

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2014
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 3, 8, 9, 10, 13 and 14, 2014</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>Survey Team: Shauna Carlson, RN - TL Julie Baumgartner, RN Shelly Miller-Vice, RN Sharon Ewing, RN Pam Williams, RN</p> <p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 5 Medicaid: 86 Other: 18 Total: 109</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on January 22, 2014, by Brenda</p>	F000000		
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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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	Meredith, R.N.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the resident's physician of significant weight loss for 1 of 3 records reviewed for weight loss since</p>	F000157	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth or facts alleged or conclusions set forth in this	02/07/2014			

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	<p>admission. (Resident #67)</p> <p>Findings include:</p> <p>On 1-10-14 at 11:04 A.M., review of the clinical record for Resident #67 indicated the diagnoses included but not limited to "...benign htn [hypertension], afib [atrial fibrillation - irregular heartbeat], myesthenia gravis, diverticulitis disease, COPD [chronic obstructive pulmonary disease], shingles, dementia, RA [rheumatoid arthritis]...."</p> <p>A physician order for Resident #67, dated 11-2-13, indicated a Regular diet. There were no orders found for a nutritional supplement.</p> <p>Review of the Nutritional Risk Data Collection and Assessment, dated 11-5-13, indicated an admission weight of 135.8 # (pounds). The assessment also indicated Resident #67 was at risk for affected nutrition related to her diagnoses of anemia, Afib, CHF (congestive heart failure), MI (myocardial infarction), dementia, and diverticulitis.</p> <p>Review of the Weights Detail Report for Resident #67 indicated the weight of 122.8 pounds on 12-4-13, a loss of 9.57% since her admission</p>		<p>Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Ironwood Health and Rehabilitation Center desires that this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective February 7, 2014. F-157: It is the practice of this facility that the resident, resident's physician, and resident's family or legal representative will be informed when there is a change of condition that leads to a significant weight loss. Corrective Action: Physician has been notified of the residents who have had a recent significant weight loss. The chart of Resident #67 will be reviewed and updated to be reflective of current status with physician notification. Nurses and nurse managers will be re-educated on physician notification and then documentation of this notification. This notification will be placed on the SBAR nursing notes and 24 hour report. How Others Identified: Residents will have the above process completed with each significant weight loss. Residents residing in the facility will be addressed by the following policy and procedure and re-educated and/or disciplinary action of employees. Preventive Measures: The DON and/or</p>				

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	<p>on 11-2-13, indicating a severe weight loss.</p> <p>Review of the RD (Registered Dietician) progress note, dated 12-6-13, indicated "...Per December weight (12/4) 122.8# resident with sig [significant] wt [weight] change. -9.57% x [times] 1 mth [month]. CBW [current body weight] within acceptable wt range. Continue on regular diet with 63% intake. Meds [medications] + [and] Labs reviewed, continues on MVI [multivitamin]. Skin w/o [without] reported pressure areas. Will monitor po + wt changes...." Progress note was signed by the facility RD (Employee #14).</p> <p>Review of the Nurses Notes from 12-4-13 to 1-10-14 showed no indication that the physician was notified of Resident #67's weight loss.</p> <p>On 1-13-14 at 5:41 A.M., interview with the DON (Director of Nursing) indicated "...weight loss is monitored between me and the dietician. Either of us can identify it, but I am the one to notify the doctor...."</p> <p>On 1-13-14 at 7:25 A.M., interview with the facility RD indicated nursing</p>		<p>designee will obtain weights as needed and pull reports to validate weekly and monthly weights. The UM and/or designee will notify physician of any significant weight loss and document this notification. Monitoring: DON will monitor weights weekly and monthly. Trend will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one-on-one re-education up to, and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>				

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F000174 SS=B	<p>was the one responsible for notifying the physician.</p> <p>On 1-14-14 at 11:00 A.M., review of the Nutritional Status policy, received on 1-10-14 at 3:11 P.M. from the facility nurse consultant, indicated "...report verified weight loss/gain of 5% to the Physician...and obtain orders as appropriate...."</p> <p>On 1-14-14 at 2:05 P.M., interview with the DON indicated she was not able to find anywhere in the chart that the physician was notified of weight loss.</p> <p>3.1-5(a)(2)</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Based on observation, interview and record review, the facility failed to provide privacy with resident's telephone usage. This affected 4 of 4 residents sampled. (Resident #24, #26, #94 and #112.)</p>	F000174	F-174: It is the facility's responsibility to provide access to the use of a telephone where calls may be made without being overheard. Corrective Action: Residents #24, 26, 94, and 112 will be re-educated on which phones may be used if	02/07/2014			

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	<p>Findings include:</p> <p>On 1/3/2014 at 10:15 A.M., a tour of the facility was conducted and an observation was made of Resident #26 using the Hall 400 nurses station telephone.</p> <p>On 1/3/14 at 10:30 A.M., an interview was conducted with Resident #26 indicating, "...I have to use that phone, it doesn't matter if it's a private phone call or not... that's all I have here...."</p> <p>On 1/3/14 at 2:00 P.M., an observation was made of Employee #58 whom was interacting on the behalf of Resident #112 indicating, "... do you want me to call your mother... come here... I'll call your mom...." Employee #58 proceeded to use Hall 400 nurses station telephone. It was indicated Employee #58 contacted Resident #112's mother and proceeded to communicate on behalf of Resident #112, "... oh, he's (Resident #112) is having a hard time... he's doing what he always does and we can't get him to calm down... here (Resident #112's name) come and talk to your mom...." It was observed that the nurses station area to be congested</p>		<p>privacy is needed during calls. Social Services will be the primary office designated to make or receive a telephone call in a private office. Jacks are available for use in every room. Cordless phones will be obtained for resident use for 400 and 300 halls. Nursing staff will be re-educated on the need to assist residents with their phone calls when requested. Phone usage policy will be reviewed during next Resident Council. How Others Identified: Residents will have the above process explained during Resident Council and through the center newsletter. Residents residing in the facility will be addressed by the following policy and procedure: Re-education and/or disciplinary action of employees. Preventive Measures: Staff will be re-educated on resident phone usage. Social Services will be re-educated on policy. Maintenance will ensure cordless phones are in place. Monitoring: Caring Partners will ask assigned residents if there are any concerns with this practice during rounds and document. They will turn in copies during morning meeting daily for two weeks, then three times a week for two weeks, and then weekly for two months and then monthly thereafter. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education</p>				

