

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155801		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/09/2013	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5-9, 2013</p> <p>Facility number: 000450 Provider number: 155801 AIM number: 100273890</p> <p>Survey team: Diane Hancock, RN TC Barbara Fowler, RN Denise Schwandner, RN Diana Perry, RN</p> <p>Census bed type: SNF/NF 30 Total 30</p> <p>Census payor type: Medicare 5 Medicaid 20 Other 5 Total 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 13, 2013, by Jodi Meyer RN</p>			F000000	<p>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 request that the plan of correction be considered our allegation of compliance effective September 4, 2013 to the annual licensure survey conducted on August 5 th through August 9 th , 2013. The facility also request that our plan of correction be considered for paper review compliance. The facility would be respectfully submit to you any compliance paper work you would need for review.</p>		

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

TITLE

(X6) DATE

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

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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 ensure the physician was notified of a resident's change in condition for 1 of</p>	F000157	<p>F157</p> <p>It is the practice of Transcendent Healthcare to assure that that the physician is notified appropriately</p>	09/04/2013	

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	<p>1 resident in a sample of 1 resident reviewed for death. (Resident #36)</p> <p>Findings include:</p> <p>The clinical record for Resident #36 was reviewed on 8/7/13 at 1:09 p.m. Resident #36 had diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease) and a history of GI (gastrointestinal) bleeding.</p> <p>A MDS (Minimum Data Set) assessment, dated 3/25/13, indicated Resident #36 had a BIMS (Brief Interview for Mental Status) score of 13, indicating the resident had slight cognitive impairment.</p> <p>A physician's order, dated 3/8/13, indicated the use of oxygen (O2) at 2L (liters) a minute through (per) a nasal cannula prn (as needed) for SOB (shortness of breath).</p> <p>A Nurse's Note, dated 3/25/13 at 9:30 p.m., indicated Resident #36 was resting quietly in bed. The note indicated the resident wanted "to go see about the dishes."</p> <p>A Nurse's Note, dated 3/26/13 at 12:15 a.m., indicated Resident #36 was "nervous and fidgety." The note</p>				<p>when there is a change of condition related to a resident.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #36 was a closed record from March 26, 2013. There are no corrections implemented for this resident.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents have been reviewed to assure that the physician is currently being notified appropriately in accordance with the regulation.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>A new policy has been implemented related to physician notification. The nurses will be in-serviced related to the policy and notifying the physician of a change of condition. In addition, nursing administration will be reviewing the 24-hr report each morning to identify any change of condition so that review can occur to assure that the physician was notified appropriately in accordance with the regulation.</p>		

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	<p>indicated Resident #36's oxygen saturation rate was 74% on room air. The note indicated nasal O2 was started on the resident at 2L/minute and Resident #36's O2 saturation rate increased to 87%. The resident's vital signs were as followed: B/P (blood pressure) 119/74, T (temperature) 95.2 degrees, P (pulse) 119, and R (respirations) 24. Resident #36 requested to be up in a recliner at that time.</p> <p>A Nurse's Note, dated 3/26/13 at 2:00 a.m., indicated Resident #36 appeared to be sleeping in the recliner. The O2 saturation rate was 90% and Resident #36's skin was dark and dusky.</p> <p>A Nurse's Note, dated 3/26/13 at 4:20 a.m., indicated Resident #36 was found unresponsive with no B/P, heart rate, or respirations. Resident #36's skin was cold to touch. The physician was paged at that time.</p> <p>The clinical record lacked any documentation that the physician was notified of Resident #36's change in condition at 12:15 a.m. when the oxygen saturation rate dropped and the resident was nervous and fidgety.</p> <p>An interview with the DoN (Director of</p>		<p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents for physician notification related to change of condition (if applicable). The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed:</p> <p>September 4, 2013</p>				

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	Nursing) on 8/9/13 at 9:37 a.m., indicated the facility did not have a policy of when to notify a physician. 3.1-5(a)(2) 3.1-5(a)(3)				

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure privacy during personal care for 1 of 5 residents observed receiving personal care, in that the window curtains were not closed during the resident's bath. (Resident</p>	F000164	<p>F164</p> <p>It is the practice of Transcendent Healthcare to assure that residents are treated in a dignified manner including the provision of privacy during care.</p> <p><i>The correction action taken for</i></p>	09/04/2013	

