

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/18/2011
NAME OF PROVIDER OR SUPPLIER  ARBORS AT MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN46360		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was done in conjunction with the Investigation of Complaints IN00091661 and IN00093400.</p> <p>Survey dates: July 10, 11, 12, 13, 14, 15, 16, 17, &amp; 18, 2011</p> <p>Facility number: 000076 Provider number: 155156 AIM number:10027160</p> <p>Survey team: Janet Adams, RN, TC July 10, 11, 12, 13, 14, 15, 16, &amp; 18, 2011 Lara Richards, RN July 10, 11, 12, 13, 14, 15, &amp; 18, 2011 Heather Tuttle, RN July 11, 12, 13, 14, 15, 16, &amp; 18, 2011 Kathleen Vargas, RN July 11, 12, 13, 14, 15, 17, &amp; 18, 2011</p> <p>Census bed type: SNF: 31 SNF/NF: 117 Total: 148</p> <p>Census payor type:</p>	F0000	The submission of this plan of correction does not indicate an admission by The Arbors of Michigan City that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of The Arbors of Michigan City. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an n economic and efficient manner. The facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirement governing the management of this facility. It is submitted as a matter of statue only.		

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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	<p>Medicare: 35 Medicaid: 92 Other: 21 Total: 148</p> <p>Stage 2 sample: 48</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/26/11 Cathy Emswiller RN</p>				

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F0156 SS=C	<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: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>				

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	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p>				

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	<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 record review and interview the facility failed to ensure the residents were informed of their right to file a complaint with the state agency about the care they receive related to the interview of 1 of 1 residents interviewed related to being informed of the right to file a complaint in the Stage 2 sample of 48. The facility also failed to ensure Medicare stop letter notices were given in a timely manner for 3 of 3 residents reviewed for liability notice. This had the potential to affect 148 of 148 residents residing in the facility. (Residents #7, #13, #14, and #41).</p> <p>Findings include:</p> <p>1. Interview with Resident #41 on 7/14/11 at 1:30 p.m., indicated he was not aware of how to formally file a complaint to the state about the care he received.</p>	F0156	<p><b>Corrective actions accomplished for Those residents found to have been Affected by the alleged deficient Practice: Resident # 41 has been informed of How to formally file a complaint To the State about care he receives. Resident #14, #13, #7 had no negative Outcome noted. Measures put into place and systemic Changes made to ensure the alleged deficient Practice does not recur: A posting of information is available in the Front lobby and a posting is placed in the Activity room. Resident council meeting education on this Process was presented to the council. Social Service or designee has a log to track The time to ensure the appropriate time frame For notifications. How the corrective measures will be monitored To ensure the alleged deficient practice does Not recur: Executive Director or designee will go over</b></p>	08/17/2011	

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	<p>Interview with the Activity Director on 7/15/11 1:00 p.m., indicated he had not given any information to the residents on how to formally file a complaint with the state agency.</p> <p>Review of the Resident Council minutes for 4/10 through 6/10, indicated resident rights were reviewed, but no specific information regarding filing a complaint with the state agency.</p> <p>2. The form titled, "Notice of Medicare Provider Non-Coverage" for Resident #14 was provided by the Administrator on 7/15/11. She indicated the forms are completed when the resident's skilled nursing services have been discontinued.</p> <p>Review of the "Notice of Medicare Provider Non-Coverage" form for Resident #14 indicated the effective date coverage of skilled nursing services ended was 1/12/11. The resident signed the notice on 1/11/11, indicating she received the notice on that date.</p> <p>When interviewed on 7/18/11 at 8:00</p>		<p><b>Resident council minutes monthly to Ensure compliance with information. Social Service will bring logs to Medicare Meeting weekly to check for compliance of Time frames of notification. Findings will Be assessed by the QA committee for 3 months Unless findings warrant continued observations With recommendations to resolve the issue Or continue Completed by: 08/17/11</b></p>		

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	<p>a.m., the Executive Director indicated the "Notice of Medicare Provider Non-coverage" forms are to provided 72 hours prior to the end of skilled services.</p> <p>Interview with Social Service staff on 7/18/11 at 9:05 a.m., indicated the Social Service department staff were responsible for providing the Medicare non-coverage notice forms. She indicated the notice forms were to be given at a minimum of 72 hours in advance. She also indicated she gives the notices to the resident if they are alert and oriented or to the family member, if the resident is cognitively impaired, or if the resident desires. She indicated the "Notice of Medicare Provider Non-Coverage" form was not provided to Resident #14 timely.</p> <p>3. Review of the "Notice of Medicare Provider Non-Coverage" form for Resident #7, indicated the effective date coverage of skilled nursing services ended was on 1/6/11. The resident signed the notice on 1/6/11 indicating she received the notice on that date.</p> <p>Interview with Social Service staff on 7/18/11 at 9:05 a.m., indicated the "Notice of Medicare Provider</p>				

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	<p>Non-Coverage" form was not provided to Resident #7 timely.</p> <p>4. Review of the "Notice of Medicare Provider Non-Coverage" form for Resident #13, indicated the effective date coverage of skilled nursing services ended was 6/14/11. Resident #13's responsible family member signed the notice on 6/13/11, indicating he received the notice on that date.</p> <p>Interview with Social Service staff on 7/18/11 at 9:05 a.m., indicated the "Notice of Medicare Non-Coverage" form was not provided to Resident #13's family member in a timely manner. She indicated the form was to be given at a minimum of 72 hours prior to the last effective day of skilled services.</p> <p>3.1-4(f)(3) 3.1-4(j)(2)</p>				

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interviews the facility failed to ensure the resident's physician was promptly notified related to pressures sores for 1 of 3 residents reviewed for pressure sores of the 13 residents who met the criteria for pressure sores. The facility also failed to ensure the</p>	F0157	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 43 was assessed and the physician was updated in regards to pressure ulcer and treatment changed. Resident</b></p>	08/17/2011			

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	<p>resident's physician was promptly notified of a resident's legal representative's requests to resume medications for 1 of 1 residents reviewed for palliative care in the stage 2 sample of 48. (Residents #42 and #F)</p> <p>Findings include:</p> <p>1. On 7/14/11 at 2:05 p.m. Resident #F was observed in bed. R.N. #1 was observed at that time performing the pressure ulcer treatment for the resident. The resident was observed with a pressure ulcer on left gluteal fold. The pressure ulcer had a red center with pink surrounding tissue. There was depth observed to the pressure ulcer. The R.N. then packed the wound the collagen dressing and secured it with an adhesive dressing.</p> <p>The record for Resident #43 reviewed on 7/13/11 at 2:42 p.m. The resident's diagnoses included, but were not limited to, renal failure, septicemia, multiple sclerosis, dysphagia (difficulty swallowing), high blood pressure, and, neurogenic bladder.</p> <p>Review of the pressure ulcer assessment sheets indicated the resident was admitted with the</p>		<p><b>42 physician was notified of POA wishes to revoke palliative care and resume previous medications prior to palliative care request. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b>  <b>Current residents with pressure ulcers have been assessed to ensure the treatment ordered is improving the pressure area and if improvement has not been noted then the physician was notified to change treatment. No other current residents with palliative care were identified to revoke palliative care. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b>  <b>Licensed nursing staff have been inserviced with regards to notify the physician if no improvement or change is noted in pressure area for two weeks for change in treatment as well as when POA requests to revoke palliative care and resume medications. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review wounds weekly to ensure healing is occurring. If improvement is not seen within</b></p>		

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	<p>pressure ulcer on 8/9/10. The following were the resident's measurements:</p> <p>4/8/11 2.5 centimeters (cm) by .7 cm by .2 cm 4/15/11 2.5 cm by .7 cm by .2 cm 4/22/11 2.5 cm by .7 cm by .2 cm 4/29/11 2.9 cm by .6 cm by .1 cm</p> <p>The above measurements indicated there was no change or improvement in the resident's pressure ulcer.</p> <p>The following measurements were taken in June 2011: 6/17/11 2.3 cm by 1.9 cm by .2 cm 6/24/11 2.4 cm by 1.9 cm by .2 cm 6/30/11 3.6 cm by 2.3 cm by .4 cm</p> <p>The above measurements indicated there was no change or improvement in the resident's pressure ulcer.</p> <p>Review of the 12/31/10 Care Plan indicated Alteration in skin integrity pressure ulcer noted. The interventions were to notify the physician and responsible party of changes in skin status if no improvements times 2 weeks.</p> <p>Review of Nurse's Notes for the months of April and June 2011 indicated there was no documentation</p>		<p><b>two weeks, the resident physician will be notified for treatment change. A pressure ulcer audit tool will be utilized weekly times six months and reviewed monly times six months through Quality Assurance. Residents with palliative care orders that the POA wishes to revoke palliative care, will have the physician notified of POA wishes to have medications resumed. Date: 8/17/2011</b></p>		

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	<p>the resident's physician was notified there was no improvement or change of the resident's pressure ulcer.</p> <p>Interview with the 200 hall Unit Manager on 7/18/11 at 9:30 a.m., indicated she was the nurse who measured the pressure ulcer at those times, and indicated the resident's physician was not notified there was no improvement or change in the wound.</p> <p>Interview with the Interim Director of Nursing on 7/15/11 at 2:57 p.m. indicated the physician should have been made aware there was no change or improvement in the wound after two weeks.</p> <p>2. Resident #42 was observed in bed on 7/13/11 at 8:56 a.m. The head of the resident's bed was elevated, the resident's eyes were closed. The resident had a feeding tube in place. The resident's daughter was at the bedside.</p> <p>Interview with the resident's daughter on 7/13/11 at 8:56 a.m. indicated she was the resident's responsible party and was making the healthcare</p>				

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	<p>decisions for the resident. She indicated the resident had a severe stroke and was not able to eat foods by mouth. She indicated she would be receiving therapies to see how much she could improve. She indicated the stroke did not affect her ability to speak and indicated the resident was aware of her surroundings.</p> <p>The record for Resident #42 was reviewed on 7/13/11 10:14 a.m. The resident had diagnoses that included, but were not limited to, hypertension, stroke with left hemiplegia, and atrial fibrillation.</p> <p>The resident was admitted to the facility on 7/4/11, the admission orders included:                      Cardizem (a cardiac medication) 30 mg (Milligrams) per tube every 8 hours                      Colace 100 mg twice daily for constipation                      Miralax 17 Grams per tube daily for constipation                      Lisinipril 5 mg (a blood pressure medication) per tube daily                      Lisinipril 7.5 mg per tube every evening                      Plavix 75 mg (a blood thinning medication) via tube daily after 7/11/1 if condition continues to be stable and CT scan without signs of bleed.</p>						

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	<p>Jevity 1.2 (a liquid feeding) at 30 cc's (cubic centimeters)/hour, if tolerates then increase to 35 cc's /hr at 6 a.m. on 7/6/11, then increase to 40 cc's /hr at 6 p.m. then, if tolerates, increase to 45 cc/hr at 6:00 a.m. on 7/7/11.</p> <p>A physician's order dated 7/7/11 indicated, "DC (discontinue) all meds, Lortab 5/500 mg (a pain mediation) via g-tube q (every) 6 hours prn (as needed), Hospice referral, continue Jevity 45 cc/hr."</p> <p>A physician's progress note written 7/8/11 indicated the resident was to receive "palliative care."</p> <p>On 7/14/11 at 8:45 a.m., the resident's record was reviewed further. Review of the July 2011 MAR (Medication Administration Record) indicated the Cardizem, the colace, the miralax and the lisinipril were all discontinued on 7/7/11. None of the medications were given on 7/8/11, 7/9/11, 7/10/11, 7/11/11, 7/12/11 or 7/13/11.</p> <p>The Social Service progress notes dated 7/11/11 indicated, ". . . spoke w/ (with) res (resident's) daughter/POA. Wants to revoke palliative care and restart meds (medications) and therapies, all disciplines notified.</p>						

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	<p>Nurses to call MD to clarify meds (medications)."</p> <p>Review of the Nursing Progress Notes dated 7/11/11 through 7/13/11 indicated the nurses had not notified the physician of the POA( Power of Attorney)'s wishes to revoke the palliative care order and to restart the medications. There was no physician's order to clarify the medications and to restart the medications.</p> <p>Interview with the Social Service Director on 7/14/11 at 10:26 a.m. indicated the family had revoked palliative care on 7/11/11. She indicated the daughter desired therapies and medications be restarted for the resident. She indicated that she informed LPN #2 of the daughters wishes and the need to contact the physician to inform him that the daughter wanted the medications to be given to the resident.</p> <p>Interview with the Acting Unit Supervisor on 7/14/11 at 2:46 p.m., indicated she was not aware of the daughter's decision to revoke the palliative care and her decision to restart the medications.</p>				

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	<p>On 7/14/11 at 12:49 p.m., the Acting Unit Supervisor was observed interviewing the resident's daughter. When questioned regarding the restarting of the resident's medications the daughter stated, " I thought they were restarted on 7/11/11." She indicated she wanted the resident to have the medications that had been ordered on admission.</p> <p>LPN #2 was interviewed on 7/15/11 at 8:40 a.m. LPN #2 indicated she was notified on 7/11/11, by the Social Service Director, of the resident's daughter's wishes to revoke the palliative care and to restart the medications. She indicated the resident developed a fever on 7/11/11 and her status declined. She indicated she did not notify the physician of the daughter's request to restart the medications and revoke the palliative care.</p> <p>Interview with the Interim DON 7/15/11 at 8:48 a.m., indicated the physician should have been notified of the daughter's wishes to restart the medications and to revoke the palliative care on 7/11/11 as requested by the resident's POA.</p> <p><b>3.1-5(a)(3)</b></p>				

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F0164 SS=E	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to provide privacy while checking residents for incontinence for 4 residents in the Stage 2 sample of 48. Residents #138, #89, #134, and #10)</p>	F0164	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Certified nurse assistant (C.N.A) #1 was immediately educated with regards to privacy of residents</b></p>	08/17/2011	

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	<p>Findings include:</p> <p>1. On 7/13/11 at 2:25 p.m., Resident #89 was observed in a geri chair in her room. The gerichair was positioned at the foot of the bed of the resident's room mate. QMA #1 pulled down the blanket that was covering the resident's lap to check the residents incontinence brief. The resident was not wearing any pants. The resident's room mate was in bed and was awake. No privacy curtains were pulled between the two residents.</p> <p>The record for Resident #89 was reviewed on 7/14/11 at 7:44 a.m. The resident's diagnoses included, but were not limited to, Alzheimer type dementia, depression, and hallucinations. The 5/11/11 Minimum Data Set (MDS) quarterly assessment indicated the resident was incontinent of urine and required extensive assist of one staff member for toileting and personal hygiene.</p> <p>When interviewed on 7/14/11 at 8:00</p>		<p><b>during care. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: All residents have the potential to be affected however no other residents has been identified as to not having their privacy maintained. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced with regards to ensuring the privacy of each resident while receiving care. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee rounds daily to ensure privacy of the resident is maintained during care. Daily rounding is part of the ongoing QA process. Date: 8/17/2011</b></p>				

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	<p>a.m., LPN #5 indicated she was assigned to care for the resident. The LPN indicated the resident was dependent on staff for activities of daily living.</p> <p>When interviewed on 7/14/11 at 3:26 p.m., QMA #1 indicated the privacy curtain should have been pulled between the residents when providing care to Resident #89.</p> <p>2. On 7/10/11 at 8:35 p.m. , Resident #138 was observed in bed. The resident's room mate was in the other bed in the room. CNA #1 entered the room to check the resident for incontinence. The CNA removed the cover to check the resident's brief. The CNA did not pull the privacy curtain between the resident and her room mate while checking the resident's brief.</p> <p>The record for Resident #138 was reviewed on 7/15/11 at 7:15 a.m. The resident's diagnoses included, but were not limited to vertigo(dizziness) and recurrent syncope (fainting).</p>				

