

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/29/2011
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NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
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F0000	<p>This visit was for the Investigation of Complaints IN00099598 and IN00099610. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00099598 - Substantiated. Federal/State deficiencies related to the allegations are cited at F328.</p> <p>Complaint IN00099610 - Substantiated. Federal/State deficiencies related to the allegations are at F224, F225, F226, F241, F312, F353, and F364.</p> <p>Unrelated deficiency cited.</p> <p>Survey date: November 17, 2011 Extended Survey dates: November 21, 22, 23, and 29, 2011</p> <p>Facility number: 000185 Provider number: 155287 AIM number: 100290840</p> <p>Survey team: Regina Sanders, RN Marcia Mital, RN</p> <p>Census bed type: SNF/NF: 107 Total: 107</p>	F0000	<p>This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.</p>	
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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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	<p>Census Payor type: Medicare: 13 Medicaid: 79 Other: 15 Total: 107</p> <p>Sample: 11 Supplemental sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/01/11 by Suzanne Williams, RN</p>						

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F0224 SS=G	<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 observation, record review, and interview, the facility failed to ensure a resident's care was not neglected related to not assisting residents to the bathroom as needed in a timely manner and call lights being turned off and the residents' needs not being met, which resulted in incontinence and tearfulness of a resident (Resident #H). This affected 1 of 9 residents who required assistance with toileting in a sample of 11 (Resident #H), 1 of 8 residents in a supplemental sample of 8 (Resident #R), and 2 of 3 families of residents confidentially interviewed.</p> <p>Findings include:</p> <p>1) During an interview on 11/21/11 at 9:15 a.m., Resident #H indicated she has to wait long periods of time to get help to the bathroom. She indicated she has been incontinent because she has had to wait so long for help. During the interview, the resident became tearful and upset when talking about having to wait for help to use the bathroom and having some incontinence of urine.</p> <p>During an observation on 11/21/11, at 12:07 p.m., the SDC (Staff Development</p>	F0224	<p>F 2241) Corrective action for the residents found to have been affected by the deficient practice: Resident #H's urinary assessment was reviewed by licensed nurses and care plan updated by licensed nurses on 12-13-11. Resident #H's call light is answered timely and will not be turned off until needs are met. Social Services assessed Resident #H on 11-21-11 through 11-28-11 and no signs of distress were noted. Resident #R is brought to the bathroom before and after meals. The care plan was updated on 12-9-11 by licensed nurse. A staff member will be available in the dining room during meals to assist residents with toileting needs. Social Services assessed Resident #R on 11-23-11 and 11-26-11 and no signs of distress were noted. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice: Residents requiring assistance with toileting needs have the potential to be affected. Residents' urinary status have been re-assessed by licensed nurses and will be completed on 12-27-11 to ensure they accurately reflect residents' toileting needs. Care plans will be</p>	12/28/2011			

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	<p>Coordinator) was passing the noon meal trays. Resident #H's call light was activated and the SDC answered the call the light, and Resident #H indicated she needed to use the bathroom. The SDC informed Resident #H she would go and get some help. The SDC then went back to passing the food trays to the residents on the unit then returned to the Nurses' Desk checking a resident's record.</p> <p>During an observation on 11/21/11 at 12:16 p.m., the SDC was still at the Nurses' Desk. No one had went in to help Resident #H to the bathroom. The SDC then left the unit without getting assistance to help the resident to the bathroom.</p> <p>During an interview on 11/21/11 at 12:20 p.m., Resident #H's family member indicated the resident had asked to go to the bathroom, but no one had come to help her.</p> <p>During an interview on 11/21/11 at 12:25 p.m., Resident #H had indicated she still needed to go to the bathroom and she was feeling very uncomfortable. The call light was reactivated and LPN #7 answered the call light and told the resident she would go and get some help to assist her to the bathroom.</p>		<p>updated or reviewed by licensed nurse by 12-27-11 with accurate toileting program for residents. Residents' call lights will be answered timely and will not be turned off until resident needs are met. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the unit for residents receiving room trays to meet residents' toileting needs. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:The Staff Development Coordinator was re-educated on 12-14-11 by the Executive Director on the policy not to turn call lights off until the residents' needs are met. Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding not turning call lights off until the resident's needs are met, answering call lights in a timely manner, and the staff members assigned to the dining room and on the halls during meals to assist residents with toileting needs. Nursing assignment sheets have been revised on 12-14-11 to include a staff member be assigned to the dining room and on the units for residents receiving room trays to meet residents' toileting needs. This education also included a review of urinary assessments, the different toileting programs used and how it affects resident care.</p>		

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	<p>During an observation on 11/21/11 at 12:30 p.m., CNA #8 and QMA #9 entered Resident #H's room to assist the resident onto the bedside commode.</p> <p>During an interview on 11/21/11 at 12:45 p.m., the SDC indicated resident #H had wanted assistance to the bathroom when she had answered the resident's call light. The SDC indicated she went and told the CNAs on the unit, the resident needed to use the bathroom.</p> <p>During an interview on 11/21/11 at 12:48 p.m., QMA #9 (working the unit) indicated she was first aware the resident needed to go to the bathroom when LPN #7 came and told her.</p> <p>During an interview on 11/21/11 at 12:50 p.m., CNA #8 (working the unit) indicated she was unaware Resident #H needed to use the bathroom until LPN #7 came and told her.</p> <p>Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated 10/28/11, indicated a cognitive pattern</p>		<p>Staff that are not currently working will not be allowed to work until they have received this education. 4) Correction actions will be monitored to ensure the deficient practice will not recur:</p> <p>Lights should be answered with in 5 minutes but no later then 10, and left on until residents' needs are addressed. Facility will interview random alert and oriented residents to ensure toileting needs are being met including each mealtime by staff. The audits will be a total of 10 combined residents taken from each unit. Interviews will be conducted by the ED/DON/designee, 3 x a week x 4 weeks then monthly x 3 months, then quarterly x 2 or until at 95% compliance. Random audits of 10 residents, for call light response time and meeting resident's needs during each mealtime will be conducted sampling all units. Audits will be conducted by the ED/DON/designee 3 x a week x 4 weeks, then monthly x 3 months then quarterly x 3 or until 95% compliance. Findings from the resident interviews and call light audits will be presented monthly by the ED/DON to the Performance Improvement Committee for further review and</p>		

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	<p>score of 15 (cognition intact), and required extensive assistance of two or more for bed mobility, transfers, and toilet use. The MDS assessment indicated the resident was frequently incontinent.</p> <p>2) During an interview on 11/21/11 at 11:55 a.m., Resident #R indicated they wait sometimes an hour for his call light to be answered and to be assisted to the bathroom. Resident #R indicated this happens frequently at meal times.</p> <p>Resident #R was identified as alert, oriented, and interviewable by RN #10 during the initial tour on 11/17/11 at 12:20 p.m.</p> <p>Resident #R's record was reviewed on 11/23/11 at 8 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The CNA care card indicated the resident required 2 persons to transfer the resident.</p> <p>3) During a confidential family interview on 11/20/11, a family member indicated during meals all the staff are off the floor, and they will not assist their family member to the bathroom until all the residents are back from the dining room. The family member indicated when their</p>		<p>recommendations 12-28-2011</p>		

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	<p>family member rings her call light, the staff will come in to answer it, turn it off and tell their family member they will be back, then it is about 15-20 minutes before anyone will come back into the room.</p> <p>4) During another confidential family interview on 11/21/11, a family member indicated sometimes their family member waits 15-30 minutes to get help to the bathroom. They indicated the staff will answer the call light, they tell the resident they will go get help, but then the resident waits a long time for the staff to return. The family member indicated this happens a lot, especially during the meal times.</p> <p>5) During another confidential family interview on 11/21/11, a family member indicated their family member sometimes has to wait an hour to an hour and a half for assistance to the bathroom. The family member indicated they have been told the resident has to wait until the dining room is cleared out before they can assist the resident to the bathroom.</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-27(a)(3) 3.1-28(a)</p>				

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F0225 SS=K	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Administrator was notified immediately of allegations of abuse and failed to</p>	F0225	F2251) Corrective action for the residents found to have been affected by the deficient practice: Resident #B had a head to toe assessment by	12/28/2011

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	<p>investigate and report the allegation of abuse to the Indiana State Department of Health (ISDH), in a timely manner, which resulted in the residents on the unit not being protected from potential further abuse for 2 of 24 residents (Residents #B and #C) who resided on the Special Care Unit and 1 of 15 residents (Resident #H) who resided on the Skilled Unit. This had the potential to affect all 24 residents who reside on the Special Care Unit and 15 residents who reside on the Skilled Unit.</p> <p>The immediate jeopardy began on 11/17/11 when the facility failed to notify the Administrator immediately of the allegation, failed to protect the residents on the Special Care Unit from potential further abuse, and failed to investigate and report the allegation of abuse. The Administrator was notified of the immediate jeopardy on 11/21/11 at 2:10 p.m. The immediate jeopardy was removed on 11/23/11, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A confidential interview on 11/21/11 indicated Resident #B had said a resident male comes in to the room and, "gropes" 		<p>nursing staff on 11-21-11 and there were no unusual findings. The physician was notified of the resident's allegation. The physician documented that Resident #B is confused quite often. Social services assessed Resident #B on 11-22-11, 11-23-11 and 11-26-11, and Resident #B exhibited no signs of distress. A Stop Sign was placed at the entrance to Resident #B's room to discourage entry for any wandering residents. Two staff members will provide care for Resident #B. Resident #B's care plan was revised on 11-21-11. Resident #C had a head to toe assessment by nursing staff on 11-21-11 and there were no unusual findings. Resident #C is incontinent and does require frequent incontinent care needs. Two male caregivers were suspended pending the outcome of the investigation. Both caregivers were brought back after the investigation was unable to be substantiated. Social Services assessed Resident #C on 11-21-11, 11-22-11, 11-27-11 and 11-28-11 and Resident #C exhibited no signs of distress. A Stop Sign was placed at the entrance to Resident #C's room to discourage entry for any wandering residents. Two staff members will provide care for Resident #C. Resident #H had a head to toe assessment by licensed nurse on 11-21-11 and there were no unusual findings.</p>				

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	<p>Resident #C . The confidential interview indicated the hospital called the facility on 11/17/11 and reported the allegation to the nurse on Resident #B's unit.</p> <p>A hospital Emergency Room (ER) report, dated 11/17/11, indicated Resident #B (Resident #C's roommate) was in the ER due to a loss of consciousness.</p> <p>An ER note, dated 11/17/11 at 11:30 a.m., indicated, "PT (patient) states there is a large, tall gentleman who sneaked into my room at night and fondeled (sic) my neighbor. (Physician's Name) notified."</p> <p>An ER note, dated 11/17/11 at 12:22 p.m., indicated, "Report given to (Nurses Name). RCC (Rensselaer Care Center)..."</p> <p>During an interview on 11/21/11 at 11:30 a.m., LPN #2 indicated after she received report from the ER nurse and was told about the allegation, she reported the allegation to her Unit Manager.</p> <p>During an interview on 11/21/11 at 11:40 a.m., The SCU (Special Care Unit) Manager indicated LPN #2 had reported the allegation to her and she then informed the Administrator and the Director of Nursing (DoN) and notified the physician on call. She indicated she had not charted the allegation in the</p>		<p>The physician and Power Of Attorney were notified on 11-20-11. Social Services assessed the resident 11-21-11 through 11-28-11 and Resident #H had no signs of distress. The CNA was suspended pending outcome of the investigation and then was terminated. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents residing in the facility have the potential to be affected. Immediately after the ED was notified of the full allegation of abuse, residents were interviewed 11-21-11 to ensure no outstanding allegations of abuse existed. Cognitively impaired residents had head to toe assessments by licensed nurse on 11-21-11 with no unusual findings. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:Executive Director was educated on 11-21-11 by the Regional Vice President on reporting allegations to ISDH and the reporting guidelines. The Unit Manager that received the report from the licensed nurse on the unit was counseled regarding her immediately reporting any abuse allegation to the Executive Director and supervisor. On 11-23-11 staff were inserviced by the facility management team on immediately reporting allegations</p>		

