

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2012
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NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00115120.</p> <p>Survey dates: August 27, 28, 29, 30, 31, 2012</p> <p>Facility number: 000517 Provider number: 155714 AIM number: 100266770</p> <p>Survey team: Carole McDaniel RN TC Terri Walters RN August 27, 28, 29, 30, 2012 Martha Saull RN Dorothy Watts RN August 27, 28, 29, 30, 2012</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 8 Medicaid: 18 Other: 9 Total: 35</p> <p>These deficiencies also reflect state</p>	F0000	F0000 By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective September 28th, 2012 to the state findings of the annual survey conducted on August 27th thru 31st, 2012.	

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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	findings cited in accordance with 410 IAC 16.2.  Quality review 9/07/12 by Suzanne Williams, RN				

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F0156 SS=B	<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 record review and interview, the facility failed to provide proper liability notice and beneficiary appeal rights on approved forms with acknowledgment of receipt to 3 of 3 residents who met the criteria for whom Medicare services had been terminated. Resident #13, Resident #1, Resident #3.</p> <p>Findings included:</p> <p>On 8/30/2012 at 3:02 P.M., the Business Manager provided copies of forms the facility provided to residents or their representatives informing them of denial of payment by Medicare for therapy services and their appeal rights.</p> <p>The forms provided were for: Resident #13 with therapy services</p>	F0156	F156  The corrective action taken for those residents found to have been affected by the deficient practice is that Residents # 1, 3, and 13 representatives have been informed by telephone and in writing of the end date of their Medicare services and that there were no skilled services incurred after the end of their Medicare benefits that they were liable for. They were also informed that whenever their family member is receiving Medicare benefits they will receive a form seventy-two hours prior	09/25/2012			

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	<p>being terminated on 3/24/12 Resident #1 with therapy services being terminated on 8/3/12 Resident #3 with therapy services being terminated on 8/4/12</p> <p>Review of the forms on 8/30/12 at 3:16 P.M., indicated the forms were not approved in content or format by CMS (Centers for Medicare and Medicaid Services) for notification use by facilities. Each form had a check box and a signature line acknowledging the Beneficiary or person acting on Beneficiary's behalf had received the information by telephone. However, there was no documentation of written or telephone follow-up to confirm that each recipient had received the information.</p> <p>On 8/30/2012 at 3:40 P.M., during an interview, the Business Manager indicated the forms she used to notify residents when Medicare would no longer pay for service were the same forms in use when she started working here 4 years ago. She did not know there were other forms available. The Business Manager indicated she was not aware the residents needed to be notified of their right to appeal or be informed of the estimated cost of the services that</p>		<p>to the end of those benefits. This form includes their right to appeal, the approximate cost of services the resident may expect to pay per self and the option of receiving or declining the items or services that Medicare will no longer pay for.</p> <p>The corrective action taken to identify other residents having the potential to be affected is that all residents with Medicare pay source have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that a new policy has been created informing residents or representatives of the end of Medicare coverage. This form includes date coverage will end, right to appeal and an approximation of costs the resident may incur from continued services. The resident then has an option of continuing to receive these services or declining.</p> <p>The measures or systemic</p>		

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	<p>were being terminated.</p> <p>The Business Manager indicated she called Resident #13's representative and left a cell phone message informing them the services Resident #13 had been receiving would no longer qualify for payment by Medicare. The documentation was lacking to establish the representative had received the message on the cell phone, was informed in writing or understood their appeal rights.</p> <p>3.1-4(a)</p>		<p>changes that will be made to ensure that the deficient practice does not recur is that the old deficient forms have been discarded. The only form in use for informing residents or their representative that Medicare benefits will be ending is the new attached form. The resident or representative will be spoken to in person or attempts made to call by phone (for a period of 72 hrs prior) to inform them of the pending end of benefits so that any questions they may have are explained. Also, each resident or representative will be mailed this form by certified mail with instructions to sign and return in an enclosed, stamped, self- addressed envelope 72 hours before the end of benefits.</p> <p>The corrective action taken to ensure performance is that a Quality Improvement Tool has been implemented to monitor the notification to residents or their legal representative of</p>	

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			<p>Medicare Benefits ending. This tool will be completed by the Business Office Manager each time the end of Medicare benefits is pending. The QI tool will be reviewed by Administrator once monthly for three months and then quarterly times three quarters. The information will be reviewed quarterly in QA meeting to see if further action is warranted.</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>A. Based on interview and record review, the facility failed to ensure a resident with a leg immobilizer who developed a stage 3 pressure area underneath the immobilizer had a care plan to address management of the immobilizer and/or skin underneath the immobilizer for 1 of 1 resident reviewed with immobilizers. Resident #3</p> <p>B. Based on observation, interview and record review, the facility failed to ensure a resident had specific interventions and/or specific goals to</p>	F0279	<p>F - 279</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as #3 has been reviewed and up-dated accordingly.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents with immobilizers and/or a urinary tract infection have the potential to be affected. A house wide review of all care plans has been</i></p>	09/28/2012	