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	<p>with activity including several nursing staff, a housekeeper and several other residents.</p> <p>On 1/10/14 at 10:00 A.M., an interview was conducted with the family of Resident #94 on the 500 Hall indicating Resident #94 to have a cordless phone in her room at her bedside, yet being the resident has no physical ability to answer, hold or use the phone, the staff are needed to use the phone for privacy issues. It was indicated, "... we [Resident #94's family] call in to her room, but she [Resident 94] is not capable of physically using the phone... we call in the main nurses station, and we have to leave messages because the staff cannot take the phone to her[Resident #94].... and then, days go by without hearing anything, then we call again... and the same scenario happens... we need to be able to communicate with [Resident #94]...."</p> <p>On 1/10/14 at 11:30 A.M., an interview was conducted with Resident #94's family, the Administrator and the Social Worker in relation to the note above. The Social Worker did not acknowledge her office or phone provision as an option for private telephone use.</p>		<p>and/or further monitoring needs. Identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>				

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	<p>On 1/10/14 at 3:10 P.M., an interview was conducted with the Resident council President indicating the facility did not have cordless phones at the nurses stations for privacy phone calls. It was indicated, "...I'm not sure what the residents are suppose to do... I know the nurses will take the residents to their phone at the nurses station, but I've had other residents come in here and ask me to help them call someone because there isn't a phone for them to use...."</p> <p>On 1/14/14 at 3:30 P.M., a record review was conducted of the Policy procedure titled," Subject. Telephone Access-private....Procedure. 1. Provide access to one or more of the following: Cordless telephone. Telephone jack in the resident room. 2. Inform the resident and/ or family of the accessibility of telephone jacks in each room or the availability of a cordless phone...5. Allow access to the following telephones. Nurses' station. Private offices. 6. Acquaint the resident with other telephones they may use. Inform them that the nurses' station telephones may be restricted during</p>			

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	<p>peak hours. 7. Utilize the Social Services office if the resident requests the privacy of an office to make/ receive a telephone call.... 8. Arrange an appropriate time for the resident to use the office phone, unless it's an emergency.... 10. Leave office to allow for privacy during communication."</p> <p>On 1/14/13 at 4:15- 4:30 P.M., interviews were conducted with the following primary staff:</p> <p>Employee #51 indicating, "...for private phone calls the Residents can use the nurses station's phones... we used to have portable phones on 200 and 400... but, I'm really not sure if we have them still or not...."</p> <p>Employee #52 indicating, "... for private phone calls the Residents can make their calls on the portable phones on halls 400, 500 and 200... or they can use the hall 100's phone...."</p> <p>Employee #53 indicating, "...for private phone calls the Residents can use the ones on the floors at the nurses stations... no, we don't have cordless/portable phones...."</p>			

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	<p>Employee #54 indicating, "... for private phone calls the Residents use... I'm not sure... to be honest, I have no idea...."</p> <p>Employee #55 indicating, "... for private phone calls the Residents and their family's can use the front offices phones, if their not using them, or in the Admissions office if it's available...or the cordless phones on each hall...."</p> <p>Employee #56 indicating, "... for private phone calls the resident can use their own phones in their rooms... or at the nurses stations... I know we don't have a cordless phone on the 300 hall... I'm really not sure about any other place they could go...."</p> <p>Employee #57 indicating, "...for private phone calls the residents can use the front office's phones if their not locked... I know we don't have cordless phones for them to use...mainly, they use the nurses station phones...."</p> <p>On 1/14/14 at 4:45 P.M., a tour of the facility's nurses stations on the 200,300,400 and 500 halls were conducted and a cordless phone was not found for private use for the</p>			
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F000226 SS=D	<p>Residents.</p> <p>3.1-3(f)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow policy and procedure for screening of new employees for 3 of 10 employee records reviewed. (CNA #3, CNA #4, CNA #5)</p> <p>Findings include:</p> <p>On 1-14-14 at 3:00 P.M., review of the record for CNA (Certified Nursing Assistant) #3, hired on 1-2-14, indicated there were no reference checks in the employee record.</p> <p>Review of the record for CNA #4, hired 1-2-14, indicated there were no reference checks in the employee record.</p> <p>Review of the record for CNA #5, hired 12-9-13, indicated there was</p>	F000226	F-226: It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property through screening of new employees. Corrective Action: Facility will ensure the completion of reference checks prior to offer of employment for new employees. Facility will continue to follow policy and procedure related to Abuse Prohibition. How Others Identified: Employee files of employees hired in the past 3 months will be validated for reference checks. Going forward, new hires will have reference checks completed prior to any offer of employment. Preventive Measures: Department Heads that hire and Human Resources Manager will be re-educated on implementing the facility's written policy and procedure related to new hires and reference checks. Monitoring:	02/07/2014			

