STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ROCHESTER	827 W 13TH ST ROCHESTER, IN 46975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00200103. Survey dates: May 9, 10, 11, 12, 13 and 16, 2016 Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 13 Medicaid: 44 Other: 14 Total: 71 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on May 23, 2016.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or			

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	interested family member. Based on interview and record review, the facility failed to ensure a family member was notified timely of a fall for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: On 5/11/16 at 10:15 A.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted on 4/29/16. The resident's diagnoses included, but were not limited to: pain, unspecified convulsions, insomnia and Alzheimer's disease. An Incident/Accident Data Entry Questionnaire form, dated 5/9/16 at 5:30 A.M., indicated Resident D had an unwitnessed fall and received a laceration to her head with no loss of consciousness. The form indicated the resident was found by QMA (Qualified Medication Aide) #3 lying on her back with her head slightly under her bed. The form indicated the physician was called at 5:40 A.M.; however, a family member wasn't contacted until 8:00 A.M. The resident's head laceration was cleansed, vital signs were taken and neurological assessments were started. The form indicated the interventions in place at the	F 0157	The facility is requesting a face to face Informal disputeresolution meeting. The facility doesnot agree that it failed to notify a family member of a fall. Resident D no longer resides at the facility. The Director of Nursing or designee completed an audit prior to June 16, 2016 of all falls within the past 30 days to ensure that proper family notification occurred. The licensed nursing staff were re-educated prior to June 16, 2016 regarding timely family notification of a resident who falls. The Director of Nursing or designee will audit 8 incidents per month for 2 months, then 6 incidents per month for 2 months, then 4 incidents per month for 2 months to ensure timely family notification takes place. Results of these audits will beforwarded to the Quality Assurance Committee for review and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	06/15/2016

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	time of the accident was for the resident to have non-skid socks on. There was no new intervention in place due to resident in the emergency room. A Nursing Note, dated 5/9/16 at 6:23 A.M., indicated resident was lying on her backside with head slightly under the bed and the resident's walker was beside her. The note indicated the resident had 2 lacerations to her left side of her hand and to see skin sheets. A Nursing Note, dated 5/9/16 at 8:32 A.M., indicated at approximately, 8:00 A.M., Resident D put her hand to her head and said "my head hurts so bad" then the resident acted very tired. The Nursing Note indicated the Assistant Director of Nursing (ADON) was notified and the ADON and a CNA (Certified Nursing Assistant) (not identified) took the resident to her room to laid her down in her bed, while LPN (Licensed Practical Nurse) #4 called physician, daughter and a ambulance. The Nursing Note indicated the resident became unresponsive and 911 was called again. During an interview, on 5/11/16 at 3:40 P.M., LPN #4 indicated she was working the day shift on the dementia unit the morning of 5/9/16. She received report a			

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	little after 6:00 A.M. and was told Resident D had a fall with a laceration to her head and her vital signs were all ok. LPN #4 indicated the nurse giving her report did not say if the family had been notified of the fall. LPN#4 indicated the resident was observed in the Day room getting her blood drawn and complained of no pain. LPN#4 indicated she started her morning medication pass and gave Resident D her morning medications and took the residents vitals sometime after 7:00 A.M. Resident D's vitals were ok at that time. LPN #4 indicated the resident had no problems with taking her medications. LPN#4 indicated she assisted the resident to her table to eat breakfast sometime near 8:00 A.M. LPN #4 indicated while the resident was eating she put her hand to her head and told LPN #4 "my head hurts so bad." LPN #4 called the ADON over to the unit, so she could call the physician, physician said to send to ER, 911 was called and then a family member was notified. LPN #4 further indicated the resident started to lean so the ADON took the resident to her room to wait for the ambulance to arrive. While the resident was in her room the resident became unresponsive, with her pupils fixed and 911 was called again. The ambulance arrived and took the resident to the ER (Emergency Rooom).			

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	On 5/13/16 at 12:05 P.M., the DON provided a policy titled, "Falls Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Management of Falls...f. The responsible party and physician are promptly notified of the occurrence and status of the resident...." 3.1-5(a)(1)			
F 0256 SS=D Bldg. 00	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide adequate lighting in 1 of 18 resident rooms. (Resident #38) Finding includes: During an interview, on 5/10/16 at 1:48 P.M., Resident #38 indicated the light was pretty dim for reading.	F 0256	The facility is requesting a face to face informal dispute resolution meeting. The facility does not agree that it failed provide adequate lighting. A floor lamp was placed in resident #38 room on 5/13/16. The Social Service Director or designee completed alert andoriented resident interviews prior to June 16, 2016 to determine that residentroom light is acceptable for each of the	06/15/2016

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	On 5/13/16 from 11:00 A.M. to 11:40 A.M., an environmental tour was conducted of the facility with the Maintenance Supervisor, the Housekeeping Supervisor, and the Administrator, during which the following was observed: At 11:15 A.M., Resident #38 was observed sitting in her recliner chair beside her bed. Resident #38 had the overhead light on above her bed. The lighting was dim in her room. There was an overhead light above the residents recliner, the resident indicated she could not reach the cord to turn the light on because the cord was behind the privacy curtain and the cord was only a couple of inches long. During an interview, on 5/13/16 at 11:16 A.M., Resident #38 indicated she loved to read but the light was so dim in her room she had a hard time reading. During an interview, on 5/13/16 at 11:17 A.M., the Maintenance Supervisor indicated he would place a floor lamp beside the residents chair to give her more light for reading. On 5/16/16 at 9:20 A.M., Resident #38 was observed sitting in her recliner chair, the light in her room was dim, there was		existing residents. The Social Service Director or designee willrandomly interview 8 residents per month for 2 months, then 6 residents permonth for 2 months, then 4 residents per month for 2 months to ensure residentsverbalize that they have adequate room lighting. Results of these audits will be forwarded tothe Quality Assurance Committee for review and additional recommendations asindicated.	

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	no floor lamp beside her chair or in the room. 3.1-19(dd)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interview, the facility failed to ensure care plans were updated timely and accurately for 1 of 1 residents regarding incontinence care needs (Resident #47) and 1 of 1 residents regarding contractures and range of motion needs (Resident #5).	F 0280	Res #47 and Res # 5 were affected. Careplans and caredirectives for these residents were updated to reflect their current needs forsplint and/or toileting. The Director of Nursing/designee audited toileting andsplint care plans to ensure they were updated. The IDT team was educatedregarding the Care	06/15/2016

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	Findings include: 1. The clinical record for Resident #47 was reviewed on 05/12/2016 at 8:47 A.M. Resident #47 was admitted to the facility on 09/15/10 with diagnoses, including but were not limited to: status post fractured hip, constipation, dementia with behavioral disturbances, depressive disorder, Alzheimer's disease, hypertension, anxiety and muscle weakness. A urinary incontinence assessment, completed on 10/06/15, indicated the resident had a urinary tract infection, could not follow directions or recognize the urge to void, could not hold her urine, could not do Pelvic exercises, was on a scheduled check and change and required extensive assist of two staff for toileting needs. The most recent Minimum Data Set (MDS) assessment for Resident #47, completed on 02/08/16, indicated the resident was always incontinent of her bowel and bladder. A monthly summary, completed on 02/14/16, indicated the Resident was incontinent of both bladder and bowel and wore briefs.		plan process. Nursing staff was educated to notify Therapywhen devices or modalities are unavailable for use. MDS or designee will attendcare plan meetings to ensure care plans are updated and documentation for MDS'sare accurate during the meeting. Audits will be performed to ensure splints are in place asordered. Residents who refuse or are non-compliant with have MD and familynotification and refusals/non-compliance careplanned. Audits will be conducted of8 residents per month x 2 months, 6 residents per month x 2 months, and 4residents per month x1 month. The results will be forwarded to the Quality AssuranceCommittee for review and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	The care plan regarding incontinence, initiated 02/20/13 and current through 08/18/16, indicated the staff were "to adjust toileting schedule prn [as needed] if elimination pattern changes, observe for non-verbal cues that resident may need to use the toilet, provide prompt peri care prn between regular scheduled toileting times, resident uses the following for elimination - toilet, resident routine toileting schedule is as follows: upon rising, before and after meals at bedtime and prn." During an interview, on 05/16/2016 at 2:56 P.M., the MDS coordinator, RN (Registered Nurse) #27 indicated indicated the care plan for Resident #47 was incorrect and needed updated. RN #27 indicated Resident #27 was supposed to be on a check and change program not a toileting program. She indicated the times were correct on the care plan just not the toileting intervention. RN #27 indicated although she was the MDS coordinator, she was not on the "care plan team" and just assumed the care plan had been updated correctly. 2. The clinical record for Resident #5 was reviewed on 5/13/16 at 2:00 P.M. Resident #5 was admitted to the facility, on 5/15/07, with diagnoses, including but			

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	were not limited to: vascular dementia without behavioral disturbance, major depressive disorder, cerebral vascular accident, aphasia and contracture of the right hand. A physician order, dated 7/21/15, indicated PT (Physical Therapy)/OT (Occupational Therapy) to eval (evaluate) and tx (treat) d/t (due to) refusal of splint use. A Rehabilitation Services Training Attendance Record, dated 8/3/15, indicated the training was for orthotic management for Resident #5 which included: 1. Cleanse R (right) hand with warm soapy water, rinse thoroughly and dry. 2. Inspect skin for breakdown or open areas. 3. Apply palm guard to R hand, place thumb through thumb hole, fold guard and slide under fingers, adjust finger separators between index and middle finger, between middle and ring finger and ring finger and pinky. Adjust strapping on back of hand with velcro closer. Patient may wear palm guard up to 12 hours per day 6 A.M. to 6 P.M. A Nursing-Therapy Referral Form, dated 8/4/15, indicated pt (patient) to utilize right hand palm guard 12 hours a day from 6 A.M. to 6 P.M. Cleanse right hand and let it dry prior to donning palm			

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	guard. Routine skin check. A physician order, dated 8/4/15, indicated may d/c (discontinue) right elbow splint. Pt (patient) may utilize right hand palm guard daily. An Occupational Therapy Plan of Treatment, dated 8/5/15, indicated the reason for the referral was due to patient not utilizing right elbow splint due to being combative when donning splint. The patient will benefit from skilled OT to assess appropriate right elbow and right hand splint to prevent further contracture and prevent skin breakdown. The hand was in a fisted position and was not able to measure ROM (Range of Motion) due to patient resisting movement. The patient was able to tolerate right hand palm guard. Patient will continue to benefit from skilled OT for caregiver education and a restorative program for splint wear. An Occupational Therapy Plan of Treatment, dated 8/18/15, indicated the patient tolerates right palm guard for 12 hours from 6 A.M. to 6 P.M. Nursing staff has demonstrated 100% (percent) accuracy in donning/doffing of right hand splint. Patient's right elbow splint has been discontinued due to poor compliance.			