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	<p>prevent urinary tract infections for 1 of 2 residents reviewed with urinary tract infections. Resident #3</p> <p>Findings include:</p> <p>A. The clinical record of Resident #3 was reviewed on 8/28/12 at 10 A.M. Diagnoses included, but were not limited to, the following: hypokalemia, hypertension, edema, anemia, history fractured left femur.</p> <p>On 8/29/12 at 2 P.M., nurses notes were reviewed. On 5/11/12 at 9 A.M., nurses' notes indicated the following: "Dr. (physician name) notified of area (sic) having an area on left lower leg which brace has rubbed skin off 2 cm x 2 cm area...intervention put fleece to keep leg from rubbing on brace..." Nurses' notes dated 5/14/12 at 10 P.M. indicated the following: "CNAs (certified nursing assistants) reported seeping from L (left) leg on change of shift..." On 5/15/12 at 8 P.M. nurses notes indicated the following: "CNA alerted this nurse to area on resident's L lower leg. Res (resident) has had immobilizer to LLL (left lower leg) for fx (fracture). Area was a 3 cm (centimeters) x 2 cm pressure are with serous draining noted and red in color with no drainage noted..."</p>		<p>completed and the care plans up-dated accordingly.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that care plans will be up-dated daily according to the current level of care each resident requires. The charge nurse receiving a physician's order or identifying a problem will address management and prevention of such concerns on the individuals specific care plan at the time of the identifying problem. The MDS Nurse/designee will double check all physicians' orders to ensure the issue has been addressed on the care plan daily (Monday-Friday). Nurses will be in-serviced on September 20 th and 21 st , 2012 concerning the management of an immobilizer and skin underneath the immobilizer as well as specific interventions and/or goals to prevent the development of skin breakdown. The instruction will also include specific interventions and /or goals on the prevention of urinary tract infections as it relates to up-dating the care plans. The nurses will also be instructed on adding any specific instructions to the CNA assignment sheet when warranted.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is the MDS Nurse/designee will double check all physicians's orders to ensure the issues have been addressed on the plan of care daily (Monday- Friday.) The DON/designee will monitor compliance with the use of a quality assurance tool to ensure management of skin</i></p>				

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	<p>Nurses' notes dated 5/19/12 at 12 P.M. indicated the following: "Res has O/A (open area) on LLE (left lower extremity) area yellow/red with scant amt (amount) serous drainage noted measures 6 (cm) x 1 (cm) x 0.1 (cm)...."</p> <p>On 8/29/12 at 2:20 P.M., the MDS (minimum data set assessment) nurse was interviewed. She indicated the resident went to the hospital with the diagnosis of a fractured left femur and returned to the facility on 4/30/12 after an ORIF (open reduction internal fixation) surgery. She indicated upon return to the facility, the resident did not have any pressure areas to her left leg. She indicated when the resident returned to the facility, she had an immobilizer on her left leg. She stated the lower end of the immobilizer "ended about where she has the open area."</p> <p>A physician order, dated 4/30/12 indicated the following: "Immobilizer to lt (left) leg when moving res (resident)..." At this time, the MDS nurse indicated she was unsure if the facility left the immobilizer on all the time or not.</p> <p>At this time, a copy of the care plan</p>		<p>conditions and prevention of urinary tract are care planned. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</p>		

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	<p>which addressed the following was reviewed: "At risk for skin breakdown due to skin very fragile, bruises et (and) tears easily NWB (non weight bearing) status Fx (fracture) Lt (left) femur." This care plan was updated 6/12/12 and 7/12/12. Approaches included, but were not limited to, the following: "weekly skin assessment, preventative treatment as ordered..." Documentation was lacking of assessment of the area underneath the immobilizer and/or management of the immobilizer.</p> <p>A progress note from the wound care specialist, dated 5/31/12, indicated the area to the left lower leg was a stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling).</p> <p>On 8/29/12 at 2:55 P.M., CNA #10 was interviewed. She indicated she was familiar with Resident #3 and had cared for her upon the resident's return from the hospital after her femur fracture. CNA #10 indicated "at first she (Resident #3) did have the immobilizer on at all times because she was afraid for us to take</p>						

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	<p>it off." CNA #10 then indicated the resident even had it on when she was in bed, and they had it propped up. CNA #10 then indicated she doesn't remember when they started removing the immobilizer at times.</p> <p>On 8/29/12 at 3 P.M. a copy of the current policy and procedure for "Skin Management Program" was received from the MDS nurse. This policy was undated but was indicated by the MDS nurse to be current. The policy included, but was not limited to, the following: "If a new skin condition is identified, the Charge nurse is responsible for assessing the area, obtaining measurements and documenting in the nurses notes concerning the skin condition....The charge nurse will also develop a care plan for the treatment of the skin condition...charge nurse will transfer the information concerning the new skin condition on the appropriate tracking form..."</p> <p>The medication/treatment records for April 30th and May 2012 were reviewed at 3 P.M. on 8/29/12. These both indicated the following: "Immobilizer to lt (left) leg when moving pt (patient)." This was initialed on the form for the one day in April and all days of May 2012.</p>						