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	<p>resident's record because she was not sure she should.</p> <p>During an interview on 11/21/11 at 12:05 p.m., LPN #2 indicated she had received report from the ER nurse at the hospital and the nurse had told her the resident had said there was a tall dark guy who comes in her room and goes over to her roommate and does something under the cover. LPN #2 indicated the ER nurse said the resident pointed toward the private area. LPN #2 indicated there was a tall, male resident on the unit (Resident #D) who wanders into other residents' rooms. LPN #2 indicated Resident #C was Resident #B's roommate.</p> <p>During an interview on 11/21/11 at 12 p.m., the Administrator indicated it was reported to him that someone went into the resident's room at night and checks her private part. He indicated he did not feel it was an allegation of abuse because it was truthful statement, because they do go in and check the resident for incontinency during the night.</p> <p>During an interview on 11/21/11 at 12:40 p.m., the Administrator indicated he had been told about a dark man going into the room but not about the private areas. He indicated he was told the tall dark man was from the hospital. He indicated he is</p>		<p>of abuse to their supervisor and the Executive Director. Nursing staff to be educated by Director of Nursing/Designee by 12-27-11 regarding immediate reporting and thoroughly investigation any allegation of abuse. 4) Correction actions will be monitored to ensure the deficient practice will not recur:ED/Social Services Director/designee will interview a total of 10 random staff. Interviews will consist of questioning staff on comprehension and understanding of the abuse policy and reporting procedures. Interviews will be conducted on each shift on a weekly basis x 4 weeks, then monthly x 3 then quarterly x 2 or until at 95% compliance. Staff will be asked different scenarios to generate discussion about their knowledge on abuse and dignity.ED/designee will interview random alert and oriented residents regarding how staff treats the resident, or if they witnessed any abuse. The interviews will be a total of 10 combined resident's taken from each unit on a weekly basis x 4 weeks, monthly x 3 then quarterly x 2 or until at 95% compliance.ED/designee will also review resident concerns/grievance log and resident council minutes to</p>				

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	<p>now hearing conflicting statements, and that from what he heard today, he would do an investigation and report the allegation.</p> <p>During an interview on 11/21/11 at 2:50 p.m., the SCU Unit Manager indicated she had reported what the ER nurse had said, that it was a tall dark man and that he touched the resident's private areas. She indicated she told the Social Service Director, and the Social Service Director told the Administrator. She indicated the policy states to notify the Administrator of all allegations.</p> <p>During an interview on 11/21/11 at 2:50 p.m., the ADoN indicated she was told it was some large man that went into the resident's room. She stated, "that is all I can remember." She indicated she thought it was someone from the hospital.</p> <p>A Witness Statement Form, dated 11/21/11 at 12:50 p.m., and signed by LPN#2, indicated, "...a nurse from (hospital name) ER called report to writer on res (resident)...reported that res...told her that a tall dark man comes in her room et goes over to roommate et touches her roommates the nurse said she...made a hand gesture insinuating touching in the peri area...Writer reported it to the Unit Manager."</p>		<p>ensure appropriate follow through and immediate investigation of allegations of abuse on a weekly basis x 4 week, monthly x 3 then quarterly x 2 or until 95% compliance.RVP/Designee will review the residents' interviews, the ED/designee audits on concerns/grievance log and the resident council minutes to ensure timely notification and thorough investigation and reporting timely to ISDH on allegations of abuse on a monthly basis x 6 months with threshold to be 100%.The Regional Director of Clinical Services/designee will review abuse investigations to ensure timely notification to the ED, thorough investigation and reporting timely to ISDH on a monthly basis x 6 months with threshold to be 100%.The ED/designee will bring results of these resident interviews and audits of the concern/grievance log and resident council minutes to the Performance Improvement Committee for further review and recommendations. 5) Date of compliance: 12-28-11</p>				

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	<p>A Witness Statement Form, dated 11/21/11 at 1:50 p.m., and signed by the Social Service Director, indicated, "writer notified on 11/17/11 by Special Care Unit Manager that charge nurse...was informed by nurse at (hospital name) that (resident name) reported a tall dark man had entered res room at night. ED (Executive Director) (Administrator) notified immediately on 11/17/11. On 11/21/11 writer & ED notified by Unit Manager that res. alleged her roommate was touched in peri-area. I was not aware of peri-area allegation until 11/21/11."</p> <p>The investigation, dated 11/21/11, and received from the Administrator, indicated a male CNA had been notified to call the facility and would be placed on suspension until the investigation has been completed. The form indicated the resident had not alleged the male CNA, but he is the only male employee that works midnights on special care and the last day the employee had worked was on 11/08/11.</p> <p>A Witness Statement Form, dated 11/21/11 at 2 p.m., and signed by the SCU Unit Manager, indicated, "... (Resident name) made an allegation that there was a tall dark man that came into their room at night & touched her</p>			
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	<p>roomates (sic) private parts...I was told this by the nurse on SCU & I reported this to the ADoN & Social Services."</p> <p>Resident #D was observed on 11/21/11 at 2:45 p.m. wandering independently around the hallway in the SCU.</p> <p>A) Resident #D's record was reviewed on 11/21/11 at 11:25 a.m. Resident #D's diagnoses included, but were not limited to, dementia.</p> <p>Resident D's nurses' notes indicated: 10/16/11 at 11:03 a.m., "...urinated on floor of co-resd (resident) room..." 10/17/11 at 5 a.m., "Res (Resident) up @ (at) 1:00 a.m. ambulating in hallway..." 10/18/11 8 p.m., "15 min (minute) safety checks continue- res ambulating in halls of SCU most of shift..." 10/20/11 at 9:30 p.m., "...Res continues to exit seek and wander in and out of other res rooms uninvited. Res not easily redirected and is uncooperative @ times." 10/21/11 at 9:45 p.m., "...Res also wanders in and out of other res rooms taking objects..." 10/24/11 at 8:15 p.m., "...15 min checks (indicated by a check mark) continue...ambulates frequently & goes into other res rooms..." 10/27/11 at 9:30 p.m. "...wanders in and out of other res's rooms..."</p>			
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	<p>10/31/11 at 6:45 p.m., "...res ambulates independently throughout unit often wanders into co-res rooms uninvited..."</p> <p>11/3/11 at 9:45 p.m., "...Res continues to exit seek, wander in/out of other res rooms taking things, and is combative and uncooperative w/ staff..."</p> <p>11/3/11 2 a.m., "...ambulates independently..."</p> <p>11/6/11 at 3:50 a.m., "...res continues to remove personal items out of others rooms..."</p> <p>11/6/11 at 11 p.m., "...res vomited in another res room..."</p> <p>11/9/11 at 9:50 p.m., "...res continues to ambulate around unit...taking other resident's belonging, and being non-cooperative w/ staff..."</p> <p>11/10/11 at 5:55 a.m., "...res ambulates independently throughout unit..."</p> <p>11/10/11 at 10 p.m., "...Res continues to exit seek, take things that don't belong to him..."</p> <p>11/14/11 at 9:00 p.m., "...Res had also urinated in another resident's trash can in their room."</p> <p>11/15/11 at 5:30 a.m., "...15 min checks (indicated by a check mark) continue...res OOB (out of bed) most of shift wandering in halls , going into co-res rooms..."</p> <p>11/15/11 at 7:30 p.m., "...Needs frequent redirection c staying out of other res rooms/belongings..."</p>			
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	<p>Resident D's care plans, indicated: A care plan, dated 10/21/11, "...I wander the units...I will often wander unit and go into co-res rooms...." A care plan, dated 11/1/11, "...I void in inappropriate places...trash cans other resident's room..."</p> <p>B) Resident #B's record was reviewed on 11/21/11 at 2:20 p.m. The resident's diagnoses included, but was not limited to, dementia with agitation and hypertension.</p> <p>Resident #B's Admission/5 day Minimum Data Set Assessment (MDS), dated 09/15/11 indicated the resident had impaired cognition.</p> <p>Resident #B's Risk worksheet for Abuse, Neglect & Exploitation, dated 11/06/11, indicated the resident was at risk for abuse due to a diagnosis of dementia and confusion.</p> <p>C) Resident #C's record was reviewed on 11/21/11 at 2:40 p.m. The resident's diagnoses included, but were not limited to, dementia and psychosis.</p> <p>The resident's Quarterly MDS assessment, dated 10/25/11, indicated the resident had a short-term memory problem and was moderately impaired for decision making.</p>				

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	<p>The resident's Risk worksheet for Abuse, Neglect & Exploitation, dated 04/22/11, indicated the resident was at risk for abuse due to a diagnosis of dementia, confusion, poor judgement skills, receiving psychotropic medications, and depression.</p> <p>2. Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated 10/28/11, indicated a cognitive pattern score of 15 (cognition intact), and required extensive assistance of two or more for bed mobility, transfers, and toilet use.</p> <p>A Facility Incident Reporting Form, incident date 11/20/11, and received at the ISDH on 11/21/11, indicated, "(resident name) reported to her nursing assistant that the (sic) she was being treated mean by the day girl (CNA name). She nudges her to use the bathroom instead of the bedside commode, and she is afraid she will fall..."</p> <p>The Witness Statement Forms indicated:</p>				

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	<p>11/20/11 at 5:35 p.m., written and signed by CNA #3, indicated, " Saturday the 19th, (CNA #3 and CNA #4 names) were putting (resident name) to bed from the wheel chair (sic) and when she stood up she wouldn't stand very well, so I had a hold of the gait belt and so did (CNA #4) and (resident name) was standing kinda still in front of the wheel chair (sic) and (CNA #4 name) said stand up or your gonna fall. Kept saying that and then... (CNA #4) let it go (gait belt) and I eased the (resident name) into the wheel chair (sic)."</p> <p>11/20/11 at 5:35 p.m., written and signed by CNA #5, indicated, "When getting report from (CNA #4) the last two times I've worked...(CNA#4) says we need to make (resident name) walk to the bathroom even if she refuses to. She says that you use the gait belt and stand her up then give her a little push and let go till she start (sic) moving her feet..."</p> <p>11/22/11 at 3:10 p.m., written and signed by LPN #6, date of incident 11/19/11, time of incident 6-2, "I was not informed of any allegations of abuse with (resident name), from family, resident or staff at any time during my shifts."</p> <p>The Skilled Unit nursing schedules, dated</p>			
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	<p>11/01/11 through 11/22/11, received from the ADoN (Assistant Director of Nursing), indicated CNA #5 had last worked on the Skilled unit on 11/18/11 and 11/20/11.</p> <p>During an interview on 11/22/11 at 2:05 p.m., CNA #5 indicated she had concerns with CNA #4 telling the resident she had to walk even though the resident had refused. She indicated on 11/20/11, when CNA #4 said to give her (resident) a little push, CNA #4 then let go of the resident. CNA #5 indicated she had not told anyone about the incident. She indicated she should have reported CNA #4 was making the resident walk to the bathroom and that she said to give the resident a little push.</p> <p>During an interview on 11/22/11 at 2:30 p.m., CNA #3 indicated CNA #4 kept telling the resident she was going to fall and then CNA #4 let go of the gait belt. She indicated she had told CNA #4 the resident needed to use the bedside commode and CNA #4 said no, she is going to use the bathroom. She indicated when CNA #4 let go of the resident's gait belt, the resident fell back and CNA #3 eased the resident into the wheelchair. CNA #3 indicated she did not report the incident to anyone. She indicated she should have reported the incident on</p>				