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	<p>only one reference check done at the time of hire.</p> <p>On 1-14-14 at 3:45 P.M., interview with the Administrator indicated it was the facility policy to complete 2 reference checks during the hiring process.</p> <p>On 1-14-14 at 4:00 P.M., review of the Abuse "...prevention and reporting..." policy, received from the Administrator on 1-13-13 at 10:48 A.M., indicated "...screen all employees for a history of abuse, neglect, or mistreatment of residents during the hiring process. Screening will consist of, but not limited to, the following:...reference checks from previous and/or current employers...."</p> <p>On 1-14-14 at 4:10 P.M., review of the "Checking references on new hires" policy, received from the Administrator on 1-14-14 at 4:06 P.M., indicated "...Individual references must be checked on each employment candidate prior to any offer of employment being made...All reference checks must be documented in writing...4. Complete a minimum of two reference checks...."</p>		<p>Administrator and/or designee will review new hire files prior to general orientation/offer of employment for needed items in file, such as reference checks. All findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one-on-one re-education, up to and including termination. Systems Changes: Completed by February 7, 2014</p>				

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F000241 SS=E	<p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to provide an environment of respect during a religious event-Communion. This affected 6 of 13 residents observed in the religious event. (Res. #83, #16, #59, #32, #60 and #62.)</p> <p>Findings include:</p> <p>On 1/14/14 at 8:45 A.M., an observation was conducted of a group of 13 residents in the day room in the front of the building to be sitting in a circle, and a Catholic nun to be attending to each resident with a bowed head and her lips to be moving with her eyes shut as if praying. It was noted that a television located on the wall to be</p>	F000241	F-241: It is the practice of this facility to maintain an environment of respect during a religious event or Communion. Corrective Action: Staff will be re-educated on the need to maintain an environmental of dignity and respect during religious events. How Others Identified: Residents residing in the facility will be apprised of the policy and procedure. There will be re-education and/or disciplinary action of employees whom are found to not follow policy. Preventive Measures: Staff will be re-educated on maintaining an environment of respect during religious events. Monitoring: Life Enrichment Director will monitor all religious events to ensure that staff are maintaining an environment of respect for residents during religious events.	02/07/2014

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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on and the volume at a level that the programming could be heard across the hall behind a shut door. Upon further observation, it was noted Employee #60 to be sitting beside the television with her eyes watching the television. The Catholic religious event was being conducted simultaneously with the television programming being on. The residents were approximately 4-10 feet apart from the television.</p> <p>On 1/14/14 at 9:30 A.M., an interview was conducted with the Catholic nun in regards to the event indicating the residents were, "...receiving communion and blessings... I do this every Tuesday for many years..." When questioned about the volume of the television and the placement of the event being in an open room near the front of the facility, it was indicated, "...well, it's just always been done this way... I don't know any different... I just assume the people don't mind... this is all I've ever known here..." It was also indicated that it was unclear to the nun if the residents participating could actually hear the blessings she was providing, "... they [the residents] are so used to everything being so loud in here... I really</p>		<p>LED will monitor these events weekly for two months, then twice a month for one month, and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>		

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	<p>couldn't say if they could hear me or not... this is just the way it is here...."</p> <p>On 1/14/14 at 10:00 A.M., a record review was conducted of the Resident Council Meeting minutes. An entry dated, "10/10/2013. Topic. Church services in the Living room. Request: Could signs be posted on the double access doors that there is a church service in session. Facility Follow Up: (left blank)."</p> <p>On 1/14/14 at 4:00 P.M., an interview was conducted with the Administrator in regards to the Catholic blessing and communion being offered in the open to public living room at the front of the building during a television show with very loud volume indicating this had not been considered as disrespectful, and should have been.</p> <p>On 1/14/14 at 4:15 P.M., a record review was conducted of the Minimum Data System (MDS) and the following was noted of 6 of the 13 Residents in attendance for the blessings and communion on the Section F0500 H- How important is it to you to participate in religious services or practices? : Resident #83, #32, #60 and #62 rated this as a "1= very important."</p>			

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F000244 SS=C	<p>Residents #16, and #59 rated this as a "2=somewhat important."</p> <p>3.1-3(t)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>1) Based on interview and record review, the facility failed to communicate the accounting of the Resident Council Groups monies. This deficiency affected 109 of 109 residents residing in the building.</p> <p>2) Based on interview and record review, the facility failed to follow-up with the concerns of the Resident Council. This deficiency affected 109 of 109 residents residing in the building.</p> <p>Findings include:</p> <p>1) On 1/10/14 at 3:11 P.M., an interview was conducted with the Resident Council President</p>	F000244	F-244: It is the practice of this facility to listen to the views and act upon grievances and recommendations concerning proposed policy and operational decisions effecting resident care and life in the facility. Corrective Action: 1) On the first work day after a fundraising event, money will be counted in the presence of the Resident Council President, recorded in the fundraising account book, and verified to the Business Office Manager prior to filing in the office by the Office Manager. Resident Fund transactions will be communicated to the Resident Council President and to any residents in attendance at the regularly-scheduled Resident Council meetings. The Life Enrichment Director and the	02/07/2014

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	<p>indicating the accounting of the Resident Council money had not been communicated. It was indicated, "...we [the Council] have money that the facility holds onto for us, and we have to give them money out of that if we [the Residents of the facility] want better prizes for Bingo... I've asked them [the facility] several times about this, I do know the Activities Director can sign out the money and I want to know why the President of the Council shouldn't be on that as well... we [the Council] don't have any idea how much money we have in there...."</p> <p>On 1/14/14 at 9:00 A.M., an interview was conducted with the Activities Director about the handling of the Councils money and how the Council obtained these monies, indicating, "...it's the activities that helps run the fund raisers, then the Council is able to keep this money and can use it as they see fit... I do not know how the accounting has been handled in the past, I do know the Business office Manager keeps the money in the front office, and I am the one who can get the money out or place the money in...no, we haven't kept a ledger in the past,... no, the Council did donate \$50 around the Christmas Holiday but</p>		<p>Business Office Manager will ensure that all authorized signatures have been obtained. The Administrator will verify that the above stated accounting procedures are completely.2) Resident Council concerns will be placed on a grievance form, given to the Social Services Director, and reviewed according to the facility's grievance policy for resident concerns. Once the grievance review process is complete, a copy of the grievance will be given to the Life Enrichment Director, who will provide the Resident Council President with follow-up information. The Life Enrichment Director will ensure that specific residents that have enunciated concerns regarding fundraising activities do receive appropriate follow-up as needed. Employees that do not adhere to facility policy will be appropriately disciplined as needed. The Life Enrichment Director and the Business Office Manager will be re-educated as to facility policy.Monitoring: 1) The Life Enrichment Director and the Business Office Manager will monitor the fundraising account on a weekly basis.2) The Life Enrichment Director and the Social Services Director will monitor the fundraising review process on a monthly basis. The Administrator will validate that follow-up is completed on a monthly basis. Trends will be reviewed in QA monthly times 3</p>		