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	A physician order, dated 8/18/15, indicated patient to utilize right hand palm guard splint from 6 A.M. to 6 P.M. The quarterly MDS (Minimum Data Set) assessment, completed on 1/27/16, indicated the resident was severely cognitively impaired, required extensive 2 person assist with bed mobility, dressing and personal hygiene and extensive 1 person assist with eating. A care plan, dated 3/15/16, indicated the resident is at risk for pain relating to immobility and contractures. Interventions included, but were not limited to: Administer/observe for effectiveness and for possible side effects from pain medication. Consultation as needed with OT/PT. Observe and report to nurse signs and symptoms of pain: crying, resist moving, resists care and agitation. Allow quiet area for me to rest. A fax order request/notification form, dated 5/6/16, indicated resident has contractures and is yelling out a lot can we please do Tylenol 650 mg (milligrams) TID (three times daily) routine for pain management? The physician responded yes. On 5/11/16 at 9:40 A.M., Resident #5			

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	was seated in her Broda chair in her room with the television on. She was awake, alert and moaning. Her right hand was uncovered her hand and fingers are contracted, no palm guard splint was observed on her hand or anywhere in the room. A Care Directive, dated 5/12/16, indicated to utilize right hand palm guard from 6 A.M.-6 P.M. Observe for and report any pain issues related to splint application. Observe skin condition under splint upon splint removal and report any areas of concern. Provide passive ROM to right upper extremity. During an interview, on 5/12/16 at 10:45 A.M., the Director of Nursing indicated the Care Directive is similar a CNA (Certified Nursing Assistant) assignment sheet it indicates to the staff the needs of each resident. On 5/12/16 at 10:54 A.M., Resident #5 was resting in her bed. Her right hand and fingers were contracted. There was no splint/palm guard observed. At 12:30 P.M., Resident #5 was observed in her Broda chair in the assisted dining room, no splint or palm guard was observed on the right hand. At 2:15 P.M., Resident #5 was observed sitting in her Broda chair in her room, her lap blanket had slid			

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	off of her arms, no splint or palm guard was observed on the right hand. On 5/13/16 at 8:59 A.M., Resident #5 was observed in the hallway in her Broda chair she was moaning loudly. CNA #12 assisted the resident back to her room and indicated she moans sometimes when she wants to go back to her room and lie down. Two CNA's assisted the resident back to bed with the use of a hoyer (mechanical) lift. CNA#12 attempted to open resident #5's fingers on her right hand, the resident moaned loudly. The skin in the palm of the residents hand was moist and had a white appearance to it, no open areas was observed. All 5 fingernails on the right hand were long and yellow with ridges on them, each nail had a dried brown substance under them and there was a foul sour odor when the CNA opened the residents fingers on her right hand. During an interview, on 5/13/16 at 9:11 A.M., CNA #12 indicated the resident had a blue hand splint for the right hand but has not seen it and is unsure why it is not on. CNA #12 indicated she does attempt to do ROM (range of motion) to the right hand and fingers but the resident does not like it and yells out like it hurts. During an interview, on 5/13/16 at 10:06			

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	155379		05/16/2016

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	A.M., the Director of Nursing indicated Resident #5 had recently moved rooms and the staff have not been able to find her right palm guard since the room move. She indicated a new palm guard will be in place today. The Director of Nursing indicated the resident should have a care plan in place for the contracture of her right hand and she does not. On 5/16/16 at 9:37 A.M., Resident #5 was observed resting in her bed her right hand and fingers are contracted no splint or palm guard was observed. 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure a preventative fall care plans were implemented consistently to prevent further falls for 2 of 3 residents reviewed for falls. (Resident #E and #F) In addition, the facility failed to ensure an incontinence care plan was implemented	F 0282	Residents E, F, and 47 were affected. Careplans and caredirectives for these residents were updated to reflect their current needs forfall prevention and/or toileting. The Director of Nursing/designee audited fall and toiletingcare plans and care directives to ensure they were updated. Staff ensured	06/15/2016

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	timely for 1 of 1 residents reviewed for incontinence. (Resident #47) Findings include: 1. The clinical record for Resident F was reviewed on 05/12/2016 at 9:07 A.M. Resident #F was admitted to the facility on 12/29/15, with diagnoses, including but not limited to: fracture of the pelvis, chronic obstructive pulmonary disease, enlarged prostate, atherosclerotic heart disease, emphysema, heart failure, hypertension, and history of fracture of the left humerus. The history and physical assessment, completed at a hospital prior to the resident's admission to the facility, on 12/25/15, indicated Resident F tripped over his oxygen tubing in his home and fell, fracturing his pelvis and humerous. A fall risk evaluation, completed on 12/29/15, indicated the resident had a history of 1-2 falls, required assistance for elimination needs, utilized a wheelchair, had multiple health risk factors and scored an 18 on the evaluation which indicated he was at high risk for falls. The intervention put in place, on 12/29/15, to prevent falls was "call light within reach."		interventions on careplans/care directives matched what was in place. The IDT team was educated onthe Care Plan process. Nursing staff educated to notify DON when fall ortoileting interventions not in place or no longer appropriate. MDS or designeewill attend care plan meetings and will update careplans during morningmeeting, IDT meetings, and careplan meetings. Audits will be performed to ensure fall and toiletinginterventions are in place 3x week x 4 weeks, weekly x 4 weeks, and weeklythereafter. The results will be forwarded to the Quality Assurance Committeefor review and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	The initial admission Minimum Data Set (MDS) assessment, completed on 01/05/16, indicated the resident scored a 14 of 15 on the (Brief Interview of Mental Status) BIMS, required extensive staff assistance for transfers, was non ambulatory and required extensive staff assistance for wheelchair locomotion and toileting needs. The resident had an indwelling urinary catheter and was frequently incontinent of his bowels. A nursing progress note, dated 03/07/16 at 12:00 A.M., indicated the resident was found on the floor in his room. The resident was confused and had been attempting to ambulate by himself. Another fall risk evaluation, completed on 03/07/16, indicated the resident was still a high risk for falls and the interventions in place were "call light in reach and education provided." An Incident/Accident Data Entry Questionnaire (sic), completed on 03/07/16 at 12:00 A.M., indicated Resident F was found on the floor by a nurse. The resident had been attempting to ambulate without any assistive devices and was alert but confused. The follow up portion of the investigative form indicated the resident was unable to balance himself independently and had			

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	no barriers which might have contributed to his fall. The resident had not utilized his call light and he had a low bed in place. The resident had previously refused hip protectors as an intervention. The interventions implemented were to continue the bed in low position and call light in reach and education regarding the call light was provided to the resident. Nursing progress notes, dated 04/22/16 at 3:54 P.M., indicated the resident slid out of his wheelchair and was found on the floor in front of his wheelchair. The most recent Fall Risk Evaluation, completed on 04/22/16 indicated the resident was still a high risk for falls and the intervention implemented was "dycem [a non slip thin material] to wheelchair." A care plan related to the resident's risk for falls, initiated on 01/04/16 and current through 07/06/16, indicated the resident was at risk for a fall as evidence by previous falls. The interventions included a fall risk assessment, invite and escort to activity programs, provide environmental adaptations- call light in reach and adequate glare free lighting, and area free of clutter, provide resident teaching for safety measures, provide wheelchair, refer to PT (physical			

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	therapy), OT (occupational therapy) and Mental health, remind to lock brakes on bed and chair before transferring, when rising from a lying position sit on side of bed for a few minutes before transferring/standing, educate to request assistance prior to ambulation, report falls to physician and responsible party. "Non-skid strips next to bed" was added as an intervention on 03/07/16 and "dysom [sic] to wheelchair" was added on 04/22/16. Nursing progress notes, on 05/02/16 at 3:39 P.M., indicated the resident was attempting to transfer himself and had not utilized the call light or requested assistance On 05/13/2016 at 10:54 A.M., there were no non skid strips observed on either side of Resident F's bed or in the bathroom. On 05/13/2016 at 10:59 A.M., Resident F was observed in the front lobby seated in his wheelchair. There was a thick cushion visible underneath the resident in the wheelchair seat. The cushion was wider than the wheelchair seat and was slightly creased in the middle and extended past the end of the wheelchair seat by approximately 1 1/2 inches. There was no dycem material visible			

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	underneath the resident. Resident F was queried regarding any thin non slip type material on the chair cushion and he indicated he did not recall any such material being applied, just the cushion. On 05/13/2016 at 2:55 P.M., Resident F was transferred with the assistance of LPN (Licensed Practical Nurse) #22 and QMA (Qualified Medication Aide) #23 from his wheelchair to his bed. His wheelchair cushion was noted to be in his wheelchair but there was no dycem type material anywhere in his wheelchair. Both staff indicated there was no dycem in his wheelchair and no non-skid strips on either side of his bed. QMA #23 looked in his closets and she could not locate any dycem material. On 05/16/2016 at 9:09 A.M., Resident F's room was observed. There were still no nonslip strips on either side of bed. 2. The clinical record for Resident E was reviewed on 05/13/2016 at 8:59 A.M. Resident E was admitted to the facility on 04/28/16 with diagnoses, including but not limited to: dementia with behavioral disturbance, depression, anxiety disorder and shortness of breath. A nursing progress note, dated 04/29/16 at 2:24 A.M., indicated a noise was heard			

