

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155073		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2012	
NAME OF PROVIDER OR SUPPLIER  PILGRIM MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PLYMOUTH, IN 46563			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 1, 2, 3, 4, 5, 2012</p> <p>Facility number: 000030 Provider number: 155073 AIM number: 100288820</p> <p>Survey Team: Shauna Carlson, RN TC Brenda Meredith, RN Lora Swanson, RN Amber Bloss, Medical Surveyor</p> <p>Census bed type: SNF: 6 SNF/NF: 48 Total: 54</p> <p>Census payor type: 7 Medicare 31 Medicaid 16 Other 54 Total</p> <p>Sample: 40</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p><b>PLEASE ACCEPT THIS PLAN OF CORRECTION AS OUR ALLEGATION OF COMPLIANCE</b></p> <p><u>Disclaimer:</u></p> <p>Pilgrim Manor does not believe and does not admit that any deficiency existed, either before, during or after the survey. Pilgrim Manor reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Pilgrim Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Pilgrim manor does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Pilgrim Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>Pilgrim Manor reserves the right to modify policies/procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.</p> <p>The systemic changes will be in effect as of November 5, 2012</p> <p>Pilgrim Manor does not agree with tag F329; however, it will not be sent IDR. It goes against all research and education</p>				

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.

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

PRINTED: 11/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

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	Quality review completed 10/14/12 Cathy Emswiller RN		that the elderly in nursing homes are under diagnosed and treated for depression. The Social Services Director, BSW, had documented signs of depression on more than one occasion and an anti-depressant was ordered. Lori A. Smith Administrator	

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview, the facility failed to prominently display in the facility written information posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups in a clear and understandable manner to the extent possible considering impediments which may be created by the resident's health and mental status, this affected 1 of 1 resident reviewed (Resident #51) and had the potential to affect 54 of 54 current residents.</p> <p>Findings include:</p> <p>On 10/1/12 at 2:10 pm, the form including names, addresses, and phone numbers of pertinent state and advocacy agencies was observed in the front hall in a frame with an</p>	F0156	<p>F156</p> <p>1.No residents were affected by this alleged deficient practice. 2.No residents have been affected by this deficient practice. 3.The sign posted with names, addresses, and telephone numbers of all pertinent State client advocacy groups has been posted in a 14 point font and lowered for more accessibility for the residents that are wheelchairs. 4.Social Service Director will visually monitor the signs to ensure they are in place with the larger font and accessible to residents in wheelchairs. Any concerns with the posting and reading of signs will be reviewed by the Social Services Director at the Monthly QA meeting . The Monthly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator,</p>	10/08/2012

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	<p>estimated 10 point font. The center of the framed information was above 4' from the ground.</p> <p>During interview on 10/3/12 at 3:00 pm Resident #51 who required a wheelchair to ambulate, indicated she was unable to read the top information including the contact information for the Ombudsman.</p> <p>On 10/5/12 at 1:15 pm, interview with Employee #17 indicated she "could see how it could be too small" for residents with aging eyesight.</p> <p>3.1-4(j)</p>		<p>Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of each monthly QA report.</p>		

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 develop a comprehensive care plan addressing assessed signs and symptoms of depression for 1 of 10 residents reviewed for unnecessary meds. (Resident #70)</p> <p>Findings include:</p> <p>On 10/5/2012 at 11:00 AM Social Service notes were reviewed for Resident #70. On 8/15/2012, Resident #70 received an assessment which indicated signs</p>	F0279	<p>F279</p> <p>1. Resident #70 experienced no negative outcome. A care plan was developed on 10-3-12 and monitoring of behaviors and interventions are in place.</p> <p>2. All residents have been reviewed for potential depression without care plans. Four residents were identified to have the potential to be affected by this alleged deficient practice. A care plan was developed for each of them with non-pharmacological interventions and behavior monitoring.</p> <p>3. Unit Managers, Social Service Director and DON have been in-serviced on writing care plans to address depression or the potential for depression when the mood assessment</p>	11/01/2012	

