>Resident #72's clinical record was reviewed on 5/10/12 at 8:30 a.m. The</p>			

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	<p>Minimum Data Set Assessment [MDS] indicated Resident #72 had a Brief Interview for Mental Status [BIMS] score of 2 out of 15, indicating severe impairment.</p> <p>Resident #72 had diagnoses including, but not limited to, chronic abdominal pain, anxiety, dementia with severe Alzheimer's, and depression.</p> <p>A target behavior documentation sheet, dated from 04/01/12 until 05/10/12, indicated Resident #72 had no behaviors between 05/07/12 through 05/10/12.</p> <p>A social service note, dated 4/18/12, indicated Resident #27 had daily wandering but no other behaviors were noted in the social service note.</p> <p>A current care plan, initiated on 10/31/11 and reviewed on 4/18/12, indicated an intervention to report to provider signs and symptoms of distress or pain unrelieved by ordered treatments and to identify precipitating factors of pain such as yelling out "ouch" or son's name or "awful awful."</p> <p>In an interview with the Social Worker on 5/10/12 at 10:00 a.m., she</p>			

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	<p>indicated the interventions for Resident #72's behaviors were to distract with the picture of fish on the television or rub Resident #72's feet. She further indicated Resident #72 did not participate in group activities. Resident #72's activities consisted of 1 to 1 staff and patient interaction. Other interventions for behavior consisted of medicating the resident for pain. She indicated Resident #72's son was resistant to giving Resident #72 Roxanol [narcotic pain medication] prescribed by the doctor. The Social Worker indicated a psychiatrist was involved in Resident #72's care.</p> <p>In an interview on 5/10/12 at 09:45 a.m. with RN #1, she indicated interventions for Resident #72 crying and saying son's name over and over were to redirect offering milkshakes or snacks, telling her her son was at work, 1 on 1 attention, folding towels and medicating for pain.</p> <p>In an interview on 5/10/12 at 10:40 a.m. with CNA #6, she indicated Resident #72's behaviors of moaning and yelling son's name started upon awakening in the morning and happened at any time of day or night.</p> <p>In an interview on 5/10/12 at 2:30</p>				

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	<p>p.m. with the Assistant Director of Nurses [ADoN], she indicated the son was the problem with treatment; he did not want them to use the stronger pain medicine. The medications were the facility's intervention for pain. The ADoN was not sure what triggered the Resident's behaviors of moaning, crying, and repeating son's name and the behaviors could happen at any time during the day. The ADoN indicated the CNAs were responsible for documenting behaviors on the behavior log, and they had not done so.</p> <p>2. Resident #21's clinical record was reviewed on 5/9/12 at 3:45 p.m. Diagnoses included, but were not limited to, mental debility, coronary artery disease, Parkinson's disease, CVA [cerebral vascular accident, stroke] with right hemiplegia, dysphagia, IDDM [insulin dependent diabetes mellitus], PVD [peripheral vascular disease], osteoarthritis, bipolar disease, affective disorder, renal failure, and shared psychotic disorder.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 2/2/12, indicated communication problems, mood issues, and the use of an antianxiety medication and antidepressant.</p>				

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	<p>The resident's care plan, reviewed by the facility on 2/12/12, included, but was not limited to, the following: A care plan for psychotropic drug use, Wellbutrin [antidepressant], Ativan [antianxiety medication] as ordered, monitor for side effects, monitor for drug related cognitive/behavioral impairment, monitor for drug-related discomfort.</p> <p>The care plan for behavioral symptoms, including yelling at staff, hitting staff during care, and being resistive to care, initiated 11/9/10 and reviewed 2/12/12, included the following interventions: "1) Give resident 5-15 min. [minutes] to calm then reapproach in friendly manner. 2) Explain care to be given and reason. 3) Have another staff member attempt if needed. 4) Attempt to engage in friendly conversation. 5) Alert MD if refusal of care becomes health concern."</p> <p>The care plan for psychosocial well-being - mood state, initiated 2/6/11 and reviewed 2/12/12, included the following interventions: "1) Ask resident to express feelings/concerns, if she feels tired/restless/having trouble with anything. 2) Assist as needed, addressing concerns/report as needed. 3) Offer TLC [tender loving</p>			

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	<p>care]/comfort/reassurance/options for activities, offers of repositioning, toilet, drink, etc. 4) Engage in friendly conversation about grandchild, pictures in room. 5) Report changes in mood."</p> <p>On 5/10/12 at 9:25 a.m., CNAs #7 and #1 were observed to turn Resident #21. The resident was resistive and angry, fighting the staff. The CNAs attempted to calm the resident.</p> <p>Review of the Behavior Symptoms Detail Report, provided by the Social Service Director on 5/11/12 at 11:15 a.m., included, but was not limited to, the following:</p> <p>4/17/12 11:33 a.m. Verbally Abusive 4/17/12 11:33 a.m. 1 to 1 4/17/12 11:33 a.m. Was 1 to 1 effective for verbal abuse? No 4/17/12 11:33 a.m. Redirection 4/17/12 11:33 a.m. Was redirection effective for verbal abuse? No 4/17/12 11:33 a.m. Toileted 4/17/12 11:33 a.m. Was toileting effective for verbal abuse? No 4/17/12 11:33 a.m. Physically Abusive 4/17/12 11:33 a.m. 1 to 1 4/17/12 11:33 a.m. Was 1 to 1 effective for physical abuse? No 4/17/12 11:33 a.m. Redirection</p>			

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	<p>4/17/12 11:33 a.m. Was redirection effective for physical abuse? No</p> <p>4/17/12 11:33 a.m. Toileted</p> <p>4/17/12 11:33 a.m. Was toileting effective for physical abuse? No</p> <p>4/17/12 11:33 a.m. Resists/Rejects care</p> <p>4/17/12 11:33 a.m. 1 to 1</p> <p>4/17/12 11:33 a.m. Was 1 to 1 effective for resisting care? No</p> <p>4/17/12 11:33 a.m. Redirection</p> <p>4/17/12 11:33 a.m. Was redirection effective for resisting care? No</p> <p>4/17/12 11:33 a.m. Toileted</p> <p>4/17/12 11:33 a.m. Was toileting effective for resisting care? No</p> <p>The behavior record indicated the resident had the same behaviors on 4/20/12 at 10:53 a.m., 4/23/12 at 12:48 a.m., 4/24/12 at 5:04 a.m., 4/25/12 at 3:50 a.m., and 4/26/12 at 8:59 a.m. It indicated all interventions were ineffective.</p> <p>In an interview with the Social Service Designee on 5/11/12 at 10:30 a.m., she indicated she reviewed the resident's psychoactive medications and behaviors in her quarterly assessments.</p> <p>Social Service Progress Notes, dated 2/12/12 were reviewed, on 5/11/12 at 10:35 a.m. and included, but were not</p>						

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	<p>limited to, the following: A behavior report, from 2/6 through 2/12/12, indicating the resident resisted care twice during that time and had verbal symptoms directed toward others. There was no evaluation of interventions to determine effectiveness. The progress note indicated the care plan was reviewed, a list of diagnoses, a list of psychopharmacologic medications, and target behaviors. There was no indication the interventions were reviewed for their success or failure.</p> <p>3. The Social Services Director Position, dated 8/7/2006, was provided by the Director of Nurses on 5/14/12 at 1:40 p.m. The essential functions included, but were not limited to, the following: "Coordinates behavior management programs with the assistance of other departments." "Assesses the social, emotional, and spiritual needs of the residents/patients and ensures that the social services intervention is a part of the resident's/patient's Plan of Care. Ensures that required social services interventions, as identified in each resident/patient Plan of Care are provided either directly through the department or through outside</p>				

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	<p>referrals."</p> <p>4. The policy and procedure for Behavior Review, dated October 2005 with revisions January 2008 and October 2008, was provided by the Director of Nurses on 5/14/12 at 1:40 p.m. The policy and procedure included, but was not limited to, the following: "Discuss with the nursing assistants and determine effectiveness of current interventions and medications." "Rule out possible causes of behavior symptoms such as: pain, medical illness, other residents, other treatable/preventable causes e.g., change in routine." "Communicate target behavior using the Care Tracker Resident Centered Program for Target Behavior/Target Mood and the appropriate Plan of Care." "Note ineffective interventions for a target behavior using Care Tracker Mood and Behavior Section." "If new interventions are tried and effective, report interventions to the nurse for additions to the appropriate Plan of Care and Care Delivery Guide." "Address ineffective behavior interventions at the next Daily Clinical review meeting."</p>						

