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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/05/2015 |
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| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 |
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| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: July 28, 29, 30, August 3, 4, and 5th, 2015.</p> <p>Facility number: 00173 Provider number : 155273 AIM number: 100290920</p> <p>Census bed type: SNF/NF: 74 Total : 74</p> <p>Census payer type: Medicare: 6 Medicaid: 46 Other: 22 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2 -3.1.</p> | F 0000 | <p>Plan of Correction for Cypress Grove Rehabilitation Center 2015 Annual Survey</p> <p>The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan ofCorrection be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit on September 4,2015</p> | |
| F 0241 SS=D Bldg. 00 | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's</p> | | | |

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

TITLE

(X6) DATE

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

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| | <p>dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was provided to 3 of 15 residents observed eating in the Restorative dining room, the resident were not served their food at the time of their tablemate's and one resident was observed to propel the wheelchair backwards. (Resident #37, Resident #6, Resident #53)</p> <p>Findings include:</p> <p>1. During an observation on 7/28/15 at 12:27 p.m., Resident #37 was observed to be seated at the same table in the restorative dining room with Resident #49 and Resident #6. CNA # 1 was observed to obtain Resident #49's tray and fed Resident #49. CNA #4 was observed to deliver trays to 4 (four) other residents at different tables in the restorative dining room before serving Resident #37 the lunch meal. Resident #6 was observed to receive the lunch meal after the other 12 residents had received their meals.</p> <p>During an interview on 8/5/15 at 7:45 a.m., CNA #2 indicated all residents who are seated at the same table are to be</p> | F 0241 | <p>F241</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Identified residents # 37 and # 6 are being served in the restorative dining room at the same time as their tablemates during meal service to ensure dignity is provided. Resident #53 received a new chair that was recommended by the therapy department to ensure she is able to propel forward without difficulty.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that eat in the dining rooms and have restrictive device orders have the potential to be affected by the alleged deficient practice. An audit was completed by the ED/designee to determine which residents eat in the dining rooms. All residents that eat meals in the dining rooms were assessed during meal times by the ED to ensure the tablemates received trays at the same time. An audit was completed by the RSM (Rehabilitation Services Manager) and determined that resident #53 was the only resident in the facility with a speed restricting device on their wheelchair.</p> | 09/04/2015 | | | |

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| | <p>served at the same time at that table before serving other resident's tables.</p> <p>The facility lacked documentation of a policy for distribution of meals in the dining meal.</p> <p>2. On 7/29/15 an observation of Resident # 53 revealed she was always seen propelling backwards in her wheelchair around the facility.</p> <p>On 7/29/15 at 11:00 a.m. Nurse Consultant indicated the facility knows her wheel chair doesn't work right and has a new one ordered.</p> <p>On 7/29/2015 4:22 p.m. the residents wheelchair was examined and found to only propel backwards smoothly, it would move forward, but with much difficulty.</p> <p>On 7/29/15 at 4:30 p.m. review of Resident #53 clinical record indicated there was an order on 6/10/15 for a speed restrict to be applied to the back of the Jensen wheelchair, check placement and function every shift.</p> <p>Record Review on 7/29/15 also indicated the resident's diagnoses included, but not limited to: Dementia, Alzheimer's, Depression, Hypertension, Peripheral</p> | | <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All staff will be in-serviced by 9/4/15 by ED/designee to ensure residents tablemates are served at the same time. The ED/designee will monitor all meals daily to ensure table mates are served at the same time. DNS/designee will in-service the IDT on restrictive device policy. During daily clinical review all new orders will be reviewed by the Interdisciplinary Team (IDT) for restrictive devices, and will follow the restrictive device policy.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliance the ED/designee is responsible for the completion of the Meal Service Observation CQI tool and the Restrictive Device CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result disciplinary</p> | | |

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| | <p>Vascular Disease. The BIMS (Brief Interviewable Mental Status) indicated the resident is severely mentally impaired. The residents BIMS score was not recorded.</p> <p>On 08/03/2015 was at 10:19 a.m. interview with RN #1 concerning speed restrict on wheelchair, she indicated it was to keep her from going forward so fast and prevent accidents, but resident goes backward quickly also.</p> <p>On 08/03/2015 10:21 a.m., interview with Head of Maintenance indicated he had installed the speed restrictors, and they are supposed to control backwards and forwards motion.</p> <p>On 08/03/2015 at 10:22 a.m. with Head of Occupational Therapy indicated they have a new Broda rocking wheel chair ordered, which will be here today to help with the speed problem</p> <p>On 8/4/15 observation was made which indicated Resident #53 had received a Broda pedal rocker with foot rests removed.</p> <p>3.1-3(t)</p> | | <p>action up to and including termination of responsible employee. Date of compliance: September,4 2015</p> | |

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| F 0272 SS=D Bldg. 00 | <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive assessment was accurate for 1 of 28 stage 2 residents reviewed as a</p> | F 0272 | <p>F272 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> | 09/04/2015 |

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| | <p>resident's MDS (Minimum Data Set) assessment was incorrectly entered for a dependent resident. (Resident #39)</p> <p>Findings include:</p> <p>During an observation on 7/28/15 at 2:34 p.m., Resident #39 was observed to be lying in bed. Resident #39 indicated she was quadriplegic and was unable to care for herself.</p> <p>The clinical record for Resident #39 was reviewed on 8/3/15 at 2:02 p.m. The quarterly MDS assessment for Resident #39 indicated the resident had walked in the room and hall at least once with extensive assist of 2 persons.</p> <p>During an interview on 8/4/15 at 3:25 p.m., CNA #4 indicated Resident #39 had never ambulated.</p> <p>During an interview on 8/4/15 at 3:34 p.m., the OT (Occupational Therapy) Director indicated Resident #39 did not ambulate and had a diagnosis of quadriplegia.</p> <p>During an interview on 8/4/15 at 3:36 p.m., the MDS Coordinator indicated the MDS assessment had been inaccurately marked and she would correct it immediately.</p> | | <p>The MDS on resident #39 has been corrected to reflect the resident's current condition.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit was completed by MDS coordinator to identify other residents that have a diagnosis of quadriplegia. No other resident had the diagnosis of quadriplegia. Only resident #39 has the potential to be affected by the deficient practice.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? MDS coordinator will be in-serviced by RAI specialist by 9/4/2015 on use of IDT Resident Review Tool. IDT Quarterly Care Plan and Resident Review Tool will be utilized by the IDT while completing an MDS to ensure accurate coding of resident diagnosis.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliance the ED/designee is responsible for the completion of the Care Plan Review CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts</p> | | |