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	<p>and symptoms of depression. Resident #70 was assessed as 'feeling down, depressed, or hopeless' with a frequency of '12-14 days (nearly every day)'.</p> <p>On 10/5/2012 at 11:10 AM Care Plans were reviewed for Resident #70 which indicated a care plan for depression wasn't developed until 10/3/12.</p> <p>On 10/5/12 at 11:30 AM during an interview, Employee #14 indicated Resident #70's signs and symptoms of depression were primarily documented through their 1:1 conversations and no other non-pharmacological intervention was considered or care planned during such time.</p> <p>3.1-35(a)</p>		<p>scores a 3 on "feeling down, depressed or hopeless" or if the mood assessment scores 5 or above overall or if the resident is displaying signs or symptoms of depression. The care plan will include non-pharmacological interventions, per the new Depression (Potential) Care Plan and Monitoring Policy.</p> <p>4. Monitoring in the electronic chart system will be done on a weekly basis. Medical Records will generate a weekly report identifying if depression words have been used, if there is a score of 3 on the mood assessment question "feeling down, depressed or hopeless" or if the overall mood assessment scores a 5 or higher and there is not a care plan, with non-pharmacological interventions, for depression or potential for depression. The Unit Managers will review the weekly report and determine if a care plan needs to be put in place. The Unit Manager will document in ECS if a care plan with interventions and monitoring of signs and symptoms was generated or they will document that no care plan with monitoring has been put in place and the reason why a care plan was not generated. The findings will be reviewed at the weekly QA meeting. The QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.</p>		

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F0329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to consider non-pharmacological interventions when indicated, instead of or in addition to medication in order to ensure a resident's drug regimen was free from unnecessary drugs, for 1 of 10 residents reviewed for unnecessary medications. (Resident #70)</p> <p>Findings include:</p>	F0329	<p><b>(F329)</b></p> <p>1. Resident #70 experienced no negative outcome. A care plan was developed on 10-3-12 and monitoring of behaviors and interventions are in place.</p> <p>2. All residents have been reviewed for potential depression without care plans. After reviewing the documentation of the Mood Assessment and mood signs and symptoms, two residents were identified to have the potential to be affected by this alleged deficient practice. A care plan was developed for each of</p>	11/01/2012	

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	<p>The clinical record for Resident #70 was reviewed on 10/5/12 at 11:00 am. Social Service notes dated 10/2/12 indicated Resident #70 was prescribed Lexapro 150mg for depressive signs and symptoms. Social Service notes dated between 8/15/12 to 10/3/12 indicated no non-pharmacological interventions were suggested during this time.</p> <p>Review of "Mood - Nurse Charting" for Resident #70 dated between 8/1/12 to 10/5/12 indicated that tracking occurred for the behaviors such as repetitious statements and questions, negative statements, anger, facial expressions.... Only one incident was tracked during this duration, on 9/2/12 Resident #70 made the statement "I'm just tired of living this way."</p> <p>On 10/5/12 at 11:30 AM during an interview, Employee #14 indicated Resident #70's signs and symptoms of depression were primarily documented through their 1:1 conversations and no other non-pharmacological intervention was considered or care planned during such time.</p> <p>3.1-48(a)(4)</p>		<p>them with non-pharmacological interventions and behavior monitoring.</p> <p>3. Unit Managers, Social Service Director and DON have been in-serviced on writing care plans to address depression or the potential for depression when the mood assessment scores a 3 on "feeling down, depressed or hopeless" or if the mood assessment scores 5 or above overall or if the resident is displaying signs or symptoms of depression. The care plan will include non-pharmacological interventions, per the Depression (Potential) Care Plan and Monitoring Policy. Prior to any increase or starting on an antidepressant, the Acute Behavior Committee will meet and review behavior signs of depression documentation and the effectiveness of the non-pharmacological interventions before making recommendations to the physician for possible need for medication. If an anti-depressant is ordered from a Physician or Nurse Practitioner without being recommended or due to an emergency situation, the Acute Behavior Committee will meet and review information the next business day.</p> <p>4. The monthly Behavior Committee, consisting of: Pharmacist, Administrator, West Unit Manager and East Unit Manager, will meet monthly and</p>		

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			review any residents who have had increases or added anti-depressants in the past month. They will review non-pharmacological interventions and supporting documentation for the increase or adding the medication. Notes of the Monthly Behavior Meeting will be in ECS. The findings will be reviewed at the weekly QA meeting, following the monthly Behavior Meeting. The QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.		