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	<p>The 3/17/11 Nursing Assessment and Data Collection form indicated the resident was occasionally incontinent of bladder and required the assistance of one staff member for toileting and dressing.</p> <p>When interviewed on 7/14/11 at 4:30 p.m., CNA #1 indicated the facility policy is to pull the curtain around residents while providing care. The CNA indicated privacy should have been provided when providing care to the resident.</p> <p>3. On 7/10/11 at 8:35 p.m., Resident #134 was observed in bed. The resident's room mate was in the other bed in the room. CNA #1 removed the blanket over the resident to check her for incontinence. The resident had a disposable brief on. The CNA did not pull the privacy curtain between the resident and her room mate while checking the resident for incontinence.</p> <p>The record for Resident #134 was</p>						

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	<p>reviewed on 7/15/11 at 7:25 a.m. The resident's diagnoses included, but were not limited to, anemia, depression, and renal insufficiency. A 7/12/11 Skilled Nursing and Assessment Data Collection form indicated the resident was incontinent of urine. A 5/18/11 care plan indicated the resident was needed assistance or was dependent in dressing. A care plan initiated on 5/18/11 indicated the resident was incontinent of bladder related to cognitive impairment and physical functioning.</p> <p>When interviewed on 7/14/11 at 4:30 p.m., CNA #1 indicated the facility policy is to pull the curtain around the residents while providing care. The CNA indicated privacy should have been provided when providing care to the resident.</p> <p>4. On 7/10/11 at 8:48 p.m., Resident #10 was observed in bed. CNA#1 entered the residents room to check the resident for incontinence. The CNA removed the resident's covers to observe her brief. The resident's</p>				

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	<p>room mate was in the room at this time. The CNA did not pull the privacy curtain between the residents and did not close the room door.</p> <p>The record for Resident #10 was reviewed on 7/15/11 at 7:36 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure and coronary artery disease.</p> <p>The 6/16/11 Skilled Nursing Assessment and Data Collection form indicated the resident had long term memory problems, disorganized thinking, and was incontinent of bowel and bladder.</p> <p>When interviewed on 7/14/11 at 4:30 p.m., CNA #1 indicated the facility policy is to pull the curtain around the residents while providing care. The CNA indicated privacy should have been provided when providing care to the resident.</p> <p>3.1-3(p)(4)</p>				

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F0166 SS=D	<p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure a resident's grievance related to care was acted upon in timely manner related to a resident's statement of being left on the bedpan for 1 of 1 residents who voiced a grievance in the Stage 2 sample of 48. (Resident #97)</p> <p>Findings include:</p> <p>When interviewed on 7/13/11 at 3:20 p.m., Resident #97 indicated she had been left on bedpan from 6:00 a.m. to</p>	F0166	<p>Corrective Actions accomplished for those Residents found to have been affected by The alleged deficient practice:</p> <p>The Administrator spoke with resident and Will talk with staff and the resident was pleased With the resolution.</p> <p>Identification of other residents having the potential To be affected by the same alleged deficient practice And corrective actions taken:</p> <p>The department leaders have been in serviced By the Executive Director, on the</p>	08/17/2011

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	<p>7:15 a.m. about a week or so ago. The resident indicated she kept putting her call light on and no one came to get her off until 7:15 a.m. The resident indicated she informed the Activity Director of the concern that morning. The resident indicated that no one had spoken to her related to her concern of being left on the bed pan since the incident occurred.</p> <p>The record for Resident #97 was reviewed on 7/13/11 at 3:33 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, depression, and anxiety.</p> <p>The 5/29/11 Nursing Admission Assessment and Data Collection form indicated the resident was alert and orientated, understood, and her speech was clear. The 5/19/11 Minimum Data Set (MDS) quarterly assessment indicated the resident had no memory problems and she required assistance with toileting, personal hygiene, and transfers.</p> <p>The facility policy titled "Service Recovery Process and Follow Up"</p>		<p>importance of using our Concern Form and the proper channels the form goes thru to ensure resolution and follow thru.</p> <p>Measures put into place and systemic changes Made to ensure the alleged deficient practice does Not recur:</p> <p>The Concern forms will be brought to morning Meeting daily and reviewed by department staff and Executive Director and or designee to ensure the Appropriate staff is aware of the concern. The Concern form will then be reviewed by Executive Director or designee to ensure all appropriate actions Have occurred.</p> <p>How the corrective measures will be monitored to ensure The alleged deficient practice does not recur:</p> <p>The Concern log will be brought thru Quality Assurance the committee will assess findings Monthly x 3 months unless findings warrant Continued observations with recommendations To resolve the issue or continue.</p>		

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	<p>was reviewed on 7/13/11 at 4:40 p.m. The policy was received from the Social Service Director who verified the policy was current. The policy was dated 10/09. The policy indicated staff were to complete a Concern Form and implement steps so the situation does no reoccur and the concern form insures that everyone is aware of the concern to work to resolve the concern. The policy also indicated concern forms were to be reviewed in daily meetings to be resolved.</p> <p>When interviewed on 7/13/11 at 4:41 p.m., the Social Service Director indicated the last grievance she was aware of from the resident was on the 27th and she was not aware of any current grievances.</p> <p>When interviewed on 7/13/11 at 3:42 p.m., the Activity Director indicated that he was working the weekend (7/10/11) and when he came in on that Sunday the resident told him that the nurse put her on the bedpan before she left and she was on it for awhile. The Activity Director indicated</p>		Date: 08/17/11		

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	<p>that he did not talk with any nursing staff about the resident's concern as the Unit Manager was not there and the nurse had left already. The Activity Director indicated he wrote the resident's concern on a piece of paper and put it in the Executive Directors mailbox on 7/10/11.</p> <p>When interviewed on 7/13/11 at 4:10 p.m., the Executive Director indicated on 7/12/11 he first reviewed the paper the Activity Director left in his box from the weekend. The Director indicated the resident had not been talked to about the issue of being left on the bedpan. The Executive Director indicated the Activity Director was the weekend manager and he left the note in his box. The note was not on a Concern Form.</p> <p>When interviewed on 7/15/11 at 2:51 p.m., the Executive Director indicated the Activity Director should have completed a Resident Concern Form at the time the resident voiced the concern.</p> <p>3.1-7(a)(2)</p>				

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

PRINTED: 08/23/2011

FORM APPROVED

OMB NO. 0938-0391

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F0172 SS=C	<p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p> <p>Based on record review and interview the facility failed to ensure the</p>	F0172	<p>Corrective actions accomplished for Those residents found to have been</p>	08/17/2011	

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	<p>residents were aware of who the Ombudsman was related to interview of 1 of 1 resident interviewed related to knowledge of the Ombudsman in the Stage 2 sample of 48. This had the potential to affect 148 of 148 residents in the facility. (Resident #41).</p> <p>Findings include:</p> <p>Interview with the Resident #41 on 7/14/11 at 1:30 p.m., indicated he was not aware of who the Ombudsman was.</p> <p>Interview with the Activity Director on 7/15/11 1:00 p.m., indicated he had handed out the pamphlets the Ombudsman left for him after attending one of the resident council meetings. The Activity Director then indicated the Ombudsman attended a resident council meeting on 4/5/2010 (over 15 months ago).</p> <p>Review of the Resident Council minutes from 4/10 through 6/10, indicated there was no documentation of who the Ombudsman was or how to get a hold of her.</p> <p>3.1-8(b)(4)</p>		<p><b>Affected by the alleged deficient Practice:</b></p> <p><b>Resident # 41 has been informed of How to formally file a complaint To the State about care he receives. Measures put into place and systemic Changes made to ensure the alleged deficient Practice does not recur:</b></p> <p><b>A posting of information is available in the Front lobby and a posting is placed in the Activity room. Resident council meeting education on this Process was presented to the council. How the corrective measures will be monitored To ensure the alleged deficient practice does Not recur:</b></p> <p><b>Executive Director or designee will go over Resident council minutes monthly to Ensure compliance with information. Be assessed by the QA committee for 3 months Unless findings warrant continued observations With recommendations to resolve the issue Or continue</b></p>		

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F0246 SS=D	<p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interviews, the facility failed to ensure the resident's call lights were positioned so that the residents could reach them and call for assistance for 2 residents in the Stage 2 sample of 48. (Residents #J and #K)</p> <p>Findings include:</p> <p>1. Resident # J was observed in bed on 7/13/11 at 11:17 a.m. The resident's call light was not within reach. The call light was on the side of the bed, attached to bed rail. The call button was hanging below the level of the mattress. When interviewed at this time, the resident indicated she could not reach the call light.</p> <p>The resident was observed in bed on 7/13/11 at 1:21 p.m. The resident's call light was not in reach. When asked if she could turn on the call light, the resident indicated that she did not know where the call light was. The call light was on side of bed,</p>	F0246	<p><b>Completed by: 08/17/11</b></p> <p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident J and K had their call lights placed within reach.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b></p> <p><b>No negative outcome was noted.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Nursing staff was inserviced with regards to call light placement to be within the reach of the resident when in their room.</b></p>	08/17/2011	

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	<p>attached to bed rail, the call button was hanging below the level of the mattress.</p> <p>The resident was observed on 7/15/11 at 8:21 a.m. The resident was in bed and her breakfast tray was in front of her on the overbed table. The head of the bed was up. The resident's call light was on the top of the pillow, above her head. It was not within her reach. When interviewed at this time, the resident indicated she did not know where call light was.</p> <p>On 7/18/11 at 7:15 a.m., the resident was observed in bed. The resident's call light was not in reach. The call button of the call light was lying on the floor.</p> <p>Interview with LPN #1 on 7/18/11 at 8:27 a.m. indicated the resident was capable of using the call light. She indicated the resident often did use the call light to request assistance.</p> <p>2. Resident #K was observed on 7/10/11 at 9:10 p.m. in bed. The resident's call light was not within reach. It was on the resident's bedside table. The resident was not able to speak and was motioning for the ceiling light to be turned off.</p>		<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will round daily to ensure that call lights are within the reach of the resident when in their room as part of the ongoing QA process.</b></p> <p><b>Date: 8/17/2011</b></p>		

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F0247 SS=A	<p>The record for Resident #K was reviewed on 7/18/11 at 7:37 a.m. The resident's diagnoses included, but were not limited to, expressive aphasia (difficulty speaking).</p> <p>The 200 Unit Supervisor was interviewed on 7/18/11 at 9:18 a.m. She indicated that the resident is able to use the call light. She indicated the resident was aphasic and could not speak, but could gesture her needs. She indicated sometimes the resident would make loud sounds to gain staff's attention. She indicated the call light should have been within the resident's reach.</p> <p>This Federal tag relates to Complaint IN00091661.</p> <p>3.1-3(v)(1)</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident was notified of a roommate change for 1 of 2 residents who had received a new roommate of the 13 who met the criteria for admission, transfer and discharge. (Resident #41)</p>	F0247	Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:At this point the documentation can not be done. Identification of other residents having the potential to be affected by the same alleged	08/17/2011	

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F0253 SS=E	<p>Findings include:</p> <p>The record for Resident #41 was reviewed on 7/15/11 at 7:00 a.m. Review of the Social Service progress notes for the dates of 10/29/10 to current, indicated there was no documentation about the resident receiving a new roommate.</p> <p>Interview with the Social Service Director on 7/15/11 at 2:04 p.m., indicated the resident had received a new roommate in the past few months. She further indicated nothing had been documented in the resident's record. She indicated that she usually just told the resident when he was getting a new roommate. She indicated documentation should have been completed in the resident's record.</p> <p>3.1-3(v)(2)</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to dust on the</p>	F0253	<p>deficient practice and corrective actions taken:Review of last thirty days shows no other infractions.Measures put into place and systemic changes made to ensure the alleged deficient practice does does not recur:All room moves will be discussed during morning meeting and reviewed that residents know about change. This will be documented on morning form.How the corrective measures will be onitored to ensure the alleged deficient practice does not recur:Social Service or designee will monitor room changes and report the results to the QA Committee. The QA Committee will assess findings with recommendations to resolve issues or continue audit functions for three months.Date: 8/17/2011</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:Room 101 was completely clean including</p>	08/17/2011			

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	<p>sprinkler heads, dust in ceiling vents, mold on the carpet, broken light fixture, marred, scratched and soiled chairs, marred and dented walls, insects in the light fixtures, heating/air conditioning units loose, detached, and paint chipped, marred, gouged and chipped doors, and missing light cords for 3 of 4 units. This had the potential to affect 116 of the 148 residents residing in the facility. (Legacy Lane, 200 Unit and 300 Unit)</p> <p>Findings include:</p> <p>The following was observed during the Environmental Tour on 7/15/11 from 1:00 p.m. to 2:30 p.m.:</p> <p>On Legacy Lane:</p> <p>a. In room 101, dead insects were observed in the light fixture in the center of the room. There was an area of mold on the carpet by the window, the mold was white in color and 12 inches in diameter. There was dust on the sprinkler head in the bathroom. The edge of the bathroom light fixture was on top of the light. There was one resident residing in room 101. There were 3 residents who used the bathroom.</p> <p>b. In room 104, the cover of the</p>		<p>bathroomRoom 104 Heating/air conditioner unit cover was repairedRoom 113 Bathroom door was repairedRoom 125 Bathroom door was repairedLegacy Lane rower room call light box was repaired and paintedRoom 202 Cord was place on overbed lightRoom 204 Closet door was painted and repairedRoom 209 Wall was painted. Closet door repaired and paintedRoom 226 Bathroom vent was cleaned and wall painted. Chair was cleaned.Room 227 Wall was repaired. Toliet bowl was cleaned.Room 234 The chair was cleanedHeating/air conditioning unit in 200 hall was repaired and paintedRoom 302 Bathroom door plate was paintedRoom 308 Wall next to and in the bathroom was painted. String was place on the pull string for the overbed light. Bathroom door was repaired and painted. The pull cord for the call light was put on.Room 310 The edge of the bathroom door and wall next to the closet doors was painted.Room 322 the bathroom door was repaired300 unit shower room light was repaired. The walls were painted and ceiling.300 unit sitting area the chairs were repaired and painted.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:Complete rounds</p>		

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	<p>heating/air conditioner unit was loose and detached from the wall. Two residents resided in room 104</p> <p>c. In room 113, the inside of the bathroom door was marred and scratched. Two residents used the bathroom.</p> <p>d. In room 125, the inside of the bathroom door was marred and scratched. 4 residents used the bathroom.</p> <p>e. There was a call light box in the Legacy Lane shower room. The box was rusted and needed to be painted or replaced. 36 residents used the shower room.</p> <p>When interviewed at the time of the Environmental Tour on Legacy Lane, the Administrator verified the above number of residents used the rooms.</p> <p>On the 200 Unit:</p> <p>a. In room 202, there was no pull cord for the overbed light above the bed near the door. 1 resident used the light.</p> <p>b. In room 204, the closet door edges were marred and gouged. 2 residents resided in the room.</p>		were made by Housekeeping Supervisor and Plant Operations Director for issues and no others were found.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Housekeeping Supervisor, Plant Operations Director and Administrator / or designees will make rounds three times a week, to inspect for issues.How the corrective meaures will be monitored to ensure the alleged deficient practice does not recur:Housekeeping Supervisor, Plant Operations Director and Administator or designee will report findings of rounds to the QA Committee. The QA Committee will assess findings with recommendations to resolve issues or continue audit functions for three months. Date: 8/17/2011		

