

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/09/2012
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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00103512.</p> <p>Complaint IN00103512 substantiated, Federal/State deficiencies related to the allegations are cited at F279, F323 and F441.</p> <p>Survey dates: March 4, 5, 6, 7, 8, 9, 2012</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Survey team: Rita Mullen, RN, TC Linda Campbell, RN Michelle Carter, RN</p> <p>Census bed type: SNF/NF: 50 Total: 50</p> <p>Census payor type: Medicare: 8 Medicaid: 34 Other: 8 total: 50</p> <p>Sample: 16</p>	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Supplemental sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/16/12 Cathy Emswiller RN</p>			

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview and record review, the facility failed to do a nursing assessment for a Resident with a full lap tray restraint attached to the wheelchair. This impacted 1 of 1 Residents reviewed for restraints in a supplemental sample of 3. (Resident #16)</p> <p>Findings include:</p> <p>During a meal observation in the A-B hall dining room, on 3/7/12 at 9:00 A.M., Resident #16 was sitting in her wheelchair with a lap tray restraint (prevents a person from standing or leaning forward) attached.</p> <p>The clinical record of Resident #16 was reviewed on 3/9/12 at 10:00 P.M. The resident's diagnoses included, but were not limited to, advanced dementia, Parkinson's disease and anxiety.</p> <p>An Annual Minimum Data Set Assessment, dated 1/27/12, indicated the resident had long and short term memory problems and severely impaired decision making skills.</p>	F0221	<p>1. Resident #16 was assessed for restraint/enabler.2. All charts of other residents, with restraints and/or enablers, have been reviewed to ensure appropriate assessment, monitoring of release, record of efficacy and careplan have been completed as per facility policy.3. Licensed staff were re-educated on the policy and procedure related to restraint assessment and use. All devices identified as restraints or enablers will be reviewed monthly by the IDT in an effort to confirm ongoing appropriate use and compliance with facility policy. Should concerns be noted, immediate corrective action shall be taken.4. The results of the aforementioned monthly reviews and any corrective actions taken, if warranted, will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>	03/22/2012	

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	<p>An Occupational Therapy Evaluation, dated 3/2/12, indicated "...Excellent positioning in w/c (wheelchair). Has cushion &amp; lap tray for positioning...."</p> <p>During an interview with the Director of Nursing, on 3/7/12 at 4:00 P.M., she indicated the lap tray was for the edema in resident # 16's arms, stating "It's there to keep her arms elevated."</p> <p>There was no Nursing assessment regarding the use of the lap tray as a restraint. The resident's clinical record also lacked documentation of the following:</p> <p>A restraint release record that documented the resident was checked every hour and released or repositioned every 2 hours.</p> <p>A record of the effectiveness of the restraint and the resident's response to the device during the first three days in initial use will be addressed on the restraint assessment.</p> <p>A HCP (Health Care Plan) updated with reason the restraint was use or a HCP added to address the potential negative outcomes related to restraint use...."</p>			

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	<p>A Policy for "Physical Restraint Use and Application", dated 8/05, received from the Facility Administrator, on 3/8/12, indicated the following:</p> <p>"...1. Prior to initiation of a restraint, the licensed nurse will complete an assessment to indicated all other least restrictive measures that have been attempted and the outcome obtained.</p> <p>7. A restraint release record will be initiated to document that the resident is checked every hour and released or repositioned every 2 hours.</p> <p>8. The effectiveness of the restraint and the resident's response to the device during the first three days in initial use will be addressed on the restraint assessment.</p> <p>9. HCP (Health Care Plan) will be updated with reason the restraint use. A HCP will be added to address the potential negative outcomes related to restraint use...."</p> <p>3.1-26(o)</p>						

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to promote dignity by not removing restraints during meal time. This effected 1 of 3 residents reviewed for restraints in a sample of 13 and 1 of 1 reviewed for restraints in a supplemental sample of 3. (Residents #8 and 16)</p> <p>Findings include:</p> <p>During a meal observation in the A-B hall dining room, on 3/7/12 at 9:00 A.M. Residents' #8 and 16 were sitting in their wheelchairs with lap tray restraints (prevents a person from standing or leaning forward) attached. They were sitting close to the dining table and were being assisted to eat by staff.</p> <p>During an interview with CNA (Certified Nursing Assistant) #6, on 3/7/12 at 9:10 A.M., she indicated the lap trays were usually off during the meals.</p> <p>During an interview with CNA #5, on 3/7/12 at 9:10 A.M., she indicated if the</p>	F0241	<p>1. Residents #8 and #16 were assessed for any negative outcomes and none were noted.2. All other residents with restraints and/or enablers have been reviewed to determine if any other residents were affected and none were noted.3. Licensed staff were re-educated on the policy and procedure related to restraint use, including when to release according to the individual plan of care and in an effort to promote dignity for the individual resident. In an effort to ensure ongoing compliance with the correct application and release of restrictive devices, administrative personnel shall be responsible to monitor for release according to plan of care during at least daily observations at random and varied times on scheduled days of work. Should concerns be observed, immediate corrective action shall be taken.</p> <p>4. Results of the aforementioned observations and any corrective actions taken will be brought to the QAA and reviewed monthly for 3 months then quarterly thereafter.</p>	03/22/2012			

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	<p>lap trays fit under the table, we were told it's Ok to leave them on.</p> <p>A Physical Restraint Use Notification form for Resident #8, dated 9/13/10, and reviewed on 3/8/12 at 11:00 a.m., indicated "...release Q [every] 2 [hours] [and] PRN (as needed) ROM (range of motion), toileting, meals."</p> <p>During an interview with the Director of Nursing, on 3/8/12 at 11:00 A.M., she indicated she had talked to the two CNAs' and they couldn't tell her who it was that said the lap trays could be left on if they fit under the table.</p> <p>3.1-3(t)</p>			

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F0253 SS=B	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to maintain the stand lift and keep the body lift clean. This effected 1 of 1 stand lifts on A-B hall and 1 of 1 body lifts on A-B hall.</p> <p>Findings include:</p> <p>During the environmental tour with Maintenance and Housekeeping Supervisors, on 3/6/12 at 10:00 A.M., the stand lift mat was peeling off the area where the Residents place their feet. It was also noted to be discolored and bits of debris was present. The body lift had a dark powder on parts of the frame.</p> <p>During an interview with the Maintenance Supervisor, on 3/6/12 at 10:05 A.M., he indicated the mat on the stand lift needed to be replaced.</p> <p>During an interview with the Housekeeping Supervisor, on 3/6/12 at 10:06 A.M., she indicated the CNAs (Certified Nursing Assistants) were suppose to clean the body and stand lift.</p> <p>3.1-19(f)</p>	F0253	<p>1. All equipment identified in the survey have been cleaned and/or repaired.2. All lift/transfer equipment was checked to determine if any additional cleaning and/or repair is required.3. The licensed and certified staff was re-inserviced on the facility equipment cleaning policy and procedure. Rounds will be completed 5x weekly at varied times to monitor the cleanliness of the lift/transfer equipment. Should non-compliance be observed, the same shall be immediately addressed.4. The results of the aforementioned rounds and any corretive action taken will be brought to QAA and reviewed monthly for 3 months then quarterly thereafter.</p>	03/22/2012			

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure comprehensive care plans were updated related to falls, pressure ulcers, and urinary tract infections for 6 of 13 residents reviewed for care plans in the sample of 16. (Residents #B, #C #D, #E, #F, #G)</p> <p>Findings include:</p> <p>1. Resident #C's clinical record was reviewed on 3/5/12 at 1:50 P.M.</p> <p>An "Incident &amp; Accident Report and</p>	F0279	<p>1. Residents B, C, D, E, F &amp; G were reviewed and care plans were updated related to falls, pressure ulcers and urinary tract infections.2. All residents identified with history of falls, pressure ulcers and urinary tract infections were reviewed and care plans were reviewed and updated, as indicated.3. The need to develop or revise/update an existing resident care plan will be determined through review of the 24 hour report, newly received physician orders and information shared in the IDT meeting. This meeting will occur 5x weekly. In an effort to ensure ongoing</p>	03/22/2012

