

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11 and 12, 2014</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Survey team: Angela Halcomb, RN, TC Jennifer Carr, RN Rita Bittner, RN Tammy Forthofer, RN</p> <p>Census bed type: SNF/NF: 144 Total: 144</p> <p>Census payor type: Medicare: 12 Medicaid: 106 Other: 26 Total: 144</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 23, 2014, by Janelyn Kulik, RN.</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>Attached you will find the completed Plan of Correction and attachments for the recertification and state licensure and complaint survey dated September 12, 2014. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 372-8447.</p> <p>Sincerely, Christopher Lung, Executive Director</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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F000241 SS=D	<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 dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview the facility failed to ensure a resident was treated with dignity for 1 of 1 random resident observations. (Resident #107)</p> <p>Finding include:</p> <p>During an observation on 9/12/14 at 6:05 a.m. Resident #107 was observed sitting up against the wall waiting for breakfast by the resident's lounge. The resident was observed with a wig not on her head and lying on her abdomen.</p> <p>Review of the Significant Change Assessment MDS (Minimum Data Set) dated 7/22/14 indicated the BIMS (Brief Interview of Mental Status), 03 which indicated the resident was cognitively impaired. The resident rarely/never was understood, her vision was moderately impaired and she was totally dependent for dressing</p> <p>An interview on 9/12/14 at 6:08 a.m.,</p>	F000241	<p>Facility is requesting Paper Compliance F 241 483.15(A) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>I. Resident # 107 is being treated with respect and dignity. Care plan is in place for resident removing her wig. The rising time for resident #107 has been adjusted. II. All residents residing in the facility have a potential to be affected. The facility practice of getting residents up at 4:30am was stopped on 9-29-14 unless the residents specifically request an early rising schedule. Grievance/concern forms are located at each nurse's station in a visible area and any concerns voiced will be addressed during Interdisciplinary Team Meeting. Any issues will be corrected immediately. III. Facility employees have been offered education regarding treating residents with respect and dignity which includes facility rising schedule for residents unless the resident specifically requests. Respect and dignity education will be provided with all</p>	10/12/2014	

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F000272 SS=D	<p>LPN #12 indicated the night shift started getting the residents up and placing them in the hall to wait for breakfast at 4:30 a.m.</p> <p>3.1-3(t)</p> <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</p>		<p>newly hired employees and yearly for facility staff. IV. The Social Service Staff will randomly interview 5 alert and oriented residents from varying units in regards to staff treating them with respect and dignity. The Social Service staff will conduct random visual audits of 3 cognitively impaired residents from varying units with regards to staff treating residents with respect and dignity weekly for 4 weeks and then monthly for 6 months. Any issues will be addressed immediately. The DNS/designee will conduct non-announced visits weekly for 30 days during early morning hours to observe for appropriate rising times for the residents. The Social Service Staff will present audit and interview results to the Performance Improvement Committee monthly. The DNS/designee will present observation audits to the monthly Performance Improvement Committee. The committee will determine when the audits can be discontinued after 6 months of completion or until a pattern of compliance is reached. Date of completion: October 12, 2014</p>	

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	<p>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, interview and record review, the facility failed to provide accurate Minimum Data Set (MDS) assessments for 2 of 31 residents reviewed for dental status (Residents #102 and #155).</p> <p>Findings include:</p> <p>1. Resident #155 was observed to be edentulous (lacking teeth) during random</p>	F000272	<p>Facility is requesting Paper Compliance F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS I. Residents #102 and #155 were assessed and oral assessments were corrected to reflect current dental status. Residents #102 and #155 MDS assessments were modified to reflect current dental status. Residents #102 and #155 were referred to ancillary services for dental exam. II. Oral assessments will be conducted</p>	10/12/2014