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	<p>the Activities did not end up using the money... no, I don't remember letting them know..."</p> <p>On 1/14/14 at 9:30 A.M., a record review was conducted of the Resident Council minutes of their meetings indicating on,"...November 14th 2013, at 2:00 P.M.... New Business:...Resident Council donating \$25 for Bingo prizes and \$25 for activities for X-mas [Christmas] party, snacks... [signatures of resident council president, Activities Director, and Administrator noted.]"</p> <p>On 1/14/14 at 11:45 A.M., an interview was conducted with the Activity Director. The Activity Director indicated no ledger accounting was being done for the money generated by the fundraiser's from the Resident Council.</p> <p>On 1/14/14 at 11:46 A.M., an interview was conducted with the Administrator indicating the funds were not used to supplement the budget of the activities department.</p> <p>On 1/14/14 at 11:47 A.M., a record review was conducted of an accounting ledger sheet dated, "1/14/14" in the Resident Council</p>		<p>and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one-on-one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs.Systems Changes: Completed by February 7, 2014</p>		

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	<p>Meetings minutes indicating a balance of,"\$319.58" including signatures of,"Custodian signature: [Activity Directors signature] and Administrators signature. Date: 1/14/14."</p> <p>On 1/14/14 at 11:55 A.M., a record was provided titled: "Resident Council Fundraising Account Ledger. Custodian: [Activities Directors signature] Payee: [Signature of unidentified person], GL [General Ledger] Amount: \$266.48. Month/Year: September 2013." The following entries were available:</p> <p>"5/17/12. Balance 380.03. "5/18/12. Michael's Paint/Crafts. <34.45> Balance: 345.58. 7/6/12. Target Wii Game. <43.85>. Balance: 301.73. 6/15/12.[sic]. Dollar Tree. Bingo Prizes/ Craft Supplies. <82.92> Balance: 218.81. 7/12/12 Dollar General- Bingo Prizes/ Craft Supplies. <45.20> Balance: 173.61. 5/18/12.[sic] Dollar General. Bingo Prizes/ Craft Supplies. <25.41>. Balance: 148.20. 7/31/12. Fundraiser. Pop and Chips. 21.00. Balance: 169.20 12/14/12. Christmas Gifts.</p>			

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	<p><117.40>. Balance: 51.80. 12/14/12. CVS. <26.60>. Balance: 25.20. 12/31/12. Fundraiser- jeans/Popcorn. 31.88. Balance: 57.08. 1/10/13. Fundraiser- Popcorn. 2.40. Balance: 59.48. 4/26/13. Fundraiser- Jeans. 81.00. Balance: 140.48. 8/2/13. Fundraiser- Jeans. 84.00. Balance: 224.48. 8/16/13. Fundraiser- Jeans. 15.00. Balance: 239.48. 9/6/13. Fundraiser- Jeans. 7.00. Balance: 246.48. 9/13/13. Fundraiser-Jeans. 4.00. Balance: 250.48. 9/20/13. Fundraiser- Jeans. 5.00. Balance: 255.48. 9/27/13. Fundraiser- Jeans. 11.00. Balance: 266.48. Verified by: [signatures of Activity Director and Business Office Manager]," no date.</p> <p>On 1/14/14 at 2:00 P.M., a record review was conducted of the Policy/ Procedure titled," Subject. Resident Council Fundraising. [Name of Activities Director handwritten in]:Custodian: Each center must assign a custodian to the Resident Council Funds. [Acronym for the Corporation] recommend that the</p>			

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	<p>Life Enrichment Director be assigned this responsibility.... [current Administer of the Facility's name handwritten in]: Administrator: Provides general oversight of Resident Council; [unidentified persons name handwritten in] Resident Council Payee- Each center must assign a Resident Council Payee for the Resident Council Funds. It must be someone other than the Resident Council Custodian....Procedure: Administrator Responsibilities. 1. Provide general oversight to the Resident Council fundraising process. 2. Review the ledger monthly for completeness and accuracy. The Administrator must: a. Review and verify cash on hand to establish manual ledger amount. b. Complete review within seven days of the Custodian completing the reconciliation of the ledger. Subject: Resident Council Fundraising: procedure: Resident Council Payee Responsibilities: 1. Receipt of Resident Council replenishment request checks from the [Acronym for Corporation] 2. Receipt of Resident Council Deposits from fundraising activities or third party donations. a. Record, Cash if necessary, and Deposit in Resident Council cash box...c.</p>			

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	<p>Maintain a record of all deposits for this account both Resident Council cash box and facility's deposits. d. Obtain a second signature for Resident Council reconciliation [verification]...."</p> <p>On 4/14/14 at 1:00 P.M., an interview was conducted with the Business Office Manager indicating the only responsibility this office had with the Resident Council money was, "...locked in the safe and [the Activity Directors name] count it and sign the account ledger...."</p> <p>On 4/14/14 at 1:45 p.m., an interview was conducted with the Activity Director indicating there had not been communication with the Resident Council President in regards to the accounting of the funds and the current president of the Resident Council should be included in the accounting of the funds generated by the Council.</p> <p>2) On 1/10/14 at 3:10 P.M., an interview was conducted with the Resident Council President indicating the facility did not listen to the grievances of,"...the noise in the hallways at night is too loud; they [the staff] roll that plastic barrel down the hall and that lid can be heard</p>			