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	<p>Investigation" dated 11/23/11 indicated the resident had fallen and was found sitting on the floor in her room. The intervention to prevent further falls was "non-skid strips placed next to bed on floor..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated "...Resident is at risk for falls and needs assistance to ambulate..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 11/23/11 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 11/28/11 indicated the resident had fallen and was found lying on the floor in her room. The intervention to prevent further falls was "keep ice chest to (L) (left) side of recliner..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated "...Resident is at risk for falls and needs assistance to ambulate..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 11/28/11 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 11/30/11 indicated the resident had fallen and was found</p>		<p>compliance, the Director of Nursing or designee will then audit at least 5 records weekly to verify efficacy and ongoing compliance with timely review/revision of resident careplans. Should non-compliance be noted, immediate corrective action and re-education shall be implemented, as warranted.4. The results of the aforementioned audits and any corrective action taken will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>				

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	<p>lying in the bathroom door in her room. The intervention to prevent further falls was "instructed resident to call for assist to change (indicated by triangle) bags, if needed...Re-educated on use of rollator (rolling walker) call X's (times) c (with) ambulation..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated "...Resident is at risk for falls and needs assistance to ambulate..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 11/30/11 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/1/12 indicated the resident had fallen and was found sitting on the floor in her room. The intervention to prevent further falls was "Reminded to call for assist if she needs to get up...instructed to ask for ice...ice pass per routine..."</p> <p>A resident care plan dated 1/3/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 1/1/12 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/31/12 indicated the</p>			

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	<p>resident had fallen and was found lying on the floor in her room. The intervention to prevent further falls was "Strips to BR (bathroom) floor - prev (previous) POC (plan of care)...was re-educated on 1/30/12 on use of rollator..."</p> <p>A resident care plan dated 1/3/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 1/31/12 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 2/16/12 indicated the resident had fallen and was found lying on the floor in the hallway. The intervention to prevent further falls was "CNA assignment sheet updated for staff to check et (and) make sure scooter is plugged in every evening..."</p> <p>A resident care plan dated 1/3/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 2/16/12 fall.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 2/28/12 indicated the resident had been left on a bedside commode alone and had fallen in her</p>			

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	<p>room. The intervention to prevent further falls was "staff educated on - not leaving residents c (with) alarms unattended..."</p> <p>A resident care plan dated 1/3/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 2/28/12 fall.</p> <p>Interview on 3/8/12 at 9:55 A.M. with the Director of Nursing indicated the care plans should have been updated after the falls.</p> <p>2. Resident #D's clinical record was reviewed on 3/8/12 at 9:00 A.M.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 3/1/12 indicated the resident slid off the side of her bed and had fallen in her room. The intervention to prevent further falls was "bed locked in proper position..."</p> <p>A resident care plan dated 8/23/11 and updated on 11/10/11, 12/1/11, 1/27/12, and 2/28/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 3/1/12 fall.</p>			

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	<p>Interview on 3/8/12 at 9:55 A.M. with the Director of Nursing indicated the care plans should have been updated after the falls.</p> <p>3. Resident #B's clinical record was reviewed on 3/6/12 at 2:10 P.M. The record indicated the resident had a left above the knee amputation and wore a prosthesis.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/26/12 indicated the resident had been found lying on the floor in the main dining room. The intervention to prevent further falls was "ensure leg on even on shower days..."</p> <p>Interview on 3/7/12 at 12:10 P.M. with the Director of Nursing indicated the resident had been placed in a wheelchair in the dining room without his prosthesis because he was scheduled for a shower later in the day.</p> <p>A resident care plan dated 10/5/11 and updated on 12/22/11 and 1/4/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 1/26/12 fall.</p>			

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	<p>An "Incident &amp; Accident Report and Investigation" dated 1/31/12 indicated the resident had been lowered to the floor by two CNAs in his room. The intervention to prevent further falls was "staff educated - follow CNA assignment sheet if prosthetic 0 (not) on res to use standup lift..."</p> <p>A resident care plan dated 8/23/11 and updated on 11/10/11, 12/1/11, 1/27/12, and 2/28/12 indicated "...The resident has multiple risk factors for falls..." Documentation was lacking to indicate the care plan had been updated with any additional interventions after the 1/31/12 fall.</p> <p>Interview on 3/8/12 at 9:55 A.M. with the Director of Nursing indicated the care plans should have been updated after the falls.</p> <p>4. The clinical record of Resident #G was reviewed on 3/7/12 at 9:15 A.M. Facility admission date was 2/14/12.</p> <p>Diagnoses for Resident #G included, but were not limited to, senile dementia, anxiety and diabetes.</p> <p>An Initial Minimum Data Set assessment, dated 2/21/12, indicated a Brief Interview for Mental Status score of 11 [moderate impairment], required extensive assist of</p>			

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	<p>one staff member for hygiene/bathing, and the extensive assist of one staff member for toileting.</p> <p>A Hospital Discharge Summary, dated 2/14/12, indicated one of Resident #G's discharge diagnoses included, but were not limited to, was Urinary Tract Infection (UTI). Discharge medications included Amoxicillin 500 mg (milligrams) by mouth twice a day for five more days.</p> <p>A Physician's order, dated 3/2/12, indicated "may obtain UA (urinalysis) [with] I&amp;O [in and out catheterization) straight cath (catheter) and Bactrim DS (an antibiotic) one twice a day for 7 days, for a UTI.</p> <p>A Lab report, dated 3/4/12, indicated Escherichia coli (organism that causes UTI) &gt; [greater than] 100,000.</p> <p>A review of the Care Plans, dated 2/15/12 through 3/7/12, indicated there was no care plan for prevention of UTIs.</p> <p>During an interview with the Director of Nursing, on 3/7/12 at 11:30 A.M., she indicated Resident #G had been doing her own perineal care but that the staff were doing it now.</p>			

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	<p>5. The clinical record of Resident #F was reviewed on 3/5/12 at 11:30 A.M.</p> <p>Diagnoses for Resident #F included, but were not limited to, dementia, anxiety and a history of cerebral vascular accident [stroke].</p> <p>A review of Nursing note from December 2011 to present, indicated Resident # F had fallen three times, 12/8/11, 1/17/12 and 2/27/12.</p> <p>A Fall Risk Assessments, dated 10/27/11, 12/13/11, 2/26/12 and 2/27/12, indicated Resident # F was at risk for falls.</p> <p>An Incident and Accident Report and Investigation report, dated 12/9/11, indicated "...fell out of walker onto floor - only one hand brake was on...Therapy screen - note added to walker to keep walker [with] her."</p> <p>An Incident and Accident Report and Investigation report, dated 1/17/12, indicated "...while ambulating [with] walker res (resident) turned to close the door to her room et (and) she leaned against door frame et lowered self to floor (sic). Res found sitting in doorway on buttocks...instructed resident to call staff and they would assist [with] shutting the door...."</p>			

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	<p>An Incident and Accident Report and Investigation report, dated 2/27/12, indicated "...Res attempted to sit down in chair. Res missed chair and fell on floor...Reminded res to feel chair (sic) behind her before she sits down...."</p> <p>A review of Care Plans for falls indicated three care plans. One dated 8/25/10, another dated 5/11/11 and the last one dated 12/6/11 and reviewed on 12/23/11, all indicated Resident # F was at risk for falls. The last addition to the interventions was on 12/7/11, to discontinue the alarm to the Resident's recliner. The Care Plan had not been updated since the fall on 12/8/11.</p> <p>6. The clinical record of Resident #E was reviewed on 3/8/12 at 9:15 A.M.</p> <p>Diagnoses for Resident #E included, but were not limited to Parkinson's disease, multiple sclerosis, and seizure disorder.</p> <p>A Quarterly Minimum Data Set assessment, dated 12/1/11, indicated Resident #E had a stage III pressure ulcer.</p> <p>A Nursing note, dated 8/11/11 at 7:05 P.M., indicated "1 cm (centimeter) x 0.5 cm open area noted to sacral area. center of wound red. No drainage</p>			