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	in the resident's room and the resident was found laying on his backside with his feet extended towards the bathroom. Resident E indicated he was trying to go to the bathroom. When the resident was asked why he did not use call light, he indicated because he could not find his call light. The call light was located on the resident's bed. Resident E was reeducated on the use of call light and need for assistance. The resident had incurred skin tears to both his elbows and the top of his left hand and to his left wrist. A nursing progress note, dated 04/29/16 at 7:52 A.M., indicated the IDT (interdisciplinary team) meeting had met in regards to Resident #E's fall that occurred early this (04/29/16) A.M. and an appropriate intervention was to place a clip to the resident's call light cord and have staff attach it to the resident's shirt/gown while he was in bed. A fall risk care plan, initiated on 04/29/16, indicated the resident was to be invited and escorted to activities, provided call light in reach and glare free lighting and area free of clutter, provide resident teaching for safety measures, provide walker/cane and wheelchair, remind resident to lock brake on bed, chair etc before transferring, when rising			

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	from lying position to sit on side of bed for a few minute, educated and reminded to request assistance prior to ambulation, report falls to physician and responsible party, report any side effects of medication, and clip to call light cord and keep cord attached to shirt or gown while in bed. A nursing progress note, dated 05/10/16 at 10:30 A.M., indicated the resident had poor safety awareness. On 05/13/2016 at 10:57 A.M., Resident E was observed sleeping in his bed on his back. His call light was lying on the floor and there was no clip noted on the cord. On 05/16/2016 at 9:38 A.M. Resident E was observed in his room in bed asleep. The resident had a low bed but his call light cord was on the floor and there was no clip on the cord. At 10:37 A.M., two staff members, LPN #25 and CNA (Certified Nursing Assistant) #26 had assisted Resident E's roommate but had not noticed the call light on the floor. On 05/16/2016 at 12:45 P.M., Resident E was observed being supervised by an unnamed staff member as he ambulated from the dining room back to his room with his walker. He then was noted to be			

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	supervised by the staff member while he got into bed. The unnamed staff member left and Resident E was observed at 1:02 P.M. in his room asleep with his shoes on. His call light cord was on the floor. At 2:07 P.M., Resident E in his bed asleep and his call light was noted on the floor. 3. The clinical record for Resident #47 was reviewed on 05/12/2016 at 8:47 A.M. Resident #47 was admitted to the facility on 09/15/10, with diagnoses, including but not limited to: status post fractured hip, constipation, dementia with behavioral disturbances, depressive disorder, esophageal reflux, Alzheimer's disease, hypertension, anxiety, iron deficiency anemia, and muscle weakness. A urinary incontinence assessment, completed on 10/06/15, indicated the resident had a urinary tract infection, could not follow directions or recognize the urge to void, could not hold her urine, and could not do Pelvic exercises, and was on a scheduled check and change and required extensive assist of two staff for toileting needs. The most recent Minimum Data Set (MDS) assessment for Resident #47, completed on 02/08/16, indicated the resident was always incontinent of her			

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	bowel and bladder. A monthly summary, completed on 02/14/16, indicated the Resident was incontinent of both bladder and bowel and wore briefs. The care plan regarding incontinence, initiated 02/20/13 and current through 08/18/16, indicated the staff were "to adjust toileting schedule prn [as needed] if elimination pattern changes, observe for non-verbal cues that [Resdeint name]may need to use the toilet, provide prompt peri care prn between regular scheduled toileting times, resident uses the following for elimination - toilet, resident routine toileting schedule is as follows: upon rising, before and after meals at bedtime and prn." During an interview, on 05/16/2016 at 2:56 P.M., the MDS coordinator, RN (Registered Nurse) #27 indicated indicated the care plan for Resident #47 was incorrect and needed updated. RN #27 indicated Resident #27 was supposed to be on a check and change program not a toileting program. She indicated the times were correct on the care plan just not the toileting intervention. A bladder pattern flow record, completed from 10/07/15 through 10/09/15			

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	indicated the resident was always incontinent and was not marked as voiding on the bed pan or toilet at any point. On 05/10/16 at 11:00 A.M., Resident #47 was observed in her room, seated in a recliner. She was noted to have a strong urine odor. On 05/12/2016 at 8:43 A.M., Resident #47 was observed seated in her wheelchair across from nurse's station. An activity staff member approached the resident and asked her if she wanted to go have juice and coffee. Resident #47 smiled and nodded "yes" and she was taken by the staff member to the front lounge. At 9:29 A.M., Resident #47 was observed seated in her recliner in her room holding a baby doll. At 11:10 A.M., she was transferred to her wheelchair, without any opportunity to toilet or have her brief changed and was pushed into the hallway in her wheelchair. On 05/13/2016 at 8:38 AM, Resident #47 was pushed to her room by CNA (Certified Nursing Assistant) #28. She was then transferred to her wheelchair without any toileting or incontinence care by CNA #28 and #29. She was covered with a lap blanket and given a doll to			

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	hold. Resident #47's room around her recliner smelled strongly of urine. Resident #47 remained in her room in her recliner from 8:38 A.M. to 11:57 A.M. Activity staff had entered the resident's room at 10:23 A.M. and had given the resident a cookie and a plastic tub of cards to look at, but she was not observed to have received an toileting or incontinence care. At 11:57 A.M., CNA #28 and #29 entered the room and transferred Resident #47 from her recliner into her wheelchair. CNA #29 asked CNA #28 if they were going to toilet the resident and CNA #29 informed CNA #28 that she and QMA #23 had stood the resident up in front of her recliner and changed her brief earlier in the morning around 9:00 A.M. Resident #47 was then taken directly to the dining room for the noon meal. During an interview, on 05/13/2016 at 2:57 P.M., QMA (Qualified Medication Aide) #23 indicated she did help change Resident #47's brief soon after she started working around 8:00 A.M. On 05/13/2016 at 1:15 P.M., Resident #47 observed in her wheelchair in the front lobby at a music activity. She remained in the activity from 1:15 P.M. to 2:40 P.M. in her wheelchair sleeping. She remained in her wheelchair in the			

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	front lounge until 3:00 P.M. when she was taken by activity staff outside to the front porch area of the facility. She remained outside with activity staff unit 3:44 P.M. She was then pushed in her wheelchair to the nurse's station on the central unit and left in the hallway. On 05/13/16 at 4:05 P.M., QMA #30 and CNA #31 were asked to please check Resident #47 for incontinence. Resident #47 was transferred to her bed, her brief, which was heavily saturated with very strong smelling urine was removed and there was also a small amount of dried formed stool stuck to the resident's coccyx area. CNA #31 indicted although the resident's skin was intact, there were deep creases from the brief and her buttocks area was reddened. QMA #30 indicated the resident had a very strong urine odor. On 05/16/16 from 8:50 A.M. to 11:17 A.M., Resident #47 was observed in her recliner in her room holding a doll dozing on and off throughout the morning. At 11:17 A.M., CNA #26 and #32 placed Resident #47 on the toilet. The resident's heavily saturated brief was removed. The resident did not void in the toilet. 3.1-35(g)(2)			

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F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for incontinence received timely incontinence care to maintain good hygiene (Resident #47). In addition, the facility failed to ensure 1 of 1 residents reviewed for grooming needs received timely fingernail care. (Resident #57) Findings include: 1. The clinical record for Resident #57 was reviewed on 05/12/2016 at 11:20 A.M. Resident #57 was admitted to the facility on 04/24/14 and readmitted on 10/20/15 with diagnoses, including but not limited to: chronic obstructive pulmonary disease, lack of coordination, intellectual disabilities, enlarge prostate, systolic and diastolic heart failure, muscle weakness, generalized anxiety	F 0312	Res #47 and Res #57 were affected. These residents wereassessed and nail and incontinence care provided. The Director of Nursing/designee in-serviced on ADL care,toileting, and nail care. Angel Care rounds to be redistributed by the ED andcompleted daily. The ED/DON/designee will audit angel care rounds 5x/week x 4weeks and weekly thereafter. Findings to be reported to the DON and addressedimmediately. Results to be forwarded to the Quality Assurance Committee forreview and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	06/15/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disorder, constipation and hypertension. The most recent Minimum Data Set (MDS) assessment for Resident #57, completed on 03/12/16 indicated the resident required extensive staff assistance of one for personal hygiene needs and was totally dependent on staff for bathing needs. The care plan for Resident #57 regarding activities of daily living (ADL's) needs, initiated on 04/24/14, indicated the resident required the extensive staff assistance of 1 to 2 staff for ADL care. The resident was to participate as able with his daily ADL's. The interventions included, but were not limited to: Provide the amount of assistance/supervision that is needed. On 05/12/2016 at 11:15 A.M., Resident #57's fingernails were noted to be long, extending over the tips of his fingers and his thumbnail on his right hands and his thumbnail and first finger on his left hand had a brownish/orangish substance underneath them. On 05/13/16 at 10:27 A.M., Resident #57's fingernails were noted to be the same length as yesterday except the 4th and 5th fingernail on his right hand was now dirty.			

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	On 5/16/2016 at 9:41 A.M., Resident #57's fingernails were noted to be the same length as they were on 05/13/16. His thumb nails and right pointer finger had orangish colored material under them. During an interview, on 05/16/16 at 10:36 A.M., LPN (Licensed Practical Nurse) #33 indicated Resident #57 was not diabetic and his nail care should be completed by the nursing assistants but was not necessarily completed in conjunction with his bathing schedule. She indicated sometimes the nail care was completed per the resident's preference. On 05/16/2016 at 2:03 P.M., Resident #57's nails were observed with LPN #22. She indicated the nails were a little long. She asked the resident if he wanted his nails trimmed. He said "suit yourself" but LPN #22 reiterated it was up to him and he said "yes." The "Personal Hygiene and Bathing" record for Resident #57, for May 2016, indicated he had received fingernail care 3 times on 05/01/16, once on 05/04/16, twice on 05/05/16, once on 05/10/16 and twice on 05/11/16. He was not documented as having received fingernail			

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	care since 05/11/16. On 05/16/16 at 3:30 P.M. the Director of Nursing (DON) provided the facility policy and procedure, titled "Fingernail Care," undated, and indicted this was the policy and procedure currently used by the facility. The policy and procedure included the following: "...4. Fingernails can be partially cleaned during hand washing and bath care....6. Nail care includes daily cleaning and regular trimming...The resident's plan of care must address: 1. When and how often nail care is to be provided...." 2. The clinical record for Resident #47 was reviewed on 05/12/2016 at 8:47 A.M. Resident #47 was admitted to the facility on 09/15/10 with diagnoses, including but not limited to: status post fractured hip, constipation, dementia with behavioral disturbances, depressive disorder, Alzheimer's disease, hypertension, anxiety and muscle weakness. A urinary incontinence assessment, completed on 10/06/15 indicated the resident had a urinary tract infection, could not follow directions or recognize the urge to void, could not hold her urine, and could not do Pelvic exercises, and was on a scheduled check and change and			