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F0356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post the total hours of licensed and unlicensed nursing staff worked daily on 4 of 4 days the Daily Staff Posting was observed, this had the potential</p>	F0356	<p>F356</p> <p>1. There were no residents affected by this alleged deficient practice.</p> <p>2. This alleged deficient practice does not require all residents to be reviewed. It requires that Staff</p>	11/01/2012	

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	<p>to affect 54 of 54 residents. (10/1/12, 10/2/12, 10/3/12, 10/4/12)</p> <p>Findings include:</p> <p>The "DAILY STAFF POSTING" was reviewed and observed during 4 days of survey, 10/1/12, 10/2/12, 10/3/12 and 10/4/12 at 2:00 p.m. The posting indicated hours worked by each direct care staff category; however, the total hours worked were not listed.</p> <p>On 10/4/12 at 11:24 am interview with Employee #15 indicated she was unaware of the requirement to have the actual and total hours listed.</p> <p>3.1-13(a)</p>		<p>be educated on how to complete the Nurse Staffing Hours Form.</p> <p>3.The following steps have been taken to ensure that the deficient practice does not recur, Education: All nurses will review the new Posted Nurse Staffing Hours Policy and have an opportunity to ask questions at the In-Service on October 25 and 30.</p> <p>4.The In-Service Director will complete a weekly audit for completion and accuracy. This will be reviewed weekly at our Weekly QA meeting. The Weekly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report. All new Nurses will be in-serviced on the Nurse Staffing Hours Form and Policy during orientation.</p>		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing and handling of drinking glasses .This deficiency affected 36 of 54 residents who received meals in the dining room. (RN #1, Employee #2, Employee #3, Employee #5, Employee #4, RN #6, LPN #7, RN #8, CNA #9, CNA #10, Employee #11, CNA #12, DON, Employee #4)</p> <p>Findings include:</p> <p>1. (a) On 10/1/12 at 11:15 a.m., RN #1 was observed washing her hands. The paper towel was hanging out from the dispenser, and was touching her uniform.</p> <p>1. (b) On 10/1/12 at 11:45 a.m., Employee #2 was observed washing her hands .The employee then used the same paper towel used to dry hands to wipe and clean around the sink. After wiping around sink</p>	F0371	<p>F371 1.No resident was affected by this alleged deficient practice. 2.No residents were affected by this alleged deficient practice. The following have been put in place to correct this alleged deficient practice:</p> <p>1.Paper towel dispenser has been moved to prevent touching anything that would be a potential infection source. 2.Staff will be in-serviced on hand washing and infection control – October 25 &amp; 30, 2012. 3.Pre-Meal Dining Policy has been developed. The policy addresses that after touching soiled table linen, the hands are considered dirty and should follow the Hand Hygiene policy . Staff will be in-serviced on October 25 &amp; 30, 2012. The Hand Hygiene policy has been revised . Policy states hand washing is for 15 seconds for all departments. Staff will be in-serviced on October 25 &amp; 26, 2012.</p> <p>The Pre-Meal Policy addresses how glass wear should be handled to avoid contamination.</p>	11/01/2012			