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	<p>c. In room 209, the wall between the baker's rack and the table had black scuff marks. The closet door edges were marred and gouged. 2 residents resided in the room.</p> <p>d. In room 226, the bathroom ceiling vents were dirty and dusty, the wall was marred, the room chair had stains. 1 resident resided in room 226 and 2 residents used the bathroom.</p> <p>e. In the bathroom of room 227, the walls next to the toilet and behind the toilet had dents in the plaster board. The toilet bowl had rust stains. 4 residents used the bathroom.</p> <p>f. In room 234, the room chair was soiled and stained. 1 resident resided in the room.</p> <p>g. The heating/air conditioning unit in the 200 hall near room 234 had missing caulking and chipped paint. 43 residents resided on the 200 unit.</p> <p>When interviewed at the time of the Environmental Tour on the 200 unit, the Administrator verified the above number of residents used the rooms.</p> <p>On the 300 unit</p>				

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	<p>a. In room 302, the bathroom door plate was scratched on the bottom. 2 residents used the bathroom.</p> <p>b. In room 308, the wall next to bathroom was marred. The wall in the bathroom was marred. The overbed light, above the bed near the door, had no pull string. The wood near the top of the bathroom door was gouged. There was no pull cord for the call light in the bathroom. 2 residents resided in the room and 4 residents used the bathroom.</p> <p>c. In room 310, the edge of the bathroom door was chipped, the wall next to the closet doors was marred. 2 residents resided in the room.</p> <p>d, In room 322, the wood was splintered on the edge of the bathroom door. 1 resident resided in the room</p> <p>e. In the 300 unit shower room, 1 of 6 lights was not functioning. 2 of 4 walls had peeling paint, 2 inches from the ceiling. The walls were in need of painting. 37 residents resided on the 300 unit.</p> <p>f. 9 of 9 chairs in the 300 unit sitting area had legs that were scratched and marred and in need of varnish.</p>				

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	<p>When interviewed at the time of the Environmental Tour on the 300 unit, the Administrator verified the above number of residents used the rooms.</p> <p>Interview with the Administrator on 7/15/11 at 3:10 p.m. indicated all the above areas were in need of repair or cleaning.</p> <p>3.1-19(f)</p>			

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F0272 SS=D	<p>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 record review and interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were completed within the correct time frame and all required area on the MDS were completed for 3 of 21 resident's MDS assessments reviewed in a Stage 2 sample of 48. (Residents #193, #223, and #241)</p>	F0272	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The MDS's have been corrected for residents 193, 223 and 241. Identification of other residents having the potential to be affected by the same alleged deficient practice and</b></p>	08/17/2011	

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	<p>Findings include:</p> <p>1. The record for Resident #241 was reviewed on 7/15/11 at 9:41 a.m. The resident was admitted to the facility on 6/15/11.</p> <p>The MDS admission assessment was reviewed. The MDS assessment was dated 6/24/11. The following sections on the MDS were not completed: Section P - Restraints Section L- Oral/Dental Status Section J- Health Conditions related to Falls and Pain. Section F- Staff Assessment of Daily and Activity Preferences Section G- Activities of Daily Living Assistance Section H- Bladder and Bowel The CAA (Care Area Assessment) Summary was also incomplete. The Location and Date of CAA Information areas were not completed.</p> <p>Interview with the Assistant Administrator on 7/16/11 at 9:23 a.m., indicated the resident's MDS assessment had not been completed within 14 days of admission.</p> <p>2. The record for Resident #193 was reviewed on 7/13/11 at 9:17 a.m. The resident was admitted to the facility on 1/26/11. The Admission MDS</p>		<p><b>corrective actions take: MDS coordinators have reviewed all current residents to ensure MDS's are completed and timely. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: MDS coordinators and Unit manager nurses have been inserviced by the MDS assessment support nurse to ensure MDS assessments are completed timely per the MDS schedule. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: MDS coordinators will review the MDS schedule weekly to ensure the MDS's are completed timely. ED/DHS and or designee will review MDS schedule weekly as part of the ongoing QA process to ensure timliness of completion of MDS's. Date: 8/17/2011</b></p>		

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	<p>(Minimum Data Set) assessment was completed on 2/4/11. There was no Quarterly MDS completed for the resident. The resident had remained in the facility since admission on 1/26/11.</p> <p>Interview with the Executive Director on 7/14/11 at 9:10 a.m. indicated the last MDS completed for the resident was an admission MDS with the completion date of 2/4/11. He indicated a Quarterly MDS should have been completed in May 2011.</p> <p>3. The record for resident #223 was reviewed on 7/14/11 at 4:00 p.m. The resident had an Admission MDS completed on 5/25/11. The Urinary Incontinence and Indwelling Catheter Care Area was triggered because the resident had a indwelling catheter in place at the time of admission. The MDS indicated there was a Care Area Assessment (CAA) Summary completed. Review of the record indicated there was no CAA summary noted for the care area of Urinary Incontinence and Indwelling Catheter.</p> <p>On 7/15/11 at 12:59 p.m. the Executive Director was interviewed. He indicated there was no Care Area Assessment summary completed for Urinary Incontinence and Indwelling</p>				

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F0279 SS=E	<p>Catheter. He indicated the Admission MDS was incomplete. He indicated the Care Area Assessment section of the MDS was not completed for Resident #223.</p> <p>3.1-31(a)</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). Based on record review and interview, the facility failed to ensure a care plan was developed related to toileting, activities of daily living, urinary tract infections and foley catheter use for 4 of 23 sampled residents of the 48 residents who were included in the Stage 2 review.</p>	F0279	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Careplans were reviewed and updated for the residents identified at the time of survey. Res F, G, J and 223. Identification of other</b></p>	08/17/2011	

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	<p>(Residents #F, #G, #J, and #223)</p> <p>Findings include:</p> <p>1. The record for Resident #G was reviewed on 7/13/11 at 10:12 a.m. The annual Minimum Data Set (MDS) Assessment dated 6/3/11, indicated the resident was extensive assist with toileting with two person physical assist. The MDS also indicated the resident had a trial of a toileting program (for example a scheduled toileted program, prompted voiding, or bladder training). The resident was also documented as being always incontinent of urine.</p> <p>The CAA (Care Area Assessment) Summary dated 6/3/11, indicated incontinence had triggered due to dementia, unable to recognize need to void. Documentation indicated the staff provided toileting assistance and incontinence care as needed. This area was to be addressed on the resident's plan of care.</p> <p>A plan of care dated 9/9/10 and reviewed on 4/20/11, indicated the resident had an ADL (activity of daily living) self-care deficit or potential for as evidenced by needs assist or is dependent in personal hygiene and toilet use.</p>		<p><b>residents having the potential to be affected by the same alleged deficient practice and corrective actions take: All current residents careplans have been reviewed and updated to reflect current status of the resident. C.N.A. assignment sheets have been updated with any changes that were made to the resident plan of care. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced with regards to the resident plan of care information being updated as well as the C.N.A. assignment sheets to deliver care of the resident. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review resident information such as physician orders or personal preferences and the careplan and C.N.A assignment sheets will be updated with that information Monday thru Friday during clinical meeting to ensure residents plan of care is followed as part of the ongoing QA process. Date: 8/17/2011</b></p>		

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	<p>Review of the interventions indicated toileting was not addressed. There was also no separate care plan related to urinary incontinence.</p> <p>2. The record for Resident #F was reviewed on 7/13/11 at 2:42 p.m. Review of laboratory results indicated an urinalysis was completed on 6/7/11. The final culture for the urinalysis indicated the resident had an urinary tract infection with greater than 100,000 e-coli (a bacteria).</p> <p>Further review of the laboratory results dated 7/7/11 indicated another urinalysis was completed. The final urine culture dated 7/9/11 indicated the resident had an urinary tract infection with greater than 100,000 e-coli.</p> <p>Interview with RN #1 on 7/15/11 at 2:09 p.m. indicated the resident had history of urinary tract infections and there probably should have been a care plan for that problem.</p> <p>3. The record for Resident #J was reviewed on 7/14/11 at 9:55 a.m. There was an Annual MDS (Minimum</p>			

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	<p>Data Set) assessment completed on 2/16/11. The resident was coded as requiring extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. It also indicated the resident required limited assistance with eating.</p> <p>The MDS indicated the resident's ADL (activities of daily living) Functional/Rehabilitative Potential was triggered and was addressed in the resident's care plan.</p> <p>Review of the resident's current care plan indicated there was no care plan for ADL function.</p> <p>Interview with 300 Unit MDS staff on 7/14/11 at 3:03 p.m. indicated there was no ADL care plan noted in the resident's current plan of care. She indicated there should have been an ADL care plan in the resident's current plan of care.</p> <p>4. Resident #223 was observed in bed on 7/11/11 at 12:10 p.m. The resident was observed to have an indwelling catheter. The catheter drainage bag had been placed in a dignity bag.</p> <p>The record for resident #223 was</p>				

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	<p>reviewed on 7/14/11 at 4:00 p.m. The resident had an Admission MDS (Minimum Data Set) completed on 5/25/11. The MDS indicated the resident had an indwelling catheter in place.</p> <p>Review of the July 2011 Physician Order Sheet indicated the resident's Foley catheter was to be changed as needed to maintain patency.</p> <p>Review of the resident's current care plans indicated there was no care plan for an indwelling catheter.</p> <p>Review of the 1/08 current Change in Condition form guidelines policy provided by LPN #6 indicated the purpose of the policy was to facilitate the thorough and consistent review and completion of the nursing probes by use of a form that documents the change in the resident status, physician response, care plan update and notification of change. The care plan update section indicated the care plan update section will be completed in its entirety.</p> <p>On 7/15/11 at 12:59 p.m. the Executive Director was interviewed. He indicated there was no care plan for the use of the indwelling catheter. He indicated there should have been</p>				

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F0282 SS=E	<p>a care plan for the use of the indwelling catheter.</p> <p>3.1-35(a)</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, record review and interview, the facility failed to ensure physician orders and/or the plan of care were followed as written related to the use of geri-sleeves, wheelchair alarms, incontinence care, providing care by females, sliding scale insulin coverage, and the lack of the use of a hooyer lift for transfers for 5 of 23 resident's reviewed in the Stage 2 sample of 48. (Residents #B, #C, #D, #G, and #H)</p> <p>Findings include:</p> <p>1. On 7/13/11 at 8:40 a.m., Resident #C was observed seated in a wheelchair in the hallway of the 300 unit. A wheelchair alarm unit was hanging from the back of the resident's wheelchair. There was no cord attached to the unit. At 10:38 a.m., the resident was in his room in</p>	F0282	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Residents B, C, D, G, and H were reviewed at time of survey to ensure wheelchair alarm is attached to resident and that residents with the hooyer lift are transferred with the hooyer lift and two assist and the resident with geri-sleeves have them in place. Incontinence care provided every two hours, C.N.A assignment sheets that designate only care provided by females is given. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents that have alarms while in wheelchair and or bed have been reviewed to ensure alarm is in place.</b></p>	08/17/2011	

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	<p>bed sleeping. The wheelchair was observed next to the resident's bed. The wheelchair alarm unit was hanging off of the wheelchair handle. No cord was attached to the unit. No sensor pad was observed in the resident's wheelchair. The sensor pad was observed on top of the toilet tank in the resident's bathroom. At 11:30 a.m., the resident was observed up in his wheelchair in the 300 unit dining room. The wheelchair alarm unit was attached to the wheelchair handle. No cord was attached and the alarm was not flashing, indicating it was not in use.</p> <p>The record for Resident #C was reviewed on 7/13/11 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dizziness, history of syncope and status post pacemaker placement.</p> <p>A Physician's Order dated 7/2/11, indicated a pressure sensitive alarm to the bed and wheelchair was to be used and the function was to be checked every shift.</p> <p>The plan of care dated 3/30/11, indicated the resident was at risk for falls due to history of falls. One of the interventions listed, indicated bed and wheelchair alarms may be used.</p>		<p><b>Current residents that are transferred via hooyer lift have been reviewed to ensure transfers are completed with two person assist and the hooyer lift. Current residents with geri-sleeves have been reviewed to ensure geri-sleeves are on the resident. Residents that are incontinent are checkd and changed every two hours as well as any personal preference for only female caregivers to provide care for he resident. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced with regards to residents that have alarms, transferred via a hooyer lift with two assist and have geri-sleeves on and incontinent residents are checked and changed every two hours along with the personal preference of having only female caregivers to provide care is followed. Careplans and C.N.A assignment sheets have been reviewed and updated with current information to care for the resident. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will randomly choose five residents</b></p>				

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	<p>Interview with CNA #1 on 7/13/11 at 3:30 p.m., indicated the resident was supposed to have a bed and chair alarm in use. She also indicated that documentation on the CNA assignment sheet indicated the resident was a fall risk and alarms were to be used.</p> <p>Interview with LPN #1 on 7/15/11 at 2:15 p.m., indicated the resident had orders for bed and wheelchair alarms due to a history of leaning in the wheelchair. She also indicated the alarm was to be attached to the wheelchair when the resident was gotten up.</p> <p>Further record review on 7/15/11 at 8:00 a.m., indicated a Physician's Order dated 7/2/11 for Glucometers before meals and at bedtime Humulin R (insulin) sliding scale coverage:</p> <p>The resident was to receive the following sliding scale coverage based on his glucometer results:</p> <p>150-199=1 unit 200-249=2 unit 250-299=3 unit 300-349=4 unit Greater than 350=5 units</p>		that have been identified with alarms, hoyer transfers and geri sleeves, check and change incontinent residents as well as resident personal preferences to only have female caregivers provide care to weekly times six months and review monthly time six months through Quality Assurance. <b>Date: 8/17/2011</b>		

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	<p>The Diabetic Flow Sheet for the month of July 2011, indicated the resident's blood sugar on 7/12/11 at 11:00 a.m., was 156, no insulin was documented as being given. On 7/13/11 at 4:00 p.m., the resident's blood sugar was 341, the resident received 5 units of insulin rather than the ordered 4 units.</p> <p>Interview with LPN #1 on 7/18/11 at 9:44 a.m., indicated the wrong insulin dose was given on 7/13/11 and no insulin was documented as being given on 7/12/11 for the blood sugar of 156.</p> <p>2. On 7/11/11 at 9:16 a.m., Resident #D was observed seated in a wheelchair in the 200 unit lounge. A dressing dated 7/10/11 was observed on the resident's right upper arm as well as a greenish/yellow bruise. The resident was wearing a short sleeve shirt.</p> <p>On 7/12/11 at 8:15 a.m., the resident was observed in her wheelchair wearing a short sleeve shirt.</p> <p>On 7/13/11 at 8:32 a.m., the resident was observed in her wheelchair being transported to the 200 unit, the resident was wearing a short sleeve shirt. At 10:09 a.m., the resident was</p>				

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	<p>in her room in bed. The resident was wearing a short sleeve shirt. At 11:30 a.m., the resident was seated in her wheelchair in the 300 unit dining room. The resident was rubbing her arms. She was wearing a short sleeve shirt at this time. At 1:10 p.m. 2:58 p.m. and 3:39 p.m., the resident was in her room in bed. The resident was wearing a short sleeve shirt.</p> <p>The record for Resident #D was reviewed on 7/13/11 at 1:17 p.m. A Physician's Order dated 6/20/11, indicated the resident was to wear geri-sleeves all the time-may take off during bath and care.</p> <p>The July 2011 Treatment Administration Record (TAR), indicated the geri-sleeves had been signed out on all 3 shifts 7/1-7/13/11</p> <p>Interview with CNA #11 on 7/14/11 at 1:20 p.m., indicated the residents who have geri-sleeves and/or alarms, were listed on their CNA assignment sheets. He also indicated a list was kept at the nurses' station. Further interview at 2:02 p.m., indicated the geri-sleeves were not listed on the resident's care card and that he put the geri-sleeves on the resident due to her scratching her arms.</p>				