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	<p>observations on 9/8, 9/9, 9/10, 9/11 and 9/12, 2014. During an observation and attempted interview on 9/9/2014 at 10:57 a.m., the resident was non-verbal and did not respond to questions. The resident's husband indicated, "She has nothing but gums."</p> <p>Resident #155's clinical record was reviewed on 09/10/2014 at 10:46 a.m. Diagnoses included, but were not limited to, dementia, congestive heart failure, anxiety and generalized pain.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/1/2014, indicated "Resident is rarely/never understood...Cognitive Skills for Daily Decision Making - severely impaired." MDS further indicated Resident #155 required "extensive assistance" and "total dependence" for personal hygiene. MDS indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. F. Mouth or facial pain, discomfort or difficulty with chewing: No."</p> <p>Quarterly MDS assessments dated 4/9/2014 and 1/14/2014 indicated the same regarding Resident #155's dental status.</p> <p>The 10/16/2013 Annual MDS assessment</p>		<p>on all residents in facility. Resident's MDS will be compared with current oral assessment and any resident assessment with incorrect information will be modified to reflect current dental status. III. Systemic changes: 1. All newly admitted residents who are assessed and found to have missing teeth or no teeth and without dentures/partials or dentures/partials that are broken, chipped or missing teeth or do not fix properly will be referred to ancillary dental service for exam and same discussed with resident or responsible party. 2. Residents with dental needs will be placed on list for next available appointment for ancillary dental services by Medical Records. 3. Nursing staff to inform Medical Records of ancillary service needs by filling out form and sending to Medical Records as soon as possible. 4. If current resident noted to have loose, missing or broken dentures/partials, staff to fill out concern form and interdisciplinary team will review on next business day to ensure that resident is referred to ancillary dental service on next available appointment. 5. Residents who are found to have broken, missing or no dentures and refuse to have assessment or treatment by ancillary dental services will be identified. Resident and/or responsible party will be offered and provided education regarding oral services,</p>				

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	<p>indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. B. No natural teeth or tooth fragments (edentulous): No. ...F. Mouth or facial pain or difficulty chewing: No. G. Unable to examine: No. Z. None of the above: Yes."</p> <p>Resident #155's 9/7/2014 Readmission Assessment indicated that she did not have any "missing teeth" and was not "edentulous/no natural teeth/tooth fragments." The assessment further indicated that the resident had "full plate dentures" and that the full upper plate "fit" and was not "loose/ill-fitting; broken/chipped." The assessment indicated that the lower full plate "fit" and was not "loose/ill-fitting; broken/chipped."</p> <p>The CNA Assignment Sheet, provided by the Director of Nursing (DON) on 9/10/2014 at 11:55 a.m., indicated that Resident #155 had dentures.</p> <p>During another interview with Resident #155's husband on 9/10/2014 at 1:40 p.m., he indicated, "They've [dentures] been broken and in there [bedside table] for as long as I've been here...for 3 months. She's been gumming her food. I know she's not getting enough to eat. Something needs to be done."</p>		<p>attending physician will be notified and a care plan updated as needed to reflect refusal of services. 6. The licensed nursing staff have been provided education on proper oral assessments and referral for ancillary dental services. 7. Social Services will be educated on the referral process for ancillary services. IV. The Director of Nursing or designee will audit new admissions, quarterly and annual assessments for accuracy daily 5 days of 7 days weekly for 30 days, weekly for 3 months and monthly for 6 months. Any concerns will be addressed immediately and corrected. The results of these audits will be presented to the Performance Improvement Committee monthly. The committee will determine when the audits can be discontinued after 6 months of completion. Date of completion: October 12, 2014</p>				