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	3.1-34(a)				

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F0253 SS=B	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and orderly interior, for 5 of 32 resident rooms reviewed, potentially affecting 10 residents who resided in the rooms, in that resident equipment was soiled and/or loose, and floors were soiled. (Rooms #154, #111, #109, #135 and Resident #25's room)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Resident #25's bathroom was observed on 5/8/11 at 9:00 a.m. The grab bar to the right of the toilet was loose. The bar was wrapped in ace type wrap which was soiled with dried spills. The resident's wheelchair was observed, at that time, to be soiled with dry spills. Resident #25 indicated, during interview, she used the grab bar when she went to the bathroom.</li> <li>Room #154 was observed on 5/7/12 at 1:01 p.m. The knee wedge positioning device was soiled with dried spills.</li> </ol>	F0253	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to provide housekeeping and maintenance services to maintain sanitary and orderly interior for the residents. Rooms 154, 111, 109, 135, and 105 were identified. The grab bar in room 105 was replaced on 5/8/12. The sink in room 111 was secured and re-caulked 5/10/12. The knee wedge positioning device in room 154 was cleaned on 5/15/12. The baseboards and floor in the bathroom of room 135 was deep cleaned on 5/16/12. The bed rails were cleaned on 5/11/12 in room 109. The nursing staff will be re-educate on the wheelchair cleaning schedule and prn cleaning of wheelchairs and other resident equipment. ADM and Maintenance Director will conduct a 100% rounds audit of all resident bathrooms and subsequent deep cleaning of bathrooms. ADM and Maintenance Director will complete rounds to review all sinks. Administrator will provide a random monitor of the resident rooms and bathrooms during daily rounds. Housekeeping Manager and Maintenance Director will monitor the</p>	06/15/2012

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	<p>3. Room # 109 was observed on 5/8/12 at 9:54 a.m. The bed rails on bed one were soiled with dried spills.</p> <p>4. Room #135 was observed on 5/8/12 at 9:46 a.m. The bathroom floor was soiled at the edges and corners with a build-up of grayish material.</p> <p>5. Room #111 was observed on 5/8/12 at 1:30 p.m. The bathroom sink was pulled away from the wall with a 1/2 inch gap.</p> <p>3.1-19(f)</p>		<p>cleanliness and upkeep of the environment through walking rounds. Housekeepers will complete room cleaning checklist daily. Daily deep cleaning schedule is communicated in morning meeting for department leaders. The resulting information, monitored 5 days x 4 weeks; then, 2 days for 4 weeks, will be presented to the QA committee monthly, and forwarded for 6 months, for review and recommendations as indicated.</p>	

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; 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 through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were comprehensively assessed in regards to pain, behaviors, and dental status, for 2 of 44 residents reviewed for comprehensive assessments in a</p>	F0272	It is the policy of Mt. Vernon Nursing and Rehab Center to ensure residents are comprehensively assessed in regards to pain, behaviors and dental status. A one time 100% medical record review was conducted to identify residents with ineffective pain management	06/15/2012

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	<p>stage 2 sample of 44, in that a resident was without teeth and the comprehensive assessment indicated the resident had no concerns with dental status, and a resident had problems with pain, cognitive status, and behaviors, and these were not comprehensively assessed. (Residents #51, #72)</p> <p>Findings include:</p> <p>1. Resident #72's clinical record was reviewed on 5/10/12 at 8:30 a.m. The Minimum Data Set [MDS] assessment, dated 4/18/12, indicated Resident #72 had behaviors of inattention and disorganized thinking coded as moderately impaired, acute onset of mental change was coded as no, behaviors directed toward others was coded for 1-3 days a week, and rejection of care was coded as not exhibited. The Minimum Data Set Assessment [MDS] indicated Resident #72 had a Brief Interview for Mental Status [BIMS] score of 2 out of 15.</p> <p>Resident #72 had diagnoses including, but not limited to, chronic abdominal pain, anxiety, dementia with severe Alzheimer's, and depression.</p>		<p>and condition changes requiring further assessment, to include dental and behavior status. Re-education will be provided by DON to licensed personnel of policy regarding episodic documentation and pain management. Re-education for department leaders will be provided on completion of comprehensive assessments in regards to pain, behavior patterns and dental status. SSD and Clinical Reimbursement Coordinator will review and coordinate individual assessments prior to completion of the MDS to assure accurate functional capacity. The SSD and CRC will monitor episodic charting and pain intervention flow sheets 5x's weekly for 4 weeks; 3x's weekly for 4 weeks and weekly thereafter. Results of the audits will be presented to the QA committee monthly, and forwarded for 6 months, for review and recommendations as indicated.</p>		

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	<p>Resident #72 was observed, on 5/7/12 at 12:39 p.m., crying for her son and saying his name. LPN #1 told Resident #72 her son was at work. Resident #72 continued to cry for her son. CNA #1 attempted to comfort the resident and offered the resident a drink. Resident #72 refused. Resident #72 stopped crying for a minute and then resumed crying for son stating his name repeatedly. LPN #1 stood nearby and appeared not to pay any attention to Resident #72. No pain assessment or intervention was observed.</p> <p>An observation was made of Resident #72 continuously on 05/09/12 from 1:55 p.m. until 3:00 p.m. Resident #72 was in her room lying in bed squirming and grabbing at anything in reach. Resident #72 was moaning son's name repeatedly. The Assistant Director of Nursing [ADoN] was observed in the room trying to redirect Resident #72 by offering a back rub, food, and drink to Resident #72. Resident #72 was saying "ouch" repeatedly. The ADoN asked RN #1 to check on pain medication for Resident #72. CNA #4 asked Resident #72 if she wished to get up and get cleaned up. Resident #72 agreed, but continued to moan son's name and say "ouch" repeatedly.</p>			

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	<p>Resident #72 smacked at CNA #4, and CNA #4 tried to redirect Resident #72 by asking her if she wanted to use the restroom. Resident #72 indicated the need to use the restroom. Resident #72 indicated her finger hurt and was pulling on the covers while sitting on the side of the bed. Resident #72 stated, "don't hurt me" and "please." Resident #72 indicated her stomach hurt. RN #1 redirected Resident #72 to use the restroom and tried to give Resident #72 pain medication. Resident #72 refused pain medication. Resident #72 was assisted to the restroom by RN#1 and CNA #4. Resident #72 continued to say son's name and stated, "my god my god my god." RN #2 and RN#1 assisted Resident #72 to her wheelchair. Resident #72 continued saying son's name repeatedly. Resident #72 cried and RN #2 wiped tears from the resident's eyes. Resident # 72 said "ouch ouch" when her tears were being wiped. RN #2 redirected the resident to her pain medication and Resident #72 took the pain medication. Resident #72 was redirected by RN #2 to look out the window and Resident #72 calmed down and no longer was crying or saying son's name.</p> <p>An observation was made on 5/10/12</p>			

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	<p>at 09:30 a.m., of Resident #72 refusing pain medications administered by RN#1. The resident was in her room crying and saying "no no" and repeating son's name over and over. RN#1 tried to redirect resident, asking if she would like a milkshake.</p> <p>A target behavior documentation sheet, dated from 04/01/12 until 05/10/12, indicated Resident #72 had no behaviors between 05/07/12 through 05/10/12.</p> <p>Social service note dated 4/18/12 indicated Resident #72 had daily wandering but no other behaviors were noted in the social service noted.</p> <p>A current care plan, dated 10/31/11 and reviewed on 4/18/12, indicated an intervention to report to provider signs and symptoms of distress or pain unrelieved by ordered treatments and to identify precipitating factors of pain such as yelling out "ouch" or sons name or "awful awful."</p> <p>In an interview on 5/10/12 at 10:40 a.m. with CNA #6, she indicated Resident #72's behaviors of moaning and yelling son's name starts upon awakening in the morning and</p>				

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	<p>happened at anytime of day or night.</p> <p>In an interview on 5/10/12 at 2:30 p.m. with the ADoN, she indicated the son was the problem with treatment; he would not let them use the stronger medication. Medications were the facility's intervention for pain and behaviors. The ADoN was not sure what triggered Resident's behaviors of moaning, crying, and repeating son's name and the behaviors could happen at any time during the day.</p> <p>2. The clinical record of Resident #51 was reviewed on 05/08/12 at 10:00 A.M. The record indicated the diagnoses included, but were not limited to, left shoulder pain, cerebral vascular accident (stroke), asthma [a breathing problem], arthritis, chronic obstructive pulmonary disease [a breathing problem], hypertension [high blood pressure].</p> <p>During observation on 05/08/12 at 9:14 A.M., Resident #51 was observed to be edentulous [without teeth]. During an interview at that time, Resident #51 stated, "I have problems with chewing, I am waiting on my dentures, Medicare says they paid for my other set, but I paid for them with my own money, the facility</p>			