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	<p>Interview with the 200 Unit Manager on 7/18/11 at 9:15 a.m., indicated the resident was to have geri sleeves on at all times. She further indicated the geri sleeves should not have been signed out on the treatment record if they were not in use.</p> <p>3. During observation on 7/15/11 at 1:10 p.m., Resident #H was taken to her room by CNA #9. When the resident was transferred out of her wheelchair and put to bed, the seat of her pants were observed to be wet. When the resident's incontinence brief was removed, the brief was saturated with urine. Interview with CNA #9 at the time, indicated the resident was last changed prior to lunch around 9:30-10:00 a.m.</p> <p>The record for Resident #H was reviewed on 7/13/11 at 8:51 a.m. The resident's diagnoses included, but were not limited to, dementia, contact dermatitis and eczema.</p> <p>The resident's plan of care dated 12/15/10 and last reviewed on 5/27/11, indicated the resident was incontinent of bowel and bladder related to cognitive impairment and decreased physical functioning.</p> <p>The following care plan interventions</p>				

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	<p>were listed:</p> <ul style="list-style-type: none"> <li>-Check and change every 3 hours and prn</li> <li>-Toilet before and after meals, upon rising in the AM and before bed at night</li> <li>-Wear incontinent product at all times</li> <li>-Monitor for signs and symptoms of urinary tract infections.</li> </ul> <p>Interview with LPN #4 on 7/18/11 at 9:50 a.m., indicated the resident was to be checked and changed for incontinence at least every two hours and as needed.</p> <p>4. On 7/14/11 at 12:45 p.m., Resident #G was observed in her room in bed. Incontinence care was being provided by two CNA #11 and CNA #15. Both of the CNA's were males.</p> <p>Interview with CNA #10, who was a female, on 7/14/11 at 12:00 p.m., indicated that she was assigned to take care of the resident.</p> <p>The record for Resident #G was reviewed on 7/13/11 at 10:12 a.m.</p> <p>A plan of care dated 6/6/11, indicated "Resident is non-reliable responder as</p>				

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	<p>evidenced by told staff she was sexually assaulted by 2 (race documented) men related to vascular dementia with psychosis, resident has not had any (race documented) male caregivers or visitors, resident confused as to whether alleged incident happened "in my dream while I was asleep."</p> <p>One of the care plan interventions indicated female caregivers whenever possible.</p> <p>A plan of care dated 6/6/11 indicated the resident had the behavior problem of delusions and hallucinations, believes she has been sexually assaulted.</p> <p>One of the interventions indicated, reduce the following stressors that may be contributing to the resident's inappropriate behaviors: female caregivers whenever possible.</p> <p>Interview with CNA #10 on 7/14/11 at 2:00 p.m., indicated the resident had a previous behavior of accusing (race stated) male CNA's of mistreatment. She further indicated no (race stated) male CNA's were supposed to care for the resident.</p> <p>Interview with RN # 4 on 7/14/11 at</p>				

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	<p>4:00 p.m., indicated whenever possible, the resident was not to have male caregivers due to an incident a few months ago.</p> <p>Interview with the 200 Unit Manager on 7/18/11 at 9:15 a.m., indicated the resident was not to have (race stated) male CNA's caring for her. She also indicated that she did not know why CNA #11 and CNA #15 put the resident back to bed when the resident was assigned to a female CNA.</p> <p>5. On 7/13/11 at 10:00 a.m., CNA #6 and CNA #7 were observed in Resident #B's room. At that time, CNA #6 was observed transferring the resident by herself with a gait belt from the wheelchair to the bed. CNA #6 transferred the resident by herself and did not use a hooyer lift to transfer the resident to bed. The resident was not able to stand by herself and did not bear any weight on both of her legs. CNA #6 indicated the resident was up in her wheelchair before she arrived to work. CNA #6 indicated the midnight shift staff were assigned to get the resident up and they</p>				

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	<p>usually get the resident up between 5:00 a.m. and 6:00 a.m. CNA #6 then indicated she had not checked or changed the resident since she had been gotten up on the midnight shift. She indicated that was her original brief that was placed on her when she was gotten up out of bed that morning. CNA #6 further indicated all residents were to be checked and changed at least every two hours. CNA #6 was then observed performing incontinence care for the resident. The resident was saturated with urine, her incontinent brief was very wet and she had dried bowel movement on her buttocks.</p> <p>On 7/14/11 at 9:03 a.m., the resident was observed sitting in hallway outside of her room.</p> <p>On 7/14/11 at 9:36 a.m., CNA #8 indicated she was going to lunch. Observation at this time indicated CNA #8 did not check the resident for incontinence at this time.</p> <p>On 7/14/11 at 9:45 a.m., the 300 Unit Manager was observed speaking with resident. The resident was not checked for incontinence at this time. The resident remained in her wheelchair in the hallway outside of her room.</p>				

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	<p>On 7/14/11 at 10:11 a.m., no staff were observed checking the resident for incontinence and the resident remained seated outside of her room.</p> <p>On 7/14/11 at 10:39 a.m., the Co-Activity Director was observed taking the resident to the activity room. The resident was not checked for incontinence by any staff member before she was taken to the activity room.</p> <p>On 7/14/11 at 11:10 a.m., the resident was observed in activity room sitting at a table waiting for her nails to be painted.</p> <p>On 7/14/11 at 11:40 a.m., the resident was observed in the dining room on the 300 hallway. No staff were observed checking the resident for incontinence.</p> <p>On 7/14/11 at 1:01 p.m., the resident was observed sitting in front of her room. The resident's red pants were observed to be wet in the peri area. CNA #8 was observed in the resident's room at this time. CNA #8 indicated she was taking care the resident and she needed to get another CNA to help her transfer the resident with the hooyer lift.</p>				

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	<p>On 7/14/11 at 1:05 p.m., the resident was observed in bed and CNA #8 was observed checking the resident for incontinence. When interviewed at this time, CNA #8 indicated she had checked the resident for incontinence around 9:00 a.m. and the resident's brief line was not blue(indicating the resident was not wet) and she did not change her at that time. CNA #8 indicated she checked the resident while she was sitting up in the wheelchair and did not lay her down. The CNA indicated the resident was a midnight get up and staff usually get the residents up between 4 and 5 a.m., but did not know exactly what time Resident #B was gotten up that day. Observation at this time indicated the residents pants were saturated with urine and her brief was saturated with urine. The residents buttocks were red and pink with wrinkles of the brief on her buttocks. The resident was observed with dark brown bowel movement on her buttocks and in her brief. CNA #8 indicated at this time, the resident had on the same incontinent brief that was placed on her when she was gotten out of bed that morning.</p> <p>The record for Resident #B was reviewed on 7/13/11 at 10:39 a.m.</p>				

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	<p>The resident's diagnoses included but were not limited to, stroke with right sided hemiplegia, chronic obstructive pulmonary disease, aphasia, and fracture neck of right femur.</p> <p>Review of the current plan of care dated 4/6/10 and updated 6/30/11 indicated the resident had an ADL (Activities of Daily Living) self care deficit and needed, assistance or was dependent in transfers and toilet use. The interventions were to transfer the resident with the a hooyer lift. Review of another current plan of care dated 4/26/11 indicated the resident was at risk for bone fracture related to osteoporosis. The interventions were to provide assistance with transfers/hoyer.</p> <p><b>Review of the current CNA assignment sheet indicated the hooyer lift was to be used to transfer the resident.</b></p> <p><b>Interview with CNA #6 on 7/13/11 at 10:00 a.m., indicated she always transferred the resident with her gait belt.</b></p> <p>Review of the CNA assignment sheet indicated the resident was to be checked every hour for wetness.</p>				

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F0309 SS=D	<p>Review of the current plan of care updated on 6/30/11 indicated the resident was incontinent of bowel and bladder related to physical functioning. The interventions were for staff to toilet the resident before and after meals, upon rising in the a.m., and before bed at night.</p> <p>3.1-35(g)(2)</p> <p>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. Based on observation, record review and interview, the facility failed to ensure medications were administered after palliative care had been revoked for 1 of 1 residents reviewed for palliative care in the Stage 2 sample of 48. The facility failed to ensure other skin conditions related to bruising were assessed for 2 of 3 residents in the reviewed for other skin conditions of the 9 residents who met the criteria for other skin conditions. (Residents #42, #155, and #244)</p> <p>Findings include:</p>	F0309	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 244 and 155 were assessed during the time of the survey and bruises were identified on the non pressure skin sheet. Physician and family were notified of bruising. Resident 42 physician was notified that the POA wished to revoke the palliative care and resume previous medications prior to palliative care. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b></p>	08/17/2011	

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	<p><b>1. On 7/13/11 at 8:52 a.m. Resident #244 was observed in bed. The resident was awake, alert, and oriented. During interview at that time, the resident indicated he just had his leg amputated last week. There were staples observed to the resident's left leg stump at this time. Red and purple bruising was also observed underneath the stump and to the left of the staples.</b></p> <p>The record for Resident #244 was reviewed on 7/13/11 at 9:00 a.m. The resident was admitted to the facility on 7/6/11 from the hospital. The resident's diagnoses included, but were not limited to, anemia, left above the knee amputation, and peripheral vascular disease.</p> <p>Review of the Admission Assessment dated 7/6/11 indicated there was no bruising on admission assessment. Review of the Nurse's Notes dated 7/6/11 at 5:00 p.m., indicated the resident had purple bruising under and to the side of left aka (above the knee amputation) stump, right hip, and right lower abdomen area.</p> <p>Review of the 7/6/11 Other Skin Impairment assessment record indicated there were no</p>		<p><b>Current residents have been assessed for any other skin condition that are non pressure such as bruises and the non pressure skin sheet and skin impairment circumstance form completed to monitor skin condition until resolved. Current resident receiving palliative care have been reviewed to ensure POA wishes to revoke palliative care and resume medications. Currently, residents receiving palliative care did not want it revoked. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced to identify any skin condition such as bruises for assessment and completion of the skin impairment circumstance form and non pressure sheet. Nursing staff have been inserviced to identify and skin condition such as bruises for assessment and completion of the skin impairment circumstance form and the non pressure skin sheet as well as when the POA requests to revoke palliative care and resume medications. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will</b></p>		

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	<p>measurements taken of the bruise located on the left stump to the left of the staples and underneath the stump.</p> <p>Interview with the 300 Unit Manager on 7/13/11 at 9:25 a.m. indicated she measures non pressure areas weekly. She indicated there was no non pressure ulcer sheet completed for the resident's bruising on his posterior stump and next to his incision line. The Unit Manager indicated she had measured the bruising to the stump today. She further indicated she had asked the nurse who admitted the resident if she measured the bruising to the stump area and she said no she did not. The Unit Manager indicated there was no monitoring of his bruising since admission up until they had measured them on 7/13/11. The Unit Manager indicated it was her responsibility to check to make sure the admitting nurse measured the non pressure areas after the residents were admitted.</p> <p>Interview with LPN #3 on 7/13/11 at 9:55 a.m. indicated she was the nurse who admitted the resident. She indicated she measured the resident's open area to his coccyx and counted his staples but did measure the bruises to the stump, right hip and</p>		<p><b>review admission/readmission skin forms to ensure any skin condition is assessed and noted on the skin impairment circumstance form as well as non pressure skin sheet Mon thru Friday to ensure non pressure skin conditions are noted and followed. A non pressure audit tool will be utilized weekly times six months and reviewed monthly times six months through Quality Assurance. Residnets with palliative care orders that the POA wishes to revoke palliative care will have the physician notified of POA wishes to have medications resumed. The medication administration record will be reviewed three times per week for six months and reviewed monthly times six months through Quality Assurance to ensure medications are administered after palliative car revoked and medications are resumed.Date: 8/17/2011</b></p>		

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	<p>abdomen.</p> <p>2. Resident #155 was observed on 7/11/11 at 10:41 a.m. seated in a wheelchair in his room. There was a reddened bruised area on his left forearm that was 1 cm (centimeter) in size. Interview with the resident at that time indicated he had the area for a week or so. He indicated he didn't know how he got it. He stated he thought he was receiving a blood thinner.</p> <p>The record for Resident #155 was reviewed on 7/14/11 at 8:38 a.m. The resident was admitted to the facility on 6/7/11. The Nursing Admission Assessment form dated 6/7/11 indicated there were no bruises or reddened areas on the resident's left forearm. The 6/7/11 admission physician orders were reviewed. There was an order for the resident to receive aspirin 81 milligrams daily.</p> <p>The June 2011 and the July 2011 TAR (Treatment Administration Record) forms were reviewed. The weekly skin assessments documented on 6/14/11, 6/21/11, 6/28/11, 7/5/11 and 7/12/11 indicated there was an "existing area of skin impairment see wound sheet" noted on each of the weekly skin assessments. There were no new</p>				

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	<p>areas of skin impairment noted on the weekly skin assessments. Review of the wound sheets indicated there was no wound sheet for the reddened area on the resident's left forearm.</p> <p>Review of the forms titled, "Skin Impairment Circumstance, Assessment and Intervention" indicated there was no form for the reddened or bruised area to the left forearm in the record.</p> <p>Review of the Nursing Progress Notes dated 6/7/11 through 7/14/11, indicated there was no documentation of a reddened or bruised area to the left forearm.</p> <p>Interview with the 400 Unit Acting Supervisor on 7/14/11 at 1:30 p.m., indicated there was a lack of documentation and assessment of the area on the resident's left arm. She indicated she did know how it occurred or when it was first noted.</p> <p>Interview with the Interim DON on 7/15/11 at 8:48 a.m. indicated there was no assessment of the reddened area. She indicated when a new area is noted a "Skin Impairment Circumstance, Assessment and Intervention" form is to be initiated. She indicated a "Skin Impairment</p>				

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	<p>Circumstance, Assessment and Intervention" form should have been completed when the reddened area on the resident's left forearm was first noted. She indicated the area should be assessed and monitored until it is healed.</p> <p>3. Resident #42 was observed in bed on 7/13/11 at 8:56 a.m. The head of the resident's bed was elevated, the resident's eyes were closed. The resident had a feeding tube in place. The resident's daughter was at the bedside.</p> <p>Interview with the resident's daughter on 7/13/11 at 8:56 a.m. indicated she was the resident's responsible party and was making the healthcare decisions for the resident. She indicated the resident had a severe stroke and was not able to eat foods by mouth. She indicated she would be receiving therapies to see how much she could improve. She indicated the stroke did not affect her ability to speak and indicated the resident was aware of her surroundings.</p> <p>The record for Resident #42 was reviewed on 7/13/11 10:14 a.m. The resident had diagnoses the included,</p>				

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	<p>but were not limited to, hypertension, stroke with left hemiplegia, and atrial fibrillation.</p> <p>The resident was admitted to the facility on 7/4/11, the admission orders included: Cardizem (a cardiac medication) 30 mg (Milligrams) per tube every 8 hours Colace 100 mg twice daily for constipation Miralax 17 Grams per tube daily for constipation Lisinipril 5 mg (a blood pressure Medication) per tube daily Lisinipril 7.5 mg per tube every evening Plavix 75 mg (a blood thinning medication) via tube daily after 7/11/1 if condition continues to be stable and CT scan without signs of bleed. Jevity 1.2 (a liquid feeding) at 30 cc's (cubic centimeters)/hour, if tolerates then increase to 35 cc's /hr at 6 a.m. on 7/6/11, then increase to 40 cc's /hr at 6 p.m. then, if tolerates, increase to 45 cc/hr at 6:00 a.m. on 7/7/11.</p> <p>A physician's order dated 7/7/11 indicated, "DC (discontinue) all meds, Lortab 5/500 mg (a pain mediation) via g-tube q (every) 6 hours prn (as needed), Hospice referral, continue Jevity 45 cc/hr."</p>				