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	<p>from one end of the hall to the other...we [the resident council] have complained and complained and complained about this and it is still no better...the cordless phones for private use aren't working or they've gone missing and the smoking times are not posted... we've also complained about the snacks, they're not anywhere to be found and the kitchen is running out of food...and, we'd like to know more about our council monies we make from our fund raisers...no, there hasn't been any follow up.... I'm not sure who is suppose to follow up with our concerns..."</p> <p>On 1/14/14 at 10:14 A.M., record review was conducted of the Resident Council Minutes of their meetings indicating to include a form titled,"Resident Council Requests. Date. Topic. Request. Facility Follow up." It was indicated by the Resident Council President that it was not completed and follow up was not provided on the requests made by the council.</p> <p>On 1/14/14 at 10:30 A.M., an interview was conducted with the Activities Director indicating the Activities Director was the 'secretary' for the Council and the form noted</p>			

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	<p>above had not been completed.</p> <p>On 1/14/14 at 11:30 A.M., an interview was conducted with the dietary Manager indicating the dietary concerns were being addressed yet, the Resident Council had not been communicated with and the form mentioned above was familiar to her yet she had used it for follow up.</p> <p>On 1/14/14 at 11:45 A.M., an interview was conducted with the Activities Director, the Business Office Manager and the Administrator. It was indicated by the Activities Manager, the Resident Council Funds had not been properly accounted for on paper and the concern of the Resident Council had not been follow up on.</p> <p>On 1/14/14 at 11:50 A.M., an interview was conducted with the Administrator indicating the follow up for the Resident council meetings had not been completed as is required.</p> <p>3.1-3(l)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure showers were given per preference for a resident who is unable to shower herself. This affected 1 of 4 resident's reviewed for ADL's (Activities of Daily Living). (Resident # 94)</p> <p>Findings Include:</p> <p>On 01/10/14 at 10:30 A.M., interview with Resident #94 indicated it had been about 2 weeks since she had received a shower. Resident #94 indicated they told her the water was to cold. Resident #94 indicated she was not offered a bed bath and she was told the staff was too busy to give her a bed bath.</p> <p>On 1/10/14 at 3:00 P.M., record review indicated Resident #94 was admitted to the facility, on 06/09/11,</p>			F000312	<p>F-312: It is the practice of the facility to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Corrective Action: Resident #94 will be re-interviewed for preferences and care plans to ensure reflective of current status. Resident bath-type detail will be reviewed daily during morning meetings by DON/or designee and Unit Manager. Nursing staff will be re-educated on providing ADL care and documentation. How Others Identified: Residents residing in the facility will be reviewed for ADL care and bath-type and will be addressed by the preceding policy and procedure and re-educated and/or disciplinary action. Preventive Measures: Nursing staff will be re-educated on providing ADL care and documentation per policy. Monitoring: The Unit</p>		02/07/2014

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	<p>with diagnosis, including but not limited to: C (cervical) 4 fracture, cervical stenosis, quadraparesis, acute central cord syndrome, muscle spasms, neuropathy and depression.</p> <p>Record review of the Activity Pursuit Plan of Care, for Resident #94, updated 12/30/13, indicated the following: Resident or family completed interview. Daily Preferences: It is very important or somewhat important to choose between a tub bath, shower, bed bath or sponge bath. The interventions included but were not limited to, provide resident preference/choice in areas somewhat or very important to them as indicated on the plan of care.</p> <p>On 1/10/14 at 3:30 P.M., Employee #13 (Unit Manager for 400 and 500 halls) indicated the last documented shower for Resident #94 was on 12/24/13 as indicated by the shower sheet filled out by the CNA (certified nurses assistant). Employee #13 indicated the CNAs should notify the nurse if a resident refuses a shower or bath and the CNA should fill out a shower sheet indicating the resident refused.</p>		<p>Manager and/or designee will review bath detail reports and nursing documentation daily for any refusals of showers. Trends will be reviewed in QA monthly time 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>		

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	<p>On 1/10/14 at 3:45 P.M. record review of the shower sheets for Resident # 94 indicated the last documented shower was on 12/24/13.</p> <p>On 1/13/13 at 9:00 A.M., Employee #13 provided a procedure titled "Clinical Administrative Manual" 16.2.1 Section P, Procedure Personal needs # 8. Document in the Progress Notes if an exception to the established plan of care occurs.</p> <p>On 1/14/14 at 3:30 P.M., record review of all nurses notes for Resident #94, between 12/13/13 and 1/12/14, indicated no documentation that Resident # 94 had refused a shower between 12/24/13 and 1/12/14.</p> <p>On 01/14/14 at 3:32 P.M., interview with Resident #94 indicated she would like to have showers on Tuesday and Friday afternoons after her therapy session.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(B)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to develop and implement dietary</p>	F000325	F-325: It is the practice of this facility to maintain nutritional status. Corrective Action: The chart of Resident #67 will be	02/07/2014	