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	<p>On 8/30/12 9:33 A.M., the DON (director of nursing) was interviewed. She indicated the staff should have been monitoring this area closer and found it before it was a stage 2. The DON stated this immobilizer should have been removed and assessed at least once a shift. She indicated documentation was lacking of this having been done and/or a plan of care to address monitoring of this area.</p> <p>B. An MDS (minimum data set assessment) dated 4/25/12 indicated the following for the resident: total cognitive score was 15, which indicated the resident was of independent cognition; required supervision and oversight for eating and was totally dependent for incontinence and personal hygiene.</p> <p>A plan of care, dated 5/1/12 addressed the following problem: "Potential for infections due to indwelling f/c (foley catheter) due to Fx (fractured) lt (left) femur..." Approaches included: "encourage fluids, I &amp; O (intake and output) q (every) shift, f/c changed monthly and prn (as needed), fc c (care) q shift, position tubing for proper urine flow." This care plan was discontinued on</p>			

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	<p>6/20/12.</p> <p>In the clinical record the Nutritional Evaluation was dated 5/9/12. This form indicated for the resident's weight of 189 lbs, the estimated fluid needs per a 24 hour period would be 2580 ccs.</p> <p>A Hospital discharge note was dated 6/20/12 and indicated the following: "...discharge diagnosis:...urinary tract infection...chronic kidney disease, stage III..."</p> <p>A Hospital discharge note was dated 7/15/12 and indicated the following: "...Final diagnosis: urinary tract infection with sepsis due to indwelling Foley catheter present on admission..."</p> <p>On 8/29/12 at 2:45 P.M., the MDS (minimum data set assessment) nurse was interviewed. She indicated the resident had a foley catheter (tube placed in the bladder to continuously drain urine) on her return to the facility after hospitalization on 4/30/12. She indicated the catheter was discontinued on June 20, 2012.</p> <p>On 8/30/12 at 9:40 A.M., the DON (director of nursing) was interviewed.</p>				

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	<p>She indicated this resident had UTIs (urinary tract infections) on the following dates: 4/25/12, 7/12/12 and also currently is being treated with IV (intravenous) antibiotics for a UTI. At this time, the DON reviewed the clinical record for a care plan to address UTIs. The DON indicated at this time, that the resident had a foley catheter (device placed through the urethra to continuously drain urine from the bladder) in place from her hospitalization with a fractured femur and returned to the facility on 4/30/12 with the foley catheter in place. The DON stated there was no care plan initiated after the foley catheter was discontinued in June 2012 to address urinary tract infections. The DON stated the resident should have a care plan in place to address prevention of urinary tract infections and/or the resident's hydration status.</p> <p>3.1-35(b)(1)</p>			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure resident's families and/or power of attorneys and/or guardians and/or health care representatives were notified of a care plan meeting for 1 of 1 resident reviewed for care plan meetings. Resident #32</p> <p>Findings include:</p> <p>The clinical record of Resident #32 was reviewed on 8/28/12 at 10 A.M. The resident was admitted to the facility on 4/12/12.</p>	F0280	F280 F280 The corrective action taken for the identified resident #32 is that the family received a care-plan invitation, followed up by a phone conversation with resident's daughter. A care-plan conference has been set for October 2, 2012 for family convenience. Family will attend. The corrective action taken to identify other residents having the potential to be affected is that all residents have the potential to be affected. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that the Policy & Procedure for care-plan invitations has been revised to	09/28/2012	

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	<p>On 8/29/12 at 10 A.M., the SSD (social service director) was interviewed. She indicated this resident is a private payor source so would have just had an admission care plan meeting and would then have care plan meetings quarterly. The SSD indicated she remembered talking to the family on the phone but didn't document this conversation and doesn't remember for sure when this was.</p> <p>The SSD indicated she thinks she sent the resident's POA (power of attorney) a letter inviting her to a care plan meeting but she isn't sure. The SSD indicated she doesn't have documentation that she sent a letter to the resident's POA for a care plan meeting which was to have happened in July 2012. The SSD indicated the resident's POA was in the building for a care plan meeting at some point but this isn't documented. The SSD indicated when a care plan meeting occurs, it should be documented in the clinical record. At this time, the clinical record was reviewed with the SSD. She indicated the only documented note of a care plan meeting being held was on 5/1/12 which indicated the following: "CP (care plan) meeting held. Res (resident) did not attend. Res refused to have meeting in her room. Res</p>		<p>include that care plan invitations are sent to the resident's family, legal representative, by certified mail three weeks before the conference date. A follow-up call will also be made within seven to fifteen (7-15) days before the date of the scheduled conference if there is no response to the certified invitation. The outcome of this call will be documented in the Social Service Notes. A note will also be written as to who did or did not attend the conference. The measures or systemic changes that will be made to ensure that the deficient practice does not recur is that the Interdisciplinary team has been in-serviced as to the requirement of notifying and extending an invitation to the resident and/or family/ legal representative to attend care-plan conference designed to meet the resident's individual needs. Included in the in-service was the requirement of proper documentation that an invitation was extended and the result of that invitation and follow-up phone call if no response. Further documentation as to who did or did not attend the conference in regards to the invitation is to be written in the Social Service notes. _ The corrective action to ensure the deficient practice will not recur is that a Performance Improvement Tool has been implemented to ensure that care-plan invitations are sent by certified mail to the</p>				