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	<p>A physician's progress note dated 7/8/11 indicated "palliative care" was to be provided.</p> <p>On 7/14/11 at 8:45 a.m., the resident's record was reviewed further. Review of the July 2011 MAR (Medication Administration Record) indicated the Cardizem, the colace, the miralax and the lisinipril were all discontinued on 7/7/11. None of the medications were given on 7/8/11, 7/9/11, 7/10/11, 7/11/11, 7/12/11 or 7/13/11.</p> <p>The Social Service progress notes dated 7/11/11 indicated, ". . . spoke w/ (with) res (resident's) daughter/POA. Wants to revoke palliative care and restart meds (medications) and therapies, all disciplines notified. Nurses to call MD to clarify meds (medications)."</p> <p>Review of the Nursing Progress Notes dated 7/11/11 through 7/13/11 indicated the nurses had not notified the physician of the POA( Power of Attorney)'s wishes to revoke the palliative care order and to restart the medications. There was no physician's order to clarify the medications and to restart the medications.</p>				

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	<p>Interview with the Social Service Director on 7/14/11 at 10:26 a.m. indicated the family had revoked palliative care on 7/11/11. She indicated the daughter desired therapies and medications be restarted for the resident. She indicated t she informed LPN #2 of the daughters wishes and the need to contact the physician to inform him the daughter wanted the medications to be given to the resident.</p> <p>Interview with the Acting Unit Supervisor on 7/14/11 at 2:46 p.m., indicated she was not aware of the daughter's decision to revoke the palliative care and her decision to restart the medications.</p> <p>On 7/14/11 at 12:49 p.m. the Acting Unit Supervisor was observed interviewing the resident's daughter. When questioned regarding the restarting of the resident's medications the daughter stated, " I thought they were restarted on 7/11/11." She indicated she wanted the resident to have the medications that had been ordered on admission.</p> <p>LPN #2 was interviewed on 7/15/11 at 8:40 a.m. LPN #2 indicated she was notified on 7/11/11, by the Social</p>						

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F0311 SS=G	<p>Service Director, of the resident's daughter's wishes to revoke the palliative care and to restart the medications. She indicated that the resident developed a fever on 7/11/11 and her status declined. She stated she did not notify the physician of the daughter's request to restart the medications and revoke the palliative care.</p> <p>Interview with the Interim DON 7/15/11 at 8:48 a.m., indicated the physician should have been notified of the daughter's wishes to restart the medications and to revoke the palliative care on 7/11/11 as requested by the resident's POA.</p> <p>3.1-37(a)</p> <p>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, record review and interview, the facility failed to ensure restorative nursing services</p>	F0311	<b>Corrective Actions accomplished for those residents found to have been</b>	08/17/2011	

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	<p>were provided for 1 of 1 residents reviewed who met the criteria of Contracture Without Range of Motion or Splint Device and for 2 of 2 residents reviewed who met the criteria for Lack of Community Discharge, which resulted in a decline in Resident #193's ability to transfer to and from the wheelchair. The resident's transfer status declined from requiring the assist of one person to requiring the assist of two persons. (Residents #116, #193 and #226).</p> <p>Findings include:</p> <p>1. Resident #193 was observed on 7/13/11 at 9:00 a.m. seated in his wheelchair in his room. Interview with the resident at that time indicated he had a stroke in January. He indicated he still could not walk because his left leg was too weak. He indicated he was currently in therapy to improve his function.</p> <p>On 7/18/11 at 8:57 a.m., the resident was observed being transferred from his wheelchair to a commode, to be toileted. CNA #3 and CNA #4 assisted the resident with the transfer. Both CNAs placed their arms under the resident's axilla's. The resident held the grab rail in front of him with his</p>		<p><b>affected by the alleged deficient practice: Resident 116, 193 and 226 were reviewed for restorative services and plan developed. Resident 193 improved and was discharged home on August 6, 2011. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Residents that are not currently receiving therapy services have been reviewed for restorative services. Residents that have been identified for restorative had a baseline assessment completed and plan developed. Restorative aides assist the resident with their restorative plan six days per week. MDS coordinators or Unit managers summarize the the restorative plan monthly Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff including restorative aides have been inserviced with the restorative forms used for documentation of the individualized restorative plan as well as transferring residents according to resident needs of 1 or 2 assist and or 2 person hooyer transfer. C.N.A. assignment sheets have been updated to reflect resident</b></p>		

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	<p>right hand. He stood up with the assistance of both of the CNAs. CNA #3 moved the wheelchair away and pulled a commode behind the resident's legs. The resident was then placed down on the commode. The resident was positioned too far forward in the commode. Both CNAs then placed one hand behind each of the resident's thighs and one arm under his axilla and lifted the resident. They then positioned him further back on the commode. Neither of the two CNA's used a gait belt or any mechanical left during the transfer.</p> <p>CNA #3 was interviewed after the transfer. She indicated the resident was able to transfer with a one person assist after his PT (Physical Therapy) had been completed. Then when he was no longer receiving PT, he began to decline and required 2 persons for the transfer. He was then referred back to PT and was now receiving PT services.</p> <p>The record for Resident #193 was reviewed on 7/13/11 at 9:17 a.m. The resident was admitted to the facility on 1/26/11. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke) with left hemiparesis, atrial fibrillation, and hypertension.</p>		<p><b>current status. Restorative aides provide and or assist the individualized restorative plan for the resident six days per week. MDS coordinators and/or Unit managers follow progress of restorative program weekly and summarize monthly making changes as indicated. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review plans monthly as part of the ongoing QA process to ensure restorative plans are in place and updated as indicated. Date: 8/17/2011</b></p>				

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	<p>The 1/26/11 admission physician orders included:                      PT (Physical Therapy) 5 x week                      OT (Occupational Therapy) 5 x week                      ST (Speech Therapy) 5 x week</p> <p>The form titled, "Occupational Therapy Initial Plan of Care" and dated 1/27/11 was reviewed. It indicated the goal for the resident was increased independence in ADL (Activity of Daily Living) with transfers and mobility."</p> <p>The resident received OT until 4/27/11. The form titled "Occupational Therapy Discharge Summary" and dated 4/27/11 was reviewed. It indicated the discharge plan was: "d/c (discharge) to nursing staff with restorative program."</p> <p>The form titled, "Physical Therapy Initial Plan of Care" and dated 1/27/11 was reviewed. It indicated the goal for the resident was to progress towards the goal of increased mobility, reduced risk of falls and to return to prior level of function."</p> <p>The resident received PT until 4/23/11. The form titled "Physical Therapy Discharge Summary" and dated 4/23/11 was reviewed. It</p>			

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	<p>indicated the discharge plan was: "patient d/c (discharged) to restorative."</p> <p>The form titled "Restorative/Functional Maintenance Program Plan" and dated 4/28/11 was reviewed. It indicated the restorative nursing program was as follows: From Physical therapy: Program was for upper and lower extremity, range of motion/strength Goal: resident will maintain range of motion/strength of upper an lower extremities. Interventions: Participate in upper/lower extremity range of motion/strength in all planes group or individual- 20 repetitions x 10 sets Special precautions: patient is flaccid in left upper extremity - patient can move left lower extremity with help of right lower extremity From Occupational Therapy: Program: sit to stand Goal: continue with minimum to moderate assist of 1-2 for sit to stand Interventions: patient to participate with repeated sit to stand Special precautions: flaccid left upper extremity, needs to be seen in morning</p> <p>The forms titled, "Restorative Nursing Care Report" for 5/8/11 through</p>				

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	<p>6/25/11 were reviewed. The reports indicated the number of days per week the resident received nursing restorative services. The resident received the following:</p> <ul style="list-style-type: none"> <li>-Active range of motion and transfers 4 x during the week of 5/8/11 through 5/14/11</li> <li>-Active range of motion and transfers 3 x during the week of 5/15/11 through 5/21/11</li> <li>-Active range of motion and transfers 3 x during the week of 5/22/11 through 5/28/11</li> <li>-Active range of motion and transfers 2 x during the week of 5/29/11 through 6/4/11</li> <li>-Active range of motion and transfers 3 x during the week of 6/5/11 through 6/11/11</li> <li>-Active range of motion 1 x on the week of 6/12/11 through 6/18/11</li> <li>-Active range of motion 2 x and transfers 1 x during the week of 6/19/11 through 6/25/11</li> </ul> <p>Interview with Restorative CNA #1 on 7/13/11 at 2:51 p.m., indicated she was providing restorative nursing for the resident. She indicated restorative nursing services are to be provided at least 6 days per week. She indicated restorative was not being completed for the resident 6 days per week</p>				

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	<p>because there was not enough staff. She also indicated the resident declined in his transfer ability and he was referred back to Physical Therapy.</p> <p>A physician order dated 6/23/11 indicated, "PT to evaluate and treat."</p> <p>Review of the "Physical Therapy Initial Plan of Care" dated 6/23/11 indicated the reason for the referral to Physical Therapy was due to, "Patient demonstrated a significant decline in functional transfers and mobility. Patient referred to skilled therapy for transfers and mobility in preparation to returning home."</p> <p>The Functional assessment: Transfers: Bed to and from Chair: prior level Maximum Assist, current level Maximum assist of 1-2 Wheelchair to and from commode prior level Maximum Assist, current level Maximum Assist of 1-2</p> <p>The Physical Therapy Manager was interviewed on 7/13/11 at 10:30 a.m. He indicated therapy sets up the restorative programs for the residents at the time of discharge. He indicated the restorative CNAs are trained to complete the program.</p>				

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	<p>The Acting 400 Unit Supervisor was interviewed on 7/14/11 at 8:30 a.m. She indicated she was very familiar with Resident #193. She indicated she was on the resident's unit from January 2011 through June 2011. She indicated the resident did not have a medical change in April, May or June, 2011. She indicated there were no infections or signs of additional strokes. She did not think there was a medical reason for the resident's functional decline.</p> <p>Review of the record indicated there were no "Change of Condition" reports noted for April, May and June 2011 available.</p> <p>Interview on 7/13/11 at 2:45 p.m., with the Physical Therapy Manager, indicated Resident #193 had declined in function after his discharge from therapy services in April 2011. He stated the restorative staff informed him of the resident's decline. He also indicated that restorative nursing services were not always provided to the resident 6 days per week.</p> <p>2. The record for Resident #226 was reviewed on 7/13/11 at 11:04 a.m. The resident's diagnoses included,</p>						

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	<p>but were not limited to, Alzheimer's dementia, congestive heart failure and chronic obstructive pulmonary disease.</p> <p>The Physical Therapy Discharge Summary dated 6/13/11, indicated the resident continued to require minimal assist with mobility and transfers. The resident also required verbal cues for energy conservation techniques secondary to shortness of breath with exertion. The discharge plan was to discontinue therapy and refer to the restorative nursing program.</p> <p>There was no documentation in the resident's record to indicate restorative therapy had been initiated from 6/13/11 through 7/13/11.</p> <p>Interview with Restorative CNA #2 on 7/14/11 at 10:40 a.m., indicated if a resident was referred to restorative therapy, it was usually communicated by the Unit Manager. She further indicated the resident had been missed and he was picked up by restorative therapy on 7/13/11 and she was planning on working with the resident on 7/15/11.</p> <p>Interview with LPN #4 on 7/18/11 at 9:50 a.m., indicated when a resident</p>				

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	<p>was referred to restorative therapy, they are now supposed to put the order in the computer and restorative will pick up the resident. She further indicated this had been a problem in the past but a new system was recently put into place.</p> <p>3. On 7/14/11 at 10:20 a.m., Resident #116 was observed in bed. The last three fingers on the resident's right hand were bent. At this time, the 300 Unit Manager asked the resident if he was able to open the fingers on his right hand that were bent down. The resident was unable to open them on his own. The Unit Manager attempted range of motion on the resident's three fingers and was able to open the three fingers until the resident complained of pain. The resident's fingers were opened with over 50 % of full range of motion.</p> <p>The record for resident # 116 was reviewed on 7/13/11 at 7:50 a.m. The resident's diagnoses included, but were not limited to, seizure disorder, left cerebral vascular accident (stroke), gout, and high blood pressure. There were no Restorative Nursing notes in the resident's clinical record.</p>						

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	<p>An Occupational Therapy Discharge Summary for therapy services from 12/22/10 thru 2/25/11 indicated the resident was discharged from Occupational Therapy on 2/26/11. The Discharge Summary indicated the resident was discharged from skilled Occupational therapy to Restorative Nursing.</p> <p><b>A Restorative/ Functional Maintenance Program Plan was completed by a Physical Therapy Aide on 2/23/11. The plan indicated services were to be provided by Restorative Therapy. Interventions included for the resident to perform upper body and lower body exercises.</b></p> <p>When interviewed on 7/13/11 at 9:31 a.m., Restorative CNA #1 indicated Resident #116 was not currently receiving Restorative services.</p> <p>When interviewed on 7/13/11 at 9:45 a.m., the Therapy Director indicated the resident was not on the list of residents receiving Restorative services. The Therapy Director indicated the resident last received skilled therapy services in 2/2011 and should have received Restorative Nursing at that time as recommended by the therapy staff.</p> <p>When interviewed on 7/14 at 12:35 p.m., the 300 unit MDS (Minimum Data Set) nurse indicated per the computer tracking record it shows that the resident did not receive Restorative Nursing services in March 2011.</p> <p>When interviewed on 7/14/11 at 2:30 p.m., the Interim Director of Nursing indicated a</p>				

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F0312 SS=E	<p>Restorative Nursing Program was not started after the resident was discharged from skilled therapy on 2/26/11.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(2)(B)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure incontinence care was completed in a timely manner for 3 residents in the Stage 2 sample of 48 who were dependent on staff for toileting and incontinence care. (Residents #B, #G, and #H)</p> <p>Findings include:</p> <p>1. On 7/13/11 at 10:00 a.m., CNA #6 was observed transferring Resident #B to bed. At that time, CNA #6 was going to also perform incontinence care. The CNA indicated the resident was up in her wheelchair before she arrived to work. She indicated the resident was a midnight get up which usually was between 5:00 a.m. and 6:00 a.m., as 6:00 a.m. was the time the midnight shift went home. CNA</p>	F0312	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident B, G, and H received incontinent care. Staff was educated immediately as to incontinence care being performed every two hours on incontinent residents. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: All residents that are incontinent have been identified and their plan of care has been updated.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced related to incontinence care and importance of providing care</b></p>	08/17/2011	

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	<p>#6 then indicated she had not checked or changed the resident since she had been gotten up on the midnight shift. She indicated the brief the resident was wearing was the original brief that was placed on her when she was gotten up out of bed in the morning. The CNA further indicated all residents were to be checked and changed at least every two hours. At that time, the resident was saturated with urine, her incontinent brief was very wet and she had dried bowel movement on her buttocks.</p> <p>On 7/14/11 at 9:03 a.m., the resident was sitting in hallway outside of her room.</p> <p>On 7/14/11 at 9:36 a.m., the resident's CNA #8 indicated she was going to lunch. She did not check the resident for incontinence at that time.</p> <p>On 7/14/11 at 9:45 a.m., the 300 Unit Manager spoke with resident but did not check her for incontinence. The resident remained in her wheelchair in the hallway outside of her room.</p> <p>On 7/14/11 at 10:11 a.m., no staff has checked the resident for incontinence. The resident remained sitting outside of her room.</p>		<p><b>every two hours. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS/designee will randomly choose five residents that have been identified as incontinent to ensure incontinence care has been completed three times per week for six months and review monthly times six months through Quality Assurance. <b>Date:</b> <b>8/17/2011</b></p>		