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	<p>#39)</p> <p>Finding includes:</p> <p>CNA #2 was observed to be giving a bath to Resident #39 on 8/8/13 at 8:52 a.m. Throughout the bathing process, the window blinds and curtain were open. Resident #39's room was located in the front of the building on the street level. During the bath, two (2) workers were observed to be outside of the facility doing yard work.</p> <p>During an interview with CNA #2, on 8/8/13 at 10:05 a.m., she indicated she thought she had closed the blinds and curtains prior to the bath as she normally would close both of them.</p> <p>A policy titled, "Privacy and Confidentiality" and obtained from the DoN (Director of Nursing on 8/9/13 at 11:43 a.m., indicated that personal care privacy required removing the resident from the visual view of others.</p> <p>3.1-3(p)(4)</p>		<p>those residents found to be affected by the deficient practice include:</p> <p>Residents #39 receives personal care services in a manner that enhances privacy.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Reinforcement of the facility policy related to privacy will occur with the nursing staff. The nursing staff has been in-serviced related to assuring that privacy is provided during personal care. The in-service will specifically address the proper pulling of the privacy curtain and/or window blinds/curtains. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p>		

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			<p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents for provision of privacy during personal care. This tool will specifically observe for the pulling of the privacy curtain and/or window blinds/curtains. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>September 4, 2013</p>	

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F000256 SS=D	<p>483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas.</p> <p>Based on observation and interview, the facility failed to provide adequate lighting to 1 of 1 rooms observed, in a sample of 10 rooms reviewed in the Stage I sample, in that the resident complained of poor lighting and the lighting was observed to be low. (Room #8)</p> <p>Finding includes:</p> <p>Room 8 was observed on 8/6/13 at 8:55 a.m. The overbed light was on over both beds and the window covering was open but the room was slightly dark.</p> <p>During an interview with Resident #7 on 8/6/13 at 8:41 a.m., the resident indicated the room was dark and the lighting seemed to have become dimmer recently. Resident #7 indicated he enjoyed reading but had difficulty due to the lights being dim in the room.</p> <p>Room 8 was observed on 8/8/13 at 2:35 p.m., with the overbed lights on. The lighting was dim in the room.</p>	F000256	<p>F256</p> <p>It is the practice of Transcendent Healthcare to assure that residents have comfortable and adequate lighting in all areas.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Room 8 has been corrected and is reading at the appropriate foot candles. Resident #7 is pleased with the changes</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All resident rooms have been reviewed to assure that appropriate comfortable lighting is present.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The checking of foot candles has been added to the preventative maintenance schedule for monthly review. The maintenance man has been in-serviced related to the</p>	09/04/2013	

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	<p>Room 8 was observed on 8/9/13 at 8:45 a.m. Resident #7 was observed to be sitting on the bed, reading a book. Resident #7 indicated it was difficult to read because of the dim light and he would use a flashlight at times to see his clothes in the closet, especially at night.</p> <p>A test was done on Room 8 using a light meter (a gauge used to measure a lighting level) on 8/9/13 at 8:45 a.m. The light output, at the level where the resident was reading a book, was 2 - 4 footcandles, indicating the lighting level was poor.</p> <p>3.1-19(dd)</p>		<p>appropriate foot candles expected in the resident rooms.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents rooms for appropriate lighting. The Director of Maintenance, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the results of the PI tools.</p> <p>The date the systemic changes will be completed:</p> <p>September 4, 2013</p>		

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 3 residents reviewed for dental issues, in a sample of 3 who</p>	F000272	<p>F272</p> <p>It is the practice of this facility to assure that the all resident assessments including the MDS</p>	09/04/2013	

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	<p>met the criteria, and 1 of 1 resident sampled for falls, in a sample of 1 who met the criteria, were comprehensively assessed regarding their dental status and/or falls. (Resident #23, #9)</p> <p>Findings include:</p> <p>1. Resident #23 was observed on 8/6/13 at 1:18 p.m., sitting in a chair in her room. Resident #23's left front tooth was broken.</p> <p>Resident #23's record was reviewed on 8/7/13 at 1:09 p.m. Resident #23 had diagnoses including, but not limited to, Alzheimer's disease.</p> <p>The MDS (Minimum Data Set) assessment, dated 6/30/13, indicated the resident did not have any dental issues.</p> <p>An interview with CNA #3 on 8/7/13 at 1:16 p.m., indicated Resident #23's left front tooth had been broken for a long time. CNA #3 indicated the resident was admitted with the broken tooth, approximately two (2) years ago. CNA #3 indicated the resident had dentures.</p> <p>During an interview with the DoN (Director of Nursing) on 8/7/13 at 1:45</p>				<p>accurately reflect the resident's condition.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #9 MDS has been corrected to accurately reflect the fall that occurred</p> <p>Resident #23 MDS has been corrected to accurately reflect the dental issue.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents MDS has been reviewed to assure that they accurately reflect any issues related to the resident. Any discrepancies identified will have corrective MDS completed.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The MDS Coordinator has been in-serviced related to assuring that the MDS assessment accurately reflects the resident's condition. It has been reinforced that the assessment should take information from the medical record as well as observation and interview for accurate reflection of the resident. The MDS Coordinator will be part of</p>		