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	<p>11/19/11.</p> <p>During an interview on 11/22/11 at 1:43 p.m., the DoN indicated she had not been told about the allegation until 11/20/11.</p> <p>The immediate jeopardy that began on 11/17/11 was removed on 11/23/11 when the facility initiated an investigation of the allegation of abuse, notified the resident's families and physicians, and implemented interventions to prevent potential abuse from occurring. The facility revised the abuse policy to include immediately notifying the Administrator if abuse is seen, heard, and/or suspected. The facility had staff assigned for continuous monitoring of the Special Care Unit to ensure resident safety. All interviewable residents in the facility were interviewed to ensure no outstanding allegations of abuse exist. 140 of 147 staff members were inserviced on the revised abuse policy. 23 employees interviewed were able to explain the revised procedure if they see, hear, and/or suspect abuse. The Administrator was inserviced by the Corporate Regional Vice President, to include the need to immediately investigate all allegations of abuse. Staff will be questioned by the facility for knowledge of the revised abuse policy. Audits were completed by the facility through interviewing alert and oriented</p>				

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	<p>residents about care issues and staff were interviewed for their knowledge of the revised abuse policy. The facility will continue to audit staff daily on all shifts for the first week and then monthly with the results of the audit to be forwarded to the performance improvement committee. The resident concerns/grievance log and resident council minutes will be reviewed to ensure immediate investigations of all concerns have been initiated. The audits will be completed weekly by the Administrator and monthly by the Regional/Divisional staff and then forwarded to the performance improvement committee.</p> <p>Noncompliance remained at the lower scope and severity level of pattern no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility has not inserviced all staff, and they will continue to audit staff and residents to ensure the facility abuse policy is followed.</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>				

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F0226 SS=K	<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 observation, record review and interview, the facility failed to follow their abuse prevention policy and procedure by failing to ensure the Administrator was notified immediately of allegations of abuse and failed to investigate and report the allegation of abuse to the Indiana State Department of Health (ISDH), in a timely manner, which resulted in the residents on the unit not being protected from potential further abuse for 2 of 24 residents (Residents #B and #C) who resided on the Special Care Unit and 1 of 15 residents (Resident #H) who resided on the Skilled Unit. This had the potential to affect all 24 residents who reside on the Special Care Unit and 15 residents who reside on the Skilled Unit.</p> <p>The immediate jeopardy began on 11/17/11 when the facility failed to notify the Administrator immediately of the allegation, failed to protect the residents on the Special Care Unit from potential further abuse, and failed to investigate and report the allegation of abuse. The Administrator was notified of the immediate jeopardy on 11/21/11 at 2:10 p.m. The immediate jeopardy was removed on 11/23/11, but noncompliance</p>	F0226	<p>F2261) Corrective action for the residents found to have been affected by the deficient practice: Resident #B had a head to toe assessment by nursing staff on 11-21-11 and there were no unusual findings. The physician was notified of the resident's allegation. The physician documented that Resident #B is confused quite often. Social services assessed Resident #B on 11-22-11, 11-23-11 and 11-26-11, and Resident #B exhibited no signs of distress. A Stop Sign was placed at the entrance to Resident #B's room to discourage entry for any wandering residents. Two staff members will provide care for Resident #B. Resident #B care plan was revised 11-21-11. Resident #C had a head to toe assessment by nursing staff on 11-21-11 and there were no unusual findings. Resident #C is incontinent and does require frequent incontinent care needs. Two male caregivers were suspended pending the outcome of the investigation. Both caregivers were brought back after the investigation was unable to be substantiated. Social Services assessed Resident #C on 11-21-11, 11-22-11, 11-27-11 and 11-28-11 and Resident #C</p>	12/28/2011	

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	<p>remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. A confidential interview on 11/21/11 indicated Resident #B had said a resident male comes in to the room and, "gropes" Resident #C . The confidential interview indicated the hospital called the facility on 11/17/11 and reported the allegation to the nurse on Resident #B's unit.</p> <p>A hospital Emergency Room (ER) report, dated 11/17/11, indicated Resident #B (Resident #C's roommate) was in the ER due to a loss of consciousness.</p> <p>An ER note, dated 11/17/11 at 11:30 a.m., indicated, "PT (patient) states there is a large, tall gentleman who sneaked into my room at night and fondled (sic) my neighbor. (Physician's Name) notified."</p> <p>An ER note, dated 11/17/11 at 12:22 p.m., indicated, "Report given to (Nurses Name). RCC (Rensselaer Care Center)..."</p> <p>During an interview on 11/21/11 at 11:30 a.m., LPN #2 indicated after she received report from the ER nurse and was told about the allegation, she reported the</p>		<p>exhibited no signs of distress. A Stop Sign was placed at the entrance to Resident #C's room to discourage entry for any wandering residents. Two staff members will provide care for Resident #C. Resident #H had a head to toe assessment on 11-21-11 by licensed nurse and there were no unusual findings. The physician and Power Of Attorney were notified on 11-20-11. Social Services assessed the resident on 11-21-11 through 11-28-11 and Resident #H exhibited no signs of distress. The CNA was suspended pending outcome of the investigation and then was terminated. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents residing in the facility have the potential to be affected. Immediately after the ED was notified of the full allegation of abuse, residents were interviewed on 11-21-11 to ensure no outstanding allegations of abuse existed. Cognitively impaired residents had head to toe assessments by licensed nurse with no unusual findings on 11-21-11. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:Executive Director was educated on 11-21-11 by the Regional Vice President on reporting allegations to ISDH and the reporting</p>		

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	<p>allegation to her Unit Manager.</p> <p>During an interview on 11/21/11 at 11:40 a.m., The SCU (Special Care Unit) Manager indicated LPN #2 had reported the allegation to her and she then informed the Administrator and the Director of Nursing (DoN) and notified the physician on call. She indicated she had not charted the allegation in the resident's record because she was not sure she should.</p> <p>During an interview on 11/21/11 at 12:05 p.m., LPN #2 indicated she had received report from the ER nurse at the hospital and the nurse had told her the resident had said there was a tall dark guy who comes in her room and goes over to her roommate and does something under the cover. LPN #2 indicated the ER nurse said the resident pointed toward the private area. LPN #2 indicated there was a tall, male resident on the unit (Resident #D) who wanders into other residents' rooms. LPN #2 indicated Resident #C was Resident #B's roommate.</p> <p>During an interview on 11/21/11 at 12 p.m., the Administrator indicated it was reported to him that someone went into the resident's room at night and checks her private part. He indicated he did not feel it was an allegation of abuse because</p>		<p>guidelines. The Unit Manager that received the report from the licensed nurse on the unit was counseled regarding her immediately reporting any abuse allegation to the Executive Director. On 11-23-11 staff were inserviced by the facility management team on immediately reporting allegations of abuse to their supervisor and the Executive Director and investigating allegations of abuse. Nursing staff to be educated by Director of Nursing/Designee by 12-27-11 regarding immediate reporting and thoroughly investigation any allegation of abuse. 4) Correction actions will be monitored to ensure the deficient practice will not recur: ED/Social Services Director/designee will interview a total of 10 random staff. Interviews will consist of questioning staff on comprehension and understanding of the abuse policy and reporting procedures. Interviews will be conducted on each shift on a weekly basis x 4 weeks, then monthly x 3 then quarterly x 2 or until at 95% compliance. Staff will be asked different scenarios to generate discussion about their knowledge on abuse and dignity. ED/designee will interview random alert and oriented residents regarding how staff treats the resident, or if they witnessed any abuse. The</p>		

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	<p>it was truthful statement, because they do go in and check the resident for incontineny during the night.</p> <p>During an interview on 11/21/11 at 12:40 p.m., the Administrator indicated he had been told about a dark man going into the room but not about the private areas. He indicated he was told the tall dark man was from the hospital. He indicated he is now hearing conflicting statements, and that from what he heard today, he would do an investigation and report the allegation.</p> <p>During an interview on 11/21/11 at 2:50 p.m., the SCU Unit Manager indicated she had reported what the ER nurse had said, that it was a tall dark man and that he touched the resident's private areas. She indicated she told the Social Service Director, and the Social Service Director told the Administrator. She indicated the policy states to notify the Administrator of all allegations.</p> <p>During an interview on 11/21/11 at 2:50 p.m., the ADoN indicated she was told it was some large man that went into the resident's room. She stated, "that is all I can remember." She indicated she thought it was someone from the hospital.</p> <p>A Witness Statement Form, dated</p>		<p>interviews will be a total of 10 combined resident's taken from each unit on a weekly basis x 4 weeks, monthly x 3 then quarterly x 2 or until at 95% compliance. ED/designee will also review resident concerns/grievance log and resident council minutes to ensure appropriate follow through and immediate investigation of allegations of abuse on a weekly basis x 4 week, monthly x 3 then quarterly x 2 or until 95% compliance. RVP/Designee will review the residents' interviews, the ED/designee audits on concerns/grievance log and the resident council minutes to ensure timely notification and thorough investigation and reporting timely to ISDH on allegations of abuse on a monthly basis x 6 months with threshold to be 100%. The Regional Director of Clinical Services/designee will review abuse investigations to ensure timely notification to the ED, thorough investigation and reporting timely to ISDH on a monthly basis x 6 months with threshold to be 100%. The ED/designee will bring results of these resident interviews and audits of the concern/grievance log and resident council minutes to the Performance Improvement Committee for further review and recommendations. 5) Date of compliance: 12-28-11</p>		

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	<p>11/21/11 at 12:50 p.m., and signed by LPN#2, indicated, "...a nurse from (hospital name) ER called report to writer on res (resident)...reported that res...told her that a tall dark man comes in her room et goes over to roommate et touches her roommates the nurse said she...made a hand gesture insinuating touching in the peri area...Writer reported it to the Unit Manager."</p> <p>A Witness Statement Form, dated 11/21/11 at 1:50 p.m., and signed by the Social Service Director, indicated, "writer notified on 11/17/11 by Special Care Unit Manager that charge nurse...was informed by nurse at (hospital name) that (resident name) reported a tall dark man had entered res room at night. ED (Executive Director) (Administrator) notified immediately on 11/17/11. On 11/21/11 writer & ED notified by Unit Manager that res. alleged her roommate was touched in peri-area. I was not aware of peri-area allegation until 11/21/11."</p> <p>The investigation, dated 11/21/11, and received from the Administrator, indicated a male CNA had been notified to call the facility and would be placed on suspension until the investigation has been completed. The form indicated the resident had not alleged the male CNA, but he is the only male employee that</p>			