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	required extensive assist of two staff for toileting needs. The most recent Minimum Data Set (MDS) assessment for Resident #47, completed on 02/08/16, indicated the resident was always incontinent of her bowel and bladder. A monthly summary, completed on 02/14/16, indicated the Resident was incontinent of both bladder and bowel and wore briefs. The care plan regarding incontinence, initiated 02/20/13 and current through 08/18/16, indicated the staff were "to adjust toileting schedule prn if elimination pattern changes, observe for non-verbal cues that resident may need to use the toilet, provide prompt peri care prn between regular scheduled toileting times, resident uses the following for elimination - toilet, resident routine toileting schedule is as follows: upon rising, before and after meals at bedtime and prn." During an interview on 05/16/2016 at 2:56 P.M., the MDS coordinator, RN (Registered Nurse) #27 indicated the care plan for Resident #47 was incorrect and needed updated. RN #27 indicated Resident #47 was supposed to be on a			

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	check and change program not a toileting program. She indicated the times were correct on the care plan just not the toileting intervention. A bladder pattern flow record, completed from 10/07/15 through 10/09/15 indicated the resident was always incontinent and was not marked as voiding on the bed pan or toilet at any point. On 05/10/16 at 11:00 A.M., Resident #47 was observed in her room, seated in a recliner. She was noted to have a strong urine odor. On 05/12/2016 at 8:43 A.M., Resident #47 was observed seated in her wheelchair across from nurse's station. An activity staff member approached the resident and asked her if she wanted to go have juice and coffee. Resident #47 smiled and nodded "yes" and she was taken by the staff member to the front lounge. At 9:29 A.M., Resident #47 was observed seated in her recliner in her room holding a baby doll. At 11:10 A.M., she was transferred to her wheelchair, without any opportunity to toilet or have her brief changed and was pushed into the hallway in her wheelchair.			

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	On 05/13/2016 at 8:38 AM, Resident #47 was pushed to her room by CNA (Certified Nursing Assistant) #28. She was then transferred to her wheelchair without any toileting or incontinence care by CNA #28 and #29. She was covered with a lap blanket and given a doll to hold. Resident #47's room around her recliner smelled strongly of urine. Resident #47 remained in her room in her recliner from 8:38 A.M. to 11:57 A.M. Activity staff had entered the resident's room at 10:23 A.M., gave the resident a cookie and a plastic tub of cards to look at, but she was not observed to have received an toileting or incontinence care. At 11:57 A.M., CNA #28 and #29 entered the room and transferred Resident #47 from her recliner into her wheelchair. CNA #29 asked CNA #28 if they were going to toilet the resident. CNA #29 informed CNA #28 that she and QMA (Qualified Medication Aide) #23 had stood the resident up in front of her recliner and changed her brief earlier in the morning around 9:00 A.M. Resident #47 was then taken directly to the dining room for the noon meal. During an interview, on 05/13/2016 at 2:57 P.M., QMA #23 indicated she did help change Resident #47's brief soon after she started working around 8:00 A.M.			

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	On 05/13/2016 at 1:15 P.M., Resident #47 observed in her wheelchair in the front lobby at a music activity. She remained in the activity from 1:15 P.M. to 2:40 P.M. in her wheelchair sleeping. She remained in her wheelchair in the front lounge until 3:00 P.M., when she was taken by activity staff outside to the front porch area of the facility. She remained outside with activity staff unit 3:44 P.M. She was then pushed in her wheelchair to the nurse's station on the central unit and left in the hallway. On 05/13/16 at 4:05 P.M., QMA #30 and CNA #31 were asked to please check Resident #47 for incontinence. Resident #47 was transferred to her bed, her brief, which was heavily saturated, with a very strong urine odor, was removed and there was also a small amount of dried formed stool stuck to the resident's coccyx area. CNA #31 indicated although the resident's skin was intact, there were deep creases from the brief and her buttocks area was reddened. QMA #30 indicated the resident had a very strong urine odor. On 05/16/16 from 8:50 A.M. thru 11:17 A.M., Resident #47 was observed in her recliner in her room holding a doll dozing on and off throughout the morning. At 11:17 A.M., CNA #26 and #32 placed			

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	Resident #47 on the toilet. The resident's heavily saturated brief was removed. The resident did not void in the toilet. CNA #32 utilized a disposable wipe and wiped Resident #47's back side and the middle of her vagina from the back. CNA #32 did not clean the front of the resident's peri area. 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to provide a physician ordered palm guard for a resident with a contracture of the right hand and fingers for 1 of 1 residents reviewed for range of motion. (Resident #5) Finding includes:	F 0318	Res #5 was affected. Orders for knee braces werediscontinued related to non-compliance. New palm protector was placed. Familywas notified. The Director of Rehab and Director of Nursing/designee auditedcurrent orders, care plans, and care directives for splint/contracture/orthoticmanage ment to ensure they were updated. Nursing and therapy	06/15/2016

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	The clinical record for Resident #5 was reviewed on 5/13/16 at 2:00 P.M. Resident #5 was admitted to the facility, on 5/15/07, with diagnoses, including but were not limited to: vascular dementia without behavioral disturbance, major depressive disorder, cerebral vascular accident, aphasia and contracture of the right hand. A physician order, dated 7/21/15, indicated PT (Physical Therapy)/OT (Occupational Therapy) to eval (evaluate) and tx (treat) d/t (due to) refusal of splint use. A Rehabilitation Services Training Attendance Record, dated 8/3/15, indicated the training was for orthotic management for Resident #5 which included: 1. Cleanse R (right) hand with warm soapy water, rinse thoroughly and dry. 2. Inspect skin for breakdown or open areas. 3. Apply palm guard to R hand, place thumb through thumb hole, fold guard and slide under fingers, adjust finger separators between index and middle finger, between middle and ring finger and ring finger and pinky. Adjust strapping on back of hand with velcro closer. Patient may wear palm guard up to 12 hours per day 6 A.M.to 6 P.M. A Nursing-Therapy Referral Form, dated		staff educatedregarding splints and contractures. Nursing staff educated to notify therapystaff when splint or other orthotic management is unavailable. Audits will be completed by the DOR/designee to ensuresplint/orthotic/contracture management devices are in place per order daily x 4weeks, 3x week x 8 weeks and weekly thereafter. Findings will be report to theDON for correction and to the Quality Assurance Committee for review andadditional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	8/4/15, indicated pt (patient) to utilize right hand palm guard 12 hours a day from 6 A.M. to 6 P.M. Cleanse right hand and let it dry prior to donning palm guard. Routine skin check. A physician order, dated 8/4/15, indicated may d/c (discontinue) right elbow splint. Pt (patient) may utilize right hand palm guard daily. An Occupational Therapy Plan of Treatment, dated 8/5/15, indicated the reason for the referral was due to patient not utilizing right elbow splint due to being combative when donning splint. The patient will benefit from skilled OT to assess appropriate right elbow and right hand splint to prevent further contracture and prevent skin breakdown. The hand was in a fisted position and was not able to measure ROM (Range of Motion) due to patient resisting movement. The patient was able to tolerate right hand palm guard. Patient will continue to benefit from skilled OT for caregiver education and a restorative program for splint wear. An Occupational Therapy Plan of Treatment, dated 8/18/15, indicated the patient tolerates right palm guard for 12 hours from 6 A.M. to 6 P.M. Nursing staff has demonstrated 100% accuracy in			

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	donning/doffing of right hand splint. Patient's right elbow splint has been discontinued due to poor compliance. A physician order, dated 8/18/15, indicated patient to utilize right hand palm guard splint from 6 A.M. to 6 P.M. The quarterly MDS (Minimum Data Set) assessment, completed on 1/27/16, indicated the resident was severely cognitively impaired, required extensive 2 person assist with bed mobility, dressing and personal hygiene and extensive 1 person assist with eating. A care plan, dated 3/15/16, indicated the resident was at risk for pain relating to immobility and contractures. Interventions included, but were not limited to: Administer/observe for effectiveness and for possible side effects from pain medication. Consultation as needed with OT/PT. Observe and report to nurse signs and symptoms of pain: crying, resist moving, resists care and agitation. Allow quiet area for me to rest. On 5/11/16 at 9:40 A.M., Resident #5 was observed awake, alert, non verbal and was moaning. She was seated in her Broda chair in her room with the television on. Her right hand was uncovered her hand and fingers were			

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	contracted, no palm guard splint was observed on her hand or anywhere in the room. A Care Directive, dated 5/12/16, indicated to utilize right hand palm guard from 6 A.M. to 6 P.M. Observe for and report any pain issues related to splint application. Observe skin condition under splint upon splint removal and report any areas of concern. Provide passive ROM to right upper extremity. During an interview, on 5/12/16 at 10:45 A.M., the Director of Nursing indicated the Care Directive is similar to a CNA (Certified Nursing Assistant) assignment sheet it indicates to the staff the needs of each resident. On 5/12/16 at 10:54 A.M., Resident #5 was observed resting in her bed with the television on. Her right hand and fingers were contracted. There was no splint/palm guard. At 12:30 P.M., Resident #5 was observed in her Broda chair in the assisted dining room, no splint or palm guard was observed on the right hand. At 2:15 P.M., Resident #5 was observed sitting in her Broda chair in her room with the television on, her lap blanket had slid off of her arms, no splint or palm guard was observed on the right hand.			