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	<p>LPN #17 indicated on 9/10/14 at 1:43 p.m. that she was frequently assigned to care for Resident #155 and stated, "All I knew is she didn't have any dentures. I didn't know she had any broken ones [dentures]."</p> <p>Resident #155 was observed on 9/10/2014 at 1:48 p.m. with the Clinical Operations Director. She opened the resident's second bed-side drawer, pulled out a denture container, opened the lid, and observed two halves of a plate of broken dentures.</p> <p>MDS Coordinator #1, RN #20 (most recent DON), DON, and the Social Services Director (SSD) were interviewed on 9/11/14 at 11:45 a.m. MDS coordinator #1 referred to "CMS's RAI Version 3.0 Manual...Dental (cont.)" and indicated, "We only answer A & F [questions] quarterly. We just look at their mouth. If their dentures aren't in, we check that they're o.k. We don't look in their drawer." RN #20 indicated that she could not recall, nor provide documentation related to, how long ago Resident #155's dentures were broken. She stated, "The staff that were here say she threw them and they broke on the floor....It was quite a while ago. I don't know when." When queried as to what</p>			

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	<p>happened after the incident was reported to management and/or how it was followed up, RN #20 indicated, "Because he [husband] didn't want to pay for the lowers, they thought he wouldn't want to pay for the broken uppers." The SSD indicated via Point-Click-Care in the nurses station computer that Resident #155's son was her Power of Attorney (POA), not her husband. RN #20 further indicated that Medical Records was responsible for scheduling dental appointments.</p> <p>The DON provided a copy of "CMS's RAI Version 3.0 Manual...Dental (cont.)" on 9/11/2014 at 12:08 p.m. "Steps for Assessment" included, but was not limited to, "...2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.) 3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove , and examine for chips, cracks, and cleanliness. removal of dentures and/or partials is necessary for adequate assessment. 4. ...The assessor should use his or her gloved fingers to adequately feel for...loose teeth. 5. If the resident is unable to self-report, then observe him or</p>			

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	<p>her while eating with dentures or partials...to determine if chewing problems or mouth pain are present...."</p> <p>During an interview with the DON on 9/11/2014 at 12:05 p.m., she indicated both MDS coordinators were LPNs and conduct the resident assessments. "An RN signs off [on the MDS assessments]. It's a group effort." She indicated, "I don't want to say [if the residents' most recent MDS assessments were accurate]."</p> <p>During an interview with Medical Records on 9/12/2014 at 9:45 a.m. She indicated she did not know how long Resident #155's dentures had been broken, how they were broken, or who broke them.</p> <p>Resident #155's daughter was interviewed on 9/11/2014 at 2:11 p.m. She indicated that her brother was POA. She indicated, "I just knew they [dentures] were gone. Someone said she threw them on the floor and broke them. I thought they were going to get her new ones. They said she got mad and threw them on the floor. She was so proud of them...thought they were really pretty and really nice and really took care of them. She never would have thrown them on the floor."</p>			

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	<p>2. Resident #102's daughter was interviewed on 9/09/2014 at 2:13 p.m. She indicated, "She has some [bad] teeth..."</p> <p>Resident #102's clinical record was reviewed on 09/10/2014 at 10:08 a.m. Diagnoses included, but were not limited to, history of CVA (stroke), aphasia, and depressive disorder.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/2/2014, indicated "Resident is rarely/never understood...Cognitive Skills for Daily Decision Making - severely impaired." MDS further indicated Resident #102 required "extensive assistance" and "total dependence" for personal hygiene. MDS indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. F. Mouth or facial pain, discomfort or difficulty with chewing: No."</p> <p>The 6/16/2014 quarterly MDS assessment indicated the same regarding Resident #102's dental status.</p> <p>The 3/15/2014 Annual MDS assessment indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. B. No natural teeth or tooth fragments (edentulous):</p>						