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	<p>POA did not attend. CP reviewed and no changes made at this time."</p> <p>On 8/30/12 at 8:25 A.M., the DON (Director of Nursing) was interviewed. She reviewed the clinical record. A "Resident Care Conference Signature" form was dated 5/1/12. This form indicated the following: was signed by SSD, activity director and the MDS (minimum data set assessment) coordinator. This form indicated the resident and family were notified but did not attend. Documentation was lacking of any additional care plan meetings and/or notification to POA of such.</p> <p>On 8/29/12 at 4:10 P.M., the SSD provided a copy of the policy and procedure for care plan invitations. This policy was dated 7/21/09 and included but was not limited to, the following: "It is the policy of (facility name) to provide family member/POA/...a written invitation to the Care Plan Conference...at least quarterly...Care plan conferences are held in the Social Service office. Written invitations to each resident's family member, POA...are mailed 3 weeks prior to the care conference for that individual...An RSVP is requested...They are also given an opportunity to call the facility to speak</p>		<p>family/ legal representative and followed up with a phone call seven to fifteen days after. This tool will be completed by the Social Service Department weekly Monday through Friday for three weeks and then monthly times six months. This tool will be reviewed weekly by the Administrator for three weeks and then monthly for six months. This information will be reviewed each quarter in QA meeting to see if further action is warranted.</p> <p>-</p>		

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	with the Social Service Designee with any concerns should they be unable to attend."  3.1-35(d)(2)(B)			

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F0314 SS=G	<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 interview and record review, the facility failed to ensure a resident with a leg immobilizer did not develop a stage 3 pressure sore underneath the immobilizer for 1 of 1 resident reviewed with an immobilizer who developed a pressure sore. Resident #3</p> <p>Findings include:</p> <p>The clinical record of Resident #3 was reviewed on 8/28/12 at 10 A.M. Diagnoses included, but were not limited to, the following: hypokalemia, hypertension, edema, anemia, history fractured left femur.</p> <p>On 8/29/12 at 2 P.M., nurses' notes were reviewed. On 5/8/12 at 0200 (2 A.M.) nurses' notes indicated the following: "...knee immobilizer cont (continues)..." On 5/10/12 at 1300 (1</p>	F0314	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #3 received an order to discontinue the immobilizer on August 1, 2012. The pressure wound was resolved on 09-04-12.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that any resident that has an immobilizer has the potential to be affected by the same deficient practice. The facility currently does not have any other residents with an immobilizer. A house wide head to toe body assessment will be completed by licensed nurses to ensure that all skin alterations are accounted for and proper plans of care implemented. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that weekly body assessments will be conducted</i></p>	09/28/2012

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	<p>P.M.) "...immobilizer intact..." At 3:30 P.M. on 5/10/12, nurses notes indicated "increased edema to bil (bilateral) lower extremities +2..." Nurses' notes on 5/11/12 at 9 A.M. indicated the following: "Dr. (physician name) notified of area (sic) having an area on left lower leg which brace has rubbed skin off 2 cm x 2 cm area...intervention put fleece to keep leg from rubbing on brace..." Nurses' notes dated 5/14/12 at 10 P.M. indicated the following: "CNAs (certified nursing assistants) reported seeping from L (left) leg on change of shift..." On 5/15/12 at 8 P.M. nurses notes indicated the following: "CNA alerted this nurse to area on resident's L lower leg. Res (resident) has had immobilizer to LLL (left lower leg) for fx (fracture). Area was a 3 cm (centimeters) x 2 cm pressure are with serous draining noted and red in color with no drainage noted..." Nurses' notes dated 5/19/12 at 12 P.M. indicated the following: Res has O/A (open area) on LLE (left lower extremity) area yellow/red with scant amt (amount) serous drainage noted measures 6 (cm) x 1 (cm) x 0.1 (cm)..."</p> <p>On 8/29/12 at 2:20 P.M., the MDS (minimum data set assessment) nurse was interviewed. She</p>		<p>by the MDS Nurse/designee and the outcome of these assessments reviewed at the weekly Interdisciplinary meeting. An in-service was conducted on September 20 and 21, 2012 for all nursing staff on addressing proper care of the resident with an immobilizer and residents with skin alteration as well as how to develop a plan of care for skin alterations. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the care of the resident with an immobilizer and the care of residents with skin alterations. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</i></p>				