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	<p>On 7/14/11 at 10:39 a.m. the resident was taken to the activity room by the Co ,Activity Director. She was not checked for incontinence by any staff member before she left.</p> <p>On 7/14/11 at 11:10 a.m., the resident remained in activity room sitting at a table ,waiting for her nails to be painted.</p> <p>On 7/14/11 at 11:40 a.m., the resident was in the dining room on the 300 hallway, no staff had checked her for incontinence.</p> <p>On 7/14/11 at 1:01 p.m., the resident was sitting in front of her room, her red pants were observed to be wet in the peri area. The CNA taking care of her was in the resident's room and indicated she needed to get another CNA to help her transfer the resident with the hooyer lift. The CNA then took a plastic bag of linens and walked down the hallway. At 1:05 p.m. CNA #8 assisted the resident to bed. The CNA indicated she checked the resident for incontinence around 9:00 a.m. and her brief line was not blue (indicating the resident was not incontinent. She indicated she did not change her at that time. The CNA indicated she checked the resident</p>				

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	<p>while she was sitting up in the wheelchair and did not lay her down. The CNA indicated she was a midnight get up and they usually get the residents up between 4:00 a.m. and 5:00 a.m., but did not know exactly what time she was gotten up that day. At that time, the residents pants were saturated with urine and her brief was saturated with urine. The residents buttocks were red and pink with wrinkles of the brief on her buttocks. The resident was observed with dark brown bowel movement on her buttocks and in her brief. CNA #8 indicated at the time, the resident had on the same incontinent brief that was placed on her when she was gotten out of bed that morning.</p> <p>The record for Resident #B was reviewed on 7/13/11 at 10:39 a.m. The resident's diagnoses included, but were not limited, to stroke with right side hemiplegia, high blood pressure, urinary tract infection, aphasia, and fracture neck of right femur.</p> <p>The MDS (Minimum Data Set) assessment dated 4/12/11 and 3/31/11 indicated the resident sometimes understood, sometimes understands, and had memory problems. The resident was not able</p>				

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	<p>to be interviewed. The resident needed extensive assistance with bed mobility transfers, dressing, toilet use, and personal hygiene. The resident was always incontinent of bladder and always incontinent of bowel. The resident was not on any toilet programming. Review of the Care Area Assessment for incontinence indicated staff were to anticipate needs and check and change resident throughout the shift.</p> <p>Review of the CNA assignment sheet indicated the resident was to checked every hour for wetness.</p> <p>Review of the current plan of care initiated on 4/6/10 and last updated on 6/30/11 indicated the resident was incontinent of bowel and bladder related to physical functioning. The interventions were for staff to toilet before and after meals, upon rising in the a.m. and before bed at night.</p> <p>The monthly elimination assessment dated 5/9/11 indicated the resident was always incontinent of bladder and wore briefs.</p> <p>Interview on 7/14/11 at 1:21 p.m. with LPN #3 indicated her expectations of the CNAs on her hallway were to check the residents for incontinence</p>						

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	<p>at least every two hours. She also indicated she monitors the CNAs by checking the residents herself. She indicated Resident #F could not tell staff when she was incontinent, therefore, she instructs the CNAs to lay the resident down to check for incontinence.</p> <p>2. On 7/10/11 at 9:23 p.m., Resident #G was observed in her room in bed. The resident was awake and asking for help. At 9:30 p.m., the 200 Unit Manager entered the resident's room. The resident indicated to the Unit Manager she wanted to get cleaned up. The Unit Manager left the resident's room and returned with towels. At 9:53 p.m., CNA #13, with the assist of the Unit Manager, removed the resident's incontinence brief. The resident's brief was wet with urine and soiled with bowel movement. CNA #13 indicated at that time, the last time she changed the resident was right after dinner, approximately a little after 7:00 p.m.</p> <p>The record for Resident #G was reviewed on 7/13/11 at 10:12 a.m. <b>The annual Minimum Data Set (MDS) Assessment dated 6/3/11, indicated the resident was extensive assist with toileting with</b></p>						

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	<p><b>two person physical assist. The MDS also indicated the resident had a trial of a toileting program (for example a scheduled toileted program, prompted voiding, or bladder training). The resident was also documented as being always incontinent of urine.</b></p> <p><b>The CAA Summary dated 6/3/11, indicated incontinence had triggered due to dementia, unable to recognize need to void. Documentation indicated the staff provided toileting assistance and incontinence care as needed. This area was to be addressed on the resident's plan of care.</b></p> <p><b>A plan of care dated 9/9/10 and reviewed on 4/20/11, indicated the resident had an ADL (activity of daily living) self-care deficit or potential for as evidenced by needs assist or is dependent in personal hygiene and toilet use.</b></p> <p><b>Review of the interventions indicated incontinence was not addressed. There was also no separate care plan related to urinary incontinence.</b></p> <p>A 4/22/11 Monthly Nursing</p>				

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	<p>Assessment, indicated the resident was always incontinent of bladder and no pattern was able to be established.</p> <p>The July 2011 Physician's Order Summary (POS), indicated the resident did not have an incontinent program.</p> <p>Interview with CNA #10 on 7/14/11 at 2:00 p.m., indicated the resident was incontinent of urine and could not voice when she needed to go to the bathroom. The CNA further indicated she just checks the resident every 2 hours for incontinence.</p> <p>3. On 7/15/11 at 1:10 p.m., Resident #H was taken to her room by CNA #9. When the resident was transferred out of her wheelchair and put to bed, the seat of her pants was observed to be wet. When the resident's incontinence brief was removed, the brief was saturated with urine. Interview with CNA #9 at the time, indicated the resident was last changed prior to lunch around 9:30-10:00 a.m.</p> <p>The record for Resident #H was reviewed on 7/13/11 at 8:51 a.m. The resident's diagnoses included, but were not limited to, dementia, contact dermatitis and eczema.</p>				

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	<p>The resident's Quarterly Minimum Data Set (MDS) Assessment dated 5/17/11, indicated the resident required extensive assist for toilet use with a two person physical assist. The MDS also indicated the resident had a toileting program and was always incontinent.</p> <p>The Monthly Nursing Assessments dated 6/23/11, 5/15/11 and 4/25/11, indicated the resident was dependent on staff for toileting with an extensive assist of 1 person. The resident was occasionally incontinent, used briefs, and no voiding pattern was able to be established.</p> <p>The resident's plan of care dated 12/15/10 and reviewed on 5/27/11, indicated the Resident was incontinent of bowel and bladder related to cognitive impairment and decreased physical functioning.</p> <p>The following care plan interventions were listed:</p> <ul style="list-style-type: none"> <li>-Check and change every 3 hours and prn</li> <li>-Toilet before and after meals, upon rising in the AM and before bed at night</li> <li>-Wear incontinent product at all times</li> </ul>				

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	<p>-Monitor for signs and symptoms of urinary tract infection</p> <p>Interview with CNA #14 on 7/14/11 at 11:00 a.m., indicated the resident can be continent at times but was mostly incontinent. She indicated the resident can tell them at times when she needs to be changed and that she was usually checked every 2 hours.</p> <p>Interview with LPN #4 on 7/18/11 at 9:50 a.m., indicated the resident was to be checked and changed for incontinence at least every two hours and as needed.</p> <p>This Federal tag relates to Complaint IN00091661 and IN00093400.</p> <p>3.1-38(a)(3)</p>				

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F0314 SS=D	<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 interviews, the facility failed to ensure treatments were changed to promote healing of existing pressure ulcers when the current treatment was not effective in healing the area for 1 of 3 residents reviewed for pressure ulcers of the 13 residents who met the criteria for pressure ulcers. (Resident #F)</p> <p>Findings include:</p> <p>On 7/14/11 at 2:05 p.m. Resident #F was observed in bed. RN #1 was observed at that time performing the pressure ulcer treatment for the resident. The resident was observed with a pressure ulcer on left gluteal fold. The pressure ulcer had a red center with pink surrounding tissue. There was depth observed to the pressure ulcer. The RN then packed the wound a collagen dressing and secured it with an adhesive dressing.</p>	F0314	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 43 was assessed and the physician was updated in regards to pressure ulcer and treatment changed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents with pressure ulcers have been assessed to ensure the treatment ordered is improving the pressure area and if improvement had not been noted then the physician was notified to change treatment. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced with regards to notify the physician if no improvement or change is noted in pressure area for two</b></p>	08/17/2011	

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	<p>The record for Resident #F reviewed on 7/13/11 at 2:42 p.m. The resident's diagnoses included, but were not limited to, renal failure, septicemia, multiple sclerosis, dysphagia, high blood pressure, and neurogenic bladder.</p> <p>Review of the pressure ulcer assessment sheets indicated the resident was admitted with the pressure ulcer on 8/9/10. The following were the resident's measurements:</p> <p>4/8/11 2.5 centimeters (cm) by .7 cm by .2 cm 4/15/11 2.5 cm by .7 cm by .2 cm 4/22/11 2.5 cm by .7 cm by .2 cm 4/29/11 2.9 cm by .6 cm by .1 cm</p> <p>The above measurements indicated there was no change or improvement in the resident's pressure ulcer.</p> <p>The following measurements were taken in June 2011: 6/17/11 2.3 cm by 1.9 cm by .2 cm 6/24/11 2.4 cm by 1.9 cm by .2 cm 6/30/11 3.6 cm by 2.3 cm by .4 cm</p> <p>The above measurements indicated there was no change or improvement in the resident's pressure ulcer.</p>		<p><b>weeks to notify physician for change in treatment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review wounds weekly to ensure healing is occurring. If improvement is not seen within two weeks, the resident physician will be notified for treatment change as part of the ongoing QA process. Date: 8/17/2011</b></p>				

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	<p>Review of the 12/31/10 Care Plan indicated Alteration in skin integrity pressure ulcer noted. The care plan was last updated on 6/30/11. The interventions were for staff to notify the physician and responsible party of changes in skin status if no improvements times 2 weeks.</p> <p>Review of Physician orders dated 3/25/11 indicated the treatment for the pressure ulcer was to cleanse wound to left gluteal with wound wash, pat dry, pack with gauze wet with silver cream, and cover with duoderm.</p> <p><b>Review of the Treatment Administration Records (TAR) for the months of 3/11 and 4/11 indicated the above treatment was signed out for the left gluteal wound.</b></p> <p><b>Review of Nursing Progress Notes dated 5/6/11 at 10:35 a.m., indicated the left gluteal pressure ulcer was observed with black and necrotic tissue. The resident's physician was finally notified and a new order was obtained.</b></p> <p><b>Review of the pressure ulcer assessment sheet indicated on 5/6/11 the pressure ulcer measured</b></p>						

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	<p><b>2.7 cm by .5 cm by .1 cm.</b></p> <p>Review of the Physician Orders dated 5/6/11 indicated to d/c (discontinue) present treatment to left gluteal and start to clean the area with wound wash, pat dry, apply Santyl (an ointment to debrided) to area, and cover with duoderm every 3 days.</p> <p>Review of Physician Orders dated 6/7/11 indicated to d/c silver ointment wound dressing to left gluteal and start-clean area with wound wash, pat to dry, apply antimicrobial wound dressing, cover with duoderm dressing and change every 3 days.</p> <p>Interview with the Interim Director of Nursing on 7/15/11 at 2:57 p.m. indicated the physician should have been made aware there was no change or improvement in the wound after two weeks.</p> <p>3.1-40(a)(2)</p>				

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a resident was treated promptly for an urinary tract infection for 1 of 3 residents reviewed for urinary tract infections in the Stage 2 sample of 48. (Resident #F)</p> <p>Findings include:</p> <p>On 7/13/11 at 8:35 a.m., Resident #F was observed in bed. The resident was awake and was alert and oriented.</p> <p>The record for Resident #F was reviewed on 7/13/11 at 2:42 p.m. The resident's diagnoses, included, but were limited to, renal failure, septicemia, multiple sclerosis, dysphagia (difficulty swallowing), high blood pressure, and neurogenic bladder.</p> <p>Review of the quarterly Minimum Data</p>	F0315	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident F's Urologist physician was notified to request physician order for treatment of UTI and physician progress note. Information obtained and treatment began.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b></p> <p><b>Current residents with UTI have been reviewed to ensure timliness of treatment began.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient</b></p>	08/17/2011	

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	<p>Set (MDS) assessment dated 5/28/11 indicated the resident was always incontinent of bladder.</p> <p>Nursing Progress Notes dated 6/7/11 indicated the resident went out to see the physician who was an urologist. At 2:20 p.m., the resident returned. There were no progress notes from the Physician available for review in the resident's chart. There were no Nurse's Notes documented on what procedures if any were completed by the urologist.</p> <p>Review of laboratory results indicated an urinalysis was completed on 6/7/11. The final culture dated 6/9/11 for the urinalysis indicated the resident had an urinary tract infection with greater than 100,000 e-coli (a bacteria). At the bottom of lab page the urologist signed her initials and dated the document 6/10/11 with instructions to start an antibiotic of Keflex 500 milligrams (mg) four times a day times for 14 days. The document was not faxed to the facility until 6/14/11 from the physician's office.</p> <p>Review of Physician orders dated 6/14/11 indicated the antibiotic of Keflex was ordered on that date (four days after the urologist had signed</p>		<p><b>practice does not recur:</b></p> <p><b>Licensed staff have been inserviced with regards to resident with UTI to ensure physician notification to obtain treatment of UTI is timely. Licensed staff will call the Urologist office or physician office if paperwork does not return with the resident to ensure what the physician has written for progress note and or any physician orders that may be needed to begin after the resident returns from appointment.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will review physician orders Mon thru Fri to ensure timliness of treatment of UTI begins. Also will follow up with licensed nurse staff for any resident returning from a physician appointment without paperwork such as physician orders and progress note to ensure information is obtained timely so treatment can begin as aprt f ongoing QA process until compliance is achieved</b></p>		

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	<p>the lab and wrote the order). A follow up appointment was made for the resident to go the doctor's office on 7/7/11 for a straight catheterization.</p> <p>Interview with RN #1 on 7/15/11 at 2:00 p.m., indicated she was the nurse taking care of the resident at the time of the physician appointment on 6/7/11. She indicated she was aware the physician had straight cathed the resident in the office that day to obtain the urine sample. She indicated the resident's spouse had informed her of that. The RN indicated she did not call the doctor's office before 6/14/11 to inquire about the results of the urinalysis or the culture report.</p> <p>Further review of Nurse's Notes dated 7/7/11 indicated the resident was sent out to the urologist office. The resident returned to the facility again with no progress notes from the physician.</p> <p>Further review of the laboratory results dated 7/7/11 indicated another urinalysis was completed. The final urine culture dated 7/9/11 indicated the resident had an urinary tract infection with greater than 100,000 e-coli.</p>		<p><b>then periodic review.</b></p> <p><b>Date: 8/17/2011</b></p>		

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F0323 SS=D	<p>Review of Nurse's Notes dated 7/11/11 indicated the physician's office called and new orders to treat the resident's urinary tract infection were obtained. Review of physician orders dated 7/11/11 indicated Keflex 500 mg four times a day times four weeks.</p> <p>Interview with R.N. #1 on 7/15/11 2 p.m. indicated it was her responsibility to call the physician's office to follow up with urinalysis and culture. She indicated she should have done so in a more timely manner.</p> <p>This Federal tag related to Complaint IN00091661.</p> <p><b>3.1-41(a)(2)</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure adequate supervision was provided related to the use of wheelchair alarms and using the hoyer lift for 2 of 3 residents of the 4 who met the criteria for accidents in a</p>	F0323	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Residents B, C, and D were reviewed at time of survey to ensure wheelchair alarm is attached to</b></p>	08/17/2011	