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	<p>present...turned onto [right] side to relieve pressure on open area."</p> <p>A Pressure Ulcer Flowsheet entry, dated 8/11/11, indicated a stage II pressure ulcer, 1 cm x 0.5 cm with no depth, to the sacral area.</p> <p>A Pressure Ulcer Flowsheet entry, dated 8/31/11, indicated a stage III pressure ulcer, 1.1 cm x 0.7 cm x 0.2 cm, to the sacral area.</p> <p>A Pressure Ulcer Flowsheet entry, dated 3/6/12, indicated a stage III pressure ulcer, 1.0 cm x 1.3 cm x UTD (unable to determine), to the sacral area with heavy serosanguineous (a clear yellow fluid) drainage.</p> <p>A Care Plan for an open area on the coccyx, started on 8/23/11 and reviewed on 9/2/11 and 12/7/11, indicated the last documented update was 1/3/12.</p> <p>Review on 3/6/12 at 2:45 P.M. of a facility policy and procedure dated 2/05, provided by the Administrator, identified as current, and titled "Fall Management Procedure" indicated "...Update the plan of care each time there is a change in intervention and communicate to staff..."</p> <p>This federal tag relates to Complaint</p>			

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	IN00103512.  3.1-35(a)			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were in place to prevent pressure ulcers and failed to ensure treatment was done appropriately for an existing pressure ulcer for 1 of 4 residents with pressure ulcers in a sample of 13. (Resident #C)</p> <p>Findings include:</p> <p>1. On 3/4/12 at 4:15 P.M., during an initial tour with LPN #1, Resident #C was identified as interviewable, having no pressure ulcers, and using an electric scooter for mobility.</p> <p>During Interview on 3/5/12 at 1:45 P.M., Resident #C indicated she had put a pillow in her electric scooter because "the sore on my bottom hurts." During observation at that time, the electric scooter was sitting next to the resident's</p>	F0314	<p>1. Resident C received a cushion in her scooter on 03/05/12 and the treatment was completed on 03/06/12.2. All residents at risk for pressure ulcers according to their Braden Score were reviewed to ensure appropriate interventions are in place to prevent pressure ulcers. All residents receiving pressure ulcer treatments were reviewed to ensure receiving proper treatments.3. All licensed staff were re-educated on the facility policy and procedure for completing a treatment. The DON or designee will observe a treatment 1x weekly on random staff, and residents will be observed 5x weekly to ensure interventions are in place to prevent pressure ulcers. Should concern be noted, immediate corrective action shall be taken. 4. The results of the aforementioned observations and any corrective actions taken will be brought to the QAA and reviewed monthly for 3 months</p>	03/22/2012			

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	<p>bed with a pillow on the seat. There was no pressure reducing cushion in place.</p> <p>During Observation on 3/6/12 at 8:30 A.M., Resident #C was eating breakfast in her bed. There was a pressure reducing mattress on the bed. The head of the bed was elevated and there was a cushion on the seat of the resident's scooter. Interview on 3/6/12 at 8:30 A.M. with Resident #C indicated "my bottom hurts. It makes me sick to my stomach."</p> <p>Observation on 3/6/12 at 8:45 A.M., with LPN #1 and the ADON indicated the resident was lying on her back in bed. The resident turned to her left side. There was a dressing which was partially loose on the inner aspect of the resident's left buttock. LPN #1 removed the dressing. There was a pressure ulcer which was described by LPN #1 as "macerated in the middle and edges with a moderate amount of serosanguineous drainage. Pink, slightly red." LPN #1 measured the wound as 2.2 cm (centimeters) wide by 3.5 cm long by less than 0.1 cm deep and identified it as a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough). LPN #1 applied Vasotex (a generic form of Xenaderm) (an ointment used to treat pressure ulcers) and an Optifoam dressing. She did not</p>		and then quarterly thereafter.	

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	<p>cleansed the wound prior to applying the ointment and dressing.</p> <p>Interview with the resident during the above observation indicated the wound "is burning like fire this morning."</p> <p>Interview on 3/6/12 at 9:15 A.M. with LPN #1 indicated she did not cleanse the wound because "I didn't have an order." She indicated if there was no order the wound was not cleansed with dressing changes.</p> <p>Resident #C's clinical record was reviewed on 3/5/12 at 1:50 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, acute/chronic anemia, leukemia, peripheral vascular disease, and restless leg syndrome.</p> <p>A Minimum Data Set (MDS) quarterly assessment dated 2/1/12 indicated the resident was cognitively intact for decision-making skills, required extensive-one person physical assistance for bed mobility and toilet use, required limited one-person physical assistance for transfer, had a catheter and was continent of bowel, was at risk for developing pressure ulcers, had a pressure reducing device for bed and chair, and had no pressure ulcers.</p>			

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	<p>A "Braden Scale for Predicting Pressure Sore Risk" dated 2/10/12 indicated score of 20 - no risk for developing pressure ulcers.</p> <p>A resident care plan dated 1/3/12 indicated "...The resident is at risk for the development of pressure ulcers due to:...ext (extensive) assist x 1 c (with) bed mobility...Intervention...Pressure redirecting (sic) mattress to bed...Encourage and assist resident with turning and repositioning at least every two hours...Apply preventative topical medication as ordered Barrier cream as prevention..." Pressure redirecting (sic) cushion to chair had been yellowed out.</p> <p>Interview on 3/6/12 at 9:15 A.M. with LPN #1 indicated she was unaware when the chair cushion had been yellowed out (indicating it was no longer in use) but the resident "had been sick and wasn't getting out of bed."</p> <p>Nurses' notes indicated the resident was sent to the hospital emergency department on 2/21/12 at 11:00 P.M. due to a fall. The resident returned to the facility on 2/23/12 at 11:30 A.M. A nurses' note indicated the resident had a laceration to the lower leg which was assessed. Documentation was lacking related to an</p>			
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	<p>assessment being completed of the resident's buttocks.</p> <p>Medication Administration Records and Treatment Administration Records dated January and February 2012 indicated documentation was lacking related to a moisture barrier being applied as a preventative measure after incontinence.</p> <p>Interview on 3/7/12 at 2:55 P.M. with the Director of Nursing indicated the moisture barrier "might be documented" on the CNAs Activity of Daily Living sheets. The ADL sheets were requested but as of exit on 3/10/12 at 2:00 P.M. were not provided for review.</p> <p>A nurses' note dated 2/24/12 at 3:00 P.M. indicated "...Opened area noted (R) (right) buttock (sic) measuring 0.5 cm x 0.7 cm. Tissue to center noted beefy red c (with) surrounding tissue noted light purple in color. MD in this evening to eval (evaluate)..."</p> <p>A "Pressure Ulcer Flowsheet" dated 2/24/12 indicated:</p> <p>2/24/12 "...Stage II...Admitted with (blank)...Acquired after admission (blank)...(L) (left) buttock...0.5 cm x 0.7 cm...purple..."</p>			

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	<p>2/28/12 "...Stage II...4.0 x 2.0...Depth...&lt; (less than) 0.1...small serous (drainage)...pink...deteriorated (indicated by X)...non-compliant c (with) T&amp;R (turning and repositioning)..."</p> <p>A resident care plan dated 2/28/12 indicated "...The resident had an open area location: (L) buttock...Interventions...Provide pressure relieving devices to reduce pressure to affected area..."</p> <p>Interview on 3/6/12 at 10:02 A.M. with the MDS Consultant and the MDS Coordinator indicated "the Braden is not the only thing we use to determine risk (of developing pressure ulcers)."</p> <p>Interview on 3/7/12 at 2:55 P.M. with the Director of Nursing indicated "she never had a cushion because she didn't need one. She's in a scooter. She indicated the resident wasn't using the scooter, however, but ambulating. Just because they are at risk doesn't mean they need a cushion." She indicated the resident may have gotten the pressure ulcer in the hospital because she laid on a cart for "12 hours."</p> <p>Review on 3/9/12 at 7:30 A.M. of "Pressure Ulcers in the Long-Term Care Setting, Clinical Practice Guideline" by</p>						