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	<p>discarded the paper towel and returned to serve resident trays.</p> <p>1. (c) On 10/1/12 at 11:55 a.m., Employee #3 was observed setting up tables for the second dining service. Employee #3 picked up the drinking glass by the bottom of the glass and then turned the glass over and set it on the table touching the rim of the glass.</p> <p>2. (a) On 10/1/12 at 11:10 am during first seating for lunch, Employee #5 was observed to wash hands for 8 seconds. Employee #5 was then observed to remove dirty dishes and linens from table and replace with clean linens without re washing hands.</p> <p>On 10/1/12 at 11:15 am Employee #5 was observed to wash hands for 4 seconds.</p> <p>On 10/1/12 at 11:16 am Employee #4 was observed to wash hands for 6 seconds before helping replace linens on lunch tables. Employee #4 was then observed to wash hands for 6 seconds and then 8 seconds while serving resident food trays.</p> <p>On 10/1/12 11:35 am RN #6 was observed to wash hands for 15</p>		<p>Staff will be in-serviced on October 25 &amp; 26, 2012 on how to not touch the rim of cups or glasses.</p> <p>3.The Hand Hygiene Policy and Pre-Meal Dining Policy have been revised to reflect all the alleged deficient practice. Weekly the In-Service Director or Designee will conduct an infection control precautions and hand hygiene audit in the dining room and observe at least 5 employees on a weekly basis. The observation will include all three meal services each month. All new staff will receive this training during orientation.</p> <p>4.The In-Service Director or Designee will present the results of her audits to the Weekly QA Committee. The Weekly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.</p>		

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	<p>seconds.</p> <p>On 10/1/12 11:36 am LPN #7 was observed to wash hands for 10 seconds.</p> <p>On 10/1/12 at 11:45 a.m. Employee #2 was observed to wash hands for 3 seconds.</p> <p>2. (b) On 10/5/12 at 2:00 pm during interview of proper handwashing technique, RN #8 indicated appropriate length of time to wash hands was 30 seconds.</p> <p>On 10/5/12 at 2:01 pm during interview of proper handwashing technique, CNA #9 indicated appropriate length of time to wash hands was 50 seconds.</p> <p>On 10/5/12 at 2:03 pm during interview of proper handwashing technique, CNA #10 indicated appropriate length of time to wash hands was 2 minutes, or sing 'Happy Birthday' twice.</p> <p>On 10/5/12 at 2:07 pm interview of proper handwashing technique, Employee #11 indicated appropriate length of time to wash hands was 20 seconds inside the kitchen, and 15 seconds in all other areas. Employee</p>				

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	<p>#11 indicated this was how she trained her staff.</p> <p>On 10/5/12 at 2:10 pm during interview of proper handwashing technique, CNA #12 indicated appropriate length of time to wash hands was 2 minutes.</p> <p>On 10/5/12 at 2:12 pm during interview of proper handwashing technique, DON indicated appropriate length of time to wash hands was to sing 'Happy Birthday' once, she was unable to indicate second duration.</p> <p>3. On 10/1/12 at 12:08 P.M., during the second seating for the lunch meal in the dining room, Employee #2 was observed to wash her hands for 3 seconds before serving a meal tray.</p> <p>4. On 10/4 at 7:00 am Employee #4 was observed to wash her hands for 12 secs; between helping residents receive and consume their breakfast.</p> <p>On 10/3/12 at 1:38 pm the policy &amp; procedure for handwashing was reviewed for all departments. The Policy indicated to "wash hands thoroughly using friction for 15 seconds".</p> <p>3.1-21(i)(3)</p>				

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F0406 SS=D	<p><b>483.45(a)</b> PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on interview and record review, the facility failed to provide mental health rehabilitative services for mental illness as required by the resident's PASRR (Preadmission Screening and Resident Review) or obtain the required services from an outside resource from a provider of specialized rehabilitative services, for 1 of 1 residents (#14) reviewed for PASRR.</p> <p>Findings include:</p> <p>On 10/4/2012 at 8:15 AM, PASRR information for reviewed for Resident #14. On 6/07/2010 Level II care was indicated for mental illness (Anxiety disorder and Depressive disorder) stating she required a yearly resident review.</p>	F0406	<p><b>(F406)</b> 1. The annual PASAAR Level II was completed on #14 on 10-4-12. Resident #14 was not affected by this deficient practice. 2. All residents that require an annual PASAAR Level II have been reviewed and no other PASAAR Level II's were missed and no residents were affected by this deficient practice. 3. Social Service Director will chart all residents requiring a level II in ECS. A reminder will be set in ECS that will go to SS and Administrator 7-10 days from the next due date, for the annual review. Social Service Director will then notify the Bowen Center that the Level II evaluation is due and ensure that the PASAAR Level II is completed. 4. Each week a weekly report will be ran that will identify any Level II that is due and has not been completed. If this report is triggered, the Social Service Director will receive the report</p>	11/01/2012			