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	On 5/13/16 at 8:59 A.M., Resident #5 was observed in the hallway in her Broda chair she was moaning loudly. CNA (Certified Nursing Assistant) #12 assisted the resident back to her room and indicated she moans sometimes when she wants to go back to her room and lie down. Two CNA's assisted the resident back to bed with the use of a hoyer (mechanical) lift. CNA#12 attempted to open resident #5's fingers on her right hand, the resident moaned loudly. The skin in the palm of the residents hand was moist and had a white appearance to it, no open areas was observed. All 5 fingernails on the right hand were long and yellow with ridges on them, each nail had a dried brown substance under them and there was a foul sour odor when the CNA opened the residents fingers on her right hand. During an interview, on 5/13/16 at 9:11 A.M., CNA #12 indicated the resident had a blue hand splint for the right hand but has not seen it and was unsure why it was not on. CNA #12 indicated she would attempt to do ROM to the right hand and fingers but the resident does not like it and yells out like it hurts. During an interview, on 5/13/16 at 10:06 A.M. , the Director of Nursing indicated			

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	Resident #5 had recently moved rooms and the staff have not ben able to find her right palm guard since the room change, she further indicated a new palm guard would be in place today. On 5/16/16 at 9:37 A.M., Resident #5 was observed resting in her bed her right hand and fingers were contracted and no splint or palm guard was observed. On 5/16/16 at 4:21 P.M., the Director of Nursing provided a policy titled "Documenting Contracture Management and Splinting Needs," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Services must be provided under the order of a physician...." On 5/16/16 at 4:30 P.M., the Director of Nursing provided a policy titled "Physician Orders/Transcription," undated and revised on 10/04, and indicated the policy was the one currently used by the facility. The policy indicated "...7. Using the telephone order form to clarify therapy orders: a. Once the therapist has completed the physician order for "evaluate and treat," the therapist writes the treatment plan on the telephone order form noting "clarification orders."...c. The physician signs the telephone order accordingly...."			

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	3.1-42(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, interviews and record review, the facility failed to ensure adequate interventions, including increased supervision, were developed and implement to prevent falls for 1 of 3 who fell resulting in a head injury and subsequant death. (Resident D) The facility also failed to ensure interventions were implemented for 2 of 3 residents reviewed for falls. (Resident's E and F) Findings include: 1. On 5/11/16 at 10:15 A.M., a review of the clinical record for Resident D was conducted. The record indicated the	F 0323	The facility is requesting a face to face informal disputeresolution meeting. The facility does not agree that it failed to ensure that increased supervision was implementedto prevent an independently ambulatory resident from falling. Resident #D, E, and F were affected. Res #D no longer resides inthe facility. Staffing was reviewed and ensured to meet the requirements forthe residents' needs. Residents E and F were reviewed for fall interventionsand ensured all fall interventions are in place as ordered. The Director of Nursing/designee reviewed staffing andresident needs on the dementia unit. Staff audited falls	06/15/2016

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	resident was admitted on 4/29/16. The resident's diagnoses included, but were not limited to: pain, unspecified convulsions, insomnia and Alzheimer's disease. An Initial Data Collection Tool/Nursing Service form, dated 4/29/16 at 2:00 P.M., indicated resident was unable/unwilling to recognize need to wait for assistance to get out of bed and was unable to wait for assistance before transferring. A Fall Risk Evaluation, dated 4/29/16, indicated the resident scored a 22. The form indicated a score of over 10 or more indicated the resident was at risk for a fall and interventions should promptly be put into place. A Minimum Data Set (MDS) Admission Assessment, dated 5/6/16, indicated a Brief Interview Mental Status (BIMS) score of 4, which indicated the resident's cognitive status was severely impaired. An Interim Care Plan, dated 4/29/16, indicated resident was at risk for a physical injury from falls related to fall risk score of 22, unsteady ambulation, unable to understand safety strategies and recent falls. The interventions included to educated resident on call light, independent for transfers/ambulation,		over the last 30 daysto ensure interventions were implemented for each fall and care plans and caredirectives were updated. Audits to be completed by the DON/designee 3x/week for 8weeks, weekly x 8 weeks for fall interventions, care plans, and directives.Audits to continue as needed thereafter. Nursing will review staffing ondementia unit to ensure adequate staff present to meet needs of the residents. Resultsto be forwarded to the Quality Assurance Committee for review and additional recommendationsas indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	monitor & encourage use of proper foot wear and glasses on prior to getting out of bed. A Nursing Note, dated 4/29/16 at 7:30 P.M., indicated the resident was admitted to the secure unit. The Nursing Note indicated the resident was alert, confused, and ambulated with a walker with 1 assist. The note indicated the resident had been taking hydrocodone (opiod pain medication) for the past 2 months for pain. A Progress Note, dated 4/30/16 at 4:24 P.M., indicated the resident required assistance of one with transfers, a scheduled toileting plan was in place, and resident complained of right knee pain. The note indicated the resident was to have an evaluation by PT (physical therapy) and OT (occupational therapy). A Plan of Treatment for OT, dated 4/30/16, indicated the resident presented with 2 weeks of weight loss (16 pounds), decreased urine output, disorientation, difficulty finding words, falls and a swollen right knee. The plan indicated the resident was admitted due to complex partial seizures with exacerbation, mental status changes and generalized weakness. The Plan of Treatment indicated the resident was able to transfer to toilet			

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	requiring contact guard assist (contact with patient due to unsteadiness) and was utilizing a rolling walker. A Plan of Treatment for PT, dated 5/1/16, indicated the resident's current level of function was as follows: The resident demonstrated a balance score of 6/16 and a gait score of 7/12 for a total balance and gait score of 12/28, which relates to a the high risk fall category. The Plan further indicated the resident ambulates 50 feet on level surfaces and required contact guard assist (contact with resident due to unsteadiness) with a rolling walker with 75% (percent) tactile and verbal instruction/cues for safety. A Nursing Note, dated 5/1/16 at 10:21 A.M., indicated the resident was noted to be leaning sideways on the bathroom sink and told nurse she felt dizzy. The note indicated the resident walked with a rolling walker, from room to dining room, approximately 100 feet with PT. An Activities of Daily Living (ADL's) care plan, dated 5/2/16, indicated resident was self-care deficit. Interventions included but were not limited to: explain all procedures prior to performing task, and provide the amount of assistance/supervision that was needed.			

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	A Nursing Note, dated 5/4/16 at 8:49 A.M., indicated resident was incontinent of urine most of the time, wears a pull up, and was ambulating independently with rolling walker. An Incident/Accident Data Entry Questionnaire form, dated 5/5/516 at 1:30 A.M., indicated the resident had an unwitnessed fall while attempting to ambulate to the restroom and received a laceration to the forehead. The form indicated the resident was found in a sitting position on the floor, no head injury was suspected. The the resident's pulse, temperature and respirations were recorded. The area for the resident's blood pressure was left blank. The questionnaire indicated it was unknown if resident was using an assistive device. The form indicated interventions were in place at time of the fall and resident was to be checked on, routinely throughout the night and the new intervention put into place was to request a medication change. The form noted a family member was notified at 2:00 A.M. and physician was notified at 8:00 A.M. A Nurse's Note, dated 5/5/16 at 1:30 A.M., indicated the resident fell tonight and daughter was notified. The note indicated the daughter wanted resident			

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	tapered off the ativan and a fax was sent to the physician. A Non-pressure Skin Condition Record, dated 5/5//16, indicated resident had a non-surgical cut on the left temple area which measured 1.2 x 0.1 centimeters (cm) and a left temple bruise which measured 1.2 x 0.5 cm. Both injuries were first observed on 5/5/16. A Neurological Assessment Flow Sheet was started 5/5/16 at 1:30 A.M. The form was completed every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour, then every 4 hours for 16 hours, then every shift until 5/7/16 (night shift). The form indicated with each observation resident had no neurological problems. A Physician's order, dated 5/5/16 at 4:45 P.M., indicated an order for urinalysis, decrease ativan (an anti-anxiety medication) 0.5 milligrams every morning and to discontinue other atvian orders. A care plan, dated 5/5/16, indicated the resident was at risk for a fall related injury as evidenced by previous fall, functional problem, medication usage, poor safety awareness, poor cognition and weakness. The interventions			

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	included by were not limited to: call light within reach, provide/observed use of adaptive devices, referral for PT/OT, educated/remind resident to request assistance prior to ambulation, appropriate footwear, report falls to physician & responsible party, obtain Urine (5/5), request decrease of ativan (5/5) and scheduled toileting (upon rising, before/after meals at bedtime and as needed) (5/9). A Nursing Note, dated 5/5/16 at 9:42 P.M., indicated resident was alert to self with confusion, does not call when she needs help going to the bathroom, the left temple had a small goose egg with cut due to fall earlier, resident using a rolling walker to ambulate. A urinalysis (U/A) report, dated 5/6/16, indicated the resident had no urine infection. A Nursing Note, dated 5/7/16 at 1:14 P.M., indicated resident continued to be unsteady on her feet, off balance with ambulation, difficulty noted with pivoting as if her feet became crossed, required one assist with transfers/ambulation, having much difficulty with simple conversation and replies with confused words.			

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	A Nursing Note, dated 5/8/16 at 8:39 P.M., indicated the neuro checks were completed, resident was confused with disoriented speech, incoherent and had mild anxiety. The Nursing Note indicated the daughter thought the resident might be having little seizures however no involuntary movement was noted by nurse after observing the resident for 15 minutes. The nursing note also indicated she contacted the DON (Director of Nursing) with the above findings and will continue to monitor closely. An Incident/Accident Data Entry Questionnaire form, dated 5/9/16 at 5:30 A.M., indicated Resident D had an unwitnessed fall and received a laceration to her head with no loss of consciousness. The form indicated the resident was found by QMA (Qualified Medication Aide) #3 lying on her back with her head slightly under her bed. The form indicated the physician was called at 5:40 A.M., however a family member wasn't contacted until 8:00 A.M. The resident's head laceration was cleansed, vital signs were taken and neurological assessments were started. The form indicated the interventions in place at the time of the accident was for the resident to have non-skid socks on and no new interventions were in place due to resident in the Emergency Room. The			

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	resident's vital signs were: pulse 69, respirations 18, temperature 96.2 and blood pressure was 120/82 A Nursing Note, dated 5/9/16 at 6:23 A.M., indicated resident was lying on her backside with head slightly under the bed and the resident's walker was beside her. The note indicated the resident had 2 lacerations to her left side of her hand and to see skin sheets. A Non-Pressure Skin Condition Record, dated 5/9/16, indicated the resident had two lacerations to left side of her head, one measured 1.0 x 0.1 x < (less than) 0.1 centimeters (cm) and the other measured 1.0 x 0.3 x <0.1 cm. A Nursing Note, dated 5/9/16 at 8:32 A.M., indicated at approximately 8:00 A.M., Resident D put her hand to her head and said "my head hurts so bad" then the resident acted very tired. The Assistant Director of Nursing (ADON) was notified and the ADON and a CNA (not identified) took the resident to her room and laid her down in her bed, while LPN #4 called physician, daughter and a ambulance. The resident became unresponsive and 911 was called again. An ER (Emergency Room) Report, dated 5/9/16, indicated the resident had arrived			