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	<p>the American Medical Directors Association indicated "...Seats should be padded with foam, gel, or air cushions..."</p> <p>Review on 3/9/12 at 10:25 A.M. of an undated facility policy and procedure provided by the Administrator, identified as current, and titled "Skin Management Program" indicated "...A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter...Interventions will be implemented according to the individual residents risk factors that will best reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas..."</p> <p>Review on 3/7/12 at 8:30 A.M. of an undated facility policy and procedure provided by the Administrator, identified as current, and titled "Interventions to Reduce the Risk of Pressure Ulcer Development &amp; Pressure Ulcer Management" indicated "...Residents at Risk:...Pressure reducing chair cushion - filled with foam, static air, gel, or water..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F0323 SS=G	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure additional interventions were implemented to prevent falls resulting in a hematoma, bruises, and a laceration on the leg requiring two hospital visits for 3 of 7 residents with falls in a sample of 13. (Residents #B, #C, #D).</p> <p>Findings include:</p> <p>1. On 3/4/12 at 4:15 P.M., during an initial tour with LPN #1, Resident #C was identified as having bed and chair alarms, having had falls and "being weak because she has leukemia and a low hemoglobin."</p> <p>Interview on 3/5/12 at 1:45 P.M. with Resident #C indicated "I fall all the time." Observation at the time of the interview indicated there was a bed alarm in place, non-skid strips on the floor by the bed. There was a recliner with a cooler on the seat. The recliner was 4 feet from the resident's bed and she could not reach the cooler while in bed.</p>	F0323	<p>1. Residents B no longer resides in the facility. Resident C received no injuries requiring hospitalization and care plan was updated as indicated. Resident D received no injuries nor hospitalizations related to falls.2. Fall Risk assessments were reviewed for all residents. Any residents identified "at risk" had their care plans reviewed and interventions were updated as indicated.3. The IDT was re-educated on the facility process for developing/reviewing and revising care plans following an incident/fall. The facility policy and procedure for Fall Management was reviewed with the licensed nursing staff, in an effort to ensure knowledge of need for immediate intervention, as well as monitor for ongoing compliance with current interventions as per plan of care. The need to develop/revise interventions related to falls will be determined through review of the 24 hour report and IDT meeting and documentation secured reflecting this process. This meeting will occur 5x weekly. The DON or designee will review all records of residents</p>	03/22/2012			

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	<p>Resident #C's clinical record was reviewed on 3/5/12 at 1:50 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, acute/chronic anemia, leukemia, stage 4 chronic kidney disease, peripheral vascular disease, anxiety, and restless leg syndrome.</p> <p>A Minimum Data Set (MDS) quarterly assessment dated 2/11/12 indicated the resident was cognitively intact in decision-making skills, required extensive one-person physical assistance for transfer and toilet use, required limited one-person physical assistance for ambulation, was not steady but was able to stabilize without human assistance for balance, had impairment of both lower extremities, and had one fall with no injury.</p> <p>"Fall Risk Assessments" dated 9/8/11, 11/27/11, 11/30/11, 12/8/11, 1/1/12, 1/31/12, 2/16/12, 2/22/12, and 2/28/12 indicated "...History of falls...PVD (peripheral vascular disease)..." The "No Risk factors, will not proceed to care plan" box was blank indicating the resident was at risk for falls.</p> <p>A physician's order recapitulation dated March 2012 indicated "...Coumadin (an anticoagulant) 2 mg (milligrams) tablet. Give 1 tablet by mouth every day except</p>		<p>incurring falls to determine compliance. Should non-compliance be noted, immediate corrective action shall be taken.4. These results of the aforementioned reviews will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>				

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	<p>on Tues &amp; Fri" and "Coumadin 3 mg. Give 1 tablet by mouth on Tues &amp; Fri..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated "...Restorative: Ambulation...Resident is at risk for falls and needs assistance to ambulate related to:...unsteady gait...Interventions...Assist resident, as recommended with ambulation restorative program...Utilize a gait belt...Resident uses the following adaptive equipment with ambulation: rolling walker, gait belt...Resident will ambulate 20 feet using rolling walker and limited assist of one staff. Use gait belt for safety and encourage resident to use good posture during ambulation. Allow rest breaks as needed..."</p> <p>A nurses' note dated 11/23/11 at 10:30 A.M. indicated "Writer called to res (resident) rm (room) by RA (restorative aide). Writer found res sitting on floor...0 (no) injuries noted. Will monitor."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 11/23/11 indicated "...Writer called to res rm by RA. Res sitting on floor...Type of injury: none...Res putting powder on self. Powder all over floor. Floor slick...Res stated she was trying to sit on side of bed &amp; she slid down onto the</p>			

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	<p>floor...Immediate action or keep-safe intervention implemented to prevent any recurrence: Non-skid strips placed next to bed on floor..."</p> <p>A "Post-Fall Investigation Worksheet" dated 11/23/11 indicated "...What was resident attempting to do at the time of the fall? Sit on side of bed...Non-skid strips - Encourage to stop using baby powder...What does the interdisciplinary team determine the cause of the fall to be? Res. continues to utilize call light for staff assistance but not for transfers - Continue to educate for compliance..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated documentation was lacking related to any additional interventions being implemented to prevent falls after the 11/23/11 fall.</p> <p>A nurses' note dated 11/28/11 at 10:00 A.M. indicated "Writer heard res calling 'help.' Went to res rm &amp; res was found lying on floor...0 (no) injuries noted..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 11/28/11 indicated "Writer heard res yelling help, responding &amp; found res lying on floor...Type of injury: none... Res said she was up getting ice &amp; her feet slipped out from</p>						

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	<p>underneath her...Immediate action or keep-safe intervention implemented to prevent any recurrence: Screen sent to therapy...Reeducated on use of brakes on walker. Brakes not locked cx (cause) of fall...Keep ice chest to (L) (left) side of recliner...Resident does not always follow instructions - did not use brakes on walker et (and) did not clear seat of rollator (rolling walker) before use...therapy re-educated resident on use of rollator..."</p> <p>A "Post-Fall Investigation Worksheet" dated 11/28/11 indicated "...What was resident attempting to do at the time of the fall? get ice from her chest in recliner chair...Were previously planned intervention in place at the time of the fall and, if so, were they effective or not and, if not, why? Non-skid strips in front of bed but not recliner...Keep ice chest to (L) side of recliner...What does the interdisciplinary team determine the cause of the fall to be? Resident does not always follow instructions-Did not use brakes on walker, did not clear seat of rollator before use..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated documentation was lacking related to any additional interventions being implemented to prevent falls after the</p>			

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	<p>11/28/11 fall.</p> <p>A nurses' note dated 11/30/11 at 11:00 P.M. indicated "Res said she slid off bed et fell 6:30 P.M. When staff got to rm, res sitting on bed - 7 PM, heard res yelling for help. Found res lying face first on floor c (with) head against door frame. Hematoma and bruise forehead. 1.4 cm (centimeters) x 1.8 cm skin tear (L) elbow...Res had fallen in BR (bathroom) while trying to disconnect tubing from catheter to change (indicated by triangle) from leg bag to night bag. Said she crawled to doorway of BR to yell for help..." The resident was sent to the hospital for care.</p> <p>An "Incident &amp; Accident Report and Investigation" dated 11/30/11 at 7 PM indicated "...Res trying to change (indicated by triangle) from leg bag to night bag on catheter. Said she fell et crawled to doorway to yell for help - staff found her face down on floor c (with) head against doorframe. Hematoma et bruise forehead...skin tear (L) elbow...Type of injury: skin tear...bruise...hematoma...send to hospital...Immediate action or keep-safe intervention implemented to prevent any recurrence: instructed res to call for assist to change (indicated by triangle) bags if needed...re-educated on use of rollator</p>						