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	<p>works midnights on special care and the last day the employee had worked was on 11/08/11.</p> <p>A Witness Statement Form, dated 11/21/11 at 2 p.m., and signed by the SCU Unit Manager, indicated, "... (Resident name) made an allegation that there was a tall dark man that came into their room at night & touched her roommates (sic) private parts...I was told this by the nurse on SCU & I reported this to the ADoN & Social Services."</p> <p>Resident #D was observed on 11/21/11 at 2:45 p.m. wandering independently around the hallway in the SCU.</p> <p>A) Resident #D's record was reviewed on 11/21/11 at 11:25 a.m. Resident #D's diagnoses included, but were not limited to, dementia.</p> <p>Resident D's nurses' notes indicated: 10/16/11 at 11:03 a.m., "...urinated on floor of co-resd (resident) room..." 10/17/11 at 5 a.m., "Res (Resident) up @ (at) 1:00 a.m. ambulating in hallway..." 10/18/11 8 p.m., "15 min (minute) safety checks continue- res ambulating in halls of SCU most of shift..." 10/20/11 at 9:30 p.m., "...Res continues to exit seek and wander in and out of other res rooms uninvited. Res not easily</p>			
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	<p>redirected and is uncooperative @ times." 10/21/11 at 9:45 p.m., "...Res also wanders in and out of other res rooms taking objects..."</p> <p>10/24/11 at 8:15 p.m., "...15 min checks (indicated by a check mark) continue...ambulates frequently & goes into other res rooms..."</p> <p>10/27/11 at 9:30 p.m. "...wanders in and out of other res's rooms..."</p> <p>10/31/11 at 6:45 p.m., "...res ambulates independently throughout unit often wanders into co-res rooms uninvited..."</p> <p>11/3/11 at 9:45 p.m., "...Res continues to exit seek, wander in/out of other res rooms taking things, and is combative and uncooperative w/ staff..."</p> <p>11/3/11 2 a.m., "...ambulates independently..."</p> <p>11/6/11 at 3:50 a.m., "...res continues to remove personal items out of others rooms..."</p> <p>11/6/11 at 11 p.m., "...res vomited in another res room..."</p> <p>11/9/11 at 9:50 p.m., "...res continues to ambulate around unit...taking other resident's belonging, and being non-cooperative w/ staff..."</p> <p>11/10/11 at 5:55 a.m., "...res ambulates independently throughout unit..."</p> <p>11/10/11 at 10 p.m., "...Res continues to exit seek, take things that don't belong to him..."</p> <p>11/14/11 at 9:00 p.m., "...Res had also</p>			
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	<p>urinated in another resident's trash can in their room."</p> <p>11/15/11 at 5:30 a.m., "...15 min checks (indicated by a check mark) continue...res OOB (out of bed) most of shift wandering in halls , going into co-res rooms..."</p> <p>11/15/11 at 7:30 p.m., "...Needs frequent redirection c staying out of other res rooms/belongings..."</p> <p>Resident D's care plans, indicated: A care plan, dated 10/21/11, "...I wander the units...I will often wander unit and go into co-res rooms...."</p> <p>A care plan, dated 11/1/11, "...I void in inappropriate places...trash cans other resident's room..."</p> <p>B) Resident #B's record was reviewed on 11/21/11 at 2:20 p.m. The resident's diagnoses included, but was not limited to, dementia with agitation and hypertension.</p> <p>Resident #B's Admission/5 day Minimum Data Set Assessment (MDS), dated 09/15/11 indicated the resident had impaired cognition.</p> <p>Resident #B's Risk worksheet for Abuse, Neglect & Exploitation, dated 11/06/11, indicated the resident was at risk for abuse due to a diagnosis of dementia and confusion.</p>			
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	<p>C) Resident #C's record was reviewed on 11/21/11 at 2:40 p.m. The resident's diagnoses included, but were not limited to, dementia and psychosis.</p> <p>The resident's Quarterly MDS assessment, dated 10/25/11, indicated the resident had a short-term memory problem and was moderately impaired for decision making.</p> <p>The resident's Risk worksheet for Abuse, Neglect & Exploitation, dated 04/22/11, indicated the resident was at risk for abuse due to a diagnosis of dementia, confusion, poor judgement skills, receiving psychotropic medications, and depression.</p> <p>2. Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated 10/28/11, indicated a cognitive pattern score of 15 (cognition intact), and required extensive assistance of two or more for bed mobility, transfers, and toilet use.</p> <p>A Facility Incident Reporting Form,</p>			
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	<p>incident date 11/20/11, and received at the ISDH on 11/21/11, indicated, "(resident name) reported to her nursing assistant that the (sic) she was being treated mean by the day girl (CNA name). She nudges her to use the bathroom instead of the bedside commode, and she is afraid she will fall..."</p> <p>The Witness Statement Forms indicated:</p> <p>11/20/11 at 5:35 p.m., written and signed by CNA #3, indicated, " Saturday the 19th, (CNA #3 and CNA #4 names) were putting (resident name) to bed from the wheel chair (sic) and when she stood up she wouldn't stand very well, so I had a hold of the gait belt and so did (CNA #4) and (resident name) was standing kinda still in front of the wheel chair (sic) and (CNA #4 name) said stand up or your gonna fall. Kept saying that and then... (CNA #4) let it go (gait belt) and I eased the (resident name) into the wheel chair (sic)."</p> <p>11/20/11 at 5:35 p.m., written and signed by CNA #5, indicated, "When getting report from (CNA #4) the last two times I've worked...(CNA#4) says we need to make (resident name) walk to the bathroom even if she refuses to. She says that you use the gait belt and stand her up then give her a little push and let go till</p>						

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	<p>she start (sic) moving her feet..."</p> <p>11/22/11 at 3:10 p.m., written and signed by LPN #6, date of incident 11/19/11, time of incident 6-2, "I was not informed of any allegations of abuse with (resident name), from family, resident or staff at any time during my shifts."</p> <p>The Skilled Unit nursing schedules, dated 11/01/11 through 11/22/11, received from the ADoN (Assistant Director of Nursing), indicated CNA #5 had last worked on the Skilled unit on 11/18/11 and 11/20/11.</p> <p>During an interview on 11/22/11 at 2:05 p.m., CNA #5 indicated she had concerns with CNA #4 telling the resident she had to walk even though the resident had refused. She indicated on 11/20/11, when CNA #4 said to give her (resident) a little push, CNA #4 then let go of the resident. CNA #5 indicated she had not told anyone about the incident. She indicated she should have reported CNA #4 was making the resident walk to the bathroom and that she said to give the resident a little push.</p> <p>During an interview on 11/22/11 at 2:30 p.m., CNA #3 indicated CNA #4 kept telling the resident she was going to fall and then CNA #4 let go of the gait belt.</p>						

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	<p>She indicated she had told CNA #4 the resident needed to use the bedside commode and CNA #4 said no, she is going to use the bathroom. She indicated when CNA #4 let go of the resident's gait belt, the resident fell back and CNA #3 eased the resident into the wheelchair. CNA #3 indicated she did not report the incident to anyone. She indicated she should have reported the incident on 11/19/11.</p> <p>During an interview on 11/22/11 at 1:43 p.m., the DoN indicated she had not been told about the allegation until 11/20/11.</p> <p>The facility policy, dated 02/09, received as current from the Administrator and titled, "Protection of residents:reducing the threat of Abuse & Neglect", indicated, "...Reporting Alleged Abuse...3. All alleged...violations...will be promptly reported to the administrator and/or director of nursing...9. The administrator, director of nursing...will complete an investigation of the incident...no later than five (5) working days after the reported occurrence...12. Federal requirements mandate the facilities must ensure all allegations of abuse are reported immediately to their state survey agency...The immediate reports should be submitted as soon as possible, but non later than 24 hours of a facility learning of</p>						

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	<p>the allegation...If the accused individual is an employee, they will be placed on suspension pending results of the investigation while the incident is being investigated. if the accused individual is not an employee, the person will be denied unsupervised access to the resident..."</p> <p>The immediate jeopardy that began on 11/17/11 was removed on 11/23/11 when the facility initiated an investigation of the allegation of abuse, notified the resident's families and physicians, and implemented interventions to prevent potential abuse from occurring. The facility revised the abuse policy to include immediately notifying the Administrator if abuse is seen, heard, and/or suspected. The facility had staff assigned for continuous monitoring of the Special Care Unit to ensure resident safety. All interviewable residents in the facility were interviewed to ensure no outstanding allegations of abuse exist. 140 of 147 staff members were inserviced on the revised abuse policy. 23 employees interviewed were able to explain the revised procedure if they see, hear, and/or suspect abuse. The Administrator was inserviced by the Corporate Regional Vice President, to include the need to immediately investigate all allegations of abuse. Staff will be questioned by the facility for</p>			
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	<p>knowledge of the revised abuse policy. Audits were completed by the facility through interviewing alert and oriented residents about care issues and staff were interviewed for their knowledge of the revised abuse policy. The facility will continue to audit staff daily on all shifts for the first week and then monthly with the results of the audit to be forwarded to the performance improvement committee. The resident concerns/grievance log and resident council minutes will be reviewed to ensure immediate investigations of all concerns have been initiated. The audits will be completed weekly by the Administrator and monthly by the Regional/Divisional staff and then forwarded to the performance improvement committee.</p> <p>Noncompliance remained at the lower scope and severity level of pattern no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility has not inserviced all staff, and they will continue to audit staff and residents to ensure the facility abuse policy is followed.</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-28(a)</p>						

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F0241 SS=G	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to provide care for residents to enhance the resident's dignity, related to not assisting the residents to the bathroom timely, which resulted in one resident (Resident #H) being incontinent at times and becoming tearful when discussing not being assisted to the bathroom timely as needed, for 1 of 9 residents who required assistance with toileting in a sample of 11 (Resident #H), 1 of 8 residents in a supplemental sample of 8 (Resident #R), and 2 of 3 families of residents confidentially interviewed.</p> <p>Findings include:</p> <p>1) During an interview on 11/21/11 at 9:15 a.m., Resident #H indicated she has to wait long periods of time to get help to the bathroom. She indicated she has been incontinent because she has had to wait so long for help. During the interview, the resident became tearful and upset when talking about having to wait for help to use the bathroom and having some incontinence of urine.</p> <p>During an observation on 11/21/11, at</p>	F0241	<p>F2411) Corrective action for the residents found to have been affected by the deficient practice: Resident #H's urinary assessment was reviewed by licensed nurse and care plan updated on 12-13-11. Resident #H's call light is answered timely will not be turned off until needs are met. Social Services assessed Resident #H on 11-21-11 through 11-28-11 and no signs of distress were noted. Resident #R is brought to the bathroom before and after meals. The care plan was updated on 12-9-11. A staff member will be available in the dining room during meals to assist residents with toileting needs. Social Services assessed Resident #R on 11-23-11 and 11-26-11 and no signs of distress were noted. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents requiring assistance with toileting needs have the potential to be affected. Residents' urinary status have been re-assessed by licensed nursing staff and will be completed on 12-27-11 to ensure they accurately reflect residents' toileting needs. Care plans will be updated or reviewed by 12-27-11</p>	12/28/2011			

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	<p>12:07 p.m., the SDC (Staff Development Coordinator) was passing the noon meal trays. Resident #H's call light was activated and the SDC answered the call the light, and Resident #H indicated she needed to use the bathroom. The SDC informed Resident #H she would go and get some help. The SDC then went back to passing the food trays to the residents on the unit then returned to the Nurses' Desk checking a resident's record.</p> <p>During an observation on 11/21/11 at 12:16 p.m., the SDC was still at the Nurses' Desk. No one had went in to help Resident #H to the bathroom. The SDC then left the unit without getting assistance to help the resident to the bathroom.</p> <p>During an interview on 11/21/11 at 12:20 p.m., Resident #H's family member indicated the resident had asked to go to the bathroom, but no one had come to help her.</p> <p>During an interview on 11/21/11 at 12:25 p.m., Resident #H had indicated she still needed to go to the bathroom and she was feeling very uncomfortable. The call light was reactivated and LPN #7 answered the call light and told the resident she would go and get some help to assist her to the bathroom.</p>		<p>with accurate toileting program for residents. Residents' call lights will be answered timely and will not be turned off until resident needs are met. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the unit for residents receiving room trays to meet residents' toileting needs. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:The Staff Development Coordinator was re-educated on 12-14-11 by the Executive Director on the policy not to turn call lights off until the residents' needs are met. Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding not turning call lights off until the resident's needs are met, answering call lights in a timely manner, and the staff members assigned to the dining room and on the halls during meals to assist residents with toileting needs. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the units for residents receiving room trays to meet residents' toileting needs. This education also included a review of urinary assessments, different toileting programs used and how it affects resident care. Staff that are not currently working will not be allowed to</p>				