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	<p>p.m., she indicated the resident had been admitted to the facility with the broken tooth on the top denture.</p> <p>Interview with the MDS Coordinator on 8/9/13 at 8:00 a.m. indicated she had incorrectly entered the MDS for dental and she would be making a change to the MDS.</p> <p>2. LPN #1 was interviewed on 8/6/13 at 1:30 p.m. She indicated Resident #9 had a fall on 8/4/13, where she slipped out of bed. The resident had slipped out of the wheelchair last</p>		<p>the interdisciplinary team that reviews the 24-hr reports, incidents, etc each routine business day to assist with updated knowledge related to the residents' condition.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A PI tool has been established that randomly reviews 5 resident MDS for accuracy. The Director of Nursing, or designee, is responsible for completion of the tool. This tool will be completed weekly x3, monthly x3, and then quarterly x3. Any identified issues will be immediately corrected. The quality assurance committee will review the PI tools at the regularly scheduled meetings with additional recommendations if there is any negative outcome on the PI tools.</p> <p>The date the systemic changes will be completed:</p> <p>September 4, 2013</p>		

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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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	<p>month she indicated.</p> <p>Resident #9's clinical record was reviewed on 8/7/13 at 9:30 a.m. The resident was admitted to the facility on 7/9/04 with diagnoses including, but not limited to, congestive heart failure, peripheral neuropathy, gastroesophageal reflux disease, anxiety, and depression.</p> <p>The resident had a Fall Risk Assessment, dated 5/30/13, with a score of 13. Ten (10) or greater indicated the resident was high risk for falls.</p> <p>Nurses' notes on 7/5/13 at 7:00 p.m. indicated, "Resident slid from w/c [wheelchair] onto w/c foot pedals. ROM [range of motion] to all extremities, no c/o [complaint of] pain or discomfort..."</p> <p>Resident #9 had a quarterly Minimum Data Set (MDS) assessment, dated 7/29/13. The assessment indicated the resident had no falls since the prior assessment.</p> <p>Interview with the MDS Coordinator on 8/8/13 at 11:00 a.m. indicated she had not recalled the fall on 7/5/13 when she did the MDS assessment for 7/29/13 and had not included it in</p>			

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	the assessment. 3.1-31(c)(3) 3.1-31(c)(9)			

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F000363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to ensure menus were followed for 1 of 1 meal observed, and ensure recipes were followed to ensure nutritional needs were met for 5 of 5 residents on pureed diets, and for 1 of 1 resident observed with orders for a calorie controlled diet. The cook did not have a menu/recipe for the number of pureed diets she was preparing. The resident on the 1800 calorie received items not menued and double portions. (Residents #9, #3, #20, #18, #23, #4)</p> <p>Findings include:</p> <p>1. On 8/8/13 at 10:40 a.m., Cook #1 indicated they had taken her recipes to the front office and when she got them back, she would prepare the pureed food.</p> <p>On 8/8/13 at 11:08 a.m., Cook #1 was</p>			F000363	<p>F363</p> <p>It is the practice of Transcendent Healthcare of Boonville North to prepare meals in accordance with the menus and their correlating recipes.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents #9, #3, #4, #18, #20, and #23 are being served their pureed diets in accordance with the recipes and their diet cards including double portions if indicated.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All pureed diets were identified in the survey findings. All menus have been reviewed to assure that recipes are being followed per the regulations. Please see systematic changes below to prevent reoccurrence.</p>		09/04/2013