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	<p>recommendations for 1 of 3 sampled residents who met the criteria for weight loss since admission. (Resident #67)</p> <p>Findings include:</p> <p>On 1-10-14 at 11:04 A.M., review of the clinical record for Resident #67 indicated the diagnoses included but not limited to "...benign htn [hypertension], afib [atrial fibrillation - irregular heartbeat], myesthesia gravis, diverticulitis disease, COPD [chronic obstructive pulmonary disease], shingles, dementia, RA [rheumatoid arthritis]...."</p> <p>A physician order for Resident #67, dated 11-2-13, indicated a Regular diet. There were no orders found for a nutritional supplement.</p> <p>Review of the Nutritional Risk Data Collection and Assessment, dated 11-5-13, indicated an admission weight of 135.8 # (pounds). The assessment also indicated Resident #67 was at risk for affected nutrition related to her diagnoses of anemia, Afib, CHF [congestive heart failure], MI [myocardial infarction - heart attack], dementia, and diverticulitis.</p> <p>Review of the Weights Detail Report</p>		<p>reviewed and updated to reflect resident's current status. Residents with significant weight loss will be reviewed by Dietary for any needs. Dietary will provide interventions and make recommendations. How Others Identified: Residents with significant weight loss will have the above process completed. Residents residing in the facility will be addressed by following policy and procedure and employees will be re-educated and/or disciplinary action will be taken. Preventive Measures: The Dietary Manager/Dietician will review significant weight changes with DON weekly and monthly after weight change reports have been pulled. Nurses and Unit Managers will be re-educated on weight policy and Care Tracker data entry. Monitoring: The DON and Dietary Manager/Dietician/ and/or designee will meet weekly and monthly to review significant weight changes. Dietary Manager/Dietician/and/or designee will review residents with significant weight change for needed interventions and make recommendations. Dietary Manager/Dietician/and/or designee will review recommendations with DON weekly. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs.</p>				

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	<p>for Resident #67 indicated the weight of 122.8 pounds on 12-4-13, or a loss of 9.57% since her admission on 11-2-13, indicating a severe weight loss.</p> <p>Review of the RD (Registered Dietician) progress note on the day of admission, 11-5-13, indicated "...Resident return from hospital 2* [secondary] L [left] shoulder surgery w/ [with] surgical closure. Continues on regular diet po [per mouth - intake] 53%. CBW [current body weight] 11/5 135.8# within IWB [ideal body weight]. Meds [medications] /labs reviewed- rec [receives] MVI [multivitamin] c [with] min [minerals] for skin integrity. Nutritional goal to maintain wt [weight] + [and] skin integrity...." Progress note was signed by the facility RD (Employee #14).</p> <p>Review of the RD progress note, dated 12-6-13, indicated "...Per December weight (12/4) 122.8# resident with sig [significant] wt change. -9.57% x [times] 1 mth [month]. CBW within acceptable wt range. Continue on regular diet with 63% intake. Meds + Labs reviewed, continues on MVI. Skin w/o [without] reported pressure areas. Will monitor po + wt changes...."</p>		<p>Identified non-compliance will result in one-on-one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>				

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	<p>Progress note was signed by the facility RD (Employee #14).</p> <p>On 1-10-14 at 3:00 P.M., review of the Nutrition Risk Plan of Care, dated 11-5-13, indicated Resident #67 was at nutritional risk related to afib, chf, and htn. An update to the care plan on 12-6-13, indicated Resident #67 was at nutritional risk related to a weight loss of 9.57% in 1 month. The goal for Resident #67 was for weight to remain stable +/- [plus or minus] 3% of 130 pounds. Interventions included, but were not limited to, diet as ordered, vitamin and mineral as ordered, monitor weights, and assisting with meals as needed. Providing fortified foods and giving supplements as ordered were possible interventions on the care plan for Resident #67 but did not have a check mark indicating they were chosen.</p> <p>On 1-13-14 at 7:25 A.M., interview with the facility RD (Employee #14) indicated if she had any recommendations for a resident who was losing weight, the only place she would document that would be in her RD progress note and if they weren't there then she hadn't recommended anything.</p>			

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	<p>On 1-14-14 at 11:00 A.M., review of the Nutritional Status policy, received on 1-10-14 at 3:11 P.M. from the facility nurse consultant, indicated "...develop and implement individualized interventions based on interdisciplinary assessments and resident and family goals...which may include, but not limited to:...offer supplements...provide enhanced food...."</p> <p>3.1-46(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 appropriately monitor the blood pressure and/or pulse per physician order before giving a cardiac medicine for 1 resident in a sample of 5 who fit the criteria for unnecessary medications. (Resident #67)</p> <p>Findings include: On 1-10-14 at 11:04 A.M., review of</p>	F000329	F-329: It is the practice of this facility to keep each resident's drug regimen free from unnecessary drugs. Corrective Action: The chart of Resident #67 was reviewed and care plans reflect current status. How Others Identified: Residents receiving blood pressure medications are reviewed for appropriate monitoring of blood pressures and/or pulse per physician orders. Residents' medications and orders are reviewed for appropriateness. Preventive: The Unit Manager and/or designees	02/07/2014			

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	<p>the clinical record for Resident #67 indicated diagnoses including but not limited to "...benign htn [hypertension], afib [atrial fibrillation - irregular heartbeat], MI [myocardial infarction - heart attack], CHF [congestive heart failure], CAD [coronary artery disease], glaucoma...."</p> <p>Physician orders written 11-2-13 indicated "Metoprolol Tart [medication for high blood pressure] 25 mg [milligram] tab...give 1 tablet orally every 8 hours. Hold if SBP [systolic blood pressure] < [less than] 100 or HR [heart rate] < 100...."</p> <p>Review of the MAR [medication administration record] from 12-1-13 to 12-31-13 indicated all doses were documented as given. No blood pressures or pulses were documented on the MAR.</p> <p>Review of the "Vital Signs - Individual Resident Flowsheet" for Resident #67 indicated documentation of blood pressures and pulses for dates 12-22-13 at 12 A.M. and 12-27-13 at 8 A.M. There were no further blood pressures or pulses documented.</p>		<p>will review new orders and ensure monitoring is listed on MAR/TAR. Nurses will be re-educated on following physician orders. Monitoring: Unit Manager or designees will monitor new orders and MAR/TARs daily for two weeks, then 3 times a week for 2 weeks, then weekly for 2 months and then monthly thereafter. Trends will be reviewed in QA monthly times 3 months and then quarterly thereafter to determine further education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>		

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	<p>On 1-10-14 at 11:35 A.M., interview with LPN #8 indicated the blood pressure and pulses would either be documented on the MAR or on the Vital Signs flowsheet in the chart.</p> <p>On 1-10-14 3:11 P.M., review of the "Medication Administration" policy, received from the facility consultant nurse at this time, indicated "...Procedure...6. Perform necessary assessments prior to administering specific medications which may include, but is not limited to: pulse, blood pressure...."</p> <p>3.1-48(a)(3)</p>			