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	<p>is helping me."</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 02/01/12, indicated Resident #51 had no cognitive impairment, experienced no problems with oral/dental status or swallowing.</p> <p>The Nursing Comprehensive Admission Data Collection and Assessment dated 04/01/11, indicated the resident had no natural teeth and that upper and lower artificial teeth were present on admission but the resident did not use them.</p> <p>3.1-31(a)</p>						

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on observation, interview and record review, the facility failed to ensure a care plan was developed for oral health needs, for 2 of 44 residents reviewed for care plans, in a stage 2 sample of 44, in that the care plans did not address dental or oral care. (Residents #51, #17)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #51 was reviewed on 05/08/12 at 10:00 A.M. The record indicated the diagnoses included, but were not</p>	F0279	It is the policy of Mt. Vernon Nursing and Rehab Center to use the results of the assessment to review and revise the resident's comprehensive care plan. A one time 100% medical record review was completed to identify oral care services. Care plans were updated to reflect oral care needs, as well, CNA assignment sheets have been updated reviewed and updated as indicated. Nursing staff have been re-educated on oral and dental care. The IDT were re-educated on policy and procedure for developing care plans according to resident needs. CRC and SSD	06/15/2012	

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	<p>limited to, left shoulder pain, cerebral vascular accident (stroke), asthma [a breathing problem], arthritis, chronic obstructive pulmonary disease [a breathing problem], and hypertension [high blood pressure].</p> <p>During observation on 05/08/12 at 9:14 A.M., Resident #51 was observed to be edentulous [without teeth]. During an interview at that time, Resident #51 stated, "I do have a problem with chewing, I am waiting on my dentures, Medicare says they paid for my other set, but I paid for them with my own money, the facility is helping me."</p> <p>The Nursing Comprehensive Admission Data Collection and Assessment, dated 04/01/11, indicated the resident had no natural teeth and that upper and lower artificial teeth were present on admission but the resident did not use.</p> <p>The most recent plan of care, dated 05/03/12, lacked any interventions related to dental concerns.</p> <p>2. Resident #17 was interviewed on 5/8/12 at 11:44 a.m. The resident indicated her teeth were not brushed daily. She indicated the 4 remaining</p>		<p>will review MDS prior to completion to assure individual needs are met and enhance follow through with service provision. Nursing administration will complete audit review of physician orders, 24 hour report sheets and quarterly nursing data collection and assessments 5 days per week for 4 weeks; then 2 times per week for 4 weeks and weekly thereafter to determine residents with dental/oral care needs. Results of reviews will be presented to QA committee monthly, and forwarded for 6 months, for review and recommendations as indicated.</p>				

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	<p>teeth were brushed weekly, with assistance of the staff.</p> <p>On 5/9/12 at 2:00 p.m., the resident indicated she did not have her teeth brushed that day.</p> <p>During interview on 5/10/12 at 3:00 p.m., in the lounge, the resident indicated she had gotten a shower that morning, but had not had her teeth brushed that day.</p> <p>On 5/11/12 at 8:30 a.m., the resident was observed in the lounge in front of the TV. During interview, she indicated she'd had no mouth care that morning. A reddish chapped area was observed to the right lower lip.</p> <p>Resident #17's medical record was reviewed on 5/9/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, cellulitis [infection of the skin and underlying tissues], diabetes, hypertension [high blood pressure], history of small bowel obstruction, hypothyroid, osteoarthritis, peripheral vascular disease, moderate mental retardation, psychomotor retardation, depression and diabetic neuropathy.</p> <p>Resident #17's quarterly Minimum</p>			

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	<p>Data Set [MDS] assessment, dated 4/15/12, had an oral/dental section that was blank. The 1/14/12 annual MDS indicated the resident had no dental/oral issues.</p> <p>The last care conference was documented 4/3/12. The care plan included ADL [Activities of Daily Living] transfer with one gait belt, neat and clean well groomed, shower assist of one, assist with hair comb, dressing, use of grab bars, and monitor tolerance to diet texture as needed.</p> <p>The care plan did not include oral hygiene or dental care.</p> <p>A Dentist visited the resident every 6 months. The last visit was 4/12/12. The note included the following: pink moist tissue 4 remaining teeth, unable to wear dentures due to gag reflex.</p> <p>Interview of CNA #1, on 5/10/12 at 10:30 a.m., indicated dental care was not given after breakfast on that day. The CNA indicated the resident was showered by the 11- 7 shift prior to her shift.</p> <p>The CNA assignment record was reviewed on 5/11/12 at 3:00 p.m. and did not indicate oral hygiene; the ADL category indicated "max assist of 1."</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure care was provided in accordance with the written plan of care for 1 of 44 residents reviewed for following care plans, in the stage 2 sample of 44, in that the care plan indicated the need for an eye screening and none was scheduled. (Resident #34)</p> <p>Finding includes:</p> <p>Resident #34's clinical record was reviewed on 5/11/12 at 9:35 a.m. The Minimum Data Set [MDS] assessment, dated 4/9/12 indicated the resident had impaired vision and she saw large print but not regular print in books or newspapers.</p> <p>Resident #34 was observed on 5/7/12 at 2:30 p.m., sitting in her room with no glasses noted on the resident.</p> <p>Resident #34 had a care plan dated 3/21/12, for sensory communication. The care plan simply indicated Resident #34 was unable to read</p>	F0282	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to ensure care was provided in accordance with the weitten plan of care. Resident participated with already scheduled eye screen on 5/16/12. Re-educate CRC and SSD to review MDS prior to completion to assure coordination of services needed related to sensory impairments related to vision. A one time 100% medical records review will be completed to assure follow through from MDS to care plan to service provision related to vision screening. An audit of ongoing MDS assessment to identify further residents with vision screening needs will be completed by SSD and CRC and presented to QA committee for recommendations as indicated. The results will be forwarded to QA committee meeting monthly and forwarded for 6 months.</p>	06/15/2012	

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	<p>small print and glasses were not with the resident and an intervention was to have eye screening as needed.</p> <p>There was no documentation of an eye screening since admission.</p> <p>The social service progress notes dated 5/9/12, 4/8/12, 3/28/12, had vision documented as nothing needing to be addressed.</p> <p>In an interview with the Social Worker on 5/11 at 12:20 p.m., she indicated the nursing assessment indicated Resident #34's vision was adequate and she was unaware Resident #34 needed glasses.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 3 residents reviewed for pain management, in a sample of 6 who met the criteria for pain recognition and management, were fully evaluated and received treatment and services to attain or maintain their well-being, in that 2 residents were not fully evaluated and treated for pain. (Residents #72, #34) The facility also failed to ensure 1 of 1 resident reviewed for palliative care, in the stage 2 sample of 44, received the palliative care according to the facility's policy and procedure. (Resident #21)</p> <p>Findings include:</p> <p>1. Resident #72 was observed on 5/7/12 at 12:39 p.m., crying for her son and saying his name. LPN #1 told Resident #72 her son was at work. Resident #72 continued to cry for her son. CNA #1 tried to comfort</p>	F0309	It is the policy of Mt. Vernon Nursing and Rehab Center to attain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Residents 72 and 21 were assessed and evaluated for effectiveness of pain medication and interventions. Their doctors were notified with request for any changes indicated. A one time 100% medical record review was completed to reflect current pain status. Nursing was re-educated on pain policy and procedure, assessment, management and flow sheet. Re-education of Palliative Care Program will be provided for all staff to reaffirm program intent. Daily orders will be reviewed by DON to ensure initiation of a pain intervention flow sheet per policy. Palliative Care reviews will be separate from daily clinical review to strictly adhere to Palliative policy and procedure. Ineffective pain interventions will be communicated to the MD for	06/15/2012			