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| F 0282 SS=D Bldg. 00 | <p>3.1-31(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was administered according to a physician's order for 1 of 3 residents reviewed for medications. (Resident #54)</p> <p>Findings include:</p> <p>During an observation on 7/29/15 at 10:21 a.m., Resident #54 was observed to be sitting in a recliner in his room with nasal oxygen on. Resident #54 indicated he had breathing problems and had recently been hospitalized.</p> | | | F 0282 | <p>until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>1.Date of compliance: September, 4 2015</p> <p>F282</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The physician's order for resident #54 to receive Guaifenesin has been clarified and is now administered per the clarified order.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All other residents that reside in the facility have the potential to be affected by the alleged deficient practice. Physician orders were</p> | | 09/04/2015 |

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| | <p>The clinical record for Resident #54 was reviewed on 7/30/15 at 2:40 p.m. Resident #54 had diagnoses including, but not limited to, chronic airway obstruction, congestive heart failure, obstructive sleep apnea, atrial fibrillation, hypertension, cerebral artery occlusion. The entry MDS (Minimum Data Set) assessment indicated Resident #54 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated no cognitive impairment.</p> <p>Resident #54 had a physician's order, dated 6/15/15 and signed on 7/20/15, for Guaifenesin (an expectorant) 400 mg (milligrams), give 1 (one) tablet orally every 8 hours for cough and to loosen mucus.</p> <p>The MAR (Medication Administration Record), dated 7/1/15 through 7/31/15, indicated Resident #54 was given the medication at 6:00 a.m., 12:00 noon, and 6:00 p.m. The medication time was set for every six (6) hours.</p> <p>The MAR (Medication Administration Record), dated 8/1/15 through 8/31/15, indicated Resident #54 had received the medication at 6:00 a.m., 12:00 noon, and 6:00 p.m. on 8/1/15, 8/2/15, and at 6:00 a.m. and 12:00 noon on 8/3/15.</p> | | <p>audited by DNS/designee during the monthly re-writes to ensure administration times on the Medication Administration Record (MAR) accurately reflects the physician orders.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All licensed nurses will be in-serviced by DNS/designee on medication pass procedure by 9/4/15. The DNS/designee will review new orders daily to ensure physician orders are transcribed accurately on the MARS.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliancethe ED/designee is responsible for the completion of the Medication Error CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedbe the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> | |

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| F 0309 SS=D Bldg. 00 | <p>During an interview with the RN #2 on 8/3/15 at 4:00 p.m., RN #2 indicated the administrative staff was aware the facility had medications that needed to be reviewed and the resident's physician would be notified immediately.</p> <p>The facility lacked a policy for following physician's orders.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary care and services. The facility failed to monitor a resident during a change in condition for 1 of 1 residents reviewed for death. (Resident #56) The facility failed to monitor a resident following dialysis or the residents dialysis access site for 1 of 1 residents reviewed for dialysis. (Resident #76)</p> | F 0309 | <p>1.Date of compliance: September, 4 2015</p> <p>F309 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #56 no longer resides in the facility. Resident #76 no longer resides in the facility. 1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> | 09/04/2015 |

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| | <p>Findings include:</p> <p>1. On 8/3/15 at 9:30 a.m., Resident #56's clinical record was reviewed. Resident #56's diagnoses included, but were not limited to, intermittent explosive disorder, gastroesophageal reflux disorder, hypertension, anxiety, hypothyroidism, and dementia with behavior disturbances.</p> <p>The telephone physician orders indicated on 2/25/15 the physician ordered Seroquel (an antipsychotic medication) 50 mg (milligrams) orally every evening.</p> <p>The Occupational Therapy Notes, dated 3/10/15 indicated therapy had discussed the residents increased lethargy. The note further indicated the resident had been unable to keep her head upright.</p> <p>The Occupational Therapy Notes, dated 3/11/15 indicated the resident had decreased alertness. The note further indicated the resident's lips were slightly blue and therapy had been unable to attain an oxygen saturation reading. The note indicated nursing had been brought into the residents room and transferred to bed. The note indicated nursing staff obtained an oxygen saturation reading of 68 percent.</p> | | <p>All other residents that reside in the facility have the potential to be affected by the alleged deficient practice. During daily clinical review the 24 hour books will be reviewed by the IDT for condition changes. All nursing staff will report to DNS/designee during daily clinical rounds on any changes of condition. Audit was completed by DNS/designee on all residents that receive dialysis to ensure appropriate orders are in place for monitoring access site.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The ED/designee will in-service ITD on daily clinical meeting process by 9/4/15. DNS/designee will ensure clinical meeting held per protocol. IDT will submit Clinical Meeting Audit tool to ED daily. The DNS/designee will complete an audit daily on all of the residents the receive dialysis to ensure access site monitoring is being documented on treatment record. The DNS/designee will complete an in-service by 9/4/15 on dialysis site monitoring for all licensed nursing staff.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</p> | |