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F000334 SS=A	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>						

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to provide the annual influenza vaccine education information for one of five residents reviewed. (Resident #106)</p> <p>Findings include:</p> <p>On 1-14-2014 at 11:00 A.M., record review of Resident #106 immunization record indicated the influenza vaccine was given on 10-21-2013. Review of nurses notes, dated 10-21-2013 at 1:30 P.M., indicated "T [temperature] 97.6. Res [resident] given flu</p>	F000334	F-334: It is the practice of this facility to provide annual influenza vaccine education information to residents and/or family when administering the vaccine. Corrective Action: Resident charts will be audited to ensure the annual influenza vaccine education information has been provided to the resident and/or family. Preventative Measures: Nurses will be re-educated on the policy and procedure for offering and administering the influenza vaccine, including the Educational Information Form. Monitoring: Unit Manager and/or designee will monitor new residents' charts for	02/07/2014

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	<p>[influenza] vaccine in L [left] deltoid." There was no evidence, in the nurses notes or under the immunization section in the chart of Resident #106 that the POA (power of attorney) was given the annual influenza vaccine information or VIS (Vaccine Information Statement) for 2013/2014 influenza season.</p> <p>On 1-14-2014 at 11:30 A.M., interview with the Employee #17 indicated that the VIS would be kept under the immunization tab in the residents chart and should be noted in the progress notes by the nurse.</p> <p>On 1-3-2014 at 10:30 A.M., the Administrator provided the Infection Prevention Procedure, last revised on April 2013, during the entrance conference as the most current. On 1-14-2014 at 1:30 P.M., review of Infection Prevention Procedure indicated under Procedure ...4. Provide the resident and /or family with a copy of the applicable VIS....a. On an annual basis, the person administering the vaccine will * Document the review of the VIS in the Nurses Progress notes and include to whom the VIS was given.</p> <p>3.1-13(a)</p>		<p>follow-up with the above policy during daily clinical review. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Identified non-compliance will result in one-on-one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>		

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F000371 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 and record review, the facility failed to ensure food and drinks were being prepared and served in sanitary conditions in regards to handwashing and improper use of hairnets. This deficiency had the potential to affect 103 residents who received meals from 1 kitchen.</p> <p>Findings include:</p> <p>On 1-3-14 from 11:50 A.M. to 12:20 P.M., observation of the lunch meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 11:56 A.M., CNA #10 was observed to wash her hands for 7 seconds in between serving trays.</p> <p>At 12:06 P.M., CNA #11 was observed to wash her hands for 10 seconds in between serving trays.</p>	F000371	<p>F-371: It is the practice of this facility to prepare and serve in sanitary conditions with regards to hand-washing and proper use of hairnets. Corrective Action: Staff will be re-educated on the appropriate hand-washing technique and hairnet use while preparing and serving residents. How Others Identified: Residents residing in the facility will be addressed by the following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. Preventive Measures: Staff will be re-educated on appropriate hand-washing techniques and use of hairnets. Monitoring: The Unit Manager, Dietary Manager, and/or designee will monitor dining room for hand-washing techniques and hairnet use daily for 2 weeks, 3 times per week for 2 weeks, weekly for 2 months, and then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine</p>	02/07/2014
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	<p>At 12:14 P.M., CNA #11 was observed to wash her hands for 10 seconds in between serving trays.</p> <p>At 12:15 P.M., CNA #12 was observed to wash her hands for 9 seconds in between serving trays.</p> <p>At 12:17 P.M., CNA #11 was observed to wash her hands for 4 seconds in between serving trays.</p> <p>From 11:50 A.M. to 12:08 P.M., the facility RD (Registered Dietician) was observed serving lunch trays to residents and entering and exiting the food preparation area of the kitchen several times while wearing a hair net slid back on the top of her head and multiple sections of hair outside of the hairnet and hanging loosely around her face.</p> <p>From 11:50 A.M. to 12:18 P.M., the Corporate RD was observed serving lunch trays to residents and entering and exiting the food preparation area of the kitchen several times while wearing a hair net slid back on the top of her head and a large section of hair hanging out of the hair net near her left ear.</p> <p>From 11:50 A.M. to 12:20 P.M.,</p>		<p>further education and/or further monitoring needs. Identified non-compliance will result in one-on-one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>				

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	<p>Employee #16 (dietary aide) was observed in the food preparation area of the kitchen cutting melons with large section of her bangs unrestrained and hanging out of the hair net.</p> <p>On 1-14-14 at 10:26 A.M., interview with the CDM (Certified Dietary Manager) indicated it was her expectation and she teaches her staff to wash their hands for 20 seconds during food service and that anyone who crosses into the food preparation of the kitchen needs to be wearing a hair net covering all of their hair.</p> <p>On 1-14-14 at 11:34 A.M., review of the kitchen "Personal Hygiene" policy, received from the CDM at this time, indicated "...Wash hands properly and as often as needed...Rub hands together vigorously for 20 seconds per food guidelines..." and "...Wear a hair restraint at all times...Cover all of hair, including facial hair...."</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to maintain</p>	F000441	F-441: It is the practice of this facility to establish and maintain	02/07/2014			