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	<p>Stage 2 sample of 48. The facility also failed to ensure geri-sleeves were worn for 1 of the 3 residents of the 9 who met the criteria for non-pressure related skin problems in a Stage 2 sample of 48. (Residents #B, #C and #D)</p> <p>Findings include:</p> <p>1. On 7/13/11 at 8:40 a.m., Resident #C was observed seated in a wheelchair in the hallway of the 300 unit. A wheelchair alarm unit was hanging from the back of the resident's wheelchair. There was no cord attached to the unit. At 10:38 a.m., the resident was in his room in bed sleeping. The wheelchair was observed next to the resident's bed. The wheelchair alarm unit was hanging off of the wheelchair handle. No cord was attached to the unit. No sensor pad was observed in the resident's wheelchair. The sensor pad was observed on top of the toilet tank in the resident's bathroom. At 11:30 a.m., the resident was observed up in his wheelchair in the 300 unit dining room. The wheelchair alarm unit was attached to the wheelchair handle. No cord was attached and the alarm was not flashing, indicating it was not in use.</p>				<p><b>resident and that resident with the hoyer lift is transferred with the hoyer lift and two assist and the resident with geri-sleeves have them in place. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b>                      Current residents that have alarms while in wheelchair and or bed have been reviewed to ensure alarm is in place.                      Current residents that are transferred via hoyer lift have been reviewed to ensure transfers are completed with two person assist and the hoyer lift. Current residents with geri-sleeves have been reviewed to ensure geri-sleeves are on the resident. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced with regards to residents that have alarms, transferred via a hoyer lift with two assist and have geri-sleeves to ensure residents plan of care is followed. Careplans and C.N.A assignment sheets have been reviewed and updated with current information to care for the resident. How the corrective measures will be</p>		

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	<p>The record for Resident #C was reviewed on 7/13/11 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dizziness, history of syncope (fainting) and status post pacemaker placement.</p> <p>A Physician's Order dated 7/2/11, indicated a pressure sensitive alarm to the bed and wheelchair was to be used and the function was to be checked every shift.</p> <p>The plan of care dated 3/30/11, indicated the resident was at risk for falls due to history of falls. One of the interventions listed, indicated bed and wheelchair alarms may be used.</p> <p>An entry in the Nursing Progress Notes dated 6/10/11 at 9:30 p.m., indicated the resident was observed sitting on his buttocks on the floor next to his bed leaning up against the CNA's legs. The CNA indicated she was responding to the alarm and the resident was standing next to his bed holding the side rails in a squatting position. The CNA was unable to assist the resident to bed so he was assisted to the floor.</p> <p>An entry in the Nursing Progress Notes dated 7/8/11 at 6:45 p.m., indicated the resident was on the</p>		<p><b>monitored to ensure the alleged deficient practice does not recur:</b> DHS/designee will randomly choose five residents that have been identified with alarms, hoyer transfers and geri-sleeves weekly times six months and review monthly time six months through Quality Assurance. <b>Date: 8/17/2011</b></p>		

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	<p>floor in front of side one Caretracker. An abrasion was observed to the resident's forehead measuring 3 centimeters (cm) x 3 cm. A 1 cm abrasion was observed to the left corner of the eye, a right pinkie finger 0.5 cm abrasion was also observed. Bleeding was controlled with pressure and the resident was sent out 911 for evaluation.</p> <p>Interview with CNA #12 on 7/13/11 at 3:30 p.m., indicated the resident was supposed to have a bed and chair alarm in use. She also indicated documentation on the CNA assignment sheet indicated the resident was a fall risk and alarms were to be used.</p> <p>Interview with LPN #1 on 7/15/11 at 2:15 p.m., indicated the resident had orders for bed and wheelchair alarms due to a history of leaning in the wheelchair. She also indicated the alarm was to be attached to the wheelchair when the resident was gotten up.</p> <p>2. On 7/11/11 at 9:16 a.m., Resident #D was observed seated in a wheelchair in the 200 unit lounge. A dressing dated 7/10/11 was observed on the resident's right upper arm as well as a greenish/yellow bruise. The</p>				

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	<p>resident was wearing a short sleeve shirt.</p> <p>On 7/12/11 at 8:15 a.m., the resident was observed in her wheelchair wearing a short sleeve shirt.</p> <p>On 7/13/11 at 8:32 a.m., the resident was observed in her wheelchair being transported to the 200 unit, the resident was wearing a short sleeve shirt. At 10:09 a.m., the resident was in her room in bed. The resident was wearing a short sleeve shirt. At 11:30 a.m., the resident was seated in her wheelchair in the 300 unit dining room. The resident was rubbing her arms. She was wearing a short sleeve shirt at this time. At 1:10 p.m. 2:58 p.m. and 3:39 p.m., the resident was in her room in bed. The resident was wearing a short sleeve shirt.</p> <p>The record for Resident #D was reviewed on 7/13/11 at 1:17 p.m. A Physician's Order dated 6/20/11, indicated the resident was to wear geri-sleeves all the time-may take off during bath and care.</p> <p>The July 2011 Treatment Administration Record (TAR), indicated the geri-sleeves had been signed out on all 3 shifts 7/1-7/13/11</p>				

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	<p>An entry in the Nursing Progress Notes dated 4/21/11, indicated the resident had a skin tear to the right elbow measuring 1 centimeter (cm) x 2 cm.</p> <p>A Physician's Order dated 6/20/11, indicated cleanse skin tear on right lower arm with wound wash, pat dry. Apply Bacitracin (an antibiotic ointment), cover with dry dressing daily x 14 days until healed.</p> <p>An entry in the Nursing Progress Notes dated 7/6/11 at 1:30 p.m., indicated, the resident had a skin tear to the right upper arm from the 300 dining room. Approximately 2.5 cm x 1 cm. Some redness and slight bluish bruising.</p> <p>Review of the 7/6/11 Incident/accident investigation for skin tear form indicated, previous pertinent interventions-geri sleeves. Using lap tray for positioning on the right side causing the lap tray to rub against the skin. Refer to PT (physical therapy) for other equipment for positioning while up in wheelchair.</p> <p>The Monthly Nursing Assessment dated 7/6/11, indicated the resident had a skin tear to the right upper arm.</p>				

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	<p>Interview with CNA #11 on 7/14/11 at 1:20 p.m., indicated the residents who have geri-sleeves and/or alarms, were listed on their CNA assignment sheets. He also indicated a list was kept at the nurses' station. Further interview at 2:02 p.m., indicated the geri-sleeves were not listed on the resident's care card and that he put the geri-sleeves on the resident due to her scratching her arms.</p> <p>Interview with the 200 Unit Manager on 7/18/11 at 9:15 a.m., indicated the resident was to have geri sleeves on at all times. She further indicated the geri sleeves should not have been signed out on the treatment record if they were not in use.</p>				

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	<p>3. On 7/13/11 at 10:00 a.m., CNA #6 and CNA #7 were observed in Resident #B's room. At that time, CNA #6 was observed transferring the resident by herself with a gait belt from the wheelchair to the bed. The other CNA was in the room at the time, however, she just stood on the other side of the bed and did not help CNA #6. The CNA did not use a hoyer lift to transfer the resident to bed. The resident was not able to stand by herself and did not bear any weight on both of her legs.</p> <p>The record for Resident #B was reviewed on 7/13/11 at 10:39 a.m. The resident's diagnoses included but were not limited to stroke with right sided hemiplegia, chronic obstructive pulmonary disease, aphasia, and fracture neck of right femur.</p> <p>Review of the Minimum Data Set (MDS) assessments dated 4/12/11 and 3/31/11 indicated the resident was sometimes understood, sometimes understands, and had memory problems, the resident was not able to be interviewed. The resident needed extensive assistance</p>				

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	<p>with bed mobility and transfers.</p> <p>Review of the Monthly Nursing Assessment dated 7/12/11 indicated the resident transfers with the assist times 2 and was extensive. The resident was non weight bearing and uses a wheelchair.</p> <p>Review of a rehabilitation screen dated 1/25/11 indicated a change in status dated 1/25/11. The findings were: The resident was most appropriate for hoyer lift during transfers for safety of resident and staff. Staff to instruct resident of positioning while in hoyer.</p> <p>Review of the current plan of care dated 4/6/10 and updated 6/30/11 indicated the problem of ADL (Activities of Daily Living) self care deficit, needs assistance or was dependent in transfers and toilet use. The interventions were for staff to transfer the resident with the use of hoyer lift. Review of another current plan of care dated 4/26/11 indicated the problem of osteoporosis at risk for bone fracture related to osteoporosis. The interventions were to provide assistance with transfers/hoyer.</p> <p><b>Review of the current CNA</b></p>				

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	<p><b>assignment sheet indicated the hoyer lift was to be used to transfer the resident</b></p> <p><b>Interview with CNA #6 on 7/13/11 at 10:00 a.m., indicated she always transfers the resident with her gait belt.</b></p> <p><b>This Federal tag relates to complaint IN00091661.</b></p> <p><b>3.1-45(a)(2)</b></p>				

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F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview the facility failed to ensure current daily staffing information signs were posted on 4 of 4 units. This deficient practice had the potential to affect 148 of 148 residents residing in the facility. (The 100, 200, 300, and 400 units)</p> <p>Findings include:</p> <p>During observation on 7/10/11 at 9:00 p.m., the</p>	F0356	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>The daily staffing information was correctd during the time of the survey.</b></p>	08/17/2011	

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	<p>staffing signs on the 100, 200, 300, and 400 units were dated 7/8/11.</p> <p>During observation on 7/16/11 at 9:20 a.m., the staffing signs on the 100, 200, 300, and 400 units were dated 7/15/11.</p> <p>During observation on 7/17/11 at 7:35 a.m., the staffing sign on the 100 hall was dated Friday 7/15/11.</p> <p>During observation on 7/17/11 at 7:40 a.m., the staffing sign on the 200 hall was dated Friday 7/15/11.</p> <p>During observation on 7/17/11 at 7:43 a.m., the staffing sign on the 300 hall was dated Friday 7/15/11.</p> <p>During observation on 7/17/11 at 7:46 a.m., the staffing sign on the 400 hall was dated Friday 7/15/11.</p> <p>When interviewed on 7/19/11 at 9:27 a.m., the Executive Director indicated the scheduler is responsible for posting the current staffing sign during the week and putting the signs for the weekends behind the Friday schedule. The Executive Director indicated the Nursing staff are then required to change the sign on the weekends.</p> <p>3.1-13(i)(4)</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take</b></p> <p><b>No negative outcome was noted.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Inservice with the scheduler for nursing and the guest relations was completed to ensure the daily staffing information is posted on all four units. The nursing scheduler will post the daily staffing information Monday thru Friday and guest relations will post on Sat and Sun.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will round daily to ensure the staffing information is posted daily as part of the ongoing QA process.</b></p>		

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions related to dust on ceiling vents, dust on pipes under he oven hood, dried food spillage inside food transportation carts, food not covered in the freezer, lids stored wet on top of each other and not the proper disinfecting concentration in the 3 compartment sink for 1 of 1 kitchens located in the facility. The facility also failed to date and label food and juice that were stored in 2 of 3 Unit Dining Room refrigerators. This</p>	F0371	<p><b>Date: 8/17/2011</b></p> <p><b>Corrective Actions accomplished for Those residents found to have been Affected by the alleged deficient Practice:</b></p> <p><b>1. a. Food three food transportation carts Were cleaned.</b></p> <p><b>Two ceiling vents above food storage Areas were cleaned of dust.</b></p> <p><b>Pipes located underneath the oven</b></p>	08/17/2011	

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	<p>had the potential to affect 144 of 148 residents who resided in the facility who received oral diets. (The Main Kitchen) (Units Legacy Lane and 300)</p> <p>Findings include:</p> <p>1. During the Initial Kitchen Sanitation Tour on 7/10/11 at 8:06 p.m., with Dietary Employee #1, the following was observed:</p> <p>a. Dried food spillage was observed on the inside as well as the outside of 3 food transportation carts.</p> <p>b. Two of two ceiling vents above the food preparation area had an accumulation of dust.</p> <p>c. The pipes located underneath the oven hood, had an accumulation of dust.</p> <p>2. During the Kitchen Sanitation Tour on 7/15/11 at 2:30 p.m., with the Registered Dietitian (RD), the following was observed:</p> <p>a. The 3 compartment sink registered zero parts per million when tested for quaternary solution. Interview with Dietary Employee #2 at the time,</p>		<p><b>Hood was cleaned of dust.</b></p> <p><b>The 3 part compartment sink was</b></p> <p><b>Emptied and the sanitizing solution replaced.</b></p> <p><b>The 6 lids were immediately rewashed and</b></p> <p><b>Dried correctly before being put away.</b></p> <p><b>The cake was thrown away.</b></p> <p><b>All items in the Legacy Lane Refrigerators that were not dated and</b></p> <p><b>Labeled were thrown away.</b></p> <p><b>The pitchers of orange juice</b></p> <p><b>Were dumped out.</b></p> <p><b>Identification of other residents having</b></p> <p><b>The potential to be affected by the same</b></p> <p><b>Alleged deficient practice and</b></p> <p><b>Corrective actions taken:</b></p> <p><b>Rounds were performed by</b></p> <p><b>Dietary Manger to ensure no further issues.</b></p> <p><b>Measures put into place and systemic changes</b></p> <p><b>Made to ensure the alleged deficient does not recur:</b></p> <p><b>Staff was in serviced on the cleaning schedules.</b></p> <p><b>Ceiling vents are on</b></p>		

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	<p>indicated there was too much water in the sink. She further indicated the sink needed to be emptied and the sanitizing solution replaced.</p> <p>b. Six lids that were used for covering the soup terrines were stored wet on top of each other.</p> <p>c. A cake in the freezer was not covered. Interview with the RD at the time indicated the cake should have been covered.</p>		<p><b>maintenance check list to be cleaned</b></p> <p><b>And or checked monthly.</b></p> <p><b>All Dietary Staff were in serviced on the procedure for Sanitation of the Compartment sink</b></p> <p><b>All staff were in serviced on the procedure for Leftovers and food storage.</b></p> <p><b>How the corrective measures will be monitored to Ensure the alleged deficient does not recur:</b></p> <p><b>Dietary manager/ or designees will monitor on rounds</b></p> <p><b>Things in refrigerator to ensure it is properly Labeled and dated daily.</b></p> <p><b>Midnight charge nurse will monitor refrigerators</b></p> <p><b>On nursing units to ensure all items are covered</b></p> <p><b>And dated appropriately.</b></p> <p><b>Findings will be reviewed by QA committee who</b></p> <p><b>Will assess findings for 3 months unless findings Warrant continued observations with</b></p> <p><b>Recommendations to resolve the issue or</b></p> <p><b>Continue audit functions.</b></p> <p><b>Date: 08/17/11</b></p>		