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	<p>call x's (times) for ambulation..."</p> <p>A "Post-Fall Investigation Worksheet" dated 11/30/11 indicated "...What was resident attempting to do at the time of the fall? Res attempting to unhook catheter tubing to change (indicated by triangle) from leg bag to night bag...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? N/A...Yes, strips to floor beside bed but not effective d/t (due to) incident in res bathroom...What does the interdisciplinary team determine the cause of the fall to be? Res. failed to use her rollator during ambulation. Res left rollator @ end of bed et did not take into bathroom...Have res ask for help to change (indicated by triangle) from leg bag to night bag if needed..."</p> <p>A resident care plan dated 3/29/11 and updated on 4/25/11 and 6/6/11 indicated documentation was lacking related to any additional interventions being implemented to prevent falls after the 11/30/11 fall.</p> <p>Nurses' notes indicated:</p> <p>12/1/11 at 6:25 A.M. "...Dk (dark) purplish bruise on Lt (left) forehead..."</p>			

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	<p>1/1/12 at 6:45 P.M. "...CNA came in DR 5:20 P - said res sitting on floor by bed. Nurse assessed...No apparent injuries...Said that (L) leg gave out..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/1/12 indicated "...CNA reported res sitting on floor by bed. Res trying to get OOB (out of bed) to get ice - said leg gave out...Type of injury: none...Was trying to get up to get ice...Immediate action or keep-safe intervention implemented to prevent any recurrence: Reminded to call for assist if she needs to get up...Screen c (with) therapy? Change (indicated with triangle) rest (restorative) program to work on transfers...instructed to ask for ice - ice pass per routine..."</p> <p>A "Post-Fall Investigation Worksheet" dated 1/1/12 indicated "...What was resident attempting to do at the time of the fall? trying to get out of bed to get ice ...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Staff reminds res to call for assist to transfer if needed...continue ice @ side of recliner...What does the interdisciplinary team determine the cause of the fall to be? Res non-compliant @ times c (with) call light (per her convenience)..."</p>						

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	<p>A resident care plan dated 1/3/12 indicated "...The resident has multiple risk factors for falls, such as:...unsteady gait et balance...Interventions...Implement intervention to reduce risk for falls: (list interventions and date initiated)...Non skid strips on floor next to bed..."</p> <p>Documentation was lacking related to the use of a rolling walker, having ice on recliner next to resident, or assisting resident to change catheter bags.</p> <p>Nurses' notes indicated:</p> <p>1/3/12 at 8:00 A.M. "Bruises found to (R) post (posterior) hip 2.4 x 6.6 cm, purple. (R) inner thigh 8.5 x 9.7 cm, purple. (L) lower back 14.0 x 12.2 cm purple et (R) post knee 8.0 x 8.6 cm purple..."</p> <p>1/31/12 at 10:30 P.M. "Heard res roommate yelling, 'Help, (Resident # C's name) fell.'" 7:45 P found res lying on back c (with) legs in front of her, arms at side, head against wall..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/31/12 indicated "...Heard res roommate yelling 'Help (Resident #C's name) fell. Found res lying on back c (with) legs in front of her, arms at sides, head against wall...Type of injury: none...Res left rollator walker at end of bed et went into BR (bathroom)</p>			

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	<p>-said legs gave out...Immediate action or keep-safe intervention implemented to prevent any recurrence: Reminded to call for assist if needed - rollator was standing at end of bed...reminded to use it to go to BR...Strips to BR floor - prev (previous) POC (plan of care)...Was re-educated on 1/30/12 on use of rollator..."</p> <p>A "Post-Fall Investigation Worksheet" dated 1/31/12 indicated "...What was resident attempting to do at the time of the fall? go to BR ...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Yes, res didn't call for assist...What does the interdisciplinary team determine the cause of the fall to be? Res continues to make (I) (independent) decisions even p (after) verbalizations of understanding..."</p> <p>A resident care plan dated 1/3/12 indicated documentation was lacking related to non-skid strips being used in the bathroom and lacking related to any additional interventions being implemented to prevent falls after the 1/31/12 fall.</p> <p>Nurses' notes indicated:</p> <p>2/1/12 at 10:00 A.M. "...Continues to ambulate c (with) rolling walker c (with)</p>			
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	<p>0 (no) difficulty. Continue to monitor..."</p> <p>A "Physical Therapy Evaluation" dated 2/7/12 indicated "...Patient fell while attempting to wash herself in the BR. Has had increasing weakness over past 2 to 4 weeks...Static Stand (balance) Fair...Dyn (dynamic) Stand (balance) Fair - (minus)...Fall Risk: Yes...Very poor endurance..."</p> <p>2/9/12 (no time) "...Res had fell on 1/31/12 &amp; has had more difficulty c (with) weight bearing for transfers and/or ambulation..."</p> <p>2/16/12 at 11:00 P.M. "Res fell 7 PM - witnessed by another res family - they said res didn't hit head..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 2/16/12 indicated "...Res trying to get from rollator/walker to plug electric W/C (wheelchair) into charger. Another res family witnessed res fall...Type of injury: none...Res said she was weak - Reminded to call staff for what she needed...Immediate action or keep-safe intervention implemented to prevent any recurrence: Reminded to call for assist...make sure scooter is plugged in every evening...offered to remove recliner from room to take scooter into room et alleviate clutter - res refused..."</p>			

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	<p>A "Post-Fall Investigation Worksheet" dated 1/1/12 indicated "...What was resident attempting to do at the time of the fall? trying to get from walker to get electric W/C plugged in - fell ...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Yes...What does the interdisciplinary team determine the cause of the fall to be? Res refuses to ask for assist for some tasks - but verbalizes she will.."</p> <p>A resident care plan dated 1/3/12 indicated documentation was lacking related to any additional interventions being implemented to prevent falls after the 2/16/12 fall.</p> <p>A nurses' note dated 2/22/12 at 11:00 P.M. indicated "Res heard yelling, 'Help.'" - found res lying on floor face down c (with) head under bed - Lg (large) skin tear on leg...4 cm x 4 cm x 0.2 cm c (with) lg blood clots. Sm (small) bump felt (R) posterior head. Res c/o (complains of) (R) elbow pain...Res said she'd been trying to get ice out of cooler et phone rang. Said she slipped off of bed..." The resident was sent to the hospital for care.</p> <p>An "Incident &amp; Accident Report and</p>			

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	<p>Investigation Worksheet" 2/22/12 indicated "...Heard res yelling for help. Found res on floor face down c (with) head under bed...Type of injury: skin tear...Res said she was trying to get ice out of cooler et room phone rang - said she slipped off bed...Immediate action or keep-safe intervention implemented to prevent any recurrence: sent to hospital - Bed and chair alarms initiated..."</p> <p>A "Post-Fall Investigation Worksheet" dated 2/22/12 indicated "...What was resident attempting to do at the time of the fall? get ice out of cooler and phone rang ...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Yes... What does the interdisciplinary team determine the cause of the fall to be? Res said she slipped off bed - sticky pads on floor by bed..."</p> <p>A "Rehabilitation Screening Form" dated 2/23/12 indicated "...Pt (patient) stated 'slipped off bed because sat on coat which was slick.'..."</p> <p>A resident care plan dated 1/3/12 indicated "2/23/12 Pressure pad alarm to bed et WC (wheelchair)..."</p> <p>Nurses' notes indicated:</p>			

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	<p>2/23/12 at 4:30 A.M. "...Bandage to lower rt (right) leg saturated c (with) blood..."</p> <p>2/23/12 at 10:30 P.M. "...RLE (right lower extremity) drsg (dressing) saturated..."</p> <p>2/24/12 at 10:30 A.M. "...Resident noted c (with) weakness while ambulating x 2 assist to the bathroom, resulting in wound/skin tear to bleed..."</p> <p>2/25/12 at 9:30 A.M. "...Dsg (dressing) to RLE cleansed and changed...Immediate compress saturated through c (with) large loose blood clot attached..."</p> <p>2/25/12 at 10:40 P.M. "...Old dsg saturated c (with) bright red blood..."</p> <p>2/26/12 at 2:40 A.M. "RLE bandage soaked through c (with) blood/drainage. When drsg removed, area of wound has large blood clot c (with) slow, active bleeding noted..."</p> <p>2/26/12 at 2:00 P.M. "...unable to ambulate from bed to BR, had to sit down d/t (due to) leg weakness..."</p> <p>2/28/12 at 11:00 P.M. "Evening shift CNA came onto floor - Res call lt (light) on - CNA went to answer it and found res on floor. Res said day shift CNA had left</p>			