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	<p>observed preparing to puree salisbury steaks. She indicated she was making 10 servings, but only needed 8. She was observed to have a recipe for 20 servings. The recipe for 20 servings indicated the following ingredients: Salisbury Steak 3 pound 12 ounces Water 3 1/2 cup Food Thickener 1/4 cup 1 tablespoon Brown Gravy 1 1/4 quart</p> <p>Instructions for 20 servings included, but were not limited to, serve one #8 scoop and top with 2 fluid ounces of beef gravy.</p> <p>The white piece of paper titled "Conversion to Portions (pureed)" indicated the following: Salisbury Steak Convert 20 to 10 (8 needed) (#8 scoop) 10 steaks 2 teaspoons of base broth 1.5 cups water 3.0 oz (ounce) thickener 2.0 oz gravy</p> <p>Cook #1 was observed to place 10 meat patties in the food processor and add 1 and 1/2 cups of water. She then added 3 ounces of thickener. After the meat had processed for awhile, she indicated to</p>		<p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>All dietary staff has been in-serviced related to following of the menus and recipes when preparing pureed food. The in-service includes assuring that there is adequate puree food available for those residents that may receive double portions. The menus are established with correlating recipes as approved by the Registered Dietician. The Dietary Manager will be responsible for assuring that the appropriate products are in place to assure that the menus/recipes can be followed. See below for monitoring to assure recipes are being followed.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 meals to verify the menus and recipes were followed related to the puree diets and assurance that resident receiving double portions are included in pureed food served. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality</p>				

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	<p>her co-worker she had left out the beef base and gravy. She then added 2 teaspoons of beef base and 2 ounces of gravy to the food processor and placed the resulting product in a steam table pan. She appeared very uncertain throughout the process and looked from the actual recipe to the conversion paper several times. She was interviewed at that time. She indicated she usually looked at the recipe, but pureed up the number of servings they needed. She indicated she was told she needed to go by the book while being watched.</p> <p>Cook #1 indicated she still had to puree the cauliflower. She had a recipe for 40 servings and a white paper titled "Conversion to Portions (Pureed)." The recipe indicated to serve a #16 scoop. The conversion was from 40 to 10 servings and indicated the amount of cauliflower to be 27 ounces. No other ingredients were listed. Cook #1 indicated she pureed food daily when she worked. She indicated she would refer to the recipe but puree the number of servings she needed.</p> <p>Cook #1 proceeded to puree the cauliflower. She scooped up seven (7) 1/2 cup servings into the food</p>		<p>Assurance Committee will review the tools at the scheduled meetings with recommendations as needed if needed based on the outcome of the tools.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>September 4, 2013</p>				

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	<p>processor. She then added an unmeasured amount of thickener and then added vegetable broth to the mix. She poured the resulting product into a steam table pan.</p> <p>The tray line was observed on 8/8/13 at 11:56 a.m. Cook #1 was observed to be serving the pureed vegetable with a #16 scoop (2 ounces). She was serving the pureed meat with a 4 ounce scoop.</p> <p>At 12:48 p.m., the pureed meals had all been served. The meat was gone and the pureed cauliflower had enough left to cover the bottom of the 1/3 size steam table pan.</p> <p>The Director of Nurses provided a list of residents with orders for puree diets on 8/9/13 at 9:15 a.m. The residents listed were Residents #9 (double portions), #3 (double portions), #20 (double portions at lunch), #18 (double portions at lunch), and #23. The facility would then require 9 portions to fulfill the orders.</p> <p>2. During observation of the tray line on 8/8/13 at 12:14 p.m., Resident #4's tray was observed to be set up in the kitchen. Cook #1 placed two salisbury steaks on her plate, and double portions of sweet potatoes</p>						

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	<p>and cauliflower. She also received bread and jello. The tray card indicated she was on an 1800 calorie diet. The spread sheet posted above the steam table did not include an 1800 calorie diet to show staff what to put on the tray.</p> <p>Resident #4's clinical record was reviewed on 8/8/13 at 2:50 p.m. Physician's orders signed 7/19/13 indicated the resident was to be on an 1800 calorie, no concentrated sweets no added salt diet. There were no orders for double portions.</p> <p>3.1-20(i)(1) 3.1-20(i)(2) 3.1-20(i)(4)</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 interview, the facility failed to ensure food was stored, prepared and distributed under sanitary conditions for 1 of 1 kitchen observed, in that scoops and measuring cups were stored in contact with ice and food thickener, freezer food had freezer burn, and floors were sticky and soiled. This had the potential to affect all residents in the facility.</p> <p>Findings include: On 8/5/13 at 6:28 p.m. the kitchen area was observed. A plastic container of ice was on a food preparation table. The scoop was setting inside the container, in contact with ice. A small container of food thickener was observed setting on the food preparation table. Two measuring scoops were stored in the container, in contact with the food thickener.</p> <p>The dry storage area had a large</p>	F000371	<p>F371</p> <p>It is the practice of this facility to assure that foods and utensils are stored properly in accordance with facility policy and that food is discarded appropriately and floors are clean.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>No specific residents were identified. The utensils are now stored properly and no longer in the ice or the thickener containers, the identified freezer burned food has been discarded, and the floors are kept clean.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially all residents could be effected. Because of the corrections that have been implemented, the utensils are stored properly, foods are discarded as needed, and the</p>	09/04/2013	