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	<p>indicated the resident went to the hospital with the diagnosis of a fractured left femur and returned to the facility on 4/30/12 after an ORIF (open reduction internal fixation) surgery. She indicated upon return to the facility, the resident did not have any pressure areas to her left leg. She indicated when the resident returned to the facility, she had an immobilizer on her left leg. She indicated the immobilizer extended from the left mid thigh to just above the resident's left ankle area. She stated the lower end of the immobilizer "ended about where she has the open area."</p> <p>A physician order, dated 4/30/12 indicated the following: "Immobilizer to lt (left) leg when moving res (resident)..." At this time, the MDS nurse indicated she was unsure if the facility left the immobilizer on all the time or not. The MDS nurse indicated she was unable to find a documented pressure sore assessment for the pressure sore identified in the nurses notes on 5/11/12. She indicated there should have been a pressure assessment sheet started for this area to start monitoring it. She indicated if the floor staff nurses find a skin area, they are to put the assessment on the skin sheet and</p>				

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	<p>give it to her. The MDS nurse indicated she does the wound measurements and skin assessments on a weekly basis.</p> <p>At this time, the MDS nurse provided current copies of the resident's "weekly pressure ulcer progress reports." The first documented entry on this form was dated 5/19/12 with the following information: stage 3 (a full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissues." The size was documented as "6 cm x 1.8 cm, depth 0.1 cm, new area..." The MDS indicated at this time, on 6/8/12, the area had "healed in the middle and split into 2 open areas." She indicated one of these open areas healed on 7/20/12. The most recent measurements of the remaining are were 1 cm x 0.7 cm with a "zero" depth. The MDS nurse indicated when the resident was not admitted with this area and it was initially found at a stage 2 (partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater)." She indicated this pressure sore was from the immobilizer. The MDS nurse indicated as far as she knew, the resident didn't have her immobilizer on when she was in bed.</p>			

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	<p>The MDS nurse indicated when staff removed the immobilizer, they should have been checking the status of the skin. She indicated this should have been documented on the Treatment sheet/medication administration record. At this time, the MDS nurse reviewed the current clinical record and indicated documentation was lacking for a care plan that addressed staff assessing the skin area under the immobilizer.</p> <p>At this time, a copy of the care plan which addressed the following was reviewed: "At risk for skin breakdown due to skin very fragile, bruises et (and) tears easily NWB (non weight bearing) status Fx (fracture) Lt (left) femur." This care plan was updated 6/12/12 and 7/12/12. Approaches included, but were not limited to, the following: "weekly skin assessment, preventative treatment as ordered..." Documentation was lacking of assessment of the area underneath the immobilizer and/or management of the immobilizer.</p> <p>A progress note from the wound care specialist, dated 5/31/12, indicated the area to the left lower leg was a stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not</p>			

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	<p>exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling).</p> <p>A physician order dated 8/1/12, indicated the immobilizer was to be discontinued.</p> <p>On 8/29/12 at 2:55 P.M., CNA #10 was interviewed. She indicated she was familiar with Resident #3 and had cared for her upon the resident's return from the hospital after her femur fracture. CNA #10 indicated "at first she (Resident #3) did have the immobilizer on at all times because she was afraid for us to take it off." CNA #10 then indicated the resident even had it on when she was in bed, and they had it propped up. CNA #10 then indicated she doesn't remember when they started removing the immobilizer at times.</p> <p>On 8/29/12 at 3 P.M. a copy of the current policy and procedure for "Skin Management Program" was received from the MDS nurse. This policy was undated but was indicated by the MDS nurse to be current. The policy included, but was not limited to, the following: "If a new skin condition is identified, the Charge nurse is responsible for assessing the area,</p>			

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	<p>obtaining measurements and documenting in the nurses notes concerning the skin condition....The charge nurse will also develop a care plan for the treatment of the skin condition...charge nurse will transfer the information concerning the new skin condition on the appropriate tracking form..."</p> <p>The medication/treatment records for April 30th and May 2012 were reviewed at 3 P.M. on 8/29/12. These both indicated the following: "Immobilizer to lt (left) leg when moving pt (patient)." This was initialed on the form for the one day in April and all days of May 2012.</p> <p>On 8/30/12 9:33 A.M., the DON (director of nursing) was interviewed. She indicated the staff should have been monitoring this area closer and found it before it was a stage 2. The DON stated this immobilizer should have been removed and assessed at least once a shift. She indicated documentation was lacking of this having been done.</p> <p>3.1-40(a)(1)</p>				