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	<p>During an observation on 11/21/11 at 12:30 p.m., CNA #8 and QMA #9 entered Resident #H's room to assist the resident onto the bedside commode.</p> <p>During an interview on 11/21/11 at 12:45 p.m., the SDC indicated resident #H had wanted assistance to the bathroom when she had answered the resident's call light. The SDC indicated she went and told the CNAs on the unit, the resident needed to use the bathroom.</p> <p>During an interview on 11/21/11 at 12:48 p.m., QMA #9 (working the unit) indicated she was first aware the resident needed to go to the bathroom when LPN #7 came and told her.</p> <p>During an interview on 11/21/11 at 12:50 p.m., CNA #8 (working the unit) indicated she was unaware Resident #H needed to use the bathroom until LPN #7 came and told her.</p> <p>Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated</p>		<p>work until they have received this education. 4) Correction actions will be monitored to ensure the deficient practice will not recur:</p> <p>Lights should be answered with in 5 minutes but no later then 10, and left on until residents' needs are addressed. Facility will interview random alert and oriented residents to ensure toileting needs are being met including each mealtime by staff. The interviews will be a total of 10 combined residents taken from each unit. Interviews will be conducted by the ED/DON/designee, 3 x a week x 4 weeks then monthly x 3 months, then quarterly x 2 or until at 95% compliance. Random audits of 10 residents, for call light response time and meeting resident's needs during each mealtime will be conducted sampling all units. Audits will be conducted by the ED/DON/designee 3 x a week x 4 weeks, then monthly x 3 months then quarterly x 3 or until 95% compliance. Findings from the resident interviews and call light audits will be presented monthly by the ED/DON to the Performance Improvement Committee for further review and recommendations.</p> <p>5) Date of compliance: 12-28-11</p>		

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	<p>10/28/11, indicated a cognitive pattern score of 15 (cognition intact), and required extensive assistance of two or more for bed mobility, transfers, and toilet use. The MDS assessment indicated the resident was frequently incontinent.</p> <p>2) During an interview on 11/21/11 at 11:55 a.m., Resident #R indicated they wait sometimes an hour for his call light to be answered and to be assisted to the bathroom. Resident #R indicated this happens frequently at meal times.</p> <p>Resident #R was identified as alert, oriented, and interviewable by RN #10 during the initial tour on 11/17/11 at 12:20 p.m.</p> <p>Resident #R's record was reviewed on 11/23/11 at 8 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The CNA care card indicated the resident required 2 persons to transfer the resident.</p> <p>3) During a confidential family interview on 11/20/11, a family member indicated during meals all the staff are off the floor, and they will not assist their family member to the bathroom until all the residents are back from the dining room.</p>			

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	<p>The family member indicated when their family member rings her call light, the staff will come in to answer it, turn it off and tell their family member they will be back, then it is about 15-20 minutes before anyone will come back into the room.</p> <p>4) During another confidential family interview on 11/21/11, a family member indicated sometimes their family member waits 15-30 minutes to get help to the bathroom. They indicated the staff will answer the call light, they tell the resident they will go get help, but then the resident waits a long time for the staff to return. The family member indicated this happens a lot, especially during the meal times.</p> <p>5) During another confidential family interview on 11/21/11, a family member indicated their family member sometimes has to wait an hour to an hour and a half for assistance to the bathroom. The family member indicated they have been told the resident has to wait until the dining room is cleared out before they can assist the resident to the bathroom.</p> <p>A facility policy, dated 11/90, and received as current from the ADoN, titled, "Call Light, Use of", indicated, "...2. Answer all call lights promptly whether or</p>				

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	<p>not you are assigned to the resident...6. Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the room. 7. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room...."</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-3(t)</p>			
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F0312 SS=G	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents receive necessary services to maintain good personal hygiene related to call lights not responded to timely or turned off and residents' needs were not met, which resulted in Resident #H to be incontinent and tearful, for 1 of 9 residents who required assistance with toileting in a sample of 11 (Resident #H), 1 of 8 residents in a supplemental sample of 8 (Resident #R), and 2 of 3 families of residents confidentially interviewed.</p> <p>Findings include:</p> <p>1) During an interview on 11/21/11 at 9:15 a.m., Resident #H indicated she has to wait long periods of time to get help to the bathroom. She indicated she has been incontinent because she has had to wait so long for help. During the interview, the resident became tearful and upset when talking about having to wait for help to use the bathroom and having some incontinence of urine.</p> <p>During an observation on 11/21/11, at 12:07 p.m., the SDC (Staff Development Coordinator) was passing the noon meal</p>	F0312	<p>F3121) Corrective action for the residents found to have been affected by the deficient practice: Resident #H's urinary assessment was reviewed by licensed nurse and care plan updated by licensed nurse on 12-13-11. Resident #H's call light is answered timely will not be turned off until needs are met. Social Services assessed Resident #H on 11-21-11 through 11-28-11 and no signs of distress were noted. Resident #R is brought to the bathroom before and after meals. The care plan was updated on 12-9-11 by licensed nurse. A staff member will be available in the dining room during meals to assist residents with toileting needs. Social Services assessed Resident #R on 11-23-11 and 11-26-11 and no signs of distress were noted. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents requiring assistance with toileting needs have the potential to be affected. Residents' urinary status have been re-assessed by licensed nursing staff and will be completed on 12-27-11 to ensure they accurately reflect residents' toileting needs. Care plans will be</p>	12/28/2011			

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	<p>trays. Resident #H's call light was activated and the SDC answered the call the light, and Resident #H indicated she needed to use the bathroom. The SDC informed Resident #H she would go and get some help. The SDC then went back to passing the food trays to the residents on the unit then returned to the Nurses' Desk checking a resident's record.</p> <p>During an observation on 11/21/11 at 12:16 p.m., the SDC was still at the Nurses' Desk. No one had went in to help Resident #H to the bathroom. The SDC then left the unit without getting assistance to help the resident to the bathroom.</p> <p>During an interview on 11/21/11 at 12:20 p.m., Resident #H's family member indicated the resident had asked to go to the bathroom, but no one had come to help her.</p> <p>During an interview on 11/21/11 at 12:25 p.m., Resident #H had indicated she still needed to go to the bathroom and she was feeling very uncomfortable. The call light was reactivated and LPN #7 answered the call light and told the resident she would go and get some help to assist her to the bathroom.</p> <p>During an observation on 11/21/11 at</p>		<p>updated or reviewed by 12-27-11 with accurate toileting program for residents. Residents' call lights will be answered timely and will not be turned off until resident needs are met. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the units for residents receiving room trays to meet residents' toileting needs. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:The Staff Development Coordinator was educated on 12-14-11 by the Executive Director on the policy not to turn call lights off until the residents' needs are met. Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding not turning call lights off until the resident's needs are met, answering call lights in a timely manner, and the staff members assigned to the dining room and on the halls during meals to assist residents with toileting needs. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the units for residents receiving room trays to meet residents' toileting needs. This education also included a review of urinary assessments, the different toileting programs used and how it affects resident care. Staff that are not currently</p>				

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	<p>12:30 p.m., CNA #8 and QMA #9 entered Resident #H's room to assist the resident onto the bedside commode.</p> <p>During an interview on 11/21/11 at 12:45 p.m., the SDC indicated resident #H had wanted assistance to the bathroom when she had answered the resident's call light. The SDC indicated she went and told the CNAs on the unit, the resident needed to use the bathroom.</p> <p>During an interview on 11/21/11 at 12:48 p.m., QMA #9 (working the unit) indicated she was first aware the resident needed to go to the bathroom when LPN #7 came and told her.</p> <p>During an interview on 11/21/11 at 12:50 p.m., CNA #8 (working the unit) indicated she was unaware Resident #H needed to use the bathroom until LPN #7 came and told her.</p> <p>Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated 10/28/11, indicated a cognitive pattern score of 15 (cognition intact), and</p>		<p>working will not be allowed to work until they have received this education. 4) Correction actions will be monitored to ensure the deficient practice will not recur:</p> <p>Lights should be answered with in 5 minutes but no later then 10, and left on until residents' needs are addressed. Facility will interview random alert and oriented residents to ensure toileting needs are being met including each mealtime by staff. The interviews will be a total of 10 combined residents taken from each unit. Interviews will be conducted by the ED/DON/designee, 3 x a week x 4 weeks then monthly x 3 months, then quarterly x 2 or until at 95% compliance. Random audits of 10 residents, for call light response time and meeting resident's needs during each mealtime will be conducted sampling all units. Audits will be conducted by the ED/DON/designee 3 x a week x 4 weeks, then monthly x 3 months then quarterly x 3 or until 95% compliance. Findings from the resident interviews and call light audits will be presented monthly by the ED/DON to the Performance Improvement Committee for further review and recommendations.</p>		

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	<p>required extensive assistance of two or more for bed mobility, transfers, and toilet use. The MDS assessment indicated the resident was frequently incontinent.</p> <p>2) During an interview on 11/21/11 at 11:55 a.m., Resident #R indicated they wait sometimes an hour for his call light to be answered and to be assisted to the bathroom. Resident #R indicated this happens frequently at meal times.</p> <p>Resident #R was identified as alert, oriented, and interviewable by RN #10 during the initial tour on 11/17/11 at 12:20 p.m.</p> <p>Resident #R's record was reviewed on 11/23/11 at 8 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The CNA care card indicated the resident required 2 persons to transfer the resident.</p> <p>3) During a confidential family interview on 11/20/11, a family member indicated during meals all the staff are off the floor, and they will not assist their family member to the bathroom until all the residents are back from the dining room. The family member indicated when their family member rings her call light, the</p>		5) Date of compliance: 12-28-11		

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	<p>staff will come in to answer it, turn it off and tell their family member they will be back, then it is about 15-20 minutes before anyone will come back into the room.</p> <p>4) During another confidential family interview on 11/21/11, a family member indicated sometimes their family member waits 15-30 minutes to get help to the bathroom. They indicated the staff will answer the call light, they tell the resident they will go get help, but then the resident waits a long time for the staff to return. The family member indicated this happens a lot, especially during the meal times.</p> <p>5) During another confidential family interview on 11/21/11, a family member indicated their family member sometimes has to wait an hour to an hour and a half for assistance to the bathroom. The family member indicated they have been told the resident has to wait until the dining room is cleared out before they can assist the resident to the bathroom.</p> <p>A facility policy, dated 11/90, and received as current from the ADoN, titled, "Call Light, Use of", indicated, "...2. Answer all call lights promptly whether or not you are assigned to the resident...6. Answer all call lights in a prompt, calm,</p>				

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	<p>courteous manner; turn off the call light as soon as you enter the room. 7. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room...."</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-38(a)(2)(C)</p>			
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F0323 SS=G	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure the residents received adequate supervision and assistance to prevent accidents, related to transferring a resident with a mechanical lift (Hoyer) with assistance of only one staff member, which resulted in the resident falling from the sling, hitting her head, and received staples to the back of her head (Resident #J), failed to ensure safety alarms were on, secure and functioning (Resident #K and #S) and failed to ensure the safety of a confused resident who gained access to a pot of hot coffee in a locked nutritional pantry (Resident #D), for 3 of 11 residents reviewed for accident and hazards in a sample of 11 (Residents #D, #J, and #K) and 1 resident in a supplemental sample of 8 (Resident #S).</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 11/17/11 at 11:55 a.m. with the Assistant Director of Nursing (ADoN), the ADoN indicated resident #J had fallen from the mechanical lift and received a laceration of the head. The ADoN indicated a CNA had transferred the resident with the</p>	F0323	<p>F3231) Corrective action for the residents found to have been affected by the deficient practice: Resident #J is no longer resides at the facility. The CNA was immediately suspended pending outcome of the investigation and was then terminated. On 11-8-11 the family and the physician were notified. On 11-8-11 maintenance inspected the mechanical lift and there were no findings. Resident #K had a physician order written on 11-30-11 for a sensory bed alarm. The care plan accurately reflects the need and placement of a bed alarm. Resident #S was reviewed in an interdisciplinary meeting for safety regimen on 12-12-11. The clip alarm was discontinued and the sensor pad alarm remains. The sensor pad enunciator box was secured to the head of the bed to promote effective function. Resident #D had a head to toe assessment done on 11/21/11 and there were no findings. The lock on the nutrition pantry was immediately changed to a key lock on 11-22-11 during the course of the survey. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents that require a</p>	12/28/2011			