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	<p>No. ...D. Obvious or likely cavity or broken natural teeth: No...F. Mouth or facial pain or difficulty chewing: No. G. Unable to examine: No. Z. None of the above: Yes."</p> <p>The resident's most recent Dental Exam, dated 5/7/2014, indicated that Resident #102 had seven lower teeth, three of which were "mobile." The record further indicated, "...is edent [no teeth] upper with no appl [appliance/dentures] in place, referral written in past for extraction of mobile teeth...."</p> <p>On 9/10/2014 at 11:40 a.m., Resident #102's teeth were observed with MDS Coordinator #2. Resident #102 was observed to have no top teeth and few brown-grey bottom teeth with foul odor. MDS Coordinator #2 indicated, "She did [have dentures]...I want to say they don't fit or...[trailed off]. The quarterly just has two questions [regarding dental status]. We only do the whole thing [dental assessment] annually."</p> <p>The CNA Assignment Sheet, provided by the DON on 9/10/2014 at 11:55 a.m., indicated that Resident #102 had dentures.</p> <p>Resident #102 was observed on 9/10/2014 at 1:45 p.m. with the Clinical</p>						

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	<p>Operations Director. She opened the resident's top bed-side table drawer, pulled out a denture container dated 9/1/14, opened the lid, and indicated it contained "upper dentures." No lower dentures were observed in the resident's mouth or in her room.</p> <p>Resident #102's sister was interviewed on 9/10/2014 at 11:55 a.m. She indicated, "...She's always had a partial on the bottom...three teeth. Her teeth are loose on the bottom. I don't know if they fit [dentures] or not."</p> <p>On 9/12/14 at 9:20 a.m., the Clinical Operations Director indicated, "She's [RN Case Manager who signs off on MDS assessments] just signing for completeness, not accuracy."</p> <p>On 9/12/2014 at 1:10 p.m., the RN Case Manager who signs off on MDS assessments indicated, "I don't [assess for accuracy of assessments]. I just sign that they're complete."</p> <p>On 9/12/2014 at 1:12 p.m., the Clinical Operations Director indicated, "I've already gone over this. I don't think you understand was MDS is."</p> <p>3.1-31(a) 3.1-31(c)(9)</p>						

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for a resident receiving psychotropic drugs for 2 of 31 residents reviewed for comprehensive care plans. (Resident #13 and Resident #33).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #13 was reviewed on 9/10/14 at 2:10 p.m. The resident diagnoses included, but were not limited to senile dementia,</p>	F000279	<p>Facility is requesting Paper Compliance F 279 483.20(d) 483.2(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>I. The Interdisciplinary Team reassessed Residents #13 and 33 and care plans were reviewed and updated to reflect monitoring of physician ordered psychotropic medications.</p> <p>II. The Interdisciplinary Team will review all residents receiving psychotropic medications and</p>	10/12/2014

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	<p>chronic airway obstruction and atrial fibrillation.</p> <p>The initial Minimum Data Set (MDS) assessment dated 2/21/2014, indicated the resident exhibited no behaviors or mood problems. The assessment indicated the resident received an antipsychotic drug seven days a week.</p> <p>The February, 2014 Medication Administration Record (MAR) and Physician's Orders indicated that Resident #13 received a scheduled, daily antipsychotic drug.</p> <p>During an interview on 9/11/2014 at 3:15 p.m. The Social Service Director indicated the nurses put in the care plan for antipsychotic drugs, then the unit manager follows up on the care plans. The Social Service Director indicated, "If the residents were having behaviors, I put the care plans in for the behaviors. I do not put in the care plans for psychotropic drug use." The Social Service Director indicated she looked at the care plan and there was nothing regarding the resident's behaviors requiring the use of psychotropic drugs.</p> <p>2. The clinical record for Resident #33 was reviewed on 9/10/2014 at 1:25 p.m. The resident diagnoses included, but</p>		<p>update all care plans to include monitoring of psychotropic medications.</p> <p>III. Systemic Changes: 1. The Social Services Director or designee will implement comprehensive care plans for all residents receiving psychotropic medications and update as needed but, not less than during resident's Comprehensive Assessments upon admission, readmission, quarterly and with any significant change in condition. 2. Any changes in resident's ordered psychotropic medication will be reviewed during Interdisciplinary Team Meeting to ensure resident's care plans are updated timely.</p> <p>IV. The Social Services Director or designee will audit all residents comprehensive assessments to ensure that any medications added or discontinued are updated on the care plan daily 5 times of 7 days a week for 4 weeks, weekly for 3 months and monthly for 6 months to ensure accuracy and completeness. The results of these audits will be reported to the monthly Performance Improvement Committee. This committee will determine if the audits can be discontinued.</p> <p>Date of Completion: October 12, 2014</p>		