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| | <p>On 3/10/15 the DCR note indicated the resident had increased lethargy and decreased oral intake. The note indicated the resident had new medications which could have caused the lethargy. The note further indicated a pharmacy review would be requested.</p> <p>The Nursing Notes indicated: On 2/20/15 at 4:00 p.m., the nurse was called to the resident room because the resident was found on the floor. The note further indicated the resident had sustained a 4 cm (centimeter) by 2.2 cm hematoma to the right side of the residents forehead and a pinpoint abrasion to the inside of the eye socket. On 2/24/15 at 4:00 a.m., the note indicated an assessment following the fall had been completed. The note lacked an assessment of the hematoma. On 2/24/15 at 3:00 p.m., the note indicated the resident had complaints of itching and 25-50 mg (milligrams) of Benadryl (an antihistamine medication) had been ordered as needed every 6 hours. On 2/25/15 at 2:30 a.m., the notes indicated an assessment following the fall had been completed. The note lacked an assessment of the hematoma. On 2/26/15 at 4:30 a.m., the note indicated an assessment following the fall</p> | | <p>To ensure compliance the ED/designee is responsible for the completion of the Daily Clinical Meeting CQI tool and Change of Condition CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>1.Date of compliance: September, 4 2015</p> | |

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| | <p>had been completed. The note further indicated the hematoma was fading.</p> <p>No further notes were recorded until 3/11/15, as indicated below:</p> <p>On 3/11/15 at 10:20 a.m., the note indicated the resident was lethargic and the residents oxygen saturation was ninety percent after placing 5 liters of oxygen via a non-rebreather mask.</p> <p>On 3/11/15 at 11:00 a.m., the note indicated the residents family had arrived. The note further indicated mottling (a discoloration of the skin in irregular patches) was present in the residents hands and feet. The note indicated the physician had been notified.</p> <p>On 3/11/15 at 4:00 p.m., the note indicated the nurse had been notified by the physician of the family's request for hospice services.</p> <p>On 3/12/15 at 3:45 a.m., the note indicated the resident was unresponsive and lacked vital signs.</p> <p>The nursing notes lacked documentation related to the new antipsychotic medication, hematoma, and the residents change in condition.</p> <p>On 8/4/15 at 2:31 p.m., the RN #2 indicated that during a change in condition staff should be monitoring</p> | | | |

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| F 0312 SS=D Bldg. 00 | <p>residents.</p> <p>On 8/5/15 at 1:30 p.m., RN #1 indicated residents are monitored for closely including, but not limited to, following falls, initiation of an antipsychotic medication, and a change in condition.</p> <p>On 8/5/15 at 2:22 p.m., the Administrator provided the Resident Change in Condition policy, revised on 1/2015. The policy included, but was not limited to: Acute Medical Change: any sudden or serious change in a resident condition manifested by a marked change in physical or mental behavior will be communicated to the physician. The policy further indicated all nursing actions/interventions will be documented in the medical record as soon as possible after the resident needs had been met.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide showers to 2 of 5 residents reviewed for ADLs (activities of daily</p> | F 0312 | <p>F312</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> | 09/04/2015 |

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| | <p>living) in a total sample of 35 stage 2 residents. (Resident #39, Resident #20)</p> <p>Findings include:</p> <p>1. During an observation on 7/28/15 at 2:34 p.m., Resident #39 was observed to be lying in bed. Resident #39's hair appeared to be oily and the resident continuously scratched her head.</p> <p>During an interview on 7/28/15 at 2:35 p.m., Resident #39 indicated she rarely received showers on her shower days. Resident #39 indicated she was supposed to receive a shower on the evening shift on Tuesdays and Thursdays. Resident #39 indicated she had not received a shower since July 16, 2015.</p> <p>The clinical record for Resident #39 was reviewed on 8/3/15 at 9:14 a.m. Resident #39 had diagnoses including, but not limited to, quadriplegia, hyperlipidemia, anxiety disorder, acute kidney failure , neurogenic bladder, urinary tract infection, and osteomyelitis.</p> <p>A quarterly MDS (Minimum Data Set) assessment indicated Resident #39 had a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment.</p> <p>During review of the "Bath Type Detail</p> | | <p>Residents #39 and #20 were given showers and or bed baths per resident preference and their care plans have been updated.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All other residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents were interviewed to determine resident bathing/shower preferences by Customer Care Representatives. Residents that reside in the facility are receiving showers and or bed baths as indicated by interviews conducted by Customer Care Representatives (CCR), shower sheet documentation, and CCR's daily rounds.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>CCRs/designees will utilize daily interviews and rounds to ensure residents are given showers and or bed baths as indicated by their preferences and care plans. Shower sheets will be audited daily by the DNS/designee to ensure completion per schedule. The DNS/designee will complete an in-service with all licensed staff by 9/4/15 on shower schedule and documentation</p> <p>1.How the corrective</p> | | | | |

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| | <p>Report," dated from 4/1/15 through 6/30/15 obtained from the RN #2 on 8/4/15 at 9:45 a.m., the report indicated Resident #39 had received a shower on 4/9/15, 4/20/15, 4/29/15, 5/14/15.</p> <p>The "Personal Hygiene Shower Schedule,"obtained from RN #2 on 8/4/15 at 9:45 a.m., indicated Resident #39 received a shower on 7/16/15, and 8/2/15.</p> <p>The shower schedule was received from the Staffing Scheduler on 7/29/15 at 3:12 p.m. The schedule indicated Resident #39 was supposed to be given on Tuesdays and Thursdays.</p> <p>During an interview on 8/3/15 at 8:52 a.m., CNA #3 indicated the resident should receive showers on the evening shift on Tuesdays and Thursdays.</p> <p>The facility lacked a policy for ADL care or showers.</p> <p>2. The clinical record of Resident #20 was reviewed on 7/30/15 at 1:28 p.m. The record indicated the diagnoses included, but were not limited to, depression, gastroesophageal reflux disease, stroke, hypercholesterolemia, bilateral cataracts, dementia, hypertension, and intracranial hemorrhage.</p> | | <p>action(s) will bemonitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</p> <p>To ensure compliance the ED/designee is responsible for the completion of the Accommodation of Needs CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of compliance: September,4 2015</p> | | | | |