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	<p>resident and offered the resident a drink. Resident #72 refused. Resident #72 stopped crying for a minute and then resumed crying for son stating his name repeatedly. LPN #1 stood nearby and appeared to pay no attention to Resident #72. No pain assessment or intervention was observed.</p> <p>Resident #72 was observed on 5/7/12 at 12:59 p.m., holding her stomach and screaming "hurry hurry."</p> <p>Resident #72 was observed on 5/7/12 at 3:45 p.m., grabbing her stomach and yelling "ouch ouch" and repeatedly saying her son's name.</p> <p>An observation was made, continuously on 05/09/12 from 1:55 p.m. until 3:00 p.m., of Resident #72 in her room lying in bed squirming and grabbing at anything in reach. Resident #72 was moaning son's name repeatedly. The Assistant Director of Nursing [ADoN] was observed in the room trying to redirect Resident #72 by offering a back rub, food, and drink to Resident #72. Resident #72 was saying "ouch" repeatedly. The ADoN asked RN #1 to check on pain medication for Resident #72. CNA #4 asked Resident #72 if she wished to get up</p>		<p>modifications to medication regime and redirection as indicated. The pain intervention flow sheets will be monitored 5x's weekly for 4 weeks; then 2x's weekly for 4 weeks, then weekly thereafter by the DON/designee to ensure evaluation of effectiveness of pain medication. Results of audits will be reported to the QA committee monthly and forwarded for 6 months for review and recommendations as indicated.</p>				

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	<p>and get cleaned up. Resident #72 agreed, but continued to moan son's name and say "ouch" repeatedly. Resident #72 smacked at CNA #4, and CNA #4 tried to redirect Resident #72 by asking her if she wanted to use the restroom. Resident #72 indicated the need to use the restroom. Resident #72 indicated her finger hurt and was pulling on the covers while sitting on the side of the bed. Resident #72 stated, "don't hurt me" and "please." Resident #72 indicated her stomach hurt. RN #1 redirected Resident #72 to use the restroom and tried to give Resident #72 pain medication. Resident #72 refused pain medication. Resident #72 was assisted to the restroom by RN #1 and CNA #4. Resident #72 continued to say son's name and stated "my god my god my god." RN #2 and RN #1 assisted Resident #72 to her wheelchair. Resident #72 continued saying son's name repeatedly. Resident #72 cried and RN #2 wiped tears from the resident's eyes. Resident # 72 stated, "ouch ouch" when her tears were being wiped. RN #2 redirected the resident to her pain medication and Resident #72 took the pain medication. Resident #72 was redirected by RN #2 to look out the window and Resident #72 calmed down and no</p>			
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	<p>longer was crying or saying son's name.</p> <p>Resident #72 was observed refusing pain medications administered by RN #1, on 5/10/12 at 9:30 a.m. The resident was in her room crying and saying "no no" and repeating son's name over and over. RN #1 attempted to redirect the resident asking if she would like a milkshake.</p> <p>The clinical record was reviewed on 5/10/12 at 8:30 a.m. The Minimum Data Set Assessment [MDS] indicated Resident #72 had a Brief Interview for Mental Status [BIMS] score of 2 out of 15. Resident #72's MDS indicated she was unable to verbalize pain and reported pain 3 to 4 times a week.</p> <p>Resident #72 had diagnoses including, but not limited to, chronic abdominal pain, anxiety, dementia with severe Alzheimer's, and depression.</p> <p>A target behavior documentation sheet, dated from 04/01/12 until 05/10/12, indicated Resident #72 had no behaviors between 05/07/12 through 05/10/12.</p> <p>Resident #72 had a doctor's order</p>						

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	<p>dated 2/29/12, for Roxanol 0.5 ml every 2 hours as needed for pain. by mouth every 4 hours for pain and no more than 6 tabs in 24 hours.</p> <p>Resident #72 had a doctor's order dated 3/1/12, for Norco 5/325 mg 2 tabs</p> <p>A record review of the Medication Administration Records [MAR], on 5/11/12 at 8:59 a.m., indicated Resident #72 had not been given any Roxanol in February, March, or April 2012.</p> <p>On 5/7/12 at 12:30 p.m., Resident #72 was given Norco (a pain medication) 2 tabs for a pain level of 10 out of 10 and at 1:00 p.m. pain was assessed at a 0 out of 10.</p> <p>On 5/7/12 at 2:00 p.m., Resident #72 was given Roxanol (a pain medication) 0.5 milliliters [ml] for a pain level of 10 out of 10 and at 3:00 p.m. pain was assessed at a 0 out of 10.</p> <p>On 5/8/12 at 12:00 noon, Resident #72 was assessed for a pain level of 10 out of 10 and given Norco 2 tabs. At 1:00 p.m. the pain level was assessed at 0 out of 10.</p>			

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	<p>On 5/9/12 at 2:00 p.m., Resident #72 was assessed for pain at 2:00 p.m. and given Norco 2 tabs. The followup assessment at 3:00 p.m. indicated a pain level of 0 out of 10.</p> <p>On 5/10/12 at 10:00 a.m., Roxanol 0.5 ml was given for pain and at 11:00 a.m. the follow up assessment indicated a pain level of a 0 out of 10.</p> <p>On 5/10/12 at 12:20 p.m. Norco 2 tabs were given for pain assessed at a pain level of 10 out of 10 and the follow up assessment at 1:20 p.m. indicated a pain level at a 0 out of 10.</p> <p>On 5/10/12 at 4:30 p.m. Resident #72 had a pain level of 10 out of 10 and was given Roxanol 0.5 ml and at 5:00 p.m. the follow up assessment for pain indicated pain level was a 0 out of 10.</p> <p>A care plan, dated 10/31/12 and reviewed on 4/18/12, indicated an intervention to report to provider signs and symptoms of distress or pain unrelieved by ordered treatments and to identify precipitating factors of pain such as yelling out "ouch" or son's name or "awful awful."</p> <p>In an interview with the Social Worker on 5/10/12 at 10:00 a.m., she</p>			

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	<p>indicated the interventions for Resident #72's behaviors were to distract with the picture of fish on the television or rub Resident #72's feet. She further indicated Resident #72 did not participate in group activities. Resident #72's activities consisted of 1 to 1 staff and patient interaction. Other interventions for behavior consisted of medicating resident for pain. Resident #72's son was resistant to giving Resident #72 Roxanol prescribed by the doctor. The social worker indicated a psychiatrist was involved in Resident #72's care.</p> <p>In an interview on 5/10/12 at 09:45 a.m. with RN#1, she indicated interventions for Resident #72 crying and saying son's name over and over were to redirect offering milkshakes or snacks, explaining her son was at work, 1 on 1 attention, folding towels and medicating for pain. Lortabs were given by mouth as the first intervention with Roxanol as the second choice.</p> <p>In an interview on 5/10/12 at 10:40 a.m. with CNA #6, she indicated Resident #72's behaviors of moaning and yelling son's name started upon awakening in the morning and happened at anytime of day or night.</p>			

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	<p>In an interview on 5/10/12 at 2:30 p.m. with the ADoN, she indicated the son was the problem with treatment; he did not want them to use the stronger pain medications. The stronger pain medications were the facility's intervention for pain and behaviors. The ADoN was not sure what triggered Resident's behaviors of moaning, crying, and repeating son's name and the behaviors can happen at any time during the day.</p> <p>2. Resident #34's clinical record was reviewed on 5/10/12 at 11:05 a.m. The record indicated a care plan, dated 5/10/12, with an intervention for Resident #34 to be premedicated to optimize participation.</p> <p>Resident #34's diagnoses included, but were not limited to left fibula fracture, degenerative cervical spinal stenosis, Candidiasis, hypertension.</p> <p>Resident #34 had a Minimum Data Set [MDS] assessment, dated 4/9/12, which indicated the resident had a frequency for pain of occasionally at a level of 7 on a 1-10 scale. It also indicated her day to day activity was limited due to pain.</p> <p>The Medication Administration</p>			

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	<p>Record [MAR] indicated Resident #34 only received pain medication intermittently in April prior to therapy and on 5/1 and 5/2 and 5/11/12 prior to therapy.</p> <p>In an interview on 5/10/12 at 11:29 a.m. with Occupational Therapist [OT] #1, the therapist indicated upper extremity movement with no contractures was the goal for Resident #34.</p> <p>The Resident Care Plan was reviewed on 5/10/12 at 10:59 a.m. The OT indicated pain inhibited Resident #34 from completing exercises and therapy had communicated to nursing staff the need to medicate Resident #34 prior to therapy. OT #1 indicated the Resident attended therapy 6 days a week.</p> <p>An observation was made on 5/11/12 at 8:35 a.m. of Resident #34 in therapy doing her hand exercises. In an interview during the therapy session, Resident #34 indicated she was not in pain and the nurse had given her pain medicine prior to therapy.</p> <p>In an interview with LPN #1 on 5/11/12 at 9:00 a.m., LPN #1 indicated she did not give Resident</p>				