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	<p>container of thickener on a shelf; two measuring cups were stored in the container in contact with the food thickener.</p> <p>Freezer #2 was observed to have a package of meat, opened 5/2/13, with freezer burn. A sausage package had been opened; the sausages had frost built up on them. No date was noted when the package was opened. Six packages of sliced lunch meat were observed with accumulated frost inside the package and freezer burn.</p> <p>The floor throughout the kitchen was soiled, especially under equipment and around the edges. The floor was sticky.</p> <p>The kitchen area was observed again on 8/8/13 at 10:40 a.m. A container of food thickener was observed on the edge of the three compartment sink. Two scoops were stored in the container, in contact with the thickener.</p> <p>Steam table pans with leftover food from breakfast, grits and gravy, were setting on a food preparation table uncovered.</p> <p>The dry storage area had a large container of sugar; the scoop was</p>		<p>floors are kept clean and are not sticky.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The dietary staff has been in-serviced related to storage of utensils separately from the food source, disposing of food items as needed, and routine cleaning of dietary floors. This will be monitored by the new dietary manager. Please refer to monitoring systems to assure compliance dishwasher sanitization and food storage.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement tool has been established that randomly reviews for storage of utensil, food products to assure that they are stored properly and discarded as needed, and observes for cleanliness of dietary floors. The Dietary Manager, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcomes of</p>				

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	<p>stored in contact with the sugar.</p> <p>Two scoops were stored in a large container of thickener in the dry storage area.</p> <p>The floor throughout the kitchen was sticky and soiled.</p> <p>Interview with the Administrator, on 8/9/13 at 8:38 a.m., indicated the dietary manager had quit early in July, 2013 and he was having problems getting a dietitian from his contracted service. He indicated oversight in the kitchen was lacking.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>the tool.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>September 4, 2013</p>				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review</p>	F000441	F441	09/04/2013			

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	<p>and interview, the facility failed to ensure the prevention of cross-contamination by use of transmission based precautions in the cleaning of the glucometer machine (a machine used to obtain a blood sugar), for 2 of 2 residents observed during blood sugar checks. The facility also failed to ensure hands were washed between soiled and clean tasks during care of 1 of 5 residents observed receiving personal care. (Residents #2, #26, #13)</p> <p>Findings include:</p> <p>1. An accucheck (blood glucose check) was performed on Resident #2 on 8/8/13 at 11:24 a.m. by RN #1. RN #1 obtained the glucometer from a box that was placed on the medication cart and performed the accucheck on Resident #2. On completion of the accucheck, RN #1 proceeded to wipe the glucometer with a germicidal wipe for approximately 2-3 seconds and placed the glucometer into the box. The glucometer was dry when checked immediately after being placed in the box.</p> <p>Upon query, RN #1 indicated the glucometer was used for all the residents who required accuchecks.</p>		<p>It is the practice of Transcendent Healthcare of Boonville North to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents #2 and #26 are have accu-checks performed by a glucometer machine that is being sanitized in accordance with the manufacturer's guidelines</p> <p>Resident #13 is receiving peri-care appropriately with the proper hand sanitation.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents that receive accu-checks are being performed by a glucometer machine that is being sanitized in accordance with the manufacturer's guidelines</p> <p>All residents could potentially be affected in the area of handwashing. Based on the systems implemented all residents are receiving services in a manner which promotes acceptable infection</p>				