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| F 0323 SS=D Bldg. 00 | <p>The quarterly MDS (Minimum Data Set) indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14 on a quarterly review dated 5/7/15.</p> <p>The ADL record indicated the resident requires limited assist/extensive assist with bed mobility, supervision/ limited assist with meals, and limited assist/extensive assist with toilet use. One shower occurred between July 24th through July 30th and no other bathing activities occurred in that time period.</p> <p>3.1-38(a)(3)(A)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 observation, record review, and observation, the facility failed to ensure the resident's environment remains free of accident hazards as is reasonably possible for 1 of 1 resident reviewed for accidents for the resident propelling self backwards in the wheelchair. (Resident # 53)</p> | F 0323 | <p>F323</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #53 received a new chair that was recommended by the therapy department to ensure she is able to propel forward without difficulty.</p> <p>1.How will you identify other</p> | 09/04/2015 |

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| | <p>Findings include:</p> <p>On 7/29/15 an observation of Resident # 53 revealed she was always seen propelling backwards in her wheelchair around the facility.</p> <p>On 7/29/15 at 11:00 a.m. the Nurse Consultant indicated the facility knows her wheel chair doesn't work right and has a new one ordered.</p> <p>On 7/29/2015 at 4:22 p.m. the residents wheelchair was examined and found to only propel backwards smoothly, it would move forward, but with much difficulty.</p> <p>On 7/29/15 at 4:30 p.m. the clinical record was reviewed of Resident #53, The clinical record indicated there was an order on 6/10/15 for a speed restrictor to be applied to the back of the Jensen wheelchair, check placement and function every shift.</p> <p>The resident's diagnosis includes, but not limited to: Dementia, Alzheimer's, Depression, Hypertension, Peripheral Vascular Disease. The BIMS (Brief Interviewable Mental Status) indicated the resident is severely mentally impaired.</p> | | <p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All other residents using wheelchairs have the potential to be affected by the alleged deficient practice. A safety check was completed on all wheelchairs by the RSM(Rehabilitation Services Manager)/designee to ensure no worn or damaged parts.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The ED/designee will in-service the maintenance director and therapy staff on wheelchair safety checks and maintenance schedule by 9/4/2015. CCR's will audit wheelchairs daily during CCR rounds to ensure wheelchairs have no worn or damage parts and are operating correctly per manufacturer's instructions.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliance the ED/designee is responsible for the completion of the Accommodation of Needs CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until</p> | | |

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| | <p>On 08/03/2015 at 10:19 a.m., interview with RN #1 concerning speed restrictor on wheelchair, she indicated it was to keep her from going forward so fast and prevent accidents, but resident goes backward quickly also.</p> <p>On 08/03/2015 10:21 a.m., interview with Head of Maintenance indicated he had installed the speed restrictors, and they are supposed to control backwards and forwards motion.</p> <p>On 08/03/2015 at 10:22 a.m. with Head of Occupational Therapy indicated they have a new Broda rocking wheel chair ordered, which will be here today to help with the speed problem</p> <p>On 8/4/15 observation was made which indicated Resident #53 had received a Broda pedal rocker with foot rests removed.</p> <p>On 8/5/15 at 11:00 a.m. a policy was received indicating wheelchairs should semi-annually have a safety check. Replace worn or damaged parts, check to see that all components are tight and working properly.</p> <p>3.1-45(a)(2)</p> | | <p>continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of compliance: September, 4 2015</p> | | |

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| F 0371 SS=F Bldg. 00 | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure the kitchen and kitchen equipment were clean and that food was prepared and served under sanitary conditions for 3 of 3 kitchen observations. The stove and oven were observed to be soiled, the walk in freezer had ice build up on the shelving, foods were open with no dates, a scoop was in the sugar bin, handling of eating utensils was done improperly, and handwashing was not done adequately by staff. This had the potential to affect 74 of 74 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 7/28/15 at 9:00 a.m., the following were observed:</p> <p>1. A box of ground beef patties were open on the shelf.</p> | F 0371 | <p>F371 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The kitchen and kitchen equipment including the stove and oven that was identified has been cleaned and sanitized. The freezer has been cleaned and sanitized and the ice is no longer present. The scoop was removed from the sugar bin and sanitized. Sugar in bin was discarded by the dietary staff. Food that was identified as being stored open and or undated has been disregarded. Staff is washing their hands adequately.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All other residents that reside in the facility have the potential to be affected by the alleged deficient practice. All equipment was inspected by the ED/designee to ensure cleanliness of all equipment. All freezers were inspected to ensure no build up of</p> | 09/04/2015 | | | |

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| | <p>2. A box of hotdogs were open on the shelf.</p> <p>3. A box of pie crusts were open on the shelf.</p> <p>4. A bag of cauliflower blend was opened with no date on it.</p> <p>5. A bag of diced green peppers was opened with no date on it.</p> <p>6. The walk-in freezer had ice build up on the shelves.</p> <p>7. A scoop was observed lying in the sugar bin.</p> <p>8. There were peas, and other debris floating in the water on the tray line, dried food was observed on the sides of the pans. This was observed after the breakfast meal.</p> <p>9. The right side of the stove had grease build up and dried food on the surface. The oven door had dried food on the sides and bottom surfaces.</p> <p>During an interview on 7/28/15 at 9:20 a.m., the Assistant Dietary Manager indicated the July cleaning schedule had missing signatures. She also indicated the tray line was supposed to be cleaned</p> | | <p>ice. All food without proper labeling was discarded by the Dietary Manager. All bins were inspected to ensure scoops were properly stored. All inspections were completed by 9/4/15. All staff has been re-educated on proper hand washing. The dietary staff have been re-educated on the storage of food, preparation of food, service of food under sanitary conditions, and on completing the cleaning schedules tasks.</p> <p>1. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The Regional Registered Dietitian educated the dietary staff on each of their specific tasks that are outlined on the cleaning schedules. The Dietary Manager/designee will complete the "Dietary Manager Daily AM Check List" daily and inspect the kitchen and kitchen equipment to ensure the cleaning schedule is being followed and ensure food that is being stored is dated and sealed properly. The ED/designee will complete a "Kitchen Sanitation/Environmental Review" daily. Skills validations will be completed by the DNS/designee for all dietary staff to ensure proper hand washing occurs by 9/4/15.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice</p> | | |