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	<p>her on bedside commode..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 2/28/12 indicated "...Res said CNA left her on commode (bedside) - when evening shift CNA came onto floor, res call light already on - CNA answered it and found res on floor...Type of injury: none...CNA (day shift) left res on bedside commode c (with) no alarms...Immediate action or keep-safe intervention implemented to prevent any recurrence: Bed &amp; chair alarms. Refuses to remove recliner from res room again. Staff educated on - not leaving residents c (with) alarms unattended..."</p> <p>A "Post-Fall Investigation Worksheet" dated 2/28/12 indicated "...What was resident attempting to do at the time of the fall? Res said day shift CNA left her on bedside commode when evening shift CNA came onto floor, res call light already on - she answered it and found res on floor...If applicable, were staff performing the skill per policy? No - Day shift CNA left res on bedside commode...supposed to have bed &amp; chair alarms on...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Left on commode - alarms not in use...What does the interdisciplinary team determine the cause</p>						

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	<p>of the fall to be? The form was blank.</p> <p>A resident care plan dated 1/3/12 indicated documentation was lacking related to any additional interventions being implemented to prevent falls after the 2/28/12 fall.</p> <p>A "Certified Nursing Assistant Assignment Sheet" reviewed on 3/7/12 at 1:00 P.M., provided by the ADON, and identified as current indicated documentation was lacking related to Resident #C having alarms to prevent falls.</p> <p>Interview on 3/6/12 at 9:30 A.M. with the ADON (Assistant Director of Nursing) indicated the resident should not have been left alone on the bedside commode.</p> <p>Interview on 3/7/12 at 2:30 P.M. with the Director of Nursing indicated the coding of the cognitive status on the MDS "doesn't mean all the time" and "the MDS is not a true reflection of the resident's condition." She indicated the resident's cognitive status fluctuated. She indicated "the ice wasn't the problem" regarding the falls. She indicated the ice wasn't the problem, 3/8/12 at the phone was the problem for the 2/22/12 fall. She indicated CNAs have been trained not to leave residents on the commode if they</p>			

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	<p>were at risk for falls and had alarms on.</p> <p>2. On 3/4/12 at 4:15 P.M., during an initial tour with LPN #1, Resident #D was identified as being interviewable, having no alarms, and having no falls.</p> <p>Interview on 3/8/12 at 10:30 A.M. with Resident #D indicated "I slipped off the bed. They got me too close to the edge. There was only one CNA in the room and she couldn't hold me. The other CNA came back right away. Usually they use a lift to get me up. They used a lift to get me off the floor. It took 4 people."</p> <p>Resident #D's clinical record was reviewed on 3/8/12 at 9:00 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, history of chronic subdural hematoma, anemia, anxiety, morbid obesity, osteoarthritis, and history of open reduction/internal fixation left ankle.</p> <p>An MDS quarterly assessment dated 1/16/12 indicated the resident was cognitively intact for decision-making skills, required extensive two-person physical assistance for transfer, was non-ambulatory, required extensive one-person physical assistance for toilet use, was unsteady and only able to stabilize balance with human assistance,</p>			

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	<p>had impairment on one side of upper and lower extremities, and had no falls.</p> <p>A resident care plan dated 8/25/11 and updated 11/10/11, 12/1/11, 1/27/12 and 2/28/12 indicated "...The resident has multiple risk factors for falls such as:...hx (history) falls, weakness, impaired balance...cognitive loss...Intervention...Implement intervention to reduce risk for falls:...Standup lift for transfers...scheduled toileting..."</p> <p>A resident care plan dated 8/25/11 and updated 11/10/11, 12/1/11, 1/27/12, and 2/28/12 indicated "...The resident requires up to ii (two) assist in performing ADLs (activities of daily living)...Intervention...stand up lift transfers..."</p> <p>A nurses' note dated 2/26/12 at 11:00 P.M. indicated "Res being assisted to bed c (with) 2 CNAs and stand up lift. Had straps undone et (and) was getting ready to lay res down. Was on side of bed. Both CNAs said res leaned forward et slipped off bed...red area on midback..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 2/26/12 indicated "...CNAs assisting res to bed. Had straps unhooked from EZ stand lift - getting</p>			

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	<p>ready to put in bed - CNAs both said res leaned forward et slid off bed...Type of injury: none...Immediate action or keep-safe intervention implemented to prevent any recurrence... Assisted to bed. EZ stand lift as ordered. New bed - siderails - remove (L) (left) side rail during transfer to allow res buttock to be further upon mattress. Updated CNA assignment sheet..."</p> <p>A "Post Fall Investigation Worksheet" dated 2/26/12 indicated "...on edge of bed...What does the interdisciplinary team determine the cause of the fall to be? Side rail removed during transfers..."</p> <p>A resident care plan dated 8/25/11 and updated on 2/28/11 indicated "...swing out (L) rail during transfers..."</p> <p>A nurses' note dated 3/1/12 at 2:15 P.M. indicated "Resident was lowered to floor c (with) 0 (no) injuries. Being assisted by 2 CNAs c (with) stand up hooyer. Bed was not propery (sic) locked into place when standing up and began to slip. Lowered to floor on bilateral buttocks c (with) BLE (bilateral lower extremities) extended..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 3/1/12 indicated "Resident sitting on edge of bed - when CNAs x 2 were trying to transfer via stand</p>			

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	<p>up up (sic) hoyer. Bed was not locked in place, resident began to slip while standing. Lowered to floor...Type of injury: none...Bed not locked in place...Immediate action or keep-safe intervention implemented to prevent any recurrence...Keep immediate environment clutter free...Bed locked in proper position..."</p> <p>A "Post Fall Investigation Worksheet" dated 2/26/12 indicated "...sitting on edge of bed waiting to be transferred... What does the safety committee determine the cause of the fall to be? Bed was not properly (sic) locked into place..."</p> <p>A resident care plan dated 8/25/11 and updated on 2/28/11 indicated documentation was lacking related to ensuring the bed was locked prior to transfer with the standup lift.</p> <p>A "Certified Nursing Assistant Assignment Sheet" reviewed on 3/7/12 at 1:00 P.M., provided by the ADON, and identified as current indicated documentation was lacking related to ensuring the bed was locked prior to transfer.</p> <p>Interview on 3/8/12 at 10:40 A.M. with the ADON indicated CNAs had been trained on how to use the standup lift and</p>						

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	<p>should have locked the bed prior to transfer.</p> <p>3. Resident #B's closed clinical record was reviewed on 3/6/12 at 2:10 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, dementia, left above the knee amputation, and balloon angioplasty of the left femoral artery.</p> <p>An MDS admission assessment dated 9/29/11 indicated the resident was cognitively intact for decision-making skills, required extensive two-person physical assistance for transfer and toilet use, was non ambulatory, was not steady and only able to stabilize balance with human assistance, and had no falls.</p> <p>A fall risk assessment dated 1/31/12 indicated "...history of falls...use of assistive devices (L) prosthesis...PVD (peripheral vascular disease)...non compliance issues..." The box for no risk factors, will not proceed to care plan was blank, indicating the resident was at risk for falls.</p> <p>A resident care plan dated 10/5/11 and updated 12/22/11 and 1/4/12 indicated "...The resident has multiple risk factors for falls such as:...poor safety awareness...dementia...impulsivity...weak</p>				