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	<p><b>#34</b> pain medication everyday that she had therapy, because she did not ask for it or complain of pain. LPN #1 also indicated Resident #34 was not care planned for pain medicine prior to therapy.</p> <p>A document provided by the DoN on 5/11/12 at 9:06 a.m., titled Pain-Assessment, and dated as revised January 2006, indicated the facility considered pain that impacted the function and quality of life and assessment would be ongoing. Pain assessments would be made verbally and nonverbally.</p> <p>3. Resident #21's record was reviewed on 5/10/12 at 9:45 a.m. Diagnoses included, but were not limited to, mental debility, coronary artery disease, Parkinson's disease, CVA [cerebrovascular accident, stroke] with right hemiplegia, dysphagia, IDDM [insulin dependent diabetes mellitus, PVD [peripheral vascular disease], osteoarthritis, bipolar disease, affective disorder, renal failure, and shared psychotic disorder.</p> <p>The record included, but was not limited to, a Plan of Care for Palliative Care, initiated 7/14/11 and reviewed 2/12/12. The palliative/comfort care</p>			

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	<p>was indicated due to mental and physical decline. The interventions included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>-Administer medication as needed/ordered</li> <li>-Arrange for psychiatric/psychological evaluation if ordered</li> <li>-encourage positive visits with loved ones</li> <li>-Allow to continue with self-care and decision-making at optimal level</li> <li>-Help to learn constructive ways to manage feelings</li> <li>--Provide for clergy visit with resident approval/request</li> <li>-Give resident affirmation, support and permission</li> <li>-Monitor effectiveness/side effects of medications</li> <li>-Assist/review Advanced Directives as needed</li> <li>-Assist with financial concerns as needed</li> </ul> <p>The Palliative Care Procedure, dated May 2001 with revisions February 2004 and January 2006, was provided by the Director of Nurses on 5/11/12 at 9:06 a.m. The Policy included, but was not limited to, the following:</p> <p>"...Palliative Care Program is a program that provides Interdisciplinary Team (IDT)</p>			

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	<p>interventions to residents with a terminal illness."</p> <p>"...[the corporation] strives to provide autonomy and allow a dignified death by honoring resident's wishes to forgo life-prolonging interventions..."</p> <p>"The Interdisciplinary Team (IDT) caring for the resident recognizes that the resident may not necessarily wish to forgo curative efforts when they accept comprehensive palliative care. the dying person or their responsible party has the right to determine the amount and type of medical care that will enhance the quality of the resident's life during the terminal phase of life. The IDT will identify and implement interventions that meet the resident's individual needs consistent with resident wishes and the wishes of their responsible party."</p> <p>"Identify the wide range of needs including physical, psychological, social, and spiritual."</p> <p>"Determine resident's specific palliative/comfort care interventions in accordance with resident wishes."</p> <p>"Include resident/responsible party in the development of the Plan of Care."</p> <p>"Develop and implement Plan of Care-Palliative Care with individualized interventions including, but not limited to:</p> <ul style="list-style-type: none"> <li>-Affirming worth by treating the resident as a valued individual</li> </ul>			

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	<p>-Assisting in attaining practical goals -Encouraging lightheartedness when appropriate -Exploring spiritual beliefs... -Providing adequate management of symptoms -Recalling uplifting memories with life review -Supporting and identifying person attributes, such as determination, courage, and serenity" "Communicate individualized interventions to staff." "Review and revise the Plan of Care as needed."</p> <p>Resident #21 was observed being cared for by CNAs #7 and #1 on 5/10/12 9:25 a.m. The CNAs were observed to turn the resident. The resident was resistive and angry. The CNAs attempted to calm the resident.</p> <p>During interview with CNA #8 on 5/11/12 8:40 a.m., she indicated "don't do anything different" for residents on palliative care.</p> <p>On 5/11/12 at 10:00 a.m., LPN #2 was interviewed regarding palliative care. She indicated, "it's just their getting to the end of their life. We know it could happen anytime. We just keep them comfortable. The care doesn't really change."</p>				

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	<p>Review of Interdisciplinary Team meeting notes from 7/15/11 through 5/11/12 indicated Palliative Care had not been discussed since 8/10/11.</p> <p>Review of the Social Service Progress Note, dated 2/12/12, indicated Palliative Care had not been addressed.</p> <p>3.1-37(a)</p>			
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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided to maintain or improve a resident's grooming and oral hygiene, for 2 of 3 residents reviewed for cleanliness and grooming, in a sample of 7 who met the criteria for activities of daily living-cleanliness and grooming, in that one resident was not assisted with doing her hair care and one resident was not assisted to do her oral care. (Residents #17, #71)</p> <p>Findings include:</p> <p>1. Resident #17 was interviewed on 5/8/12 at 11:44 a.m. The resident indicated her teeth were not brushed daily. She indicated the four remaining teeth were brushed weekly, with assistance of the staff.</p> <p>On 5/9/12 at 2:00 p.m., the resident indicated she did not have her teeth brushed that day.</p> <p>Interviewed on 5/10/12 at 3:00 p.m. in the lounge, the resident indicated she</p>	F0311	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to ensure services are provided to maintain or improve a resident's grooming and oral hygiene. Residents # 17 and 71 were identified. ADON reviewed care plans and CNA assignment sheets to assure that the oral care and hair care were identified. Licensed staff were re-educated to provide both oral hygiene and hair care for residents in their care and to refer to their CNA assignment sheets. A 100% medical record review of ADL care plans will be completed to assure appropriateness with identified needs and coordinated with CNA assignment sheets. Nursing staff will be re-educated on ADL care, ie., oral care and hair care. DON/designee will monitor 5x's per week for 4 weeks; then weekly for 4 weeks to assure ADL maintenance. ADM/designee will provide documentation from daily rounds 5 x's per week for 4 weeks; then random weekly. Results of audits will be forwarded to QA committee monthly for 6 months with recommendations as indicated.</p>	06/15/2012			

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	<p>had gotten a shower that morning, but had not had her teeth brushed that day.</p> <p>Resident #17 was observed on 5/11/12 at 8:30 a.m. in the lounge in front of the TV. During interview at that time, she indicated no mouth care was done that morning. A reddish chapped area to right lower lip was observed.</p> <p>Resident #17's clinical record was reviewed on 5/9/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, cellulitis [infection of skin and underlying tissue], diabetes, hypertension [high blood pressure], history of small bowel obstruction, hypothyroid, osteoarthritis, peripheral vascular disease [PVD], moderate mental retardation, psychomotor retardation, depression, and diabetic neuropathy.</p> <p>The last care conference was held 4/3/12. The care plan reviewed at that time included ADL [Activities of Daily Living] transfer with one gait belt, neat and clean well groomed, shower assist of 1, assist with hair comb, dressing, use of grab bars. Monitor tolerance to diet texture as needed. The care plan did not include oral hygiene or dental care.</p>			

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	<p>The dentist visited the resident every 6 months. The last visit was dated 4/12/12. The note included the following, pink moist tissue 4 remaining teeth, unable to wear dentures d/t [due to] gag reflex.</p> <p>Interview of CNA #1, on 5/10/12 at 10:30 a.m., indicated dental care was not given after breakfast on that day. The CNA indicated the resident was showered by the 11-7 shift prior to her shift.</p> <p>The CNA assignment record was reviewed on 5/11/12 at 3:00 p.m., and did not indicate oral hygiene, the ADL category indicated, "max assist of 1."</p> <p>2. The clinical record of Resident #71 was reviewed on 05/07/12 at 1:00 p.m. The record indicated the diagnoses of Resident #71 included, but were not limited to, "Seizures, Altered Mental Status, Depression, Insomnia."</p> <p>During a confidential family interview on 05/07/12 at 1:09 p.m., the family member indicated Resident #71 did not receive assistance with Activities of Daily Living [ADL's] that she needed.</p>			

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	<p>The most recent care plan, dated 04/11/12, for ADL/Mobility indicated Resident #71 required assistance with ADL's and interventions included, but were not limited to, "Assist...comb hair..."</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 4/11/12, indicated Resident #71 required extensive assist of two staff for personal hygiene including oral care.</p> <p>During an observation of care on 05/10/12 at 10:00 a.m., CNA #2 and CNA #6 were observed to provide a.m. care to Resident #71. The staff were not observed to brush the hair of Resident #71 before returning the resident the common lounge.</p> <p>On 05/10/12 at 12:00 noon, Resident #71 was observed sitting in a wheelchair in the hallway with her hair disheveled.</p> <p>In an interview with LPN #1 on 05/11/12 at 8:00 a.m., she indicated a resident who required extensive assist with ADL's [Activities of Daily Living] would need assistance that included, but was not limited to, hair care.</p>			