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| | <p>after each meal.</p> <p>10. During an observation of dining on 7/28/15 at 12:03, the Housekeeping Supervisor was observed to wash his hands for 7 seconds, and then touch the paper towel dispenser handle with his bare hand prior to assisting with serving trays. He was observed to do the same at 12:18 for 3 seconds, at 12:15 for 3 seconds, and at 12:20 for 6 seconds. The Activities Director was observed on 7/28/15 at 11:56, to wash her hands for 15 seconds, then touch the paper towel dispenser handle with her bare hand, prior to serving meal trays. She was observed to do the same at 12:14 for 6 seconds.</p> <p>11. On 8/3/15 at 11:47 a.m., Dietary Aid # 1 and Dietary Aid # 2 were observed to handle eating utensils by the eating surface.</p> <p>12. During an observation on 7/28/15 at 12:02 p.m., CNA #4 was observed to be delivering trays on the hall into resident rooms. CNA #4 was observed to sneeze into her left hand. No hand hygiene was done after sneezing. CNA #4 was then observed to obtain a glass by the rim, pour tea into a glass, and obtain 2 (two) sweetener packets. CNA #4 was then observed to obtain a tray and deliver it to</p> | | <p>will not recur, i.e., quality assurance program will be put into place?</p> <p>To ensure compliance the ED/designee will review the ManagerDaily AM Check List and the Kitchen Sanitation/Environmental Review daily x 6months until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. IF 100% compliance is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of compliance: September, 4 2015</p> | | |

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| | <p>Resident #5.</p> <p>During an interview on 8/3/15 at 2:15 p.m., the Dietary Manager, indicated the dietary staff has a cleaning schedule that is to be signed when the cleaning is completed.</p> <p>During an interview on 8/4/15 at 3:00 p.m. the Dietary Manager indicated opened food is to be sealed and dated. The Dietary Manager indicated the eating utensils should be handled by the handles only.</p> <p>During an interview on 8/4/15 at 1:59 p.m., the Director of Nursing indicated the proper handwashing technique was to turn on the water, adjust temperature, have arms down, soap up, wash hands using friction, including washing nails on the palm of the hands, cleaning between fingers, do this for twenty seconds, rinse hands and dry them. She indicated to use a paper towel to touch the handle of the towel dispenser to disperse the paper towels.</p> <p>During a record review on 8/4/15 at 10:30 a.m., the cleaning schedule for July 2015 was observed to have the days of July 4th, 5th, 11th, and 12th completed for the tray line cleaning. All other days in July were not completed. The cleaning</p> | | | |

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| F 0406 SS=D Bldg. 00 | <p>schedule indicated the tray line should be cleaned after each use. The July 2015 cleaning schedule indicated the stove top should be cleaned after each use, and the top of the oven should be cleaned once per day. July 1st, 2nd, and 4th were completed for these cleanings, all other days in July were not completed.</p> <p>On 8/4/15 at 9:55 a.m., the Dietary Manager provided a policy titled AMERICAN SENIOR COMMUNITIES Sanitation of Kitchen which stated the dietary staff would maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule.</p> <p>On 8/5/15 at 10:33 a.m., RN (Registered Nurse), # 2, provided a policy titled, "AMERICAN SENIOR COMMUNITIES Handling Clean Equipment and Utensils", which indicated clean equipment and utensils will be handled in a way to prevent contamination.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as,</p> | | | |

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| | <p>but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, record review, and interview, the facility failed to provide specialized rehabilitative services for 1 of 2 residents assessed with a level 2 evaluation, who had recommendations for services. (Resident #2)</p> <p>Findings include:</p> <p>During an observation on 7/29/15 at 11:20 a.m., Resident #2 was observed to be sitting in a wheelchair in the hall.</p> <p>During an observation on 8/4/15 at 2:15 p.m., Resident #2 was observed to be in bed. A music program was being presented in the main dining room and the activity assistant was observed to be in the activity room with 4 (four) residents painting.</p> <p>The clinical record for Resident #2 was reviewed on 7/30/15 at 1:15 p.m. Resident #2 had diagnoses including, but</p> | F 0406 | <p>F406</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The PASRR (Pre-Admission Screening and Resident Review) for level 2 recommendations have been reviewed. Special rehabilitation services are being provided to resident #2 and plan of care has been updated</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All PASRR level 2 residents have the potential to be affected by the alleged deficient practice. An audit was completed to identify residents that have PASRRlevel 2 recommendations. Residents identified by the audit are receiving special rehabilitation service as recommended in the PASRR level 2 and the plans of carehave been updated.</p> <p>1.What measures will be put into place or what systemic</p> | 09/04/2015 |

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| | <p>not limited to, mental retardation, seizure disorder, coronary artery disease, congestive heart failure, diabetes, bilateral below the knee amputation, hypertension, hyperlipidemia, depression, and peripheral vascular disease. A quarterly MDS (Minimum Data Set) assessment, dated 4/28/15, indicated Resident #10 had a BIMS (Brief Interview for Mental Status) of 10, indicating mild cognitive impairment.</p> <p>The PASRR (Pre-Admission Screening and Resident Review) for level 2 recommendations, dated 11/26/14, indicated Resident #2 might benefit from "opportunities for recreational and leisure activities, both inside and outside of the facility to develop and/or enhance social interaction skill, cognitive stimulation, and community involvement."</p> <p>During an interview on 7/30/15 at 1:45 p.m., the AD (Activity Director) indicated Resident #2 had not been able to go outside of the facility since having the bilateral below the knee amputations. The AD indicated the facility had not had transportation for the size of the wheelchair the resident was using. The AD further indicated no one from the facility had been out for a bus ride recently as the facility bus had been broke.</p> | | <p>changes will you make to ensure that the deficient practice does not recur? PASRR level 2 recommendations will be audited by the Social Service Director (SSD)/designee and the Interdisciplinary Team (IDT) monthly or as needed to ensure residents are receiving special rehabilitation service as indicated by the level 2 recommended The ED/designs will in-service the SSD (Social ServiceDirector) on PASRR level 2 recommendations by 9/4/15.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliance the IDT will review the PASRR level2 audits monthly x 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If 100% compliance is not achieved an action plan will bedeveloped. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>1.Date of compliance: September, 4 2015</p> | | |