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	<p>Hoyer without having help from another staff member.</p> <p>Resident #J's record was reviewed on 11/22/11 at 8:40 a.m. The resident's diagnoses included, but were not limited to, dementia and seizures.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 10/25/11, indicated the resident had short and long term memory problems, and required extensive assistance of two or more staff for bed mobility and toilet use. The MDS assessment indicated transfers from surface to surface occurred only once or twice and required assistance of two or more staff members, and the resident's range of motion was impaired on both sides of the body.</p> <p>The CNA Care Guide, dated 11/21/11, indicated the resident required two people to assist with transfers with the Hoyer.</p> <p>A physician's order, dated 09/06/11, indicated an order for the resident to be transferred with Hoyer lift.</p> <p>A care plan, dated 11/08/11, indicated the resident was a risk for falls due to poor trunk control. The interventions included to transfer with two assistants and the Hoyer lift.</p>		<p>mechanical transfer have the potential to be affected. The mechanical lifts were inspected by maintenance on 11-9-11. Therapy screened residents requiring a mechanical lift for appropriate device which was completed on 11-14-11. Residents requiring alarms to alert staff of a resident attempting to self transfer have the potential to be affected. Residents with alarms were reviewed by licensed nurse for appropriate alarm usage and care plans updated on 12-12-11. Bed alarm boxes will be attached to the head of the bed. Residents have the potential to be affected by gaining access to the nutritional pantry. The lock was changed to a key lock on 11-22-11. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding the use of two nursing staff when transferring residents with mechanical lifts, attaching alarm boxes to the head of the bed to ensure they are secure and functioning, and checking for potential accidents hazards in patient care areas to keep residents safe. Competencies were repeated with nursing staff by DON/Designee and will be completed by 12-27-11 with nursing staff to ensure proper transfer techniques are being</p>				

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	<p>A, "Facility Incident Reporting Form", dated 11/08/11, indicated, "...Employee was transferring (sic) a resident out of bed with a Hoyer lift when the resident slipped off the pad. Resident went down to floor and hit head on hoyer bar..."</p> <p>A hospital Emergency Room report, dated 11/08/11, indicated the resident received six staples to the back of her head.</p> <p>An employee termination form, dated 11/09/11, indicated the CNA had been terminated for transferring the resident with the Hoyer lift and only one staff member assisting.</p> <p>A professional resource, titled, "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program July 1998", Topic 22: Transferring, indicated, "...4. A mechanical lift...have at least one co-worker assist when using a mechanical lift..."</p> <p>2. Resident #S's record was reviewed on 11/29/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and anoxic brain damage.</p> <p>The resident's Quarterly MDS assessment,</p>		<p>used when transferring residents with a mechanical lift. Licensed nurses will check alarms once a shift for positioning and documentation on the Treatment Administration Record (TAR). 4) Correction actions will be monitored to ensure the deficient practice will not recur: The DON/designee will conduct random audits of the TAR for alarm check documentation. The audit will consist of 10 total residents including each unit and each shift weekly x 4 weeks, monthly x 3, then quarterly x 2 or until 95% compliance. Random observations of mechanical lift transfers will consist of 10 total including each unit and each shift and will be conducted by SDC/designee to ensure compliance weekly x 4 weeks, monthly x 3 then quarterly x 2 or until at 95% compliance. Random audit of alarm function and positioning will consist of 10 total including each unit and each shift and will be conducted by SDC/Designee to ensure compliance weekly x 4 weeks, monthly x 2 then quarterly x 2 or until at 95% compliance. Rounds to be made on Special Care Unit on each shift with audit tool by ED/Designee to ensure the environment remains free of</p>		

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	<p>dated 08/09/11, indicated the resident required extensive assistance by two or more staff for bed mobility and had one prior fall without injury since the last assessment had been done.</p> <p>A care plan, dated 12/20/10 and revised 11/28/11, indicated the resident was a risk for falls. The interventions included, (07/10/11) clip alarm while in bed for resident safety.</p> <p>The resident's CNA care guide, dated 11/29/11, indicated the resident required two plus assistance for toileting and was totally dependent for transfers.</p> <p>A Nurses' Note, dated 11/25/11 at 5:45 a.m., indicated, "writer walking down the hall, noticed from hallway that res (resident) was sitting on floor on landing strip on (L) (left) side of bed, clip alarm was on res et (and) alarm box in res bed was not sounding..."</p> <p>A Nurses' Note, dated 11/25/11 at 8:30 a.m., indicated the resident had been changed for incontinence about 30 minutes prior to being found on floor.</p> <p>During an interview on 11/29/11 at 10:10 a.m., LPN #15 indicated the residents who are on an air mattress need to have the clip alarm box securely attached to the</p>		<p>accidents hazards and the nourishment room remains secure X 4 weeks, then monthly X 2 then quarterly X 2 or until at 95% compliance. Results of the mechanical lift observations, alarms audit, environmental rounds will be brought to the ED/DON. These findings will be presented monthly by the ED/DON to the Performance Improvement Committee for further review/recommendations.5) Date of compliance: 12-28-11</p>		

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	<p>bed or the alarm box will slide with the resident. She indicated the alarm box was not attached to the bed, and was laying on the bed when the resident fell from the bed and the alarm had not activated. She indicated the alarm could have been knocked off, but at the time of the fall, the alarm box was not secure.</p> <p>During an interview on 11/29/11 at 11:15 a.m., the Director of Nursing indicated she worked 11/25/11 during the night. She indicated she had just checked and changed the resident and turned her prior to the fall.</p> <p>3. Resident K's record was reviewed on 11/22/11 at 8:45 a.m. Resident K's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, and anemia.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 10/12/11, indicated the resident was cognitively impaired and required assistance of one to two staff for transfers and ambulation.</p> <p>A fall risk assessment, dated 10/12/11, indicated the resident had a total score of 20. The form indicated a score of 10 or higher is at risk for falls.</p> <p>A care plan, dated 3/11/11 and updated 7/24/11, indicated "I have unsteady</p>				

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	<p>gait/balance at times...I am at risk for falls. 7/24/11 I had an unattended fall while self transferring....Approaches...Sensory pad alarm to bed 7/24/11..."</p> <p>The resident's nurses' notes, dated 11/2/11 at 6:10 a.m., indicated "Sound heard from Nurse's Station upon investigation resd (resident) observed on floor c (with) walker flipped over. Resd laying supine...Bed pressure alarm on but not functioning. Alarm immediately replaced...no injuries noted..."</p> <p>Review of the resident's CNA care guide, dated 11/29/11, indicated the resident had a sensory alarm to her bed.</p> <p>The resident's physician's order recapitulation, dated, 11/11, lacked documentation of the bed alarm.</p> <p>The resident's treatment administration record, dated 11/11, lacked documentation of the bed alarm or of checking to ensure functioning.</p> <p>During an interview on 11/29/11 at 8:55 a.m., LPN #11 indicated the resident had a bed alarm. She indicated there was usually an order for the bed alarm and the nurses check for functioning on the treatment administration record (TAR).</p>				

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	<p>She indicated the resident did not have an order and it was not on the resident's TAR to check to ensure the alarm was functioning. She indicated the alarm should have been functioning when the resident fell on 11/2/11.</p> <p>4. Resident D's record was reviewed on 11/21/11 at 11:25 a.m. Resident D's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>An admission MDS (Minimum Data Set) assessment, dated 10/13/11, indicated resident D was cognitively impaired, and had exhibited physical behavioral symptoms one to three days and had put others at significant risk for physical injury.</p> <p>A care plan, dated 10/21/11 and updated 11/15/11, indicated "I have dx (diagnosis) of dementia and I can become agitated at times r/t (related to) my dementia and confusion. I can become easily frustrated and become uncooperative and combative towards staff..."</p> <p>A nurses' note, dated 10/17/11 at 9:30 p.m., indicated "Res (resident) alert walking around halls of SCU (Special Care Unit). Remains on 15 min (minute) checks (indicated by a check mark) for behaviors ...Somehow, res was able to</p>			

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	<p>figure out how to get into the SCU's locked kitchenette. Res was found by staff walking out of DR (dining room) and into hallway w\ (with) a hot pot of coffee. Three staff members were required to get the hot pot of coffee out of res hands. No one was injured, however, res was very uncooperative and combative towards staff during this time..."</p> <p>A social service progress note, dated 10/18/11, indicated "on 10/14/11 res was exit seeking and was uncooperative c (with) staff & combative toward staff. Res continues to urinate in inappropriate places...Res was able to get into kitchenette and had a pot of coffee. Staff was able to remove it, but he remained very uncooperative & combative towards staff. Res continues on 15 min checks."</p> <p>The resident's care plans, dated 10/10/11 and updated 11/15/11, lacked documentation to indicate any interventions had been put into place to prevent the resident from entering the locked kitchenette.</p> <p>During an interview on 11/22/11 at 8:42 a.m., the Maintenance Director indicated the last time the code on the door to the special care unit's kitchenette had been changed was at least a year ago.</p>				

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	<p>During an interview on 11/22/11 at 9:50 a.m., the SCU Manager indicated the resident had gotten into the kitchenette but it had not happened again since then. She indicated the staff were monitoring him and he was on 15 minute checks. She indicated the resident went everywhere and walks constantly.</p> <p>During an interview on 11/22/11 at 10 a.m., the SCU Manager indicated she was unable to find where they had done anything to keep the resident out of the kitchenette.</p> <p>3.1-45(a)(2)</p>			
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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident's who require oxygen had oxygen administered, for 2 of 5 residents on oxygen in a sample of 11 residents, which resulted in one resident's oxygen not being on and the resident's oxygen saturation dropping to 81% (normal 90-100) (Resident K). (Residents E and K)</p> <p>Findings include:</p> <p>1. Resident K's record was reviewed on 11/22/11 at 8:45 a.m. Resident K's diagnoses included, but were not limited to chronic obstructive pulmonary disease, dementia, and anemia.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 10/12/11, indicated, the resident was cognitively impaired and required assistance of one to two staff for transfers , ambulation and locomotion on and off the unit.</p>	F0328	<p>F3281) Corrective action for the residents found to have been affected by the deficient practice: Resident #K On 11-2-11 when Resident #K's oxygen saturation rate dropped, Resident #K was then put on oxygen as ordered by the physician. The physician orders were reviewed and the physician discontinued the PRN oxygen order on 12-12-11. The care plan was updated on 12-12-11. Resident #E's oxygen was immediately applied. No adverse effects were noted. Resident #E's care plan also states ...I often remove my oxygen, noncompliant with wearing it at times. The physician orders and the care plan were reviewed on 12-12-11.</p> <p>2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents requiring oxygen have the potential to be affected. The DON reviewed orders and care plans for residents requiring continuous oxygen and PRN oxygen for</p>	12/28/2011			