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide care and services to prevent urinary tract infections and/or promote urinary continence for 2 of 2 residents reviewed with urinary tract infections and or incontinence. Resident #3 Resident #42</p> <p>Findings include:</p> <p>1. The clinical record Resident #3 was reviewed on 8/28/12 at 2 P.M. Diagnoses included, but were not limited to, the following: recent stroke, anemia, osteoporosis, anxiety and depression.</p> <p>An MDS (minimum data set assessment) dated 4/25/12 indicated the following for the resident: total cognitive score was 15, which indicated the resident was of</p>	F0315	<p>F – 315 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #3 had her decreased fluid intake reported to their physician and the care plan up-dated. The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #42 was placed on a three day bowel and bladder assessment to determine her potential needs for a toileting program as warranted.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this practice. All residents were placed on a three day bowel and bladder assessment to determine each residents' specific toileting needs. Specific toileting programs to prevent incontinence</i></p>	09/28/2012			

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	<p>independent cognition; required supervision and oversight for eating and was totally dependent for incontinence and personal hygiene.</p> <p>A plan of care, dated 5/1/12 addressed the following problem: "Potential for infections due to indwelling f/c (foley catheter) due to Fx (fractured) It (left) femur..." Approaches included: " encourage fluids, I &amp; O (intake and output) q (every) shift, f/c changed monthly and prn (as needed), fc c (care) q shift, position tubing for proper urine flow." This care plan was discontinued on 6/20/12.</p> <p>In the clinical record the Nutritional Evaluation was dated 5/9/12. This form indicated for the resident's weight of 189 lbs, the estimated fluid needs per a 24 hour period would be 2580 ccs(cubic centimeters).</p> <p>A Hospital discharge note was dated 6/20/12 and indicated the following: "...discharge diagnosis:...urinary tract infection...chronic kidney disease, stage III..."</p> <p>A Hospital discharge note was dated 7/15/12 and indicated the following: "...Final diagnosis: urinary tract infection with sepsis due to indwelling</p>		<p>were implemented based on the outcome of the assessments and care plans implemented to address each individual resident's toileting needs. CNA assignment sheets were up-dated to reflect the resident's toileting program as warranted. All residents who are currently on intake and output have their recommended fluid intake calculated and placed on their individual intake and output records. Physicians have been notified on those residents who consistently consume less than the recommended estimated daily fluid needs. Care plans were up-dated accordingly. Any resident that is currently being treated for a urinary tract infection was placed on intake and output to monitor for adequate hydration. Care plans were up-dated on those resident with a history of and./or currently have a urinary tract infection. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility reviewed and revised their intake and output policy to include those resident with a urinary tract infection. The nurses will be in-serviced on September 20 and 21, 2012 on the revised policy. The nurses will also be instructed on addressing interventions and/or goals to prevent urinary tract infections as well as their responsibility for documenting intake and output information on</p>				

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	<p>Foley catheter present on admission..."</p> <p>On 8/29/12 at 12 P.M. CNA #10 was observed in Resident #3's room collecting her meal tray. Resident #3 had eaten lunch in her room. The resident was observed to have two cartons of a health shake on her tray. Each carton of health shake was labeled to contain 120 ccs. They were of a chocolate flavor. Both health shake cartons were empty and were observed to have been poured into a clear, larger glass. From the larger glass, the health shake had been poured into a smaller plastic disposable glass. There was about an an inch depth of chocolate shake in the small disposable glass and the larger glass was nearly full of chocolate shake. The CNA looked at the small disposable plastic glass and indicated the resident had consumed most of the health shake. She was made aware of the larger glass with the remaining chocolate health shake in it on the resident's tray and stated "she drank about 10 ccs of the health shake."</p> <p>On 8/29/12 at 4 P.M. the medical records staff provided a copy of the August 2012 Food Intake Record. For 8/29/12 the record indicated the</p>		<p>the clinical record. The nurses were also instructed that three day bowel and bladder assessments are to be completed on admission, annually and with any significant change. The intake and output records will be reviewed weekly by the interdisciplinary team and physician's notified when warranted. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor compliance. The tool will monitor for the timely completion of bowel and bladder assessments, intake and output records being completed per policy, care plans being implemented to address urinary tract infections and urinary continence. The tool will also monitor to ensure that toileting program information is provided to the nursing staff on their respective assignment sheets as warranted. The tool will also monitor based on observation and interview of the resident to ensure that care is being provided in accordance with the residents' plan of care. The DON and/or designee will complete this tool weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tool will be reviewed at</i></p>				

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	<p>following: "health shake, 240 ccs" consumed with the lunch meal.</p> <p>On 8/29/12 at 2:45 P.M., the MDS (minimum data set assessment) nurse was interviewed. She indicated the resident had a foley catheter (tube placed in the bladder to continuously drain urine) on her return to the facility after hospitalization on 4/30/12. She indicated the catheter was discontinued on June 20, 2012. The MDS coordinator indicated the resident is currently on Intravenous vancomycin (antibiotic) for a UTI (urinary tract infection). The MDS coordinator indicated residents are only on I and O (intake and output) when they have a catheter and /or have continuous IVF (intravenous fluids). She indicated the total intake for a resident when they are not on I and O would be documented on the food consumption record.</p> <p>On 8/30/12 at 9:40 A.M., the DON (director of nursing) was interviewed. She indicated this resident had UTIs (urinary tract infections) on the following dates: 4/25/12, 7/12/12 and also currently is being treated with IV (intravenous) antibiotics for a UTI. At this time, the DON reviewed the clinical record for a care plan to</p>		the quarterly Quality Assurance meeting to determine if additional action is warranted.		