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| F 0431 SS=E Bldg. 00 | <p>During an interview with the AA (Activity Assistant) on 8/3/15 at 2:12 p.m., the AA indicated the resident had not gone outside of the facility for any activities. The AA indicated the resident usually only attended music activities and food activities at the facility. The AA indicated the facility van had been broke since June 23, 2015. The AA further indicated the broken facility van had to be shared with 2 (two) other facilities when it was running.</p> <p>During an interview on 8/5/15 at 7:47 a.m., the SW (Social Worker) indicated she had just started employment this week with the facility. The SW indicated she had spoken with Resident #2's case manager regarding the recommendations for the resident. The SW indicated she would be checking all of the recommendations for the level 2 residents and would be following up.</p> <p>3.1-23(a)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in</p> | | | |

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| | <p>sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and record review, the facility failed to ensure that medications were locked, narcotics counts were correct, and medications were labeled with open dates in 2 of 4 medication carts observed. (Gardens Unit - Hall B, Willows Unit - Hall E) (Resident #28)</p> | F 0431 | <p>F431</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The keys were removed from the top of the medication cart and the cart was locked. A new narcotic count system has been implemented to ensure accuracy of medication counts.</p> | 09/04/2015 |

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| | <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation of a medication cart on 8/3/15 at 8:48 a.m., indicated the medication keys were left unattended on top of the medication cart for approximately 2 minutes and the medication cart was unlocked on the Gardens Unit - Hall B. 2. Observation of a narcotics count on 8/5/15 at 8:29 a.m., indicated the narcotics sheet for Morphine (pain medication) 5 mg/ml (milligrams per milliliters) was 9 ml and the bottle contained 5 ml of the medication on the Gardens Unit - Hall B. 3. Observation of a medication cart on 8/5/15 at 9:05 a.m. on the Willows Unit - Hall E, indicated Levemir (antidiabetic medication) 100 u/ml for Resident #28, had no open date. <p>A policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" was provided by RN #2 on 8/5/15 at 10:33 a.m. The procedure included, but was not limited to, the following: "Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility</p> | | <p>1.How will you identify other resident shaving the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All other residents that reside in the facility have the potential to be affected by the alleged deficient practice. Medications carts were inspected by DNS/designee to ensure carts remain locked. All narcotics were audited by DNS/designee to ensure accuracy in narcotic count.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>In-service will be completed by DNS/designee on ensuring medication carts remain locked when not in use by 9/4/2015. In-service will be completed by DNS/designee on narcotic count procedure by 9/4/2015. DNS/designee will conduct rounds on all shifts daily to ensure that med carts are locked. DNS/designee will review narcotic count on all shifts daily.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</p> <p>To ensure compliance the DNS/designee is responsible for the completion of the Medication Storage Review CQI tool weekly</p> | | |

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| F 0441 SS=D Bldg. 00 | <p>staff should record the date opened on the medication container when the medication has a shortened expiration date once opened and Facility should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items. Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law."</p> <p>3.1-25(e)(3) 3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> | | X 4 weeks, monthlyX 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of compliance: September,4 2015 | | |

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| | <p>(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed for 2 of 2 residents observed receiving care, in that, hand hygiene measures and glove changes were not followed. (Resident #33, Resident # 10.)</p> <p>Findings include:</p> <p>1. On 7/30/2015 at 2:21 p.m., a dressing</p> | F 0441 | <p>F441 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff is washing their hands for 20 seconds or longer and changing gloves per policy. Resident #33 receives dressing changes per the infection control policy. Resident #3 receives ADL care per the infection control policy.</p> <p>1.How will you identify other resident h aving the potential</p> | 09/04/2015 |

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| | <p>change of a Stage 4 pressure area was observed on Resident #33 by RN #1. RN #1 first performed urinary catheter care. Without changing gloves or handwashing, RN #1 proceeded to remove the old dressing from the pressure area. RN #1 took a clean wash cloth from a basin of warm water, applied Shampoo and Body Wash, and cleansed out the wound. Changing washcloths, she rinsed the bloody area around the pressure area. RN #1 proceeded to measure the wound area. RN #1 began wound care and was prompted to change her gloves. RN #1 changed the gloves, but no handwashing was done. RN #1 proceeded to flush the wound with saline vials until the wound was clean. There was no signs of infection or drainage. The area was then dried with 4 x 4 gauze, gloves were changed with no hand hygiene observed. Skin prep was applied to area and allowed to dry, then stoma-adhesive powder was applied to the area. Algisite was applied further into deep wound. RN #1 proceeded to apply a clean dressing to the wound. No hand hygiene was performed by RN #1 until after completing the wound care.</p> <p>Resident # 33's clinical record was reviewed on 7/29/15 at 10:00 a.m., resident was admitted to the facility on 8/14/14 with a diagnoses including, but</p> | | <p>to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All staff have been re-educated by DNS/designee on hand washing and the infection control policy using skills validation. All licensed staff will be re-educated by DNS/designee on dressing change using skills validation.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? DNS/designee will conduct rounds each shift to ensure staff hand washing completed per policy. DNS/designee will observe one dressing change daily to ensure glove changing and hand washing occurs per policy. In-service will be completed by DNS/designee for all licensed staff on hand washing procedure by 9/4/2015. In-service will be completed by DNS/designee for all licensed nursing staff on dressing change procedure by 9/4/2015.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place? To ensure compliance the DNS/designee is responsible for the completion of the Infection</p> | |