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	<p>On 10/4/2012 at 8:20 AM during record review for Resident #14, no yearly resident review was located.</p> <p>During interview on 10/4/2012 at 9:06 AM, Employee #14 indicated that she was unable to locate a yearly resident review for Resident #14. She indicated she had placed a call into their outside service provider to inquire whether they had completed the yearly review for Resident #14 and they had not.</p> <p>3.1-23(a)(1)</p>		<p>and will review any residents triggered, that have not had their Level II completed and will ensure that Bowen Center is aware and scheduled to do the evaluation. This will be reviewed in the monthly QA meeting. The Monthly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.</p>		

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F0441 SS=F	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F0441	F441 1. No residents were cited for this alleged deficient practice.	11/01/2012			

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	<p>ensure the infection control program contained the current procedures, was easily accessible, was maintained in a timely fashion, and the information utilized in a manner to assist the facility to investigate, control, and prevent the spread of infection. This deficient practice potentially affected 54 of 54 residents.</p> <p>Findings include:</p> <p>On 10/3/12 at 1:20 PM, the infection control records were reviewed. The last completed "Infection Control Report" was July 2012. The "Infection Control Report" dated June 2012 indicated an increase of 5 UTI's from the previous month for a total of 7 UTI's in July 2012. The "Infection Control Report" dated July 2012 indicated an increase of UTI's of 1 for a total of 8 in July 2012. The "Infection Control Report" for August 2012 was unavailable for review.</p> <p>On 10/3/12 at 1:25 PM, Employee #15 reported that July 2012 was the last month for which the "Infection Control Report" was completed. When asked when the reports are to be completed after each month, Employee #15 responded they should be complete by the 9th day following</p>		<p>2. There were no residents affected by this alleged deficient practice. 3. Systemic changes: Instituted a new Infection Control Report Policy Developed a new tracking log for infections, per the Infection Control Report Policy. Developed a new monthly summary report, which includes 4 months of trending Calculating the monthly infection rate Calculating the HAI infections The monthly summary report will be completed within 3 business days of the 1 st of the month. The Infection Control nurse will review the report at the Monthly QA Meeting with any identified trends or concerns. This will be reported on the 1 st Friday following the 1 st complete week of the month. Observations in the dining room: o Paper towel dispenser has been moved to prevent touching anything that would be a potential infection source. o The Hand Hygiene policy has been revised. Policy states hand washing is for 15 seconds for all departments. o Pre-Meal Dining Policy has been developed. The policy addresses that after touching soiled table linen, the hands are considered dirty and should follow the Hand Hygiene policy . It also addresses how glass wear should be handled to avoid contamination. o The Hand</p>				

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	<p>the end of each month.</p> <p>On 10/3/12 at 1:25 PM during an interview, Employee #15 indicated in response to a trend of infection, 1:1 inservices are done with staff and also on floor audits to monitor proper infection control techniques during care. Employee #15 indicated no document was kept regarding 1:1 inservice training or audits.</p> <p>On 10/1/12 at 11:15 a.m., RN #1 was observed washing her hands. The paper towel was hanging out from the dispenser, and was touching her uniform.</p> <p>On 10/1/12 at 11:45 a.m., Employee #2 was observed washing her hands .The employee then used the same paper towel used to dry hands to wipe and clean around the sink. After wiping around sink discarded the paper towel and returned to serve resident trays.</p> <p>On 10/1/12 at 11:55 a.m., Employee #3 was observed setting up tables for the second dining service. Employee #3 picked up the drinking glass by the bottom of the glass and then turned the glass over and set it on the table touching the rim of the glass.</p>		<p>Hygiene Policy and Pre-Meal Dining Policy have been revised to reflect all the alleged deficient practice.</p> <ul style="list-style-type: none"> <li>o Weekly the In-Service Director or Designee will conduct an infection control precautions and hand hygiene audit in the dining room and observe at least 5 employees on a weekly basis. The observation will include all three meal services each month. Any individual training in regards to the information gathered through the audits, will be documented in ECS.</li> <li>o Staff will be in-serviced on October 25 &amp; 26, 2012.</li> <li>o New staff will be in-serviced on Infection Control/Hand Hygiene during orientation.</li> </ul> <p>4. The In-Service Director or Designee will present the results of her audits to the Weekly QA Committee. The Infection Control Nurse will review the Monthly Infection Control Report once a month on the 1 st Friday after the 1 st full week at the Weekly QA Committee meeting. Weekly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.</p>				