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	<p>2. On 7/15/11 at 1:15 p.m., during the Environmental Tour, the refrigerator in the Legacy Lane restorative dining room was observed. Inside of the refrigerator was a bowl covered with foil. There was an onion slice, a tomato slice and a slice of cheese in the bowl. There was no date on the bowl. There was also a slice of sugar cream pie in the refrigerator. The pie was not covered and it did not have a date.</p> <p>Interview with the Administrator, at that time, indicated all food items in the dining room refrigerators were to have dates listed on them as to when they were placed in the refrigerator. She indicated the bowl of onion, tomato and cheese, and the pie slice should have been covered and dated.</p> <p>3. During the Environmental Tour at on 7/15/11 at 1:50 p.m., the 300 Unit dining room refrigerator was observed. There were two pitchers of orange juice noted in the refrigerator. The pitchers of orange juice had no covers on them and were not dated.</p> <p>Interview with the Administrator at that time, indicated the orange juice pitchers should have been covered and should have been dated.</p>	F0371	<p><b>Corrective Actions accomplished for Those residents found to have been Affected by the alleged deficient Practice:</b></p> <p><b>1. a. Food three food transportation carts Were cleaned. Two ceiling vents above food storage Areas were cleaned of dust. Pipes located underneath the oven Hood was cleaned of dust. The 3 part compartment sink was Emptied and the sanitizing solution replaced. The 6 lids were immediately rewashed and Dried correctly before being put away. The cake was thrown away. All items in the Legacy Lane Refrigerators that were not dated and Labeled were thrown away. The pitchers of orange juice Were dumped out.</b></p> <p><b>Identification of other residents having The potential to be affected by</b></p>	08/17/2011	

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	<p>The policy titled, "Date Marking", and dated 2009, was provided by the Administrator on 7/17/11 at 8:45 a.m. The policy indicated all prepared foods that are stored will be properly dated to ensure food safety; Procedure: 1. Date marking is an identification system. The system helps identify when the food was prepared and when it is to be discarded. 2. When to date mark: A. If an opened food item is not used within 24 hours B. The food requires refrigeration B. A commercially-prepared item is opened. D. When a ready-to-eat food item is stored regardless of temperature E. When potentially hazardous foods are stored F. When leftovers are stored G. When purchased, ready-to-eat foods are removed form their original container and not served during the next meal.</p> <p>Interview with the Administrator on 7/17/11 at 8:45 a.m., indicated the food found in the dining room refrigerators on 7/15/11 was not dated as required by the facility's policy.</p> <p>3.1-21(i)(3)</p>		<p><b>the same</b> <b>Alleged deficient practice and Corrective actions taken:</b></p> <p><b>Rounds were performed by Dietary Manger to ensure no further issues.</b></p> <p><b>Measures put into place and systemic changes Made to ensure the alleged deficient does not recur:</b></p> <p><b>Staff was in serviced on the cleaning schedules. Ceiling vents are on maintenance check list to be cleaned And or checked monthly. All Dietary Staff were in serviced on the procedure for Sanitation of the Compartment sink All staff were in serviced on the procedure for Leftovers and food storage.</b></p> <p><b>How the corrective measures will be monitored to Ensure the alleged deficient does not recur:</b></p> <p><b>Dietary manager/ or designees will monitor on rounds Things in refrigerator to ensure it is properly Labeled and dated daily.</b></p>		

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F0425 SS=E	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure Tuberculin solution was not store longer then the recommended</p>	F0425	<p><b>Midnight charge nurse will monitor refrigerators On nursing units to ensure all items are covered And dated appropriately. Findings will be reviewed by QA committee who Will assess findings for 3 months unless findings Warrant continued observations with Recommendations to resolve the issue or Continue audit functions.</b></p> <p><b>Date: 08/17/11</b></p> <p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient</b></p>	08/17/2011	

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	<p>30 days after being first opened in 1 of 3 medication rooms observed. This had the potential to affect 38 of 38 resident's residing on the 300 hall. (The 300 hall medication room)</p> <p>Findings include:</p> <p>On 7/18/11 at 9:38 a.m., the 300 unit medication room was observed. Inside the medication room there was an opened vial of Tuberculin. The date open sticker indicated the vial had been opened on 6/16/11.</p> <p>Interview with the 300 hall Unit Manager at that time indicated the Tuberculin should have been discarded after 30 day of opening. She indicated there were 38 residents that lived on the unit who had the potential for using the Tuberculin injection.</p> <p>Review of the 2/1/10 current Medication Ordering and Receiving policy provided by the Interim Director of Nursing indicated The date opened and initials of the first person to use the vial are recorded on the multi dose vials. The recommended expiration dates for PPD (Tuberculin) test solution were to discard after 30 from the date opened.</p>		<p><b>practice:</b></p> <p><b>Each medication room on all 4 units was checked at the time of survey to ensure the Tuberculin solution was dated and within the 30 day timeframe for usage. Tuberculin solution was ordered from th pharmacy for the 300 unit.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b></p> <p><b>No negative outcome resulted with any resident.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Licensed staff have been inserviced to date the Tuberculin solution once open and to either use before the 30 day expiration date or destroy and order another bottle of Tuberculin solution for use.</b></p>		

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	3.1-25(o)		<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will check all medication rooms weekly to ensure the Tuberculin solution is dated and not past the 30 day expiration from date opened as part of the ongoing QA process.</b></p> <p><b>Date: 8/17/2011</b></p>		

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F0431 SS=E	<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, record review, and interview, the facility failed to ensure the proper labeling was on all multi-dose vials of insulin and multi-dose vials of insulin were dated after opening 3 of 4 units. (Residents #21, #97, #244 and #246) (Units 200, 300, and 400)</p>	F0431	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>All multi dose insulin vials were checked on each unit to ensure a label is present with</b></p>	08/17/2011	

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	<p><b>Findings include:</b></p> <p>1. On 7/18/11 at 9:24 a.m., the 400 unit medication room was observed. Resident #246 had a vial of Novolin regular insulin that was opened. There was no date open sticker on bottle or box.</p> <p>Review of the 7/11 medication record for Resident #246 on 7/18/11 at 11:33 a.m., indicated the resident received the insulin on 7/7, 7/10 and 7/11/11.</p> <p>2. On 7/18/11 at 9:38 a.m. the 300 unit medication room was observed. There were two vials of opened insulin observed in a specimen cup. On top of the orange medication lid resident #244's name was hand written on top of cup. Both vials of opened insulin did not have a label on them containing the resident's name, doctor, or dosage.</p> <p>When interviewed at this time, the Unit Manager indicated the open insulin vials should have been labeled with the resident's name, doctor and dosage.</p> <p>3. On 7/18/11 at 9:44 a.m. the 200</p>		<p><b>the res name, doctor and dosage. Also verified date open stickers were in place at time of survey.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</b></p> <p><b>No negative outcome resulted from the audit of the multidose insulin vials.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Licensed nurss have been inserviced in regards to placing a small label with the resident name, doctor and dosage on either the multidose vial of insulin removed from the EDK as wll as a date open sticker when vial of insulin is opened. Licensed nurses to verify daily the above is in place on the container.</b></p> <p><b>How the corrective measures will be monitored to ensure the</b></p>		

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	<p>unit medication room was observed. There was one vial of opened Novolin 70/30 insulin in specimen cup with only Resident #21's name on top of the orange cap. There was no medication label noted on the outside of the specimen cup or on the vials.</p> <p>There were also two vials of opened insulin in specimen cup with Resident #97's name on top of the cap. Again there were no medication labels on the vials of insulin or on the outside of the specimen cups.</p> <p>Interview with R.N.#1 at that time, indicated there were no medication labels on the vials of insulin.</p> <p>Review of the 2/1/10 current Medication Ordering and Receiving policy provided by the Interim Director of Nursing indicated vials and ampules sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container. The date opened and initials of the first person to use the vial are recorded on the multi dose vials.</p> <p>Interview with the Interim Director of Nursing on 7/18/11 at 2:23 p.m., indicated the vials of medication should have been labeled with the</p>		<p><b>alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will spot check randomly each unit weekly to ensure the multidose insulin vials have the above mentioned label and date open sticker in place as part of the ongoing QA process.</b></p> <p><b>Date: 8/17/2011</b></p>		

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	<p>date opened and the medication labels should have been correctly labeled with the resident's name, physician, and dosage.</p> <p><b>3.1-25(k)(6)</b></p>				

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F0441 SS=E	<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, record review and interview, the facility failed to ensure staff members completed handwashing after direct resident care contact for 4 residents observed</p>	F0441	<b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Immediate inservicing with nursing staff</b>	08/17/2011	

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	<p>for incontinence. The facility also failed to ensure a glucometer was cleansed with a germicidal wipe after being used for 1 of 2 glucometer checks observed. (Residents #B, #134, #138, #206, and #245) (QMA #2, RN #3, and CNA #1)</p> <p>Findings include:</p> <p>1. On 7/10/11 at 9:00 p.m., QMA #2 was observed performing an incontinence check for Resident #206. The QMA proceeded to remove the resident's blankets and pull down the hip guards. The resident's brief was felt for wetness. The QMA was not wearing gloves at this time. The QMA also did not wash her hands prior to leaving the resident's room.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 7/18/11 at 11:30 a.m., indicated the QMA should have worn gloves, and washed her hands prior to leaving the room.</p> <p>2. On 7/16/11 at 6:31 a.m. R.N. #3 was observed performing a nebulizer treatment during medication pass with Resident #245. At that time, the nurse was observed to assess the</p>				<p><b>began with regards to handwashing, glove use and for licensed nurses how to clean the glucometer with sani wipes. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: No negative outcome resulted Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed and non licensed nursing staff have been inserviced and competencies completed with regards to handwasing, glove usage. Licensed nurses have had a competency check off of glucometer cleansing with the sani-wipes. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will randomly choose five nursing staff members three times per week times six months and review monthly times six months to ensure handwashing, glove usage, and cleaning of glucometers is completed per policy. Date: 8/17/2011</b></p>		

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	<p>resident's lung sounds and heart rate. The nurse took the resident vital signs at that time. The nurse used her bare hands and did not wash her hands after she completed the assessment. The nurse then applied clean gloves to check the resident's blood sugar using a glucometer. The nurse then obtained the resident's blood sugar by the way of the glucometer. After she was finished she used the same gloved hands and wiped the glucometer down with an alcohol wipe. She then removed her gloves and placed them in the trash on the side of the cart. The nurse did not wash her hands with soap and water after performing the glucometer check and after cleaning the glucometer for the resident. The nurse then walked back into the room and assisted the resident with his nebulizer treatment. After repositioning the resident she walked back into the hallway to her medication cart and charted her findings in the medication book.</p> <p>Review of the current and undated Glucometer Cleaning Guideline policy provided by the Administrator indicated the glucometer if used from one resident to another should be cleaned and disinfected after each use. The disinfectant material should either be a registered</p>				

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	<p>detergent/germicide or a dilute bleach solution of 1:10.</p> <p>Interview with R.N. #3 at that time, indicated the procedure for cleaning the glucometer was by using a alcohol wipe and wiping it down after each use. Further interview with R.N.#3 at that time indicated she did not wash her hands with soap and water or use alcohol gel after removing her gloves.</p> <p>3. On 7/10/11 at 8:35 a.m., CNA #1 entered the room shared by Resident's #134 and #138 to check the residents for incontinence. The CNA pulled the covers off of Resident #138, checked her brief and indicated the line on the brief was blue and stated this meant the brief was wet. The CNA then replaced the covers over Resident #138. The CNA was not wearing gloves and did not apply alcohol gel or wash her hands after she checked Resident #138.</p> <p>CNA #1 then walked over to check Resident #134 for incontinence. The CNA pulled the covers off of Resident #134 and checked the resident's brief for incontinence. The CNA was not wearing gloves. The CNA removed Resident #134's covers to check the resident's brief. Stool was observed coming from the brief. The CNA did not wash her hands or</p>						

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F0465 SS=C	<p>use alcohol gel to her hands after checking the resident.</p> <p>The CNA then left the residents room and walked to door of another resident room and did not check or provide care or contact any resident care in this room. CNA #1 then entered the room of Resident #B at 8:50 p.m.</p> <p>When interviewed on 7/10/11 at 8:50 p.m., CNA #1 indicated the facility policy was for handwashing to be done when leaving a room. The CNA indicated she did not wash her hands at the above times.</p> <p>3.1-18(a) 3.1-18(l)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained for 1 of 1 kitchens throughout the facility related to scuffed floor tile, paint chipped walls, missing cabinet handles, and an</p>	F0465	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Dry food storage room was cleaned and walls were repaired. Basboard underneathe the 3 compartment sinck was cleaned. The Handle	08/17/2011	

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	<p>accumulation of dust and debris along the base boards. This had the potential to affect 144 of 148 residents who received oral diets in the facility. The facility also failed to ensure a functional environment was maintained related to a hole in the wall in the laundry room. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Initial Kitchen Sanitation Tour on 7/10/11 at 8:03 p.m., with Dietary Employee #1, the following was observed:</p> <p>a. The floor tile in the dry food storage room was scuffed and marred. The walls located in the dry food storage room were also paint chipped and marred.</p> <p>2. During the Kitchen Sanitation Tour on 7/15/11 at 2:30 p.m., with the Registered Dietitian (RD), the following was observed:</p> <p>a. The tile baseboard located underneath the 3 compartment sink had an accumulation of dust and food crumbs.</p> <p>b. A handle was missing on the</p>		<p>on the cabinet door that housed the dishes was repaired. The wall behind the washing machine was repaired. Identificatin of other residents having th potential to be affected by the same alleged deficient practice and corrective actions taken::Sanitation rounds were be conducted by the Dietary Manager, Housekeeping Supervisor or designees of the health campus to identify any other areas. If any were noted those items were immediately corrected.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Sanitation documented rounds will be conducted three times per week by the Dietary Manager, Housekeeping Supervisor or designees of the health campus.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:Dietary Manager, Housekeeping Supervisor or designee will report findings of rounds to the QA Committee. The QA Committee will assess findings with recommendations to resolve issues or continue audit functions for three months. Date: 8/17/011</p>		

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F0469 SS=D	<p>cabinet door that housed the dishes.</p> <p>Interview with the RD at the time, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3. On 7/15/11 the Environmental Tour was completed from 1:00 p.m. through 2:30 p.m. The laundry room was observed during the Environmental Tour.</p> <p>The wall behind the washing machines was observed to have a large hole. The hole in the plaster board was 3 feet x 6 inches in size.</p> <p>Interview with the Maintenance Supervisor at that time, indicated the wall was in need of repair.</p> <p>3.1-19(f)</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interviews, the facility failed to ensure an effective pest control program was maintained related to insects in 1 of 40 resident bathrooms observed. (Room 309).</p> <p>Findings include:</p>	F0469	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The 2567 is stated incorrectly and should have stated room 208. room 309 was inspected and no ants were present. The contracted exterminator sprayed and cleared room 208 of ants. Identification of other residents having the</p>	08/17/2011	

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	<p>The bathroom floor of room 309 was observed on 7/12/11 at 8:31 a.m. Ants were observed on the floor around the toilet.</p> <p>On 7/13/11 at 11:32 a.m., ants were again noted on the floor of the bathroom near the toilet.</p> <p>During observation on 7/14/11 at 7:50 a.m., ants were noted on the bathroom floor near toilet.</p> <p>On 7/15/11 at 7:58 a.m. ants were observed on the bathroom floor around the toilet.</p> <p>On 7/15/11 at 2:05 p.m., during the Environmental Tour, interview with the Housekeeping Supervisor indicated there have been problems with ants in the bathroom of room 309.</p> <p>At 7:41 a.m. on 7/17/11 ants were observed on the floor of the bathroom in room 309. Interview with the Housekeeping Supervisor at that time indicated there were ants on the floor. He indicated the facility routinely had a pest control company spray for insects. He indicated that the current routine for the pest control company may not be adequate to control the ants in room 309.</p>		<p>potential to be affected by the sme alleged dificient practiceand corrective actions taken:Complete rounds were made by Housekeeping Supervisor and cntracted exterminator for pest and no others were found.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Housekeeping Supervisor and Administrator / or designees will make rounds three times a week, to inspect for pests.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:Housekeeping Supervisor or designee will report findings of rounds to the QA Committee. The QA Committee will assess findings with recommendations to resolve issues or continue audit functions for three months. Date: 8/17/2011</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-19(f)(4)				