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| | <p>not limited to, pressure area stage 4, muscle weakness, depression disorder, rheumatoid arthritis, open wound buttock without mention complication.</p> <p>On 8/4/15 at 9:00 a.m., the Administrator was informed of the dressing change which didn't include handwashing and glove changed. He indicated more education would be done on infection control and handwashing.</p> <p>On 8/4/15 at 9:15 a.m. LPN #1 was queried on glove and handwashing in between and clean area for dressing changes and she indicated that gloves should be changed and handwashing done prior to starting procedure and in between changing the dirty dressing and applying the new dressing.</p> <p>On 8/14/15 a policy was received on 8/4/15 at 11:30 a.m., a policy was received titled "Dressing Change" dated 1/2010, which included, but not limited to, wash hands prior to dressing change, remove old dressing, remove old gloves, handwashing, apply new gloves, perform wound care, remove old gloves, handwash, apply new gloves.</p> <p>2. On 8/3/15 at 9:35 p.m., RN #3 was observed to provide care for Resident #16. After Resident #16 was assisted to</p> | | <p>Control CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>1.Date of compliance: September, 4 2015</p> | | | | |

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| F 0465 SS=E Bldg. 00 | <p>the commode, RN #3 completed hand washing for 11 seconds.</p> <p>During an interview on 8/4/15 at 1:59 p.m., the Director of Nursing indicated the proper handwashing technique was to turn on the water, adjust temperature, have arms down, soap up, wash hands using friction, including washing nails on the palm of the hands, cleaning between fingers, do this for twenty seconds, rinse hands and dry them. She indicated to use a paper towel to touch the handle of the towel dispenser to disperse the paper towels.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 11 of 24 rooms observed in a stage 1 sample. (Rooms 121, 124, 125, 133, 142, 145, 194, 197, 209, 211, 150)</p> | F 0465 | <p>F465</p> <p>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Room #121: The corners and edges have been cleaned and sanitized by housekeeping and</p> | 09/04/2015 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 08/05/2015 |
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| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 |
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| | <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 7/29/15 at 10:50 a.m., Room 121 was observed to have dirt and debris along the edges and in the corners of the cove base. The bathroom wall had black marks under the light switch, wet towels were on the floor under the sink, and the caulking around the sink was cracked with a brown substance on it. The same was observed on 8/4/15 at 8:13 a.m., except there were no wet towels in the floor. 2. During an observation on 7/29/15 at 1:30 p.m., Room 124 was observed to have dirt and debris along the edges and in the corners of the cove base. The bathroom door frame had chipped paint and the bathroom had gouges in the wall by the door. The tile was broke between the bathroom and the bedroom and the bathroom floor was marred. The doors were scraped and the heating/cooling register at the head of the bed was bent and dusty. The same was observed on 8/4/15 at 9:17 a.m. 3. During an observation on 7/29/15 at 10:55 a.m., Room 125 was observed to have dirt and debris along the edges and in the corners of the cove base. The heating/air conditioning unit had dirt and | | <p>are free of dirt and debris. The bathroom has been clean, sanitized by housekeeping and free of the black marks under the light switch. The caulking around the sink was removed and re-caulked by maintenance. Room#124: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The bathroom door frame and walls have been repaired or repainted by maintenance and are free of chips and gouges. The tile between the bathroom and bedroom has been replaced by maintenance. The doors and have been repainted by maintenance and are free of scrapes. The heating/cooling register has been replaced and cleaned by maintenance. Room #125: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The heating/airconditioning unit has been clean by maintenance and is free of debris. The pillow was removed from the floor and sanitized by housekeeping. The candy wrapper and plastic medication patch cover has been removed and discarded by housekeeping. The commode was cleaned and sanitized by housekeeping and free of black stains. Room #133: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris.</p> | |

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| | <p>debris in it. A pillow and a blue positioning device for the elevating the feet was on the floor. A candy wrapper and a plastic cover from a medication patch was observed on the bedroom floor. The base of the commode had a black stain on it. The same was observed on 8/4/15 at 9:20 a.m.</p> <p>4. During an observation on 7/29/15 at 11:24 a.m., Room 133 was observed to have dirt and debris along the edges and in the corners of the cove base. The heating/air conditioner unit had dirt and debris in it. The commode was had a brown substance on the seat and urine was observed in the commode. The cove base in the bathroom under the toilet paper holder was loose. The screws on the base of the commode were uncapped. The same was observed on 8/4/15 at 9:11 a.m.</p> <p>5. During an observation on 7/29/15 at 1:45 p.m., Room 142 was observed to have a strong urine odor and the bathroom wall was dirty. On 8/4/15 at 10:00 a.m., the urine odor was gone but the bathroom wall remained dirty.</p> <p>6. During an observation on 7/29/15 at 2:05 p.m., Room 145 was observed to have a strong urine odor and the commode lid on the back of the</p> | | <p>The heating/airconditioning unit has been clean by maintenance and is free of debris. The commode has been cleaned and sanitized by housekeeping and is free of brown substances. Maintenance replaced the cove base cove base in the bathroom and capped the screws in the base of the commode. Room #142: The bathroom was cleaned and sanitized by housekeeping and is free of odor and free of dirt on the walls. Room #145: The bathroom was cleaned and sanitized by housekeeping and is free of odor and free of stains on the commode lid. Room#150: The ceiling has been painted by maintenance and is free of stains. Room #194: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The floor has been cleaned and sanitized by housekeeping and the floor is free of dirt particles. The bathroom was cleaned and sanitized by housekeeping and is free of the dried yellow substances under the soap dispenser and shower. The wash cloth was removed by nursing. Maintenance repaired the commode that was running continuously. The toothbrushes, coffee cup, Fixodent and toothpaste were discarded by nursing and replaced with ones that were labeled and placed in proper resident specific containers. Room #197: The</p> | |