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	<p>RN #1 indicated she was going to do another accucheck on Resident #26 at that time. RN #1 was stopped prior to obtaining another accucheck.</p> <p>Upon query, RN #1 indicated she thought the glucometer was dry. RN #1 proceeded to read the directions on the germicidal wipe package. RN #1 proceeded to obtain another germicidal wipe and rewiped the glucometer. RN #1 laid the glucometer out to dry for 2 full minutes. On query, RN #1 indicated there were no residents who were immuno-compromised in the facility at that time.</p> <p>The instructions for the germicidal wipe, obtained from LPN #1 on 8/8/13 at 11:49 a.m., indicated the surface of the item was to be thoroughly wet. The instructions indicated the treated surface was to remain visibly wet for a full 2 minutes.</p> <p>During an interview with the DoN (Director of Nursing) on 8/8/13 at 2:15 p.m., she indicated the glucometer was to be visibly wet for a full 2 minutes.</p> <p>A policy, obtained from the DoN on 8/9/13 at 9:06 a.m., indicated the manufacturer's guidelines were to be</p>		<p>control.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted for all nurses and QMAs related to proper sanitizing of the glucometer machine in accordance with the manufacturer's guidelines. An in-service has also been conducted for all nursing staff related to proper infection control practices in relation to handwashing. The facility will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents related to following of proper infection control procedures during the provision of services. The observations incontinence care and glucometer sanitation. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately</p>				

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	<p>followed based on the disinfectant that was used for cleaning and disinfecting.</p> <p>2. Resident #13 was observed to receive pericare on 8/8/13 at 8:20 a.m. CNA #1 was observed to wash her hands and apply clean gloves prior to giving the care. During the pericare, Resident #13 was observed to have had a BM (bowel movement). CNA #1 was observed to change her gloves after cleaning the feces from the resident's rectal area. CNA #1 proceeded to turn Resident #13 onto her right side and change the bottom sheet and under pad without washing her hands before or after changing her gloves.</p> <p>During an interview with CNA #1 on 8/8/13 at 9:42 a.m., CNA #1 indicated she had forgot to sanitize her hands before turning the resident to her side and changing the bottom sheet and under pad.</p> <p>A policy, titled "Infection Control" and obtained from the DoN (Director of Nursing on 8/8/13 at 11:10 a.m., indicated staff should wash their hands at appropriate times and handwashing was the best way to prevent the spread of infection.</p>		<p>occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed:</p> <p>September 4, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/09/2013
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	3.1-18(b)(1) 3.1-18(l)				

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the environment was sanitary and comfortable for 3 of 19 rooms observed in the Stage I sample of 19 rooms observed for odors. (Rooms 7, Room 8, and Room 15)</p> <p>Findings include:</p> <p>During the initial tour of the facility on 8/6/13, the following rooms were found to have strong urinary odors:</p> <ol style="list-style-type: none"> Room 7 was observed on 8/6/13 at 12:54 p.m. There was an odor of urine in the bathroom. The room was observed again on 8/9/13 at 7:35 a.m. The room continued to have a strong odor of urine the the bathroom, Room 8 was observed on 8/6/13 at 8:55 a.m. There was a strong odor of urine in the bathroom and the commode had a dark yellow stain around the base. The room was observed again on 8/9/13 at 7:37 a.m. There was a strong odor of urine in the bathroom. 	F000465	<p>F465</p> <p>It is the practice of Transcendent Healthcare of Boonville North to assure that a safe, functional, sanitary, and comfortable environment for residents, staff, and the public is provided.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>No specific residents were identified. Rooms 7, 8, and 15 bathrooms have been thoroughly cleaned and have no odors.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents rooms/bathrooms have been reviewed to assure clean and odor free.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p>	09/04/2013			

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	<p>3. Room 15 was observed on 8/6/13 at 4:28 p.m. There was a strong odor of urine and feces in the room. There room was observed again on 8/9/13 at 7:40 a.m. The room had a strong odor of urine.</p> <p>During an interview with the Adm (Administrator) on 8/9/13 at 9:02 a.m., the Adm indicated the bathrooms of rooms 7 and 8 did have a strong urine odor and the rooms did not meet his standards. The Adm indicated the bathrooms would be cleaned.</p> <p>3.1-19(f)</p>		<p>An in-service has been conducted for nursing staff and housekeeping staff related to cleanliness of resident rooms and bathrooms. Housekeeping is to clean each resident bathroom every day for cleanliness. Nursing has the responsibility to notify housekeeping if an odor is identified that needs to be immediately resolved. Administration will be making rounds through the facility daily to assure that rooms/bathrooms are clean and odor free.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents rooms/bathrooms related to cleanliness. The Administration, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><i>The date the systemic changes will be completed:</i></p>		

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