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	<p>ness...(L) AKA (above knee amputation)...Intervention...Implement intervention to reduce risk for falls:...Bed et W/C alarms 9/22/11...Remind resident to use call light for assist c (with) transfers et toilet use 9/22/11..."</p> <p>A resident care plan dated 10/5/11 and updated 12/22/11 and 1/4/12 indicated "...The resident suffers from cognitive loss as evidenced by: poor decision making...poor safety awareness...impulsivity..."</p> <p>A "Behavioral Health Consultation" dated 11/21/11 indicated "...impulsive behavior. He also often engages in dangerous behavior including attempting to get out of his wheelchair without assistance...He lacked insight into the dangers of getting up and injuring himself, which is a concern..."</p> <p>A nurses' note dated 10/10/11 at 9:50 P.M. indicated "CNA found res on floor of bathrm (bathroom)..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 10/10/11 indicated "...CNA found res on floor of bathrm...Type of injury: none...Res transferring self without asking for assistance...'I was getting in my wheelchair'...Immediate action or</p>			

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	<p>keep-safe intervention implemented to prevent any recurrence...Sensor alarm on BR door was imitated today..."</p> <p>A resident care plan dated 10/5/11 and updated 12/22/11 and 1/4/12 indicated "10/10/11 motion sensor alarm to BR door..."</p> <p>Nurses' notes indicated:</p> <p>10/17/11 at 7:00 P.M. "Resident removing bed pad alarm from bed and placing on chair..."</p> <p>10/27/11 at 1:30 P.M. "...continues to have poor safety awareness et impulsiveness d/t dementia...NSG (nursing) is unable to leave resident unsupervised d/t res appears alert et unstands (sic) what is requested (ie-use call light prior to transfers) but does not follow directions appropriately d/t dementia..."</p> <p>11/6/11 at 9:00 A.M. "...non-compliant c (with) alarms x 2 this shift. Attempting to go to BR unassisted..."</p> <p>1/26/12 at 6:00 A.M. "Res alarm was sounding...Found lying on floor in front of W/C on rt (right) side...stated he slipped from his W/C. Hit head on floor receiving a 2 cm laceration above rt</p>						

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	<p>eyebrow...Placed up to DR (dining room) tabled to keep res from leaning forward..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/26/12 indicated "...found lying on floor in front of W/C on rt side...Type of injury: laceration...Attempting to stand - Res had been seen earlier attempting to stand...Immediate action or keep-safe intervention implemented to prevent any recurrence...Res was placed up to a DR table so as to prevent leaning forward...Alarms were functioning @ X (at time) of fall...Ensure leg on even on shower days..."</p> <p>A "Post Fall Investigation Worksheet" dated 1/26/12 indicated "...Stated he slipped from W/C. Had earlier been seen attempting to stand from W/C...Were previously planned interventions in place at the time of the fall and if so were they effective or not, and if not why? Alarm in W/C was sounding, so alarm was effective...What does the safety committee determine the cause of the fall to be? Res attempted to stand unaided - cushion in chair when res on floor so don't believe res slid from chair...Re-educate resident..."</p> <p>A resident care plan dated 10/5/11 and updated on 1/4/12 indicated</p>			

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	<p>documentation was lacking related to any additional interventions being implemented to prevent falls after the 1/26/12 fall.</p> <p>A nurses' note dated 1/31/12 at 11:00 P.M. indicated "5:30 P 2 CNAs assisting res from W/C to toilet. Res unable to help stand. Eased to floor..."</p> <p>An "Incident &amp; Accident Report and Investigation" dated 1/31/12 indicated "...2 CNAs assisting res to toilet from W/C. Unable to hold him up enough to get on toilet. Eased to floor...Type of injury: skin tear...Immediate action or keep-safe intervention implemented to prevent any recurrence...Alarms, 2 assist...Staff educated - follow CNA assignment sheet if prosthetic 0 (not) on res to use standup lift..."</p> <p>A "Post Fall Investigation Worksheet" dated 2/26/12 indicated "...Being assisted to toilet c (with) 2 CNAs...What does the safety committee determine the cause of the fall to be? Staff did not follow CNA assignment sheet - education following POC (plan of care)..."</p> <p>A resident care plan dated 8/25/11 and updated on 2/28/11 indicated documentation was lacking to indicate additional interventions had been</p>						

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	<p>implemented to prevent falls after the 1/31/12 fall.</p> <p>Interview on 3/7/12 at 12:10 P.M. with the Director of Nursing indicated "it wasn't about the alarms, he didn't have his prosthesis on. The intervention was to have his leg on before breakfast."</p> <p>Review on 3/6/12 at 2:45 P.M. of a facility policy and procedure dated 2/05, provided by the Administrator, identified as current, and titled "Fall Management Procedure" indicated "...The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls and/or injuries related to falls...update the plan of care each time there is a change in intervention and communicate to staff..."</p> <p>This federal tag relates to Complaint IN00103512.</p> <p>3.1-45(a)(2)</p>						

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F0372 SS=D	<p>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to keep the dumpster area free of refuse. This effected the area behind 1 of 1 dumpster's.</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance and Housekeeping Supervisors, on 3/6/12 at 9:13 A.M., the area behind the dumpster, along a fence, had empty soda cans, clear plastic wrap, a small TV set and a wooden pallet.</p> <p>During an interview with the Maintenance Supervisor, on 3/6/12 at 9:15 A.M., he indicated he had not been out there to clean the area that morning and he had been having a problem with people driving in and dropping off their trash at the facility behind the dumpster.</p> <p>3.1-21(i)(5)</p>	F0372	<p>1. The refuse identified in the survey was removed upon discovery.2. All areas around the dumpster area were checked to determine if any additional cleaning is required.3. The Maintenance Director was re-educated on the facility policy and procedure for disposal of garbage and refuse. Rounds will be completed 5x weekly to monitor the cleanliness of the area around the dumpsters. The maintenance department has included a preventative maintenance schedule to provide ongoing monitoring and correction.4. The results of the aforementioned rounds will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>	03/22/2012	

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F0441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to initiate</p>	F0441	1. Illness incurred by Resident "H" has resolved and the resident no	03/22/2012	

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	<p>proper isolation procedures for a Resident who was positive for the Influenza A virus. This affected 1 of 1 supplemental residents reviewed for proper isolation procedures in a supplemental sample of 3. This deficient practice had the potential to effect 48 of 49 Residents residing in-house at the facility. (Resident #H &amp; I)</p> <p>Findings include:</p> <p>During observation upon entering the facility, on 3/4/12 at 4:00 P.M., the staff and visitors were wearing protective masks. The double doors leading into the A-B hallway were closed. During interview at that time, LPN #9 indicated there had been an outbreak of nausea, vomiting and diarrhea that day and precautions were being taken to prevent the spread of infection. The staff were not traveling between the hallways, were wearing masks and were giving visitors masks as well.</p> <p>A Flu Monitoring Log received from the Director of Nursing (DoN), on 3/5/12 at 10:00 A.M., indicated six Residents were on the active watch list. The DoN indicated the Flu Monitoring Log was used to track for possible facility infection outbreaks, not just flu.</p>		<p>longer requires isolation.</p> <p>Resident "I" no longer resides in the facility.2. As all residents could be affected, the following corrective action(s) has been taken:3. In an effort to ensure ongoing compliance with initiation of proper isolation procedures, licensed nursing staff has received inservice training in regard to types of isolation, use of the Infection Control Manual as a resource, as well as available resources (i.e., local health department) in an effort to ensure appropriate isolation procedures are initiated. The licensed nurse on duty shall be responsible to contact the Director of Nursing upon receipt of an order for isolation or notification of a communicable disease process, in an effort the DON can then confirm appropriate isolation procedures are in place and staff notified accordingly. The DON shall be responsible to monitor to ensure appropriate isolation procedures remain in place until the resident is deemed no longer contagious/asymptomatic and said procedures have been discontinued by the physician.4. As a means of quality assurance, the DON shall be responsible to report continued compliance with isolation procedures to the QAA committee on a quarterly basis.</p>				