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	<p>records of incidents and the infection control process of surveillance in accordance to their facility procedures. This deficiency had the potential to affect 109 of 109 residents residing in the facility.</p> <p>Findings include:</p> <p>On 1/14/14 at 8:10 A.M., an interview was conducted with the ADON (Assistant Director of Nursing) indicating it was the responsibility of the ADON to follow the Infection Control Processes of the facility. It was indicated that the forms provided for review were "new this month..." and a completed record of incidents and follow through could not be provided minus the current month January 2014.</p> <p>On 1/14/14 at 8:30 A.M., a record review was conducted of the forms used to survey the infection control process:</p> <p>The "Quarterly Healthcare Associated Infection Incidence Rate" form included the opportunity to monitor: "Calculates and obtains a percentage of incidents housewide," dated, "11-13." No further dates were provided for review.</p>		<p>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. Corrective Action: The ADON was re-educated on the Infection Control process of surveillance in accordance to facility procedure. How Others Identified: Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. Preventive Measures: Staff will be re-educated on the Infection Control process. Monitoring: The DON will monitor this weekly for two months, then every two weeks for one month and then monthly thereafter. Trends will be reviewed in QA monthly times 3 months and then quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014</p>		

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	<p>The "Monthly Healthcare Associated Infection Incidence Rate" form included the opportunity to monitor, " particulars of each resident of concern; admission date; room; hall; Infection type; site; onset date; culture date taken; results; antibiotic type; start date; met CDC (Centers for Disease Control) definition; admitted <(less than) 72 hours; Precautions: standard-contact-droplet Airborne; Infection Class: Infectious, Community Acquired, Healthcare Associated, Type of Isolation Precautions." A form dated: "Jan, 2014," was provided for review along with "7-13, 1-2013, and December 2013." No further dates were provided for review.</p> <p>The "Infection Surveillance Worksheet" from included the opportunity to monitor: The Resident, Room, Date started, Room and Admission date; Type of symptoms exhibited, and Doctor notification and guidance. The following date and Residents were provided for review:</p> <p>"January of 2014: Infectious Surveillance Worksheets" for the following residents with established infections identified: Resident #103</p>			

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	<p>(two incidents), #38 (two incidents), #22, #11, #61, #34, #115, #30, #10, #102, #106, #99, #11, #24, #104 and 2 unidentifiable residents due to illegible handwriting and 1 identified resident no longer a resident with the facility. No further dates were provided for review.</p> <p>A facility wide map was provided with the following information dated,"Jan 2014": "UTI [urinary tract infections], EYE, Resp [respiratory infection], Skin and GI [gastro-intestinal infections.] Each route of infections was given a different color to signify that particular routes existence within the facility. No further dates were provided for review.</p> <p>On 1/14/14 at 9:00 A.M., the ADON was interviewed indicating, "...I've only been doing this job since June of last year, and I'm finding out today that I've been doing this all wrong...."</p> <p>On 1/14/14 at 9:01 A.M., the DON (Director of Nursing) was interviewed indicating that upon her hire in July of 2013, "...I just assumed she [ADON] was doing it...to be honest with you, there have been too many people in charge of</p>			

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	<p>the Infection Control Program at this facility [listed 3 other past staff names whom held this role prior to the current ADON]... and I'm sure we aren't doing this the way it's suppose to be done...."</p> <p>On 1/14/14 at 9:24 A.M., a record review of the facility's Infection Control Policy and Procedure was provided by the DON. It indicated,"...Subject. Infection Prevention....The analytic review of the data may be completed, as applicable, by one or more of the following including, but not limited to: Infection Control Coordinator, Infection Control/Prevention Team and Leader, Quality performance Improvement Committee [QPI], Physician...As a result of this collection and review of data, a follow-up plan of action is prepared and implemented.... procedure:...2. Review the criteria for infections as written...3. Recognize communicable disease outbreaks...4. Contain communicable disease outbreaks....5. Report communicable disease to the local/ state health departments...7. Follow the surveillance program for infections among residents..."</p> <p>On 1/14/14 at 4:40 P.M., an</p>			

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F009999	<p>interview was conducted with the Administrator in compliance with the Quality Assurance Assessment indicating the facility was aware of the infection control program not being conducted in a manner to consistently monitor the infectious nature of organisms in the facility.</p> <p>3.1-18 (b)(1)(A) 3.1-18 (b)(1)(B) 3.1-18 (b)(1)(C)</p> <p>3.1-14 PERSONNEL</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) documentation of orientation to the facility and to the specific job skills.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of job orientation was complete for 3 of 10 employee records reviewed. (CNA #5, CNA #6,</p>	F009999	F-9999: It is the practice of this facility to maintain current and accurate personnel records for all employees. Corrective Action: Active employee personnel files will be audited to ensure the Job Orientation Checklists are complete and signed. The orientation to facility will be completed during the employee's orientation period and maintained in the employee's personnel file. Preventative Measures: The Educational Training Director and the Human Resources Manager will be educated on the need to develop and maintain a tracking checklist to ensure that the appropriate documentation is completed timely. Monitoring: Human Resources will conduct a monthly audit review of new hires that are hired within the past 30 days. Educational Training	02/07/2014

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	<p>CNA #7)</p> <p>Findings include:</p> <p>On 1-14-14 at 3:00 P.M., review of the record for the CNA (Certified Nursing Assistant) #5, hired 12-9-13, indicated the "General Orientation Program Topics Reviewed" checklist was blank and the space for the DON (Director of Nursing) to sign it as completed was blank.</p> <p>Review of the record for CNA #6, hired 10-21-13, indicated the "General Orientation Program Topics Reviewed" checklist was blank and the space for the DON to sign it as completed was blank.</p> <p>Review of the record for CNA #7, hired 11-20-13, indicated the "General Orientation Program Topics Reviewed" checklist was missing from the employee record.</p> <p>On 1-14-14, interview with the Administrator indicated it was the expectation of the facility to have those completed and in every employee record.</p>		<p>Director and the Human Resources Manager will implement a tracking system to identify those employees needing the signed Job Orientation in their file. The monthly review and tracking system will be checked weekly for 3 months and then monthly for 3 months by Human Resources. The Administrator will validate. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Identified non-compliance will result in one-on-one re-education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by February 7, 2014 The facility alleges substantial compliance and asks that the facility be granted a desk review due to compliance maintenance.</p>		

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