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	<p>During an interview with CNA #2 on 05/11/12 at 9:53 a.m., she stated, "I forgot to comb her hair yesterday when I got her up."</p> <p>3.1-38(a)(2)</p>			

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F0313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 3 residents reviewed for vision problems, in a sample of 23 residents who met the criteria for vision, received an eye screening as care planned. (Resident #34)</p> <p>Finding includes:</p> <p>Resident #34's clinical record was reviewed on 5/11/12 at 9:35 a.m. The resident's Minimum Data Set [MDS] assessment, dated 4/9/12, indicated the resident had impaired vision and saw large print but not regular print in books or newspapers.</p> <p>Resident #34 was observed on 5/7/12 at 2:30 p.m., sitting in her room with no glasses noted on resident.</p> <p>Resident #34 had a care plan, dated 3/21/12, for sensory communication.</p>	F0313	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to ensure that residents receive proper treatment and assistive devices to maintain vision abilities. Resident kept her already scheduled vision screen on 5/16/12 and has now ordered new glasses. Nursing staff will be re-educated on the appropriate assistive devices and necessary communication to assure follow through with care plan on sensory impairments related to vision. A one time 100% medical record review will be completed to assure all residents eye wear is appropriate by SSD. Re-educate CRC and SSD to coordinate section B of the MDS to assure that upon initial and subsequent assessments, the individual needs will be communicated and care planned appropriately. SSD will audit MDS/care plans on follow through regarding vision services from a list generated from the MDS regarding vision impairments. CRC will audit MDS</p>	06/15/2012			

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	<p>The care plan indicated, Resident #34 was unable to read small print and glasses were not with the resident. An intervention was to have eye screening as needed.</p> <p>There was no documentation of an eye screening since admission.</p> <p>The social service progress notes dated 5/9/12, 4/8/12, 3/28/12, had vision documented as nothing needing to be addressed.</p> <p>In an interview with the Social Worker on 5/11 at 12:20 p.m., she indicated the nursing assessment indicated Resident #34's vision was adequate and she was unaware Resident #34 needed glasses.</p> <p>3.1-39(a)(1)</p>		<p>assessments 3x's weekly for 4 weeks; then weekly for 4 weeks for vision impairment Results of these audits will be presented to the QA committee for review monthly for 6 months. Committee will provide recommendations as indicated.</p>		

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 resident reviewed for pressure sores, in a sample of 1 who met the criteria for pressure sores, received the treatment and services to prevent pressure sores, in that the resident was not routinely turned and repositioned, was observed being slid in the bed, and developed a small pressure sore. (Resident #37)</p> <p>Finding includes:</p> <p>Resident #37 was observed on 5/9/12 at 11:22 a.m., lying in bed on the right side. The HOB [head of bed] was elevated and the full, padded siderails were up.</p> <p>Resident #37 was observed on 5/9/12 at 2:13 p.m., lying on the right side in bed with the HOB elevated.</p>	F0314	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to ensure that a resident that enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrated that they were unavoidable, and a resident having a pressure sore receives necessary treatment &amp; services to promote healing and prevent infection. Resident #37 was turned and repositioned. A treatment order clarification was obtained and treatment provided to resident #37. Pink skin grids were reviewed with no changes required. A 100% medical record review of current in-house residents to identify residents at risk for skin breakdown will be completed. Record review will include but not be limited to physician orders, Braden Risk Assessments &amp; Skin Integrity Assessment and Plan of Care. Residents identified as being at risk for skin breakdown will be reviewed to ensure they are on an</p>	06/15/2012			

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	<p>On 5/9/12 at 3:12 p.m., Resident #37 was observed in bed lying on right side with the HOB elevated.</p> <p>On 5/10//12 at 7:18 a.m., Resident #37 was observed lying on her back in bed with head of bed elevated at 90 degrees. Her tray was on the overbed table with scrambled eggs on the tray and no plate. The resident's fluids had been consumed and she had eaten all of her oatmeal from the cup.</p> <p>On 5/10/12 at 8:09 a.m., Resident #37 was observed lying on her back with the HOB elevated 45 degrees and the padded full siderails up.</p> <p>On 5/10/12 at 9:45 a.m., Resident #37 was observed on her left side with the head of the bed flat. The full padded siderails were up.</p> <p>On 5/10/12 at 11:20 a.m., Resident #37's family were observed visiting with the resident. The resident was observed lying on her left side with the HOB elevated 45 degrees.</p> <p>On 5/11/12 at 7:50 a.m., Resident #37 was observed lying on her left side with HOB elevated 90 degrees. Her chin was resting on chest and she had nasal 02 [oxygen] going at 2</p>		<p>appropriate turning and repositioning program per facility policy.DON will re-educate nursing staff on policy and procedure for wound prevention and treatment including but not limited to appropriate treatment orders, lifting when turning and repositioning as well as individualized turning and repositioning programs.DON/designee will monitor turning and repositioning program to assure compliance 3x's per day, 5 day a week for 4 weeks; then weekly for 4 weeks. Results of audits will be presented to QA committee monthly for 6 months for review and recommendations as indicated.</p>				

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	<p>liters/minute.</p> <p>Resident #37's clinical record was reviewed on 5/9/12 at 9:34 a.m. The nurse's notes indicated Resident #37 had a pressure area on her right gluteal area measuring 1.5 x 1 cm [centimeter] which was purple in color that was identified on 5/8/12, but there was no staging of the pressure area noted in the nurse's notes. The resident's physician was notified on 5/8/12 and orders were received to cleanse the pressure area with soap and water, pat dry, and apply Dimethicone Cream every shift and as needed for 14 days.</p> <p>According to the MDS [Minimum Data Set Assessment] dated 4/1/12, Resident #37 was cognitively impaired, was at risk for pressure ulcers, and the resident was total care for mobility . The "Skin Integrity Assessment: Prevention and Treatment Plan of Care" done on 4/1/12, indicated Resident #37 had a very high risk for pressure ulcers according to the Braden Risk Assessment Scale [a scale for measuring pressure ulcer risk]. The Plan of Care dated 5/8/12, indicated that on 5/7/12, Resident #37 had a right gluteal pressure ulcer 1.5 x 1.0 cm, the goal was to have the area</p>			
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	<p>heal in less than 14 days, and the treatment to area as ordered, therapy to evaluate and address wheelchair cushion.</p> <p>During interview of LPN #1 on 5/8/12 at 2:00 p.m., she indicated she had discovered the pressure area on Resident #37 on 5/8/12 and it was unstageable. On interview of the DoN [Director of Nursing] on 5/8/12 at 2:18 p.m., she indicated the resident had an unstageable pressure ulcer to her right gluteal fold.</p> <p>On interview with LPN #1 on 5/10/12 at 9:45 a.m., she indicated the resident's blood pressure had declined on 5/9/12 and the resident had a change in condition. She indicated the resident was to remain in bed and be turned and repositioned every 2 hours.</p> <p>On 5/10/12 at 12:00 noon, Resident #37 was observed receiving pericare. Staff applied their gloves and Resident #37 was washed and dried on the left side of her buttocks by LPN #1. On observation of the pressure ulcer on 5/10/12 at 1:41 p.m., Resident #37 had a reddish - slight purple area at the gluteal fold with redness noted to the side. LPN #1 indicated the area had gotten</p>			

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	<p>worse as the new red area to the side of the initial wound had become larger. LPN #1 indicated the wound was unstageable and indicated the resident had been incontinent and needed pericare done. LPN #1 indicated she had applied Dimethicone cream earlier that day and the resident did not need it reapplied again. CNA #2 came into the resident's room after obtaining supplies to perform pericare. CNA #2 and CNA #3 provided pericare and placed a clean incontinence brief and then proceeded to slide Resident #37 up in bed using a lift sheet with Resident #37 being placed on her back for the noon meal. The "Skin Integrity Assessment" form indicated the resident was to be lifted and not slid.</p> <p>The DoN [Director of Nursing] was interviewed on 5/11/12 @ 7:55 a.m., the DoN indicated the facility did not have a wound nurse and Resident #37's orders were not written properly. She indicated she oversaw the wounds. When interviewed regarding Resident #37 's pressure area, she indicated she had discovered it in the chart on 5/9/12, the orders were not written properly and she had the nurse who had written the original orders to</p>			