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	to the ER due to a fall at the nursing home and received a minimal laceration to the left temporal area and her right pupil was poorly reactive. The report indicated the resident was in an unresponsive state with a left temporal contusion and huge contrecoup to her right subdural hematoma. (Mosby's Medical Dictionary 4th Edition, 2009, defined the contrecoup injury as follows: an injury, usually involving the brain, in which the tissue damage in on the side opposite the trauma site, as when a blow to the left side of head results in brain damage on the right side.) The Report indicated a head CT (Computerized Tomography) scan showed a massive cerebral subdural hematoma. Arrangements were made for comfort measures and hospice level care at the hospital. A radiology report, date 5/9/16, indicated the resident had an acute subdural hemorrhage overlying the right cerebral convexity with a right to midline shift. The report indicated brain swelling in the right cerebral hemisphere of the brain. A Patient Progress Note-Nursing Activities & Physical Assessment, dated 5/11/16 at 5:03 A.M., indicated time of death 4:30 A.M., the patient was a Do Not Resuscitate and the family was at the			

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	bedside. During an interview, on 5/11/16 at 1:45 P.M., the Director of Nursing (DON) indicated the interventions to prevent a fall for Resident D, after her fall on 5/5/16, were to obtain a U/A and decrease the resident's ativan, staff were to be rounding every 15 minutes and station themselves in the hallway. The DON further indicated the root cause of Resident D's fall were: taking herself to the bathroom, and ativan causing more confusion. During an interview, on 5/11/16 at 3:40 P.M., LPN (Licensed Practical Nurse) #4 indicated she was working the day shift on the dementia unit the morning of 5/9/16. She received report a little after 6:00 A.M. and was told Resident D had a fall with a laceration to her head and her vital signs were all ok. LPN #4 indicated the nurse giving her report did not say if the family had been notified of the fall. LPN #4 indicated the resident was observed to be in the Day room getting her blood drawn and complained of no pain. LPN#4 indicated she started her morning medication pass and gave the Resident D her morning medications and took the residents vitals sometime after 7:00 A.M. and Resident's vitals were ok. LPN #4 indicated the resident had no			

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	problems with taking her medications. LPN #4 indicated she assisted the resident to her table to eat breakfast sometime near 8:00 A.M. LPN #4 indicated while the resident was eating she put her hand to her head and told LPN #4 "my head hurts so bad." LPN #4 called the ADON over to the unit, so she could call the physician, physician said to send to ER, 911 was called and then a family member was notified. LPN #4 indicated the resident started to lean so the ADON took the resident to her room to wait for the ambulance to arrive. While the resident was in her room the resident became unresponsive, with her pupils fixed and 911 was called again. The ambulance arrived and took the resident to the ER. During an interview, on 5/12/16 at 10:00 A.M., CNA #5 indicated she was working the morning shift of 5/9/16 and when she arrived to the unit Resident D was observed at the nursing station. CNA #5 indicated the resident was smiling, talking and had dried blood on the left side of her head. CNA #5 indicated she had taken care of the resident before 5/9 and resident was a stand by assist with toileting and transfers. She indicated she had caught the resident trying to get out of bed on her own several times. CNA #5 indicated			

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	during breakfast the resident complained of nausea and a headache. She remembered the nurse contacting the ADON when the resident complained about her head pain. During an interview, on 5/12/16 at 10:20 A.M., the ADON indicated LPN #4 contacted her on the morning of 5/9/16 regarding concerns with Resident D. The ADON indicated when she arrived on the unit the resident was sitting in the dining area and looked tired. The ADON indicated the resident laid her head on the ADON's shoulder. She then transferred the resident to a wheelchair and took the resident to her room and assisted her to bed while LPN #4 made phone calls. During an interview, on 5/13/16 at 1:30 P.M., QMA #3 indicated she worked the secure dementia unit from 2:00 A.M. thru 6:00 A.M. on 5/9/16 by herself. QMA #3 indicated she rounded the unit every 15 minutes to check on the residents and at approximately 5:15 A.M., Resident D was observed to be in bed under her covers. QMA #3 indicated the resident had a 6:00 A.M. pain medication and entered the resident's room and found the resident lying on her back, with head at foot of the bed. The QMA #3 indicated the resident's walker was located on the other side of a recliner that sat beside the			

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	resident's bed. QMA#3 indicated the resident was crying and trying to sit up on her own. QMA #3 indicated the resident had non-skid socks on and resident's call light was clipped to her bed. The QMA called the manager on duty and she assessed the resident, cleansed her wound and called the doctor. QMA #4 got a wheelchair and assisted the resident to the restroom then resident transferred herself to the toilet with stand by assist and was taken by wheelchair to the nurse's desk to be monitored. The QMA indicated the resident was talking and sitting in the wheelchair when she left the unit. On 5/13/16 at 12:05 P.M., the DON provided a policy titled, "Falls Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Each resident will be assessed throughout the course of treatment for different parameters such as: cognition, safety awareness, fall history, mobility, sensory status, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions...."			

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	A Staffing Schedule, dated 5/8/16, and provided by the DON on 5/16/16, indicated a RN (Registered Nurse) worked the night shift till 2:00 A.M. on 5/9/16, then QMA #3 worked from 2:00 A.M. until 6:00 A.M. There were no other staff members to work the secure dementia unit on the morning of 5/9/16. During an interview, on 5/16/16 at 12:45 P.M., the DON indicated on the morning of 5/9/16 there were 13 residents on the secure dementia unit, 10 of those residents required 1 assist for transfers and toileting and one resident was a stand by assist for transfers and toileting. The DON indicated there was one staff member on the unit working the night shift. When the DON was asked who was supervising the rest of the residents while the one staff member was assisting a resident to the restroom she indicated "no one." 2. The clinical record for Resident F was reviewed on 05/12/2016 at 9:07 A.M. Resident F was admitted to the facility, on 12/29/15, with diagnoses, including but not limited to: fracture of the pelvis, chronic obstructive pulmonary disease, enlarged prostate, atherosclerotic heart disease, emphysema, heart failure, hypertension, and history of fracture of			

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	the left humerus. The history and physical assessment, completed at an acute care facility prior to the resident's admission to the facility, on 12/25/15, indicated Resident F tripped over his oxygen tubing in his home and fell, fracturing his pelvis and humerous. A fall risk evaluation, completed on 12/29/15, indicated the resident had a history of 1 to 2 falls, required assistance for elimination needs, utilized a wheelchair, had multiple health risk factors and scored an 18 on the evaluation which indicated he was at high risk for falls. The intervention put in place, on 12/29/15, to prevent falls was "call light within reach." The initial admission Minimum Data Set (MDS) assessment, completed on 01/05/16, indicated the resident scored a 14 of 15 on the (Brief Interview of Mental Status) BIMS, required extensive staff assistance for transfers, was non ambulatory, and required extensive staff assistance for wheelchair locomotion and toileting needs. The resident had an indwelling urinary catheter and was frequently incontinent of his bowels. A nursing progress note, dated 03/07/16 at 12:00 A.M., indicated the resident was			

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	found on the floor in his room. The resident was confused and had been attempting to ambulate by himself. Another fall risk evaluation, completed on 03/07/16, indicated the resident was still a high risk for falls and the interventions in place were "call light in reach and education provided." An Incident/Accident Data Entry Questionnaire (sic), completed on 03/07/16 at 12:00 A.M., indicated Resident F was found on the floor by a nurse. The resident had been attempting to ambulate without any assistive devices and was alert but confused. The follow up portion of the investigative form indicated the resident was unable to balance himself independently and had no barriers which might have contributed to his fall. The resident had not utilized his call light and he had a low bed in place. The resident had previously refused hip protectors as an intervention. The interventions implemented were to continue the bed in low position and call light in reach and education regarding the call light was provided to the resident. A Nursing progress note, dated 04/22/16 at 3:54 P.M., indicated the resident slid out of his wheelchair and was found on the floor in front of his wheelchair.			

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	The most recent Fall Risk Evaluation, completed on 04/22/16, indicated the resident was still a high risk for falls and the intervention implemented was "dysem [a non slip thin material] to wheelchair." A care plan related to the resident's risk for falls, initiated on 01/04/16 and current through 07/06/16, indicated the resident was at risk for a fall as evidence by previous falls. The interventions included a fall risk assessment, invite and escort to activity programs, provide environmental adaptations- call light in reach and adequate glare free lighting, and area free of clutter, provide resident teaching for safety measures, provide wheelchair, refer to PT (physical therapy), OT (occupational therapy) and Mental health, remind to lock brakes on bed and chair before transferring, when rising from a lying position sit on side of bed for a few minutes before transferring/standing, educate to request assistance prior to ambulation, report falls to physician and responsible party. "Non-skid strips next to bed" was added as an intervention on 03/07/16 and a "dysom [sic] to wheelchair" was added on 04/22/16. A Nursing progress note, dated 05/02/16			

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	at 3:39 P.M., indicated the resident was attempting to transfer himself and had not utilized the call light or requested assistance. On 05/13/2016 at 10:54 A.M., Resident F's room observed and there were no non-skid strips observed on either side of his bed or in the bathroom. On 05/13/2016 at 10:59 A.M., Resident F was observed in the front lobby seated in his wheelchair. There was a thick cushion visible underneath the resident in the wheelchair seat. The cushion was wider than the wheelchair seat and was slightly creased in the middle and extended past the end of the wheelchair seat by approximately 1 1/2 inches. There was no dycem material visible underneath the resident. Resident F was queried regarding any thin non slip type material on the chair cushion and he indicated he did not recall any such material being applied, just the cushion. On 05/13/2016 at 2:55 P.M., Resident F was transferred with the assistance of LPN #22 and QMA #23 from his wheelchair to his bed. His wheelchair cushion was noted to be in his wheelchair but there was no dycem type material anywhere in his wheelchair. Both staff confirmed there was no dycem in his			

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	wheelchair and no non-skid strips on either side of his bed. QMA #23 looked in his closets and she could not locate any dycem material. On 05/16/2016 at 9:09 A.M., there were still no nonslip strips on either side of Resident F's bed. 3. The clinical record for Resident E was reviewed on 05/13/2016 at 8:59 A.M. Resident E was admitted to the facility on 04/28/16, with diagnosis, including but not limited to: dementia with behavioral disturbance, depression, anxiety disorder and shortness of breath. A nursing progress note, dated 04/29/16 at 2:24 A.M., indicated a noise was heard in the resident's room and the resident was found laying on his backside with his feet extended towards the bathroom. Resident E indicated he was trying to go to the bathroom. When the resident was asked why he did not use call light, he indicated because he could not find his call light. The call light was located on the resident's bed. Resident E was reeducated on the use of call light and need for assistance. The resident had incurred skin tears to both his elbows and the top of his left hand and to his left wrist.			

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	A nursing progress note, dated 04/29/16 at 7:52 A.M., indicated the IDT (interdisciplinary team) meeting had met in regards to Resident E's fall that occurred early this (04/29/16) A.M. and an appropriate intervention was to place a clip to the resident's call light cord and have staff attach it to the resident's shirt/gown while he was in bed. A fall risk care plan, initiated on 04/29/16, indicated the resident was to be invited and escorted to activities, provided call light in reach and glare free lighting and area free of clutter, provide resident teaching for safety measures, provide walker/cane and wheelchair, remind resident to lock brake on bed, chair etc before transferring, when rising from lying position to sit on side of bed for a few minute, educated and reminded to request assistance prior to ambulation, report falls to physician and responsible party, report any side effects of medication, and clip to call light cord and keep cord attached to shirt or gown while in bed. A nursing progress note, dated 05/30/16 at 1:47 A.M., indicated the resident required standby by assistance for transfers and ambulation and he utilized a walker.			

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	A nursing progress note, dated 05/10/16 at 10:30 A.M., indicated the resident had poor safety awareness. On 05/13/2016 at 10:57 A.M., Resident E was observed sleeping in his bed on his back. His call light was lying on the floor and there was no clip noted on the cord. On 05/16/2016 at 9:38 A.M., Resident E was observed in his room in bed asleep. The resident had a low bed but his call light cord was on the floor and there was no clip on the cord. The resident's call light cord remained on the floor and the resident remained sleeping in his bed from 9:38 A.M. to 11:00 A.M. His shoes were off and he was wearing non-skid socks on both feet. At 10:37 A.M., two staff members, LPN #25 and CNA #26 had assisted Resident E's roommate but had not noticed the call light on the floor. On 05/16/2016 at 12:45 P.M., Resident E was observed being supervised by an unnamed staff as he ambulated from the dining room back to his room with his walker. He then was noted to be supervised by the staff member while he got into bed. The unnamed staff member left and Resident E was observed, at 1:02 P.M., in his room asleep with his shoes on and his call light cord was on the			

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	floor. He was observed again, at 2:07 P.M., in his bed asleep and his call light was on the floor. 3.1-45(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interviews and record review, the facility failed to ensure food was stored, served and prepared in a sanitary manner. This had the potential to affect 69 of 69 residents who receive meals and ice from 1 of 1 kitchen, and 19 of 19 residents on the South hallway and 38 of 38 residents who receive snacks from 2 of 3 nourishment refrigerators. Findings include: On 5/9/16 from 10:05 A.M.-10:35 A.M. the initial kitchen tour was conducted	F 0371	The paper towel dispenser was re-filled, the two identifiedbowls and plate were re-washed, the metal cart sides and wheels were cleaned,the rubber gasket by the backsplash was cleaned, the meat slicer was cleaned,the ice machine and floor was cleaned, the un-dated and expired refrigeratoritems were discarded, Central hallway refrigerator drawers were cleaned. The Dietary Manager or designee re-educated the dietarystaff prior to June 16, 2016 regarding the need to follow the kitchen cleaningschedules. The Housekeeping Manger	06/15/2016

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	with the Dietary Manager and the following was observed At 10:05 A.M., the paper towel dispenser located above the main sink in the kitchen did not have paper towel in the dispenser. A roll of paper towel was observed in a wire basket that was mounted on the wall beside the sink, the basket also contained hair nets, the paper towel roll was on top of the hair nets. A Dietary Aide was observed washing her hands and then attempting to retrieve paper towel from the roll without dropping the roll onto the floor. At 10:07 A.M., the Dietary Manager indicated they were currently out of paper towels for the dispenser and were having to use paper towel rolls that did not fit in the dispenser. At 10:10 A.M., two porcelain bowels was observed in a metal cabinet, the bowels were put away as clean, each bowel had a dried yellow substance on the inside of it. At 10:12 A.M., one porcelain plate was stacked and put away as clean in the plate warmer for lunch service, the inside of the plate had a dried green substance on it. At 10:15 A.M., a metal open cart used to		ordesignee re-educated the housekeeping staff prior to June 16, 2016 regardingthe need to following cleaning schedules for the unit refrigerators as well asto monitor for un-dated and expired items. The Dietary Manager or designee will complete a kitchensanitation audit 3 times per week for 6 weeks, then 2 times per week for 6 weeks,then weekly for 6 weeks. TheHousekeeping Manger or designee will complete a unit refrigerator audit 3 timesper week for 6 weeks, then 2 times per week for 6 weeks, then weekly for 6weeks. Results of these audits will beforwarded to the Quality Assurance Committee for review and additionalrecommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	serve dessert trays was observed loaded with 8 trays of apple pie desserts covered with plastic ready for lunch service. The sides of the cart had a yellow sticky substance on it and the bottom of the cart around the wheels there was a black greasy substance along with cob webs and hair. At 10:20 A.M., the tile back splash located above the dish washing area was observed to have a rubber gasket between the backsplash and the stainless steel counter, the rubber gasket was observed to have a black/tan mildew like substance on it. At 10:25 A.M., a metal meat slicer was observed on top of a metal cart in the corner of the kitchen not in use, the slicer was uncovered and had a dried yellow substance on it. At 10:35 A.M., the ice machine was observed in a separate room across the hall from the kitchen. The ice machine was observed to have a black substance across the inside of the lid area. The tile floor under the ice machine was wet and the room smelled musty. At 10:40 A.M., the Dietary Manager indicated the Maintenance Department cleans the ice machine every other week			

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	and was unsure why the tile floor was wet other than maybe ice was spilled on the floor and it melted. On 5/12/16 at 9:45 A.M., a second kitchen tour was conducted with the Dietary Manager the following was observed: At 9:46 A.M., the sides of the metal serving cart for desserts was observed to still have a yellow sticky substance on the sides of it and around the wheels still had a black greasy substance along with cob webs and hair. The Dietary Manager was notified of the second observation, she removed the cart and had the Maintenance Director pressure wash the cart outside. At 10:05 A.M., the rubber gasket below the back splash of the dishwashing area still was observed to have a black/tan mildew like substance on it. At 10:12 A.M., the ice machine was observed to still have a black substance across the inside of the lid area. The tile under the floor was still observed to be wet and during this observation the water was running across to the doorway of the room. At 10:14 A.M., the Dietary Manager			

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	indicated the Dietary staff have a daily cleaning schedule for the kitchen equipment, she further indicated her expectation would be that dishes and utensils would be put away clean. On 5/12/16 at 10:15 A.M., an observation of the nourishment refrigerators on the nursing units was conducted with the Dietary Manager during which the following was observed: At 10:00 A.M., the South hallway: One plastic pitcher half full of orange juice with no date was observed. A half gallon of white milk was opened and had an expiration date of 4/28/16. A half gallon of chocolate milk was opened and had an expiration date of 5/10/16. There was a small rubber maid container with a food item inside there was no name or date on it. At 10:10 A.M., the Central hallway: One plastic pitcher of ice tea was opened and dated use by 5/8/16. A plastic container with fruit juice was half full and had no date on it. One peanut butter sandwich was in a plastic bag and dated 5/10/16. One glass of chocolate milk with a plastic lid had no name and no date on it. There was a red sticky substance in both pull out drawers of the refrigerator.			

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	At 10:15 A.M., the Dietary Manager indicated it is the responsibility of the Housekeeping Department to clean, maintain, check the temperature of the refrigerator and freezer and discard any outdated foods/liquids. On 5/12/16 at 3:13 P.M., the Dietary Manager indicated currently there was no policy regarding the cleaning and maintaining of the nourishment refrigerators and there was no current policy regarding the storage of dishes and utensils. On 5/12/16 at 3:23 P.M., the Dietary Manager provided a policy titled "Preventative Maintenance-Ice Machines," undated and revised on 3/15/04, and indicated the policy was the one currently used by the facility. The policy indicated "...It is policy that all ice machines in the facility will be inspected by the in-house maintenance department on a monthly basis and the coils will be cleaned every quarter...Daily: the Dietary Department will wipe off the ice guard daily. The Dietary Department will wipe off the exterior daily (including catch basin). Any problems will be reported to the maintenance department via a work order. Monthly: The Maintenance Department will inspect each ice machine monthly...All areas will be checked for			

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	cleanliness...." On 5/12/16 at 3:25 P.M., the Dietary Manager provided a policy titled "Sanitation and Maintenance," undated and revised on 1/1/07, and indicated the policy was the one currently used by the facility. The policy indicated "...Food and Nutrtion Services Associates are trained in the proper use, cleaning and sanitation of all equipment and utensils...The Director of Food and Nutrition Services develops a cleaning schedule and posts the schedule each month...." 3.1-21(i)(3)			
F 0441 SS=F Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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	(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure 2 of 6 staff (CNA #28 and 30) observed providing care for 1 of 1 residents (Resident #47) reviewed for incontinence needs changed their gloves and washed their hands timely, and thorough incontinence care was given. In addition, the facility failed to maintain an infection control program which ensured facility data regarding infections was documented and analyzed timely to	F 0441	Resident #47 and had the potential to affect all 71residents. Staff #28 and #30 were educated on pericare, hand hygiene, andchanging gloves. The Infection Control binder was audited for inconsistencies.Infection Control binder was updated and SDC educated on the Infection Controlprogram. SDC obtained the most recentguidelines for hand hygiene and provided education to all staff. SDC to provided inservicing to all staff on	06/15/2016

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	ensure any trends or issues were identified. This had the potential to affect 71 of 71 residents. Findings include: On 05/16/16 at 2:00 P.M., an interview was conducted with the Director of Nursing (DON) and Staff Development Nurse-RN (Registered Nurse) #34. The DON indicated the Infection Control program responsibilities were part of the Staff Development nurse's job but since she (RN #34) was new since February that she, the DON, had been trying to cover the program. The DON was unaware of the most recent handwashing procedures from Centers for Disease Control (CDC) until she was informed of the new procedures, on 05/11/16, when an outdated procedure was noted hanging above a handwashing station in the kitchen. The DON indicated the tracking forms for infections were "on the computer." She indicated she had not put any of the information for April or May into the system yet. She provided a blank form which indicated the resident's name, location (of resident's room), nosocomial or community acquired status, symptom onset date, infection category, antibiotic, disposition and status of any infections were to be documented. The DON indicated a pharmacy form regarding		hand hygiene and changing gloves and all nursing staff were educated on peri/incontinencecare. DON/designee audited the infectioncontrol binder for completeness. The facility updated their hand hygiene policy to includethe most recent recommendations from theCenters for Disease Control. The Director of Nursing or designee willobserve one staff member to ensure incontinence care and proper hand washingand glove technique are complete 3 times per week for 8 weeks, 2 time per weekfor 6 weeks, weekly for 4 weeks. Audits of infection control binder to be completed weeklyfor 4 weeks and monthly thereafter. All audit findings to be forwarded to the QualityAssurance Committee for review and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	infections was utilized for the QA (Quality Assurance) meeting. The form provided, for March 2016, which was discussed on the April 19, 2016 QA meeting, and indicated there were 6 infections in March: *3 urinary tract infections - 2 of which were in house acquired, *2 respiratory infections, *1 wound infection. There was comparative information for February 2016 but no other information was provided on the form. The DON indicated she was monitoring the "infections" during "grand rounds" which she completed every morning. There was no documentation to refer to for infections documented in a systematic form which could be analyzed. 2. During an observation of care, conducted on 05/16/16 at 11:17 A.M., Resident #47 was transferred from her recliner to her wheelchair and then to the toilet by CNA (Certified Nursing Assistant) #32 and #26. Both CNA's had washed their hands and donned disposable gloves. After removing the resident's wet brief, while she was seated on the toilet, CNA #22 removed her gloves, washed her hands, and then donned another pair of gloves. CNA #22 and #32 stood Resident #47 up from the			

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	toilet, and CNA #32 wiped the resident's backside and the middle of her vagina with a disposable wipe from the back. The resident's front perineal area was not washed. There was a very strong urine odor. CNA #32 left her contaminated gloves on while she assisted the resident back into her wheelchair, touched the door knob to the resident's closet, call light cord, and lap blanket before removing her gloves. CNA #22 left her gloves on while she put a clean brief on the resident, pulled her outside pants in place, and handled the leg rests for the wheelchair. On 05/16/16 at 2:19 P.M., CNA #30 and CNA #35 were observed providing incontinence care for Resident #47. CNA #30 had donned gloves and transferred Resident #47 into her bed. CNA #30 then removed her gloves, washed her hands, and obtained a clean brief and a package of disposable wipes from the resident's bathroom. CNA #35 entered the room and both CNA #30 and #35 donned a pair of gloves. Resident #47's wet brief was removed by CNA #30 and she was cleaned from the backside only with disposable wipes by CNA #30. Without changing her gloves, CNA #30, with the assistance of CNA #35 applied a clean brief to the resident. CNA #30 left her gloves on while she folded up a gait			

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	belt and placed it in the pocket of her scrubs, touched the handle to the resident's wheelchair and her foot rests, removed the soiled trash from the trash can. She then removed her gloves and exited the resident's room. She walked across the hall and opened a utility room and threw away the trash bag. Without washing her hands, she then walked into another resident's room and patted the resident on the shoulder and held onto the resident's 1/2 side rails before she washed her hands. The facility policy and procedure, titled "Personal Hygiene Care for the Female Resident, " undated and provided by the DON on 05/16/16 at 3:30 P.M., indicated gloves were to be worn while giving care and were to be removed after the care was completed. In addition, instruction indicated the resident was to be washed from the center to her thighs in both the front and back. There were also instruction on washing the resident's labia and urethral area. The policy provided instructions for utilizing wash clothes and soap, not disposable wipes. The facility policy and procedure, titled "Hand Hygiene," undated, and provided by the DON on 05/16/16 at 3:30 P.M. indicated the following instructions: "When hands are visibly dirty,			

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	contaminated, or soiled, wash with non-anti-microbial or anti-microbial soap and water." The policy indicated hands were to be washed for "20 seconds." The facility policy and procedure did not include the most recently updated CDC (Centers for Disease Control) guidelines for washing hands. 3.1-18(a) 3.1-18(l)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 provide a safe and clean resident environment related to, stained floor tiles in restrooms, urine odors and baseboard trim that is loose in resident restrooms, resident rooms floors stained and have sticky substances on them. This had the potential to affect 7 of 12 residents residing on the Martin hallway, 6 of 20 residents residing on the East hallway, and 9 of 18 residents residing on the West hallway.	F 0465	The floor in room 116 was cleaned, the toilet in room 110 was cleaned, the walls in room 110 were painted, the bathroom floor in room 110 was cleaned, the tile in the bathroom of room 113 was cleaned and the caulk replaced, rooms 117, 119, 113, 110, 202, 206 were deep cleaned, the paint onbathroom wall of room 119 was touched up, the edge of the base board and the tub in room 214 were cleaned, the bathroom floor and tub of room 215 werecleaned, the bathroom and bedroom floor in	06/15/2016

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	Findings include: On 5/11/16 at 1:48 P.M., an observation of Room 116 bed 2 on the Martin hallway was made. There was a 3 x 2 inch area of dried blood located under the bed. During an interview, on 5/11/16 at 1:50 P.M., LPN (Licensed Practical Nurse) #11 indicated the room was cleaned after the resident was transferred to the hospital on 5/9/16. On 5/13/16 from 11:00 A.M. to 11:40 A.M., an environment tour was conducted with the Maintenance Director, the Housekeeping Supervisor, and the Administrator, during which the following was observed: 1. Martin Hallway: At 11:00 A.M., Room 110 was observed to have a strong urine odor and the tile on the floor around the toilet was stained with a brown/black color. All 4 walls in the restroom had small white patches on each wall. During an interview, on 5/13/16 at 11:02 A.M., the Maintenance Director indicated the Maintenance Department had patched the holes and had not had time to sand		room 216 were cleaned, the baseboard trim in room 216 was reattached to the wall, the tile under the toilet in room 217 was cleaned, the drywall in room 217 was repaired, the paint above thebaseboard in room 217 was touched up, the floor, recliner and baseboards ofroom 202 were cleaned, the shared bathroom of room 211 and 212 was deep cleaned, the baseboard of room 212 was reattached. The Housekeeping Manager re-educated the housekeeping staff priorto June 16, 2016 regarding proper cleaning procedures for resident room areas. The Housekeeping Supervisor or Designee will complete environmental rounds 3 times per week for 6 week, then 2 times per week for 6 weeks and then weekly for 6 weeks. Results of these audits will be forwarded to the Quality AssuranceCommittee for review and additional recommendations as indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.	

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	the patched areas yet. He further indicated once the areas are sanded the walls would be painted. He indicated the urine odor was from the urine seeping in under the tile. He indicated the floor needed to be cleaned and the wax needed to be stripped off of the tile. At 11:03 A.M., Room 113 was observed to have a strong urine odor, the tile and caulk around the base of the toilet had a brown discoloration, the caulk around the base of the toilet was also cracked and peeling. At 11:05 A.M., Room 117 was observed to have a strong urine odor. At 11:06 A.M., Room 119 was observed to have a strong urine odor, the paint was peeling above the baseboard trim in the bathroom, the tile under the toilet was discolored with a brown substance and the floor was sticky when walking cross it. During an interview, on 5/13/16 at 11:07 A.M., the Maintenance Director indicated the humidity in the rooms can cause the wax on the floors to become sticky. 2. East Hallway: At 11:10 A.M., Room 214 was observed			

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	to have a brown/black substance around the edges of the baseboard trim in the restroom. The tub in the bathroom was observed to have 2 dried brown smears on the edge of the tub, this same dried substance was observed on the tub on 5/9, 5/10, 5/11 and 5/12/16. At 11:12 A.M., Room 215 was observed to have brown stains on the bathroom floor, the tub has a large brown stain around the drain. At 11:15 A.M., Room 216 was observed to have brown stains on the bathroom floor. The baseboard trim in the bathroom was pulled away from the wall and the paint is peeling above the trim. Bed 3 in Room 216 was observed to have dried brown stains on the floor behind the recliner, and a yellow sticky substance on the floor in front of the recliner. The floor around the recliner was also observed to have food crumbs and wrappers around it. At 11:20 A.M., Room 217 was observed to have brown stained tile under the toilet. The drywall above the baseboard in the restroom was roughly cut, the paint was peeling above the baseboard trim in the restroom. 3. West Hallway:			

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	At 11:21 A.M., Room 202 bed 1 the floor was observed to have crumbs around the bed and the floor was sticky when walking across it. The baseboard in Room 202 had a white sticky substance on it. The shared restroom was observed to have a strong urine odor. Bed 2, the recliner was observed to have a strong urine odor. During an interview, on 5/13/16 at 11:22 A.M., the Maintenance Director indicated it is the nursing staffs responsibility to notify the Maintenance Department when furniture is soiled and needs cleaned. He further indicated at that time he would remove the recliner from the room, deep clean it and return the chair after it was dry. At 11:25 A.M., Room 206 was observed to have food crumbs on the floor around the residents bed. The bathroom was observed to have a strong urine odor. At 11:30 A.M., the shared restroom for Room 211 and 212 was observed to have a strong urine odor, the restroom floor had brown stains on it and the floor was sticky when walking across it. The baseboard behind the sink and toilet was peeling away from the wall. The tile located under the toilet had black stains			

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	on it. During an interview, on 5/13/16 at 11:35 A.M., the Maintenance Director indicated this restroom was a focus room for cleaning and that the restroom was cleaned 2-3 times a day. He further indicated one of the male residents urinates on the floor and the walls of the restroom. 3.1-19(f)			