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| | <p>commode had 2 (two) light brown - yellow stains on it.</p> <p>7. During an observation on 7/28/15 at 3:35 p.m., Room 194 was observed to have dirt and debris along the edges and in the corners of the cove base. The floor was observed to have dirt particles on it. A brown dried substance was observed under the soap dispenser in the bathroom and the shower had a dried yellow substance stuck on it. The bathroom had a coffee cup which held 5 (five) toothbrushes and 1 toothbrush in a container in it with no names on them. The commode was running continuously. The room was shared with Room 196. The same was observed on 8/4/15 at 10:05 a.m., as well as, the coffee cup had 5 toothbrushes, 1 (one) denture brush and 1 toothbrush in a holder in it. A unlabeled tube of Fixodent and an unlabeled tube of toothpaste were on the sink. A soiled, wet washcloth was observed lying on the sink.</p> <p>8. During an observation on 7/28/15 at 2:52 p.m., Room 197 was observed to have dirt and debris along the edges and in the corners of the cove base. The mattress was observed to have food particles in it and along the edges of the side rails. The heating/ air conditioner unit had dirt and debris in it and the door</p> | | <p>corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The mattress and along the edges of the side rail has been cleaned and sanitized by housekeeping and is free of food particles. The heating/air conditioning unit has been clean by maintenance and is free of debris. The bathroom has been clean, sanitized byhousekeeping and free of the brown substances. The bathroom wall behind the commode has been painted by maintenance.</p> <p>Room#209: The corners and edges around the cove base have been cleaned and sanitized by housekeeping and is free of dirt and debris. The bedroom floor has been cleaned and sanitized by housekeeping and the floor is free of food particles and dirt. The towel was removed and discarded by nursing.</p> <p>Maintenance removed the non-skid strips and replaced them with new ones. The wooden bar was painted by maintenance. The wall at the head of the bed has been cleaned and sanitized and is free of black marks. The wet washcloths were removed by nursing and the soap was rinsed from the sink. The caulking on the outside of the shower was removed and re-caulked by maintenance. The nasal oxygen tubing was removed from the hallway and discardedby nursing.</p> <p>Room#211: The corners and</p> | |

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| | <p>were scraped. A brown substance was observed to be on the bathroom wall under the call light and the bathroom wall behind the commode was missing paint. The same was observed on 8/3/15 at 3:45 p.m.</p> <p>9. During an observation on 7/29/15 at 9:02 a.m., Room 209 was observed to dirt and debris along the edges and in the corners of the cove base. The bedroom floor was observed to have food particles and dirt on it. A towel observed to be lying on the overbed table was observed to have food particles on it and it was stained with an orange colored substance. The non-skid strips in front of the bed were observed to be dirty and pieces were missing. A wooden bar at the head of the bed was observed to have chipped paint. The wall at the head of the bed had black marks on it. The sink was observed to have wet washcloths and soap in it and the caulking around the outside edge of the shower had a yellowish-brown substance on it. A nasal oxygen tubing was observed to be lying outside of the bedroom in the hall on the floor. The same was observed on 8/3/15 at 8:45 a.m.</p> <p>10. During an observation on 7/28/15 at 4:05 p.m., Room 211 was observed to have dirt and debris along the edges and in the corners of the cove base. The</p> | | <p>edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The heating/airconditioning unit has been clean by maintenance and is free of debris. Maintenance removed the non-skid strips and replaced them with new ones. The wall paper behind the commode was secured by maintenance. The bathroom was cleaned and sanitized by housekeeping and is free of stains. The heating/cooling register cover has been replaced by maintenance.</p> <p>1. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The ED/designee will in-service all staff regarding a safe, comfortable and sanitary environment by 9/4/15. The ED/designee will educate the housekeeping and maintenance staff on cleaning schedules and maintenance request. Inspection of all rooms will be conducted daily by ED/designee to identify areas of non-compliance. The identified areas will be corrected by 9/4/15.</p> <p>1. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The ED/designee will in-service</p> | | |

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| | <p>heating/air conditioning unit had dirt and debris in it. The non-skid strips beside of the bed was missing pieces. The wall paper behind the commode was loose from the wall and an orange stain was observed in front of a file cabinet under the sink. The cover for the heating/cooling register in the bathroom was missing. The same was observed on 8/4/15 at 2:20 p.m.</p> <p>During an interview with on 8/3/15 at 10:20 a.m., the Housekeeping Supervisor indicated he had just began employment with the facility. He indicated the facility had hired several new people for the department but it would take a little while to get the facility into shape. The housekeeping supervisor indicated he had to make a cleaning schedule and a deep clean schedule since he had started employment at the facility. The housekeeping supervisor indicated the previous housekeepers had not really cared for the facility and the facility had suffered.</p> <p>A cleaning guideline form, provided by the Regional Dietician on 8/4/15 at 10:40 a.m., indicated one resident room would be deep cleaned daily.</p> <p>11. On 07/28/2015 at 3:18 p.m. during Stage 1 of resident observation, Room</p> | | <p>all staff a safe, comfortable, and sanitary environment by 9/4/15. Daily rounds will be conducted by the ED/designee to ensure rooms are safe, comfortable and sanitary.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</p> <p>To ensure compliance the ED/designee is responsible for the completion of the Laundry, Housekeeping, Cleaning Schedule CQI tool weekly X 4 weeks, monthly X and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If 100% compliance is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>1.Date of compliance: September, 4 2015</p> | | |

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| | <p>150 was observed to have a large stain on celing over bed was noted and the light string over sink was not long enough to reach. The light string was about 3 inches long.</p> <p>On 08/04/2015 at 9:32 a.m. recheck of Room 150, revealed pull string was still short for light to sink, talked to head of maintainence, he indicated he will fix it right away.</p> <p>On 08/04/2015 9:56 a.m. the Room 150 was rechecked and the light string over sink had been fixed, the stain on the ceiling remained.</p> <p>3.1-19(f)</p> | | | |