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	<p>were not limited to dementia, anxiety, congestive heart failure and restless leg syndrome.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 7/15/2014, indicated the resident exhibited no psychosis. The assessment indicated the resident received an antipsychotic drug seven days a week.</p> <p>The July, 2014 Medication Administration Record (MAR) and Physician's Orders indicated that Resident #33 received a scheduled, daily antipsychotic drug.</p> <p>There was no care plan related to the use of psychotropic drug. Interview with (Licensed Practical Nurse) LPN #1 on 9/11/2014 at 2:50 p.m., indicated she looked at the care plan and there was nothing regarding psychotropic drugs.</p> <p>During an interview on 9/11/2014 at 3:15 p.m. The Social Service Director indicated the nurses put in the care plan for antipsychotic drugs, then the unit manager follows up on the care plans. The Social Service Director indicated, "If the residents were having behaviors, I put the care plans in for the behaviors. I do not put in the care plans for psychotropic drug use." The Social Service Director</p>						

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F000280 SS=D	<p>indicated she looked at the care plan and there was nothing regarding the resident's behaviors requiring the use of psychotropic drugs.</p> <p>3.1-35 (a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review the facility failed to update a Care Plan following a fall for 1 of 3 residents reviewed for Accidents (Resident #153)</p> <p>Findings include:</p> <p>The clinical record for Resident #153 was</p>	F000280	<p>Facility is requesting Paper Compliance F280 483.20(d)(3) 483.10(k)(2) RIGHT TO PARTICIPATE IN PLANNING CARE-REVISE CARE PLAN</p> <p>i. Resident # 153 care plans were reviewed and updated to ensure all interventions regarding falls were in place and</p>	10/12/2014

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	<p>reviewed on 09/11/2014 at 9:30 a.m. The admission MDS (Minimum Data Set) assessment, dated 8/26/14, indicated Resident #153 had diagnoses including but not limited to chronic respiratory failure, chronic airway obstruction, congestive heart failure, chronic kidney disease stage III, atrial fibrillation, and hypertension. The resident was hard of hearing, had no hearing aids, does not speak, was usually understood and understands others, had a BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment, needs extensive assistance with bed mobility, transfers, dressing, toileting and locomotion on and off the unit with a one person physical assist.</p> <p>Review of the electronic clinical record indicated resident ' s care plan for falls was initiated on 08/17/2014, and revised on 08/22/2014. Interventions included remind resident to request assistance prior to transfer/ambulation, encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, encourage resident to use recommended assistive devices in ambulating, ensure resident was wearing appropriate footwear, follow facility fall protocol, monitor for gait changes, monitor medication for side effects that may</p>		<p>up to date.</p> <p>II. All residents have potential to be affected. Interdisciplinary Team will review all residents with falls in last 30 days and ensure that care plan is accurate and includes all interventions.</p> <p>III. All residents who sustain a fall will be reviewed by Interdisciplinary Team daily for 5 days of 7 per week to ensure care plans reflect current intervention. Fall follow-up will be initiated per facility Fall Management Policy. Licensed nursing staff received education regarding facility Fall Management Policy.</p> <p>IV. The Director of Nursing or designee will review residents care plans daily 5 times per week for 4 weeks, weekly for 3 months and monthly for 12 months to ensure accuracy and completeness. The results of these reviews will be discussed at the facility Quality Assurance Performance Improvement meeting monthly for 12 months and the plan of action adjusted accordingly until 100% compliance is achieved.</p> <p>Date of Completion: October 12, 2014</p>				