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	<p>On 10/1/12 at 11:10 am during first seating for lunch, Employee #5 was observed to wash hands for 8 seconds. Employee #5 was then observed to remove dirty dishes and linens from table and replace with clean linens without re washing hands.</p> <p>On 10/1/12 at 11:15 am Employee #5 was observed to wash hands for 4 seconds.</p> <p>On 10/1/12 at 11:16 am Employee #4 was observed to wash hands for 6 seconds before helping replace linens on lunch tables. Employee #4 was then observed to wash hands for 6 seconds and then 8 seconds while serving resident food trays.</p> <p>On 10/1/12 11:35 am RN #6 was observed to wash hands for 15 seconds.</p> <p>On 10/1/12 11:36 am LPN #7 was observed to wash hands for 10 seconds.</p> <p>On 10/1/12 at 11:45 Employee #2 was observed to wash hands for 3 seconds.</p> <p>On 10/5/12 at 2:00 pm during interview of proper handwashing</p>						

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	<p>technique, RN #8 indicated appropriate length of time to wash hands was 30 seconds.</p> <p>On 10/5/12 at 2:01 pm during interview of proper handwashing technique, CNA #9 indicated appropriate length of time to wash hands was 50 seconds.</p> <p>On 10/5/12 at 2:03 pm during interview of proper handwashing technique, CNA #10 indicated appropriate length of time to wash hands was 2 minutes, or sing 'Happy Birthday' twice.</p> <p>On 10/5/12 at 2:07 pm interview of proper handwashing technique, Employee #11 indicated appropriate length of time to wash hands was 20 seconds inside the kitchen, and 15 seconds in all other areas. Employee #11 indicated this was how she trained her staff.</p> <p>On 10/5/12 at 2:10 pm during interview of proper handwashing technique, CNA #12 indicated appropriate length of time to wash hands was 2 minutes.</p> <p>On 10/5/12 at 2:12 pm during interview of proper handwashing technique, DON indicated appropriate</p>			

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	<p>length of time to wash hands was to sing 'Happy Birthday' once, she was unable to indicate second duration.</p> <p>On 10/1/12 at 12:08 P.M., during the second seating for the lunch meal in the dining room, Employee #2 was observed to wash her hands for 3 seconds before serving a meal tray.</p> <p>On 10/4 at 7:00 am Employee #4 washed her hands insufficiently: 12 secs. between helping residents receive and consume their breakfast.</p> <p>On 10/3/12 at 1:38 pm reviewed policy &amp; procedure for handwashing for all departments. Policy indicated to "wash hands thoroughly using friction for 15 seconds".</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(1)(C) 3.1-18(b)(4) 3.1-18(b)(3)</p>				