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	<p>A care plan, dated, 3/17/11 and updated 11/2/11, indicated "I am at risk for s/s (signs and symptoms) respiratory distress...am receiving continuous oxygen. I become SOB (short of breath) with exertion and fatigue easily... Check O2 (oxygen) sats (saturations) as ordered and administer oxygen as ordered..."</p> <p>A physician's order, recapitulation, dated 11/11, indicated "3/10/11 oxygen at 3 liters /min per NC (nasal canula) prn (as needed) for O2 sats < (less than) 90% and notify MD. 3/25/11 Check O2 sats Q (every) day/ Q shift when O2 3L (liter)/min per NC in use."</p> <p>The resident's treatment administration record (TAR), dated 11/11, indicated the resident's oxygen saturations with three liters of oxygen on were as follows: 11/1/11 the 10 p.m.-6 a.m. shift 93%, the 6 a.m.-2 p.m. shift 94%, and the 2 p.m.-10 p.m. shift 95%. 11/2/11 the 10 p.m.-6 a.m. shift 91%.</p> <p>The resident's nurses' notes indicated: 11/2/11 2:40 p.m., "Res (resident) transferred from (room number) to room (number)." 11/2/11 at 4:30 p.m., "Writer noted res sitting on couch. Res pale. Skin warm to touch...P (pulse) 92, R (respirations)</p>		<p>accuracy on 12-9-11. No discrepancies were found. Residents on oxygen were monitored on 12-9-11 to ensure the portable oxygen tanks and concentrators were turned on and on the correct liter flow. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur:Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding CNAs must inform the licensed nurses when the resident would need oxygen turned on. Licensed nurses' education to include administering oxygen and obtaining oxygen saturation rates as ordered by the physician. 4) Correction actions will be monitored to ensure the deficient practice will not recur:DON/Unit Managers/designee will conduct random rounds on residents' utilizing oxygen to ensure the oxygen is set on the correct flow rate, canula in place and is turned on. The audit will also include a review of the resident's care plan and that the oxygen saturation are being documented on the TAR. The audit will total 10 reviews from each unit and each shift weekly x 4 weeks, monthly x 3 then quarterly x 2 or until 95% compliance.Findings from these audits will be presented</p>				

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	<p>22...Sao2 (oxygen saturation) 81% on RA (room air). Res placed on O2 @ (at) 2l/NC. Sao2 between 86-87%, O2 up (indicated by an arrow) to 3L/NC. O2 Sats between 87-90% Call placed to (name of hospital) ER (emergency room). Writer spoke c (with) (nurses' name) RN, nurse very short c writer as writer attempted to give report. N.O. (new order) rec'd (received) to sit Pt (patient) straight up, increase (indicated by an arrow) to 4L/NC. Monitor O2 sats x (times) 2 hrs (hours) -if no (indicated by an o) improvement- Call (name of hospital) ER."</p> <p>11/2/11 at 7:30 p.m., "...O2 sats remain in upper (indicated by an arrow pointed up) 90's- O2 in place at 4L per NC."</p> <p>11/2/11 at 9 p.m., "...sat checked (indicated by a check mark) p (after) ambulating 92%..."</p> <p>The resident's TAR, dated 11/11, indicated the resident's oxygen saturations on 4 liters of oxygen on 11/2-11/6/11 were 94-97%.</p> <p>During an interview on 11/22/11 at 9:07 a.m., LPN # 7 indicated the resident had transferred from a different hall onto South hall on 11/2/11. She indicated there should have been an assessment to show the resident did not need the oxygen if it had been removed on 11/2/11. She</p>		<p>monthly by the DON/ED to the Performance Improvement Committee for further review/recommendations.5) Date of compliance: 12-28-11</p>				

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	<p>indicated she was not sure what had happened. She indicated another staff member had brought the resident to her attention and she had seen the resident sitting on the couch without any oxygen on. She indicated the resident was pale and did not respond as usual. She indicated she had done vital signs and oxygen saturations and started the resident on oxygen and called the hospital emergency room.</p> <p>During an interview on 11/22/11 at 9:20 a.m., LPN #11 indicated she had been working on the south hall the day the resident had been transferred. She indicated she had received in report that the resident was on oxygen continuously at three liters because the resident's oxygen saturations dropped. She indicated the resident had the oxygen on during her shift. She indicated she did not know what happened after her shift.</p> <p>During an interview on 11/22/11 at 10:20 a.m., LPN #6 indicated she had taken care of the resident before the resident was transferred to the south hall and the resident had been using her oxygen continuously.</p> <p>2. Resident E's record was reviewed on 11/22/11 at 11:10 a.m. Resident E's diagnoses included, but were not limited</p>				

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	<p>to, dementia and severe aortic stenosis.</p> <p>The resident's physician order recapitulation, dated 11/11, indicated "4/1/11 oxygen at 2 liters/min per NC continuously."</p> <p>A care plan, dated 1/10/11 and updated 10/31/11, indicated "I am at risk for s/s respiratory distress...need use of oxygen...administer oxygen as ordered..."</p> <p>Resident E was observed on 11/17/11 at 12:42 p.m., sitting in the main dining room. The resident's portable oxygen tank was not turned on and the nasal canula was on the resident's lap.</p> <p>During an interview on 11/17/11 at 12:43 p.m., LPN #12 indicated the resident's oxygen was suppose to be on at 2 liters. LPN #12 then applied the nasal canula and turned the portable oxygen tank on to 2 liters.</p> <p>This Federal tag relates to Complaint IN00099598.</p> <p>3.1-47(a)(6)</p>				

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F0353 SS=G	<p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to ensure there was sufficient staff to provide assistance with eating in a timely manner to prevent the resident's food from becoming cold for 6 residents who received rooms trays on the skilled unit and 14 residents who received room trays on the core unit for 2 of 3 units in the facility.</p> <p>The facility also failed to provide care as indicated on the CNA Care Guide, and toilet residents in a timely manner, which resulted in a resident having incontinent episodes, for 1 of 9 residents who required assistance with toileting in a sample of 11 (Resident #H) and 2</p>	F0353	F3531) Corrective action for the residents found to have been affected by the deficient practice: Resident #H's urinary assessment was reviewed by licensed nursing staff and care plan updated licensed nursing staff on 12-13-11. Resident #H's call light is answered timely will not be turned off until needs are met. Social Services assessed Resident #H on 11-21-11 through 11-28-11 and no signs of distress were noted. Resident #R is brought to the bathroom before and after meals. The care plan was updated on 12-9-11. A staff member will be available in the dining room during meals to assist residents with toileting needs. Social Services assessed	12/28/2011	

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	<p>residents in a supplemental sample of 8 (Resident #R and #S), and 2 of 3 residents whose families were confidentially interviewed.</p> <p>Findings include:</p> <p>1) During an interview on 11/21/11 at 9:15 a.m., Resident #H indicated she has to wait long periods of time to get help to the bathroom. She indicated she has been incontinent because she has had to wait so long for help. During the interview, the resident became tearful and upset when talking about having to wait for help to use the bathroom and having some incontinence of urine.</p> <p>During an observation on 11/21/11, at 12:07 p.m., the SDC (Staff Development Coordinator) was passing the noon meal trays. Resident #H's call light was activated and the SDC answered the call the light, and Resident #H indicated she needed to use the bathroom. The SDC informed Resident #H she would go and get some help. The SDC then went back to passing the food trays to the residents on the unit then returned to the Nurses' Desk checking a resident's record.</p> <p>During an observation on 11/21/11 at 12:16 p.m., the SDC was still at the Nurses' Desk. No one had went in to help</p>		<p>Resident #R on 11-23-11 and 11-26-11 and no signs of distress were noted. Resident #S was reviewed in an interdisciplinary meeting for safety regimen on 12-9-11. The clip alarm was discontinued and the sensor pad alarm remains. The sensor pad enunciator box was secured to the head of the bed to promote effective function. 12-15-11 Resident bowel and bladder assessment along with ADL function was reviewed by licensed nursing with Care Plan update to reflect resident need for 1-2 assist for toiling. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice:Residents requiring room trays and toileting have the potential to be affected. The Executive Director, Director of Nursing, and nursing administration reviewed the nursing assignments and resident needs to ensure there is sufficient staff to provide assistance for the residents as needed. Nursing assignment sheets have been revised on 12-14-11 to include staff to be assigned to the dining room and on the units for residents receiving room trays to meet residents' toileting needs and staff assigned to pass out room trays. The ED verified the ads placed for employment on 12-13-11 continue to run, as it relates to fulfill staffing needs. 3) Measures/systemic changes</p>		

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	<p>Resident #H to the bathroom. The SDC then left the unit without getting assistance to help the resident to the bathroom.</p> <p>During an interview on 11/21/11 at 12:20 p.m., Resident #H's family member indicated the resident had asked to go to the bathroom, but no one had come to help her.</p> <p>During an interview on 11/21/11 at 12:25 p.m., Resident #H had indicated she still needed to go to the bathroom and she was feeling very uncomfortable. The call light was reactivated and LPN #7 answered the call light and told the resident she would go and get some help to assist her to the bathroom.</p> <p>During an observation on 11/21/11 at 12:30 p.m., CNA #8 and QMA #9 entered Resident #H's room to assist the resident onto the bedside commode.</p> <p>During an interview on 11/21/11 at 12:45 p.m., the SDC indicated resident #H had wanted assistance to the bathroom when she had answered the resident's call light. The SDC indicated she went and told the CNAs on the unit, the resident needed to use the bathroom.</p> <p>During an interview on 11/21/11 at 12:48</p>		<p>put into place to ensure the deficient practice does not recur:Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding not turning call lights off until the resident's needs are met, and answering call lights in a timely manner. This education also included the revised assignment sheets, reflecting assignments for the dining room and on the halls during meals, and to assist residents with toileting needs. In addition, these assignments include passing room trays out timely to ensure food is palatable related to the temperature of the food. 4) Correction actions will be monitored to ensure the deficient practice will not recur:ED/designee will conduct temperature checks on test room trays for 2 meals per day with varying meal times, x 6 days per week for 4 weeks, monthly x 3 then quarterly x 2 or until at 95% compliance.ED/designee will interview random alert and oriented residents receiving room trays about the palatability of their food. The interviews will be a total of 10 combined residents taken from each unit 3 x a week x 4 weeks, monthly x 3, then quarterly x 2 or unit at 95% compliance.Random audits of 10 residents, for call light response time and meeting resident's needs during each mealtime will be conducted sampling all units.</p>		

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	<p>p.m., QMA #9 (working the unit) indicated she was first aware the resident needed to go to the bathroom when LPN #7 came and told her.</p> <p>During an interview on 11/21/11 at 12:50 p.m., CNA #8 (working the unit) indicated she was unaware Resident #H needed to use the bathroom until LPN #7 came and told her.</p> <p>Resident #H's record was reviewed on 11/22/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease.</p> <p>The resident's Admission/5-day Minimum Data Set (MDS) assessment, dated 10/28/11, indicated a cognitive pattern score of 15 (cognition intact), and required extensive assistance of two or more for bed mobility, transfers, and toilet use. The MDS assessment indicated the resident was frequently incontinent.</p> <p>2) During an interview on 11/21/11 at 11:55 a.m., Resident #R indicated they wait sometimes an hour for his call light to be answered and to be assisted to the bathroom. Resident #R indicated this happens frequently at meal times.</p>		<p>Audits will be conducted by the ED/DON/designee 3 x a week x 4 weeks, then monthly x 3 months then quarterly x 3 or until 95% compliance. Findings from the resident interviews, temperature checks and call light audits to be presented monthly by the ED/DON to the Performance Improvement Committee for further review/recommendations. 5) Date of compliance: 12-28-11</p>				