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	<p>address UTIs. The DON indicated at this time, that the resident had a foley catheter (device place through the urethra to continuously drain urine from the bladder) in place from her hospitalization with a fractured femur and returned to the facility on 4/30/12 with the foley catheter in place. The DON stated there was no care plan initiated after the foley catheter was discontinued in June 2012 to address urinary tract infections. The DON stated the resident should have a care plan in place to address prevention of urinary tract infections and/or the resident's hydration status.</p> <p>The DON indicated at this time, fluid intakes are monitored by the meal consumption records as well as the Intake and Output (I and O) records. She indicated if a resident has a foley catheter they should have their I and O monitored.</p> <p>On 8/30/12 at 10:20 A.M. the DON provided copies of the resident's I &amp; O for June and July 2012. From June 1 - June 18 the resident's oral intake ranged from 1220 ccs to 2140 ccs for a 24 hour fluid intake. From July 1 to July 11, the oral intake ranged from 1300 ccs to 1800 ccs for daily oral intake. From July 17 (the resident returned from the hospital on July 16)</p>				

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	<p>to July 28, the oral intake for 24 hour period range from 940 ccs to 1680 ccs.</p> <p>The DON also indicated at this time, she was unaware how they monitor dehydration status here as she indicated she began employment with the facility a few weeks ago. She indicated the meal intake is documented on the food consumption record. She indicated the total intake would be recorded on the intake and output record if the resident is on I &amp; O. She indicated the CNAs on the halls document the meal intakes for the residents eating on the halls. The DON indicated the consumption of the health shakes is documented by the CNAs. The DON indicated the nurses monitor the intakes on the consumption sheet daily. The DON indicated the resident was currently on Intake and output due to having recent UTIs. The DON indicated the nursing staff was monitoring the I and O. The DON stated they should have reported the lack in intake to someone.</p> <p>2. The clinical record of Resident #42 was reviewed on 8/28/12 at 10:00 A.M. The MDS of 7/04/12 indicated the resident was incontinent of bladder. The 7/04/12 Evaluation for Bladder retraining potential indicated</p>			

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	<p>the resident was unable to participate in retraining because of "cognitive impaired due to Dementia" and was toileted every 2 hours and as needed due to total dependence on staff for toileting needs. The 11/16/11 Care Plan and all revisions since, directed toilet every 2 hour and as needed.</p> <p>On 8/30/12 at 7:30 A.M., Resident #42 was observed to be in her wheelchair throughout breakfast and then went directly to an activity without opportunity to void. At 10:15 A.M., the activity ended and LPN #2 and CNA #1 returned the resident to bed with full weight bearing pivot transfer. The resident was wearing a disposable incontinent brief which was dry. The resident was not given an opportunity to be toileted before her nap. At that time the CNA was interviewed and she indicated the resident was always dry at this time. She indicated the resident "Is sopping wet in the morning and then is dry until after lunch and is wet again then." The assignment sheet the CNA was using did not direct toileting every 2 hours.</p> <p>On 8/30/12 at 12:50 P.M., the Director of Nursing indicated, after being informed of the above, "I talked to the girls and they said she</p>				

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	(Resident #42) can even tell them when she has to go (when cued). She needs to be toileted, and I am making the assignment sheets over."  3.1-41(a)(2)				

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate of greater than 5%, for 7 of 83 opportunities observed to administer medications correctly, resulting in an error rate of 8.43%. This affected 2 of 15 residents observed during medication administration. Resident #25 Resident # 19</p> <p>Findings include:</p> <p>1. On 8/28/12 at 7:20 A.M., LPN #1 was observed preparing medication for Resident # 19. She crushed tablets and emptied capsules for 6 medications and combined the powders in the bottom of a plastic medication cup. She put pudding on top of the powdered medications and lightly mixed the top half of the medication cup. After administering the medications and leaving the room to dispose of the medication cup, the nurse was requested to show it' contents. The pudding was almost entirely gone and there remained 1/3 to 1/2 of the medication powder which</p>	F0332	<p>F - 332</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as resident # 25 and #19 are now receiving their medications in accordance with the physician's orders. The nurse identified as LPN #1 has been re-educated on medication administration and reprimanded for the medication error. Medication error reports were completed and the physicians' have been notified of the medication errors.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the same deficient practice. The DON/designee will conduct medication pass audits on all licensed nursing personnel and QMAs to ensure acceptable standards of practice are being followed.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that an in-service for licensed nurses and QMAs will be conducted on September 20 and 21, 2012 to review acceptable standards of practice related</p>	09/28/2012	