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F0465 SS=C	<p>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 environment related to resident rooms, common areas, and medication storage room, this has the potential to affect 54 of 54 residents.</p> <p>Findings include:</p> <p>On 10/4/12 at 9:15 AM during the environmental tour with Employee #16 and Employee #17, the following were observed:</p> <p>A. Cobwebs in the corner of the west exit. B. A 6 inch area where the base board is caved in near the west exit. C. The clean lined cover looked soiled. D. An employee drink was found in the closet housing depends. E. Showerhead in west wing spurting and in disrepair when water is turned on. F. Ceiling vent near entry of east wing appears dirty. G. East wing ceiling tiles look old and bowing. H. Beauty shop has two large</p>	F0465	<p><b>(F465)</b></p> <p>1.No residents were affected by this alleged deficient practice. 2.No residents were affected by this alleged deficient practice. 3.The following measures have been taken:</p> <p>1.Cobwebs have been removed from the West door vestibule. 2.Baseboard has been repaired. 3.Linen cover was washed and stains removed. 4.A policy has been developed, Employee Personal Belongings. This policy addresses employee drinks in the facility and where employees will store their personal items, such as bags, coats, sweaters and purses. They will not be kept where any resident or resident care supplies are located. 5.All shower heads were inspected and replaced or repaired. 6.New vents in the hall ways, are being installed. 7.Ceiling tiles will be replaced, a new ceiling will be installed in the hallways and the medication room in the near future. 8.Beauty shop and</p>	11/05/2012			

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	<p>overhead florescent lights without covers.</p> <p>I. Two ceiling tiles were split in half, one in the activity hall and the other in the west hall.</p> <p>During room observations on 10/1/2012 and 10/2/2012, the following was observed:</p> <p>A. Room #31-1 had a bathroom light bulb out.</p> <p>B. Room #29-1 had a bathroom light without a cover.</p> <p>C. Room #29-1 had a loose safety rail.</p>		<p>medication room lights have plastic tubes over the fluorescent lights and all fluorescent lights that were burned out, have been replaced and are in good working order.</p> <p>9. See "Letter G above".</p> <p>10. Room Observations:</p> <p>i. All bathrooms have been inspected for light bulbs burned out and light covers in place. All bathrooms have working bulbs and light covers are in place. ii. All safety rails have been inspected and repaired.</p> <p>1. Medication Room:</p> <p>i. Fluorescent lights have been replaced. ii. Fluorescent lights have safety tubes over the bulbs. iii. Air duct now has a vent cover in place. iv. Ceiling tiles will be replaced, a new ceiling will be installed in the near future. v. Area above the sink will have a fiberglass board in place to protect wall from water splash damage. vi. Refrigerator temperatures have been monitored daily and have remained between 41 – 36 degrees F. vii. Personal items will not be kept in the medication storage room. An Employee personal items storage policy has been developed. 4. An in-service will be held on October 25 and October 26, 2012. The in-service will address monitoring the temperature of the refrigerator</p>		

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	<p>During observation of medication storage room on 10/4/12 at 2:30 pm the following items were identified to be in disrepair: No plastic covers on 4 of 8 florescent lights, 2 of 8 lights burned out, air duct over cabinets storing medicines open with no cover on it, ceiling tiles observed with 2 tiles bowing, 2 tiles cracked with missing corners, wallpaper over sink peeling, heater in corner of room with cover bent and misshaped.</p> <p>During observation of the medication storage room on 10/4/12 at 2:30 pm the refrigerator temperature was read by Employee #4 to be 46 degrees F.</p>		<p>in the Medication Storage Room, storage of personal items (including drinks). An Environmental Rounds Form has been developed. Weekly Environmental Services will conduct the rounds and report their findings at the Monthly QA meeting. The Monthly QA committee consists of 13 Department Heads: Administrator, DON, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office Manager, Social Service Director, Medical Records, Activity Director, Dietary Director, Maintenance Director and Environmental Director. The Medical Director will receive a copy of the weekly QA report.</p>		

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	<p>During follow up observation on 10/5/12 at 9:13 am refrigerator temperature was read by Employee #1 to be 38 degrees F.</p> <p>During observation of the medication storage room on 10/4/12 at 2:30 pm, personal items consisting of 4 bags, 1 white shirt and 1 green sweater were observed on hooks in corner of room. Interview with Employee #4 indicated that there was a separate place to keep personal belongings and room was cleaned every day by housekeeper</p> <p>Interview on 10/4/12 at 2:45 with Employee #5 (Environmental Supervisor) indicated she did not have a key to the medication room and neither does any of the housekeepers. Housekeepers were not allowed to be in med room with nurse accompaniment.</p> <p>3.1-19(f)</p>				