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	<p>re-document the orders to indicate the wound was a "stage E." [DoN indicated this meant the wound was unstageable].</p> <p>An interview with O.T. [Occupational Therapist] #1, done on 5/11/12 at 7:30 a.m., indicated Resident #37 received physical therapy for assistance to get Resident #37 into the wheelchair. O.T. #1 indicated a new cushion for the resident's wheelchair had been ordered to assist with pressure and positioning of the resident. Resident #37 had a cushion in her wheelchair but remained in bed.</p> <p>The DoN provided the policy and procedure on 5/14/12 at 3:00 p.m., for wound prevention and treatment, dated 4/2009, which indicated "a pressure ulcer was any lesion caused by unrelieved pressure that resulted in damage to the underlying tissue(s). Although friction and shear are not the primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers." The Procedure for Wound Prevention and Treatment indicated a resident with pressure ulcers would receive continued preventive interventions and necessary treatment and</p>			

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	<p>services to promote healing and prevent infection.</p> <p>3.1-40(a)(2)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to adequately monitor 1 of 10 residents reviewed for unnecessary medications, in that Digoxin [heart medication] levels were not monitored and potential adverse consequences for the use of Colace [stool softener] with other medications were not monitored. (Resident #65)</p> <p>Finding includes:</p>	F0329	<p>It is the policy of Mt Vernon Nursing and Rehab Center to adequately monitor for unnecessary medications via levels monitoring and potential adverse consequences. A 100% medical record review was completed on 5/11/12. Re-education with nurses to assure all medication orders received are immediately written and reflect correctly on the MAR. Pharmacist made aware of lack of monitoring of excessive duration of digoxin and reommendation follow up.</p>	06/15/2012

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	<p>Resident #65's clinical record was reviewed on 5/10/12, at 2:30 pm. The diagnoses included, but were not limited to, MS [ multiple sclerosis], HTN [hypertension-high blood pressure],hypercholesterolemia [high cholesterol], anxiety, depression, GERD [gastroesophageal reflux disease], nicotine dependence, anemia, lung cancer, CAD [coronary artery disease] with triple bypass, and history of myoma of heart.</p> <p>The initial pharmacy review note was recorded 2/21/12, which summarized the use of Digoxin for treatment of Atrial Fibrillation. Additional pharmacy reviews were completed 3/22/12, and 4/24/12. There was no request for blood levels of Digoxin, to determine if the current dosage was therapeutic.</p> <p>The pharmacy review, dated 2/21/12, recommended to the physician:</p> <ol style="list-style-type: none"> <li>1. "Please consider discontinuing the Colace due to the on-going diarrhea [will likely continue while on Tarceva [used for lung cancer]."</li> <li>2. "May also want to consider alternate therapy in lieu of Diltiazem [alternative for hypertension might be amlodipine or lisinopril.]"</li> <li>3. "Change time of Welchol [used for diarrhea] to be at least an a hour after</li> </ol>		<p>DON/designee will monitor all new medication orders to assure proper lab orders to be obtained through clinical review team. Re-education for nurses regarding proper documentation of MD lab requests or denials, obtained and placed in the medical record.Results of DON/designee review of med orders will be presented to the QA committee for review monthly for 6 months. Clinical team will initiate recommendations as indicated.</p>	

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	<p>morning meds to avoid absorption interactions with her other medications."</p> <p>The physician signature on the pharmacy recommendation was not dated. It appeared the physician had circled the name "Colace," and written "STOP" beside the circle.</p> <p>The other two recommendations were not addressed and/or noted by the physician.</p> <p>The 3/22/12 pharmacy note recorded the Colace was discontinued on 3/6/12.</p> <p>The current physician monthly recap of orders included Colace 2 caps qd [every day] start date of 4/12/12. The order was hand written onto the recap orders, with the date 4/12/12 added, the record did not contain a verbal order, telephone order or physician order.</p> <p>There was no documentation regarding the adverse side effects with Tarceva.</p> <p>During interview with LPN #2 on 5/10/12 at 2:53 p.m., she indicated the doctor said get her what she wants regarding the Colace, which was 2 tabs every morning. LPN #2</p>			

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	<p>was unaware the order was lacking for the Colace. She had looked through the medical record at that time.</p> <p>LPN #2 reviewed the medical records for Digoxin orders and /or labs, she was unable find where they had ever been ordered. LPN #2 called the physician office at that time, and requested an order. LPN #2 indicated the laboratory test was ordered for the next morning.</p> <p>3.1-48(a)(3)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions for 1 of 1 kitchen. This deficient practice had the potential to affect 64 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour of the kitchen on 5/7/12 at 10:05 a.m., the dry storage room was observed to have a dirty floor. There were potato chips in a bag that had been opened with no date on them. Pudding was observed to be covered in dishes in the refrigerator with no dates on them. Also, a pair of used gloves was observed under the steam table.</p> <p>During observation of the dishwashing room on 5/7/12 at 10:25 a.m., it was observed the dishwasher was not reaching a temperature of at least 180 degrees Fahrenheit during the rinse cycle. During interview with</p>	F0371	<p>It is the policy of Mt. Vernon Nursing and Rehab Center to store, prepare, distribute and serve food under sanitary conditions. This alleged deficit practice has the potential to affect all residents. No residents were identified to have any ill effects. RD and Dining Manager provided re-education for all dining staff regarding the cleaning and sanitizing schedule. Staff will initial when completing their assigned duties. Dining Manager re-educated all staff regarding the dishwasher temp log and directed staff to document temp and initial upon completion of assigned task. All staff re-educated on Sanitation policy and procedure manual. All staff have been re-educated on sanitation rounds checklist and will participate in the daily audits with the DM and RD and ADM. The coffee carafes have been replaced. The DM will monitor the cleaning schedule and the temperature logs daily and will initial her acknowledgement of compliance. Maintenance Director will provide</p>	06/15/2012

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	<p>D.A. [dietary assistant] #1, she indicated the dishwasher had only reached 177 degrees Fahrenheit since the beginning of May. The Dietary Manager was notified. The Dietary Manager indicated she notified Maintenance employee #1 for the facility, and the company from which the dishwasher was purchased. The dishwasher was not in operation during the noon meal and the facility used disposable serving items at that time with the exception of items the dietary manager indicated had been properly washed in the three compartment sinks. The dietary manager also indicated the pudding that was in dishes for lunch had been discarded. At 4:09 p.m. on 5/7/12, the dietary manager indicated the dishwasher had been repaired and the dishwasher was operational.</p> <p>On 5/9/12 at 9:30 a.m., the kitchen was observed. There was a dirty fork left under the serving steam table. The food preparation table was soiled and had a sanitizing bucket setting on it. The dry storage room floor was dirty and there were dented cans on the floor. The area behind the steam table was found to have accumulated dirt and unopened packets of butter, sweetener, etc. behind it. DA #2 cleaned behind the steam table after</p>		<p>documentation of preventative maintenance audit weekly for DM. Ecolab representative will perform preventative maintenance on dish manchine monthly. He will provide his monthly monitoring review for both DM and Maintenance Director. Administrator will complete one sanitation check per week. DM will monitor the aforementioned 5 days per week for 4 weeks; 2 times per week for 4 weeks and weekly thereafter. Results of monitoring from DM, ADM, RD, Ecolab and Maintenance Director will be presented to the QA committee monthly and forwarded for 6 months for review and recommendations as indicated.</p>	

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	<p>the area was noted to be dirty. The plate rack, located in the dishwashing room, contained clean plates but was dirty with food particles on it as was the plate lid rack. The air conditioner cover located in the dishwashing room, and the ceiling in the dishwashing room were dirty. The paper towel dispenser in the dishwashing room was empty and dirty and on interview with DA #2, she indicated she was going to insert more paper towels into it for staff. Two utensil drawers located under the prep table were soiled. Thirteen (13) out of a sample of 13 coffee carafes were stained with coffee. The top of the toaster had crumbs on it.</p> <p>During interview of the dietary manager on 5/9/12 at 9:40 a.m., she indicated the cans on the storage room floor were to be returned.</p> <p>The "Procedure for Cleaning and Sanitizing" indicated the entire Nutrition Services team maintained clean and sanitary kitchen centers and equipment. Walls, floor, ceilings, equipment, and utensils were clean, sanitized, and in good working order. The procedure indicated the dishes were to be logged on the "Sanitation Rounds" log sheet indicated in the "Environment" section that the floor</p>			

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	<p>was to be clean and without build up and equipment was clean and in working order.</p> <p>The "Quick Kitchen Sanitation Rounds," which were to be "looked at daily by the dietary manager," indicated there should be no dented cans in the storage room and nothing stored on the floor in the food storage room. It also indicated the dish machine temperatures were to be recorded and logs checked and the floor was to be clean and equipment was to be cleaned and in working order.</p> <p>3.1-21(i)(3)</p>			