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	<p>increase risk for falls, notify physician as appropriate, and 1/4 top 2 side rails on bed for transfers and bed mobility.</p> <p>Review of the progress notes, dated 08/23/2014 with a time listed as "1630" (4:30 p.m.), indicated an Incident Note by LPN (Licensed Practical Nurse) #10 in which the resident stated, on paper, she slid to the floor.</p> <p>Review of the Clinical Assessment Report - Post Fall Evaluation, dated 08/23/2014 with a time listed as "16:30" [sic] (4:30 p.m.), provided by MDS Coordinator #1 on 09/11/2014 at 9:54 a.m., listed the fall as unwitnessed, and under item M. 1. " List All Interventions taken to protect Resident " , Chair Alarm was listed. Under item O. 1. " Carnelian Review and Revision " , the item did not contain a check mark indicating the task was completed. This report was signed by LPN #10. The care plan was not updated following the fall. The chair alarm was not documented on the care plan.</p> <p>An interview, on 09/11/2014 at 2:38 p.m., with MDS Coordinator #1, in regards to the procedure following a fall, she indicated the nurse assesses the resident, gets them up, and initiates a protection intervention such as personal</p>						

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	<p>safety equipment. This could be a chair or bed alarm. The nurse notifies the DON (Director of Nursing), and if there needs to be a different kind of personal safety equipment, like a low bed, they would use that. The nurse would call the family and doctor, and monitor the resident for 72 hours, documenting in the progress notes. If the resident hits their head, staff has to perform neuro (neurological) checks until the doctor orders to discontinue them. Neuro checks would be charted on a form in the chart. For an unobserved fall, if resident was not alert and oriented, staff assumes they hit their head. If the resident was alert and oriented and does not have a diagnosis of Dementia or Altered Mental Status, staff just asks the resident if they hit their head.</p> <p>An interview, on 09/11/2014 at 2:40 p.m., with RN #9, the unit manager, indicated that all unwitnessed falls require neuro checks to be done for 72 hours. Neuro checks were not listed on the care plan.</p> <p>An interview, on 09/12/2014 at 1:00 p.m., with MDS Coordinator #1, indicated the facility did not have a chair alarm policy and procedure. It was a nursing intervention that could be initiated and discontinued at the nurse's</p>			

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F000315 SS=D	<p>discretion.</p> <p>On 09/12/2014 at 10:08 a.m., MDS Coordinator #1 provided the Resident Event Response Procedure, dated ... "04/28/09 R", and indicate the policy was the one currently being used by the facility. Listed under Documentation Guidelines, step #4. " Update resident ' s care plan, " was noted.</p> <p>3.1-35(e)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview the facility failed to provide a diagnosis for the use of a Foley catheter and urine output for 1 of 1 resident reviewed for Foley catheters (Resident #192).</p> <p>Findings include:</p> <p>The clinical record for Resident #192 was</p>	F000315	<p>Facility is requesting Paper Compliance F 315 483.25(D) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>I. Resident # 192 record reviewed and documentation to support diagnosis of indwelling catheter is present as resident had documented post void residuals</p>	10/12/2014