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	<p>she had failed to administer. The medications and their Physician orders/ dates, verified by clinical record review at 8:30 A.M., were as follows:</p> <p>5/29/12 Fluoxetine 10 mg (milligrams) po (by mouth) daily 5/29/12 Potassium Chloride 8 meq (milliequivalents) po daily 5/29/12 Lisinopril 5 mg 1 tablet daily 5/29/12 Metropolol Tartrate 25 mg po daily 5/29/12 Furosemide 20 mg 1 tablet daily 7/29/12 Magnesium oxide 400 mg daily</p> <p>2. On 8/28/12 at 7:58 A.M., LPN #1 was observed preparing and administering medications to Resident #25. The clinical record for the resident was reviewed at 8:15 A.M. and physician orders were compared to the medications observed to have been administered. There was a 4/19/12 order for Terazosin 1 mg po daily which had been omitted.</p> <p>3. On 8/28/12 at 8:45 A.M., LPN #1 was interviewed regarding concerns. She indicated she was unable to determine dose amounts of any of the 6 medications not administered to</p>		<p>to medication administration.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a medication pass audit tool will be utilized by the DON/designee to conduct medication pass audits. These audits will be conducted weekly for three weeks, then monthly for three months and then quarterly for three quarters. Any areas of concern identified during these audits will be addressed with the nurse/QMA responsible with the use of additional education and/or disciplinary action as warranted. The outcome of the quality assurance tool will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</i></p>		

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	<p>Resident# 19. She indicated since she had counted medications (for observation verification) administered to Resident #25, she "must have missed" the Terazosin for Resident #25.</p> <p>On 8/29/12 at 10:30 A.M. the Director of Nursing was interviewed regarding Policies and Procedures related to medication administration. She indicated the nurses were to check their medication container labeling against the Medication administration record twice to ensure accuracy and observe that all of each dose was consumed before leaving the resident.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>				

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F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 ensure a pantry ice machine was maintained in a clean and sanitary manner for 1 of 1 pantry ice machine observations. This had the potential to affect all 35 residents in the facility.</p> <p>Findings include:</p> <p>On 8/30/12 at 4 P.M., the nutrition room was toured with the DON (director of nursing). She indicated at this time, the ice machine in this room serviced all the residents on the nursing units. This would include 35 residents. At this time, the front door of the ice machine was opened. The ice machine was 1/2 full of ice. On the top, interior portion of the ice machine was a white, plastic ledge which extended the entire length of the interior portion of the ice machine. On the bottom edge of this ledge, was observed a reddish residue which extended intermittently across the entire length of the ledge. The reddish residue gave the the white plastic ledge a pinkish hue. On the right side of the ledge was observed</p>	F0465	<p>F465 The corrective action taken for those residents found to have been affected by the deficient practice is that no residents were identified to have been affected by the deficient practice. The corrective action taken to identify other resident having the potential to be affected is that all residents have the potential to be affected. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that a Policy &amp; Procedure has been written for cleaning and sanitizing the ice machine monthly by Housekeeping and twice yearly by Thomas Refrigeration; according to manufactures guidelines. Ice machine was cleaned and sanitized by Thomas refrigeration on 9-21-12. The measures or systemic changes that will be made to ensure that the deficient practice does not recur is that an in-service has been done with Housekeeping Supervisor on the proper timely cleaning and disinfecting of the ice machine. The corrective actions taken to monitor and ensure performance is that a Quality Improvement Tool has been implemented to monitor that the Policy and</p>	09/28/2012			

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	<p>spots of brown/black material. The spots were smaller than a pencil eraser and were observed scattered over approximately a 1/2 inch length.</p> <p>On 8/30/12 at 4:05 P.M., the maintenance man was interviewed. He indicated he never cleans the ice machine.</p> <p>On 8/30/12 at 4:10 P.M., the housekeeping supervisor was interviewed. She indicated the interior of the ice machine is clean "about every 3 - 4 months." She indicated they do not document when the ice machine is cleaned. She indicated the ice machine was last cleaned about 2 1/2 months ago. She indicated when they clean the machine, they take all the ice out and wipe the interior of the ice machine down with disinfectant.</p> <p>On 8/30/12 at 4:20 P.M. the housekeeping supervisor was interviewed. She indicated she was unable to provide a policy and procedure regarding cleaning of the interior of the ice machine. She was also unable to provide documentation of a cleaning schedule for the ice machine.</p> <p>On 8/31/12 at 8:15 A.M., the</p>		<p>Procedure for cleaning and disinfecting the ice machine is being followed. The QI tools will be monitored by the Administrator monthly times three months and then quarterly for three quarters. This information will be reviewed in Quality Assurance meeting quarterly to see if further action is warranted. - - -</p>				

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	<p>Administrator was interviewed. She indicated prior to yesterday, the facility didn't have a policy and procedure for cleaning the ice machine. She indicated yesterday after she was made aware of the above information, she met with the housekeeping supervisor and they developed a policy and procedure for disinfecting ice machines.</p> <p>3.1-19(f)</p>			