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to act upon a pharmacy recommendation regarding the use of the medication Colace [a stool softener], and the pharmacist failed to recommend laboratory tests regarding the use of Digoxin [a heart medication], for 1 of 10 residents reviewed for unnecessary medications. (Resident #65)</p> <p>Finding includes:</p> <p>Resident #65's clinical record was reviewed on 5/10/12, at 2:30 pm. The diagnoses included, but were not limited to, MS [ multiple sclerosis], HTN [hypertension-high blood pressure],hypercholesterolemia [high cholesterol], anxiety, depression, GERD [gastroesophageal reflux disease], nicotine dependence, anemia, lung cancer, CAD [coronary artery disease] with triple bypass, and history of myoma of heart.</p>	F0428	<p>It is the policy of the Mt. Vernon Nursing and Rehab Center to assure that each resident must be reviewed at least once a month by a licensed pharmacist. Resident #65 was identified. LPN reviewed the medical record and called the doctor to request an order for the following morning for the lab indicating medication levels monitoring. There were no adverse effects. Re-education of nurses scheduled to assure all medication orders received are immediately written and reflect correctly on the MAR. Pharmacist made aware of lack of monitoring of excessive duration of digoxin and recommendation follow up. DON/designee will monitor all new medication orders to assure proper lab orders to be obtained through clinical review team. Re-education for nurses regarding proper documentation of MD lab requests or denials obtained and placed in the medical record. Medication orders monitored will be collected daily</p>	06/15/2012

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	<p>The initial pharmacy review note was recorded 2/21/12, which summarized the use of Digoxin for treatment of Atrial Fibrillation. Additional pharmacy reviews were completed 3/22/12, and 4/24/12. There was no request for blood levels of Digoxin, to determine if the current dosage was therapeutic.</p> <p>The pharmacy review, dated 2/21/12, recommended to the physician:</p> <ol style="list-style-type: none"> <li>1. "Please consider discontinuing the Colace due to the on-going diarrhea [will likely continue while on Tarceva [used for lung cancer]."</li> <li>2. "May also want to consider alternate therapy in lieu of Diltiazem [alternative for hypertension might be amiodipine or lisinopril.]"</li> <li>3. "Change time of Welchol [used for diarrhea] to be at least an a hour after morning meds to avoid absorption interactions with her other medications."</li> </ol> <p>The physician signature on the pharmacy recommendation was not dated. It appeared the physician had circled the name "Colace," and written "STOP" beside the circle.</p> <p>The other two recommendations were not addressed and/or noted by the</p>		to be presented to the QA committee monthly for 6 months. Recommendations will be as indicated by the QA review.				

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	<p>physician.</p> <p>The 3/22/12 pharmacy note recorded the Colace was discontinued on 3/6/12.</p> <p>The current physician monthly recap of orders included Colace 2 caps qd [every day] start date of 4/12/12. The order was hand written onto the recap orders, with the date 4/12/12 added, the record did not contain a verbal order, telephone order or physician order.</p> <p>There was no documentation regarding the adverse side effects with Tarceva.</p> <p>During interview with LPN #2 on 5/10/12 at 2:53 p.m., she indicated the doctor said get her what she wants regarding the Colace, which was 2 tabs every morning. LPN #2 was unaware the order was lacking for the Colace. She had looked through the medical record at that time.</p> <p>LPN #2 reviewed the medical records for Digoxin orders and /or labs, she was unable find where they had ever been ordered. LPN #2 called the physician office at that time, and requested an order. LPN #2 indicated the laboratory test was</p>			

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	ordered for the next morning.  3.1-25(h)			

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure opened liquid medications were dated when opened, for 1 of 3</p>	F0431	It is the policy of Mt Vernon Nursing and Rehab Center to ensure opened liquid medications are dated when opened. Nursing audited the medication carts. Any	06/15/2012			

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	<p>medication carts. This affected 2 residents whose medications were randomly observed in this cart. (Unit I cart, Residents #57, #79)</p> <p>Findings include:</p> <p>During observation of a medication storage cart on Unit I on 05/11/12 at 8:00 a.m., the following was observed:</p> <p>An undated, opened bottle of Mi acid [a medication for indigestion] and Extra Action Cough Syrup for Resident #57,</p> <p>An undated, opened bottle of Milk of Magnesia [a medication for constipation] for Resident #79.</p> <p>In an interview with LPN #2 on 05/11/12 at 8:05 a.m., she indicated the liquid medications should have been dated on the day they were opened.</p> <p>The policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, provided by the DoN [Director of Nursing] on 05/14/12 at 3:00 p.m. indicated, "...Procedure ...5. Once any medication .... is opened ...Facility staff should record the date opened</p>		liquid medications opened and undated were disposed of and re-ordered, at Center expense.Nursing staff were re-educated regarding dating liquid medication when opened on 5/11/12.DON/designee will monitor medication carts 5x's per week for 4 weeks; then weekly for 4 weeks. Results of monitoring will be presented to QA committee monthly for 6 months for review and recommendations as indicated.				

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	<p>on the medication container when the medication has a shortened expiration date once opened..."</p> <p>3.1-25(j)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F0441	It is the policy of Mt.Vernon Nursing and Rehab Center to	06/15/2012	

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	<p>ensure infection control procedures were followed during care of 4 of 4 residents observed in the Stage II sample of 44. Six (6) of 8 staff observed failed to perform hand hygiene between soiled and clean glove changes and/or placed soiled linens on clean surfaces during care. (Residents #72, #71, #35, #37) (CNA #4, CNA #2, CNA #1, CNA #7, LPN #1, CNA #3)</p> <p>Findings include:</p> <p>1. An observation made on 5/9/12 at 01:55 p.m. CNA #4 was assisting Resident #72 with toileting and changing of urine soaked incontinence brief and urine soaked gown. CNA #4 washed hands and put gloves on. She then removed Resident #72's urine saturated brief and urine saturated gown. CNA #4 then handled clean brief and clean gown without washing hands and applying new gloves.</p> <p>2. During an observation of care on 05/10/12 at 10:00 a.m., CNA #2 was observed to provide peri-care for Resident #71, remove gloves, and apply new gloves without performing handwashing or hand hygiene. CNA #2 was then observed to apply</p>		<p>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. Residents identified were #'s 72, 71, 35, and 37. This alleged deficit practice has the potential to affect all residents. Through medical record review, no ill effects were noted. Re-education of licensed personnel regarding policy and procedure for hand washing between glove changes was completed on 5/11/12. DON/ designee provided re-education on Infection Control on 5/12/12. Direct observation of hand washing and glove use to be monitored 5x's per week for 4 weeks; then weekly for 4 weeks, by ADON/designee. Direct observation of peri care and linen handling within infection control guidelines will be monitored by ADON/designee 5 x's weekly for 4 weeks; then weekly for 4 weeks. Audits will be presented to QA committee monthly for 6 months for review and recommendations as indicated.</p>				

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	<p>protective cream to the periaerea.</p> <p>In an interview with LPN #1 on 05/11/12 at 8:00 a.m., she indicated handwashing or hand hygiene should be performed between glove changes.</p> <p>The policy and procedure for Hand Hygiene-Plain Soap and Water Handwash provided by the DoN on 05/14/12 at 3:00 P.M. indicated, "A plain soap and water handwash or an alcohol hand rub may also be used...after removing gloves."</p> <p>3. On 5-10-12 at 8:40 am, CNA #1 and CNA #7 were observed caring for Resident #35. The resident was soiled with feces. CNA #7 cleansed the resident's perineal area. She then changed gloves, but did not perform hand hygiene between the soiled gloves and the clean gloves.</p> <p>4. On 5/10/12 at 12:00 noon, Resident #37 was observed receiving pericare. LPN #1 sanitized her hands and applied her gloves. Resident #37 was washed on the left side of her buttocks by LPN #1. CNA #2 entered Resident #37's room after obtaining more supplies to perform pericare. CNA #2 sanitized her hands and applied her gloves. The resident was</p>			

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	<p>turned to right side and CNA #3 washed Resident #37's right side of buttocks and dried it with a towel. The towel was placed on top of the overbed table. Resident #37 was placed on her back and CNA #3 washed the groin and periaarea. The area was dried with a different section of the same towel and towel was placed on top of the overbed table. CNA #2 and CNA #3 applied the resident's brief and changed their gloves after sanitiziing their hands. CNA #2 and CNA #3 proceeded to move Resident #37 up in the bed using a lift sheet and placed the resident on her back for the noon meal.</p> <p>3.1-18(b)(1)</p>			