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	<p>reviewed on 9/10/2014 at 1:25 p.m. The resident diagnoses included, but were not limited to, hemiplegia, history of CVA (stroke), congestive heart failure (CHF), and urinary tract infection.</p> <p>The initial Minimum Data Set (MDS) assessment, dated 3/27/2014, indicated that Resident #192 had an indwelling catheter and it also indicated no urinary toileting program was attempted.</p> <p>A nurses note, dated 3/24/2014, indicated Resident #192 was receiving an antibiotic for a UTI (urinary tract infection). On 4/4/2014, Resident #192 received Bactrim DS for UTI. On 4/14/14 a nurses note indicated Resident #192 complained of pain at the Foley catheter site, catheter was removed and a new catheter reinserted. Resident #192 screamed in pain, catheter was removed.</p> <p>A nurses note dated 4/18/2014, indicated new orders for Bactrim DS one tablet by mouth for 7 days for UTI and to place Foley catheter 18 french change every 30 days and PRN (as needed).</p> <p>On 5/15/2014 Resident #192 received levaquin for UTI.</p> <p>A comprehensive physician's orders dated 6/26/2014 and 7/11/2014, indicated</p>		<p>of greater than 500 ml after catheter was removed. Resident was assessed and no acute changes were noted. The Intake and Output form is accurately being recorded which will only include output records.</p> <p>II. All residents will indwelling catheters have potential to be affected. All residents with indwelling catheters have been identified and diagnoses reviewed to ensure that indwelling catheter is medically necessary. The Intake & Output form is being documented for output only for those residents identified with indwelling catheters.</p> <p>III. The licensed nursing staff and Certified Nursing Assistants have been provided education regarding documentation of output from indwelling catheter. The licensed nursing staff have been re-educated on appropriate supporting diagnoses for indwelling catheters.</p> <p>IV. The Unit Manager/designee will audit output flow sheet for all residents with indwelling catheter daily to ensure completeness and accuracy daily for 30 days, three times weekly for 60 days and weekly for 6 months. Any issues will be identified and immediately corrected.</p> <p>Residents with indwelling catheters will be assessed with any change in condition and at</p>				

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	<p>Resident #192 received Bactrim DS one tablet by mouth for 7 days for UTI.</p> <p>A comprehensive physician's order dated 8/12/2014 indicated Resident #192 received Keflex 500 mg (milligrams) one tablet by mouth TID (three times a day) for 7 days for UTI.</p> <p>A review of Resident #192's Comprehensive Intake-Output Record for the months of July 2014 and August 2014 indicated the form was only filled out for the following days: 7/9/14 day shift, 7/12/14 day shift, 7/15/14 day and evening shift, 7/16/14 day and evening shift, 7/19/14 evening shift, 7/23/14 day shift, 7/25/14 day and evening shift, 7/26/14 evening and night shift, 7/28/14 day and night shift, 8/1/14 evening shift, 8/2/14 day and night shift, 8/3/14 evening and night shift, 8/12/14 night shift, 8/18/14 day shift, 8/22/14 day shift, 8/26/14 day shift, 8/28/14 day shift, and 8/30/14 day shift.</p> <p>During an interview on 9/11/2014 at 9:21 a.m. The Director of Nursing (DON) indicated Resident #192 has a catheter, and the catheter was for retention of urine, and I am not sure if we tried a bladder training program.</p> <p>During an interview on 9/11/2014 at</p>		<p>least quarterly to determine the appropriateness of the continuation of the foley catheter. The Director of Nursing or designee will audit residents with indwelling catheters for supporting diagnosis and appropriateness for removal of indwelling catheter weekly for 3 months and monthly for 12 months. Any issues will be identified and immediately corrected. The results of these audits will be reported to the monthly Performance Improvement Committee. The committee will determine if the audits can be discontinued.</p> <p>Date of Completion: October 12, 2014</p>				

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F000328 SS=E	<p>11:07 a.m. Licensed Practical Nurse (LPN) #2 indicated the Comprehensive Intake-Output Record sheets were supposed to be filled out every shift.</p> <p>A Comprehensive Intake-Output Record with a revised date of 4/28/2009 was provided by Medical Records on 9/10/2014 at 1:30 p.m. "Purpose of the Form: To maintain an accurate record of the resident's fluid balance for residents: Indwelling Catheters (output only) Instructions for Use: 6. On each day, record the fluid output (in ml's) each shift. 7. Total the fluid output each shift. 8. Total the fluid output for 24 hours"....</p> <p>Resident #192's chart lacked any documentation of a urology consultation.</p> <p>3.1-41 (a)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 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. Based on record review, observation and interview, the facility failed to ensure</p>	F000328	Facility is requesting Paper Compliance	10/12/2014			

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	<p>sterile technique and proper procedure was maintained when caring for an IV line for 1 of 1 