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	<p>Resident #R was identified as alert, oriented, and interviewable by RN #10 during the initial tour on 11/17/11 at 12:20 p.m.</p> <p>Resident #R's record was reviewed on 11/23/11 at 8 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The CNA care card indicated the resident required 2 persons to transfer the resident.</p> <p>3) During a confidential family interview on 11/20/11, a family member indicated during meals all the staff are off the floor, and they will not assist their family member to the bathroom until all the residents are back from the dining room. The family member indicated when their family member rings her call light, the staff will come in to answer it, turn it off and tell their family member they will be back, then it is about 15-20 minutes before anyone will come back into the room.</p> <p>4) During another confidential family interview on 11/21/11, a family member indicated sometimes their family member waits 15-30 minutes to get help to the bathroom. They indicated the staff will answer the call light, they tell the resident they will go get help, but then the resident</p>			

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	<p>waits a long time for the staff to return. The family member indicated this happens a lot, especially during the meal times.</p> <p>5) During another confidential family interview on 11/21/11, a family member indicated their family member sometimes has to wait an hour to an hour and a half for assistance to the bathroom. The family member indicated they have been told the resident has to wait until the dining room is cleared out before they can assist the resident to the bathroom.</p> <p>6) During a confidential interview on 11/21/11, they indicated there was not enough staff to serve the resident's meals. They indicated the resident's trays had to sit up to an hour and a half before they were served. They indicated there was only one staff member left on the hall to feed the residents and if someone had to use the bathroom who needed more than one person to assist them they had to wait until someone came back from the dining room when the meal was over or until they could find someone to assist them. They indicated the residents were incontinent more now because of not having enough staff to toilet the residents. They indicated the residents were not being laid down after meals because there was not enough time to get everyone laid</p>			
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	<p>down.</p> <p>7) The noon meal food cart, which contained room trays for the core unit, was observed on 11/21/11 at 12:10 p.m., sitting on the south hall.</p> <p>CNA #13 was observed taking the food cart from the south hall to the west hall on 11/21/11 at 12:14 p.m. CNA #13 indicated she had already served south hall and the food trays which were left to be served were on the east and west halls.</p> <p>LPN #10 and RN #14 were observed serving room trays on the west hall on 11/21/11 at 12:15 p.m.</p> <p>On 11/21/11 at 12:24 p.m., there were still 2 trays observed in the food cart on the west unit.</p> <p>During a confidential staff interview on 11/21/11, they indicated there was not enough staff to get the residents fed timely. They indicated there were three residents who had to be fed and one resident takes an hour to feed. They indicated the resident who takes an hour has to wait until the other two residents were fed before they could even begin to feed her. They indicated the food was usually not to warm by the time the trays were passed.</p>				

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	<p>The last tray was observed to be served on the west hall on 11/21/11 at 12:30 p.m.</p> <p>The test tray temperatures were taken with the Dietary Manager on 11/21/11 at 12:30 p.m.: the fish was 93.7 degrees, spinach was 97.7 degrees, potatoes were 94 degrees and the milk was 52.7 degrees. The fish and spinach were cold to the taste. The potatoes were cold and rubbery and the milk was barely cold.</p> <p>During an interview on 11/21/11 at 12:37 p.m., the Dietary Manager indicated the cart came out of the kitchen at 11:55 a.m.</p> <p>The kitchen "Food Temperature Log" for the noon meal on 11/21/11, indicated the fish had been 211 degrees, spinach was 181 degrees and the potatoes were 181 degrees, and the milk was 37 degrees when they were served in the kitchen.</p> <p>8) During an interview on 11/23/11 at 10:18 a.m., the DoN (Director of Nurses) indicated there were two food carts delivered on the halls. She indicated if the staff were not ready to feed the resident, their tray would go back to the kitchen because the staff were feeding someone else. They wouldn't want the resident's food to get cold so it would go back to the kitchen. She indicated there</p>			
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	<p>were 2 staff on the hall to feed the residents, one nurse and one CNA. She indicated if there were three residents who needed to be fed, then one resident's meal would go back to the kitchen to stay hot because the other staff have to be in the dining room to assist with meals.</p> <p>9) During a confidential family interview on 11/20/11, the family member indicated when the family member eats meals in the room, the food is cold.</p> <p>10) During a confidential resident interview on 11/21/11, the resident indicated the food is always cold when it is served in the room. The resident indicated the staff were not asked to warm up the food because when they were asked, it took them 30 minutes to bring the food back to the resident.</p> <p>11) During an observation on 11/21/11 at 12 p.m., the SDC (Staff Development Coordinator) was passing noon meal trays on the Skilled Unit. QMA #9 was feeding a resident in their room, while the SDC was passing trays to other residents on the unit.</p> <p>The resident's noon meal trays were completely passed at 12:15 p.m. The test tray on the food cart included fish, spinach, scalloped potatoes, corn bread, milk, and blueberry pie.</p>				

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	<p>Upon tasting and obtaining temperatures of the test tray, the spinach was luke warm at 115.3 degrees, the fish was cool at 103.9 degrees, the potatoes were cool at 115 degrees, the corn bread was cool and the milk was warm at 51.3 degrees.</p> <p>12) Resident #S's record was reviewed on 11/29/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and anoxic brain damage.</p> <p>The resident's Quarterly MDS assessment, dated 08/09/11, indicated the resident required extensive assistance by two or more staff for bed mobility.</p> <p>The resident's CNA care guide, indicated the resident required two plus assistance for toileting and was totally dependent for transfers.</p> <p>During an interview on 11/29/11 at 10:10 a.m., LPN #15 indicated the Director of Nursing came in to work as a CNA on 11/25/11 night shift due to a call off.</p> <p>A Nurses' Note, dated 11/25/11 at 8:30 a.m., indicated the resident had been changed for incontinence about 30 minutes prior to being found on floor.</p>			
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	<p>During an interview on 11/29/11 at 11:15 a.m., the Director of Nursing indicated she worked 11/25/11 during the night. She indicated she had just checked and changed the resident and turned her prior to the fall. She indicated she had provided the care to the resident by herself.</p> <p>The facility schedules from 11/23/11 through 11/28/11, received from the Assistant Director of Nursing as correct, indicated on the core unit, there were two nurses and two CNAs scheduled for the Core Unit (East, South, and West Hall) on the 10 p.m. to 6 a.m. shift on November 23, 24, 27, and 28, 2011. The Schedules indicated there were two additional staff members scheduled for the Special Care and Skilled Units on November 23,24, 27, and 28.</p> <p>The CNA Care Guides, received from the Unit Manager and the Director of Nursing as current, dated 11/29/11, indicated there are a total of 67 residents on the Core Unit, and 37 residents required two or more assistance with toileting and 27 residents required assistance of one person for toileting, which leaves three residents who need set-up for toileting.</p> <p>This Federal tag relates to Complaint IN00099610.</p>						

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(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
F0364 SS=E	<p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was palatable, related to the temperature of residents' food who received room trays, for 6 residents who received rooms trays on the skilled unit and 14 residents who received room trays on the core unit for 2 of 3 units in the facility.</p> <p>Findings include:</p> <p>1. The noon meal food cart, which contained room trays for the core unit, was observed on 11/21/11 at 12:10 p.m., sitting on the south hall.</p> <p>CNA #13 was observed taking the food cart from the south hall to the west hall on 11/21/11 at 12:14 p.m. CNA #13 indicated she had already served south hall, and the food trays which were left to be served were on the east and west halls.</p> <p>LPN #10 and RN #14 were observed serving room trays on the west hall on 11/21/11 at 12:15 p.m.</p> <p>On 11/21/11 at 12:24 p.m., there were still 2 trays observed in the food cart on</p>			F0364	<p>F3641) Corrective action for the residents found to have been affected by the deficient practice: Residents in question did not voice complaints about the quality or temperature of their food at the time of survey. 2) Corrective action taken for those residents having the potential to be affected by the same deficient practice: Residents receiving room trays have the potential to be affected. The Executive Director, Director of Nursing, and nursing administration reviewed the nursing assignments on 12-13-11 and the assignment sheet was updated to reflect specific assignments to assist with passing out room trays timely. A heated 2 stack dish dispenser to warm plates prior to the meal service and additional enclosed tray trucks have been ordered on 12-1 and 12-13-11 to help maintain the temperature of the food. 3) Measures/systemic changes put into place to ensure the deficient practice does not recur: Nursing staff to be educated by the Director of Nursing/designee and will be completed by 12-27-11 regarding the updated nursing assignment sheets. These assignments include passing room trays out</p>		12/28/2011

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	<p>the west unit.</p> <p>During a confidential interview on 11/21/11 at 12:25 p.m., they indicated there was not enough staff to get the resident fed timely. They indicated there were three residents who had to be fed, and one resident takes an hour to feed. They indicated the resident who takes an hour has to wait until the other two residents were fed before they could even begin to feed her. They indicated the food was usually not too warm by the time the trays were passed.</p> <p>The last tray was observed to be served on the west hall on 11/21/11 at 12:30 p.m.</p> <p>The test tray temperatures were taken with the Dietary Manager on 11/21/11 at 12:30 p.m. were the fish was 93.7 degrees, spinach was 97.7 degrees, potatoes were 94 degrees and the milk was 52.7 degrees.</p> <p>The fish and spinach were cold to the taste. The potatoes were cold and rubbery and the milk was barely cold.</p> <p>During an interview on 11/21/11 at 12:37 p.m., the Dietary Manager indicated the cart came out of the kitchen at 11:55 a.m.</p> <p>The kitchen "Food Temperature Log" for the noon meal on 11/21/11, indicated the</p>		<p>timely to ensure food is palatable related to the temperature of the food. 4) Correction actions will be monitored to ensure the deficient practice will not recur: ED/designee will conduct temperature checks on test room trays for 2 meals per day with varying meal times, x 6 days per week for 4 weeks, monthly x 3 then quarterly x 2 or until at 95% compliance. ED/designee will interview random alert and oriented residents receiving room trays about the palatability of their food. The interviews will be a total of 10 combined residents taken from each unit 3 x a week x 4 weeks, monthly x 3, then quarterly x 2 or unit at 95% compliance. Random audits of 10 residents, for call light response time and meeting resident's needs during each mealtime will be conducted sampling all units. Audits will be conducted by the ED/DON/designee 3 x a week x 4 weeks, then monthly x 3 months then quarterly x 3 or until 95% compliance. Findings from the resident interviews, temperature checks and call light audits to be presented monthly by the ED/DON to the Performance Improvement Committee for further review/recommendations. 5) Date of compliance: 12-28-11</p>		

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	<p>fish had been 211 degrees, spinach was 181 degrees and the potatoes were 181 degrees and the milk was 37 degrees when they were served in the kitchen.</p> <p>2. During a confidential family interview on 11/20/11, the family member indicated when the family member eats meals in the room, the food is cold.</p> <p>3. During a confidential resident interview on 11/21/11, the resident indicated the food is always cold when it is served in the room. The resident indicated the staff were not asked to warm up the food because when they were asked, it took them 30 minutes to bring the food back to the resident.</p> <p>4. During an observation on 11/21/11 at 12 p.m., the SDC (Staff Development Coordinator) was passing noon meal trays on the Skilled Unit. QMA #9 was feeding a resident in their room, while the SDC was passing trays to other residents on the unit.</p> <p>The resident's noon meal trays were completely passed at 12:15 p.m. The test tray on the food cart included fish, spinach, scalloped potatoes, corn bread, milk, and blueberry pie.</p> <p>Upon tasting and obtaining temperatures of the test tray, the spinach was luke</p>			
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	<p>warm at 115.3 degrees, the fish was cool at 103.9 degrees, the potatoes were cool at 115 degrees, the corn bread was cool and the milk was warm at 51.3 degrees.</p> <p>This Federal tag relates to Complaint IN00099610.</p> <p>3.1-21(a)(2)</p>			
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