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	<p>A Resident Influenza Surveillance Log received from the DoN, on 3/6/12 at 9:30 A.M., indicated all Residents on the watch list had received the Flu immunization.</p> <p>A Flu Monitoring Log received from the Director of Nursing (DoN), on 3/6/12 at 9:30 A.M., indicated Resident #H had tested positive for influenza A. The DoN also indicated this Resident had been moved to another room, was in isolation and Tamiflu (an antiviral) had been given to all the facility Residents.</p> <p>A Flu Monitoring Log received from the Director of Nursing (DoN), on 3/8/12 at 10:00 A.M., indicated Resident #I had been sent the hospital with an increased temperature and respiratory symptoms. Resident #I tested positive for influenza A and was still in the hospital.</p> <p>The clinical record of Resident #H was reviewed on 3/9/12 at 10:30 A.M.</p> <p>Diagnosis for Resident #H included, but were not limited to, Parkinson's disease, dementia, diabetes and high blood pressure.</p> <p>A Physician's order, dated 3/6/12 at 2:00 A.M., indicated "send to ER for evaluation due to [increased] temp</p>			

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	<p>(temperature) &amp; wheezes/Ronchi.</p> <p>A hospital patient discharge instruction sheet, dated 3/6/12 at 0500 (5:00 A.M.), indicated "Influenza A and pneumonia. Take Tamiflu for 5 days. Keep in isolation until treatment completed...."</p> <p>A Physicians' order, dated 3/6/12 at 7:00 A.M., indicated "1. Tamiflu 75 mg (milligrams) po (by mouth) BID (twice a day) x 5 days. 2. Keep Res in isolation until Tx (treatment) completed...."</p> <p>A Nursing note, dated 3/6/12 at 3:00 P.M., indicated "...Res (Resident) has nonproductive cough..."</p> <p>A Nursing note, dated 3/7/12 at 3:00 P.M., indicated "...Res has nonproductive cough...."</p> <p>A Nursing note, dated 3/8/12 at 3:00 P.M., indicated "...Res has nonproductive cough...."</p> <p>A Nursing note, dated 3/9/12 at 1:00 A.M., indicated "...loose intermittent non-productive cough...."</p> <p>During an interview with the DoN, on 3/9/12 at 11:00 A.M., she indicated the facility had put Resident #H in standard isolation, the hospital discharge</p>			

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	<p>instructions just said isolation and the facility doctor had just ordered isolation, we have masks if any of the staff want to use them.</p> <p>A Pandemic Influenza Plan, no date, received from the Facility Administrator, on 3/8/12 at 1:00 P.M., indicted the following:</p> <p>"...Protect persons caring for influenza residents in healthcare settings from contact with pandemic influenza virus. Persons who must be in contact should:</p> <p>Wear a surgical or procedure masks for close contact with infectious residents.</p> <p>Use contact and airborne precautions...."</p> <p>A Centers for Disease Control and Prevention "Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities", dated 12/19/11, indicated the following:</p> <p>"...Implement Standard and Droplet Precautions for all residents with suspected or confirmed influenza.... examples of standard precautions include:</p> <p>Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.</p>						

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	<p>Wear a gown if soiling of clothes with a resident's respiratory secretions is anticipated.</p> <p>Changing gloves and gowns after each resident encounter and performing hand hygiene.</p> <p>Perform hand hygiene before and after touching the resident, after touching the resident's environment, or after touching the resident's respiratory secretions, whether or not gloves are worn. Gloves do not replace the need for performing hand hygiene.</p> <p>Examples of Droplet Precautions include:</p> <p>Placing ill residents in a private room....</p> <p>Wear a facemask (e.g., surgical or procedure mask) upon entering the resident's room. Remove the facemask when leaving the resident's room and dispose of the facemask in a waste container...."</p> <p>A long Term Care Pocket Guide for Infection Control, published by the Healthcare Compliance Company, dated 1/2008, indicated the following:</p> <p>"...Standard precautions</p>			

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	<p>1. Wash hands</p> <p>2. Wear gloves</p> <p>3. Wear a gown, mask, and gloves. If you know you might get splashed with blood or body fluids...</p> <p>Airborne transmission</p> <p>The patient should have a private room, possibly with a special air filter.</p> <p>Keep the patient's room door closed.</p> <p>Wear a mask...</p> <p>...Droplet transmission:</p> <p>Some germs can only travel short distances through the air, usually not more than three feet. Sneezing, coughing, and talking can spread these germs. Examples of diseases caused by droplet germs: flu, pneumonia....</p> <p>Wear a mask when working close to the patient (within three feet)...."</p> <p>This federal tag relates to Complaint IN00103512.</p> <p>3.1-18(b)(2)</p>			

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F0463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to maintain four of the Resident room call lights in working order. This impacted 4 of 26 unoccupied bed call lights. (Unoccupied beds B-7 door, C-2 window, C-9 window and B-3 window)</p> <p>Findings include:</p> <p>During the environmental tour with Maintenance and Housekeeping Supervisors, on 3/6/12 at 9:30 A.M., the Resident call light for bed B-7 door, was tested. The call light did not light up or sound. At 10:30 A.M. the Resident call light for bed C-9 window was tested. The call light did not light up or sound. All rooms in the facility, that functioned as Resident rooms, were tested. Two other call lights were found to be nonfunctional, C-2 window and B-3 window. These beds were unoccupied at the time of the tour.</p> <p>During an interview with the Maintenance Supervisor, on 3/6/12 at 9:30 A.M., he indicated he randomly checks three call lights a week and all nonfunctional call</p>	F0463	<p>1. Unoccupied beds B-7 door, C-2 window, C-9 window and B-3 window call lights were repaired or replaced during the survey.2. All call lights were checked to determine if any additional repairs or replacements were needed with none noted.3. The Maintenance Director was re-educated on the facility policy regarding Preventative Maintenance schedules, including assessment of call light function. Rounds will be completed 5x weekly to monitor call lights and ensure they remain in working order. Should non-compliance be noted, immediate corrective action shall be taken.4. The results of the aforementioned monitoring and any corrective action taken will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>	03/22/2012			

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	lights should be reported to his office by the nursing staff.  3.1-19(u)(1)			

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to paint and patch a dining room wall and properly clean a shower room floor along the wall. This effected 1 of 2 dining rooms and 1 of 2 shower rooms with the potential to effect 50 of 50 Residents who resided in the facility and used the dining room and shower room.</p> <p>Findings include:</p> <p>1. During the environmental tour with Maintenance and Housekeeping Supervisors, on 3/6/12 at 10:15 A.M., the A-B hall dining room's outside wall had areas of missing plaster and marred paint.</p> <p>During an interview with the Maintenance Supervisor, on 3/6/12 at 10:20 A.M., he indicated the chairs and wheelchairs of the Residents hit the wall and cause damage and that it would be repaired.</p> <p>2. During the environmental tour with Maintenance and Housekeeping Supervisors, on 3/6/12 at 10:45 A.M., the C-D hall shower room had a dark brown and black substance along the base of the</p>	F0465	<p>1. The areas identified in the survey (i.e., dining room wall and shower room floor) were cleaned and/or repaired during the survey.2. Both dining rooms and both shower rooms were checked to determine if any additional cleaning or repairs were needed with no concerns noted.3. The housekeeping staff was re-inserviced on the facility policy and procedure for daily cleaning. Rounds will be completed 5x weekly at varied times to monitor the cleanliness of the shower rooms. Should concerns be noted, immediate corrective action shall be taken. The Maintenance Director was re-educated to the facility Preventative Maintenance schedules. Rounds will be completed 5x weekly to monitor and ensure walls remain in good repair. Should concerns be noted, immediate corrective action shall be taken.4. The results of the aforementioned rounds and any corrective aciton taken will be brought to QAA and reviewed monthly for 3 months and then quarterly thereafter.</p>	03/22/2012			

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	wall behind the sink and toilet.  During an interview with the Housekeeping Supervisor, on 3/6/12 at 10:45 /A.M., she indicated the floor along the wall would be cleaned.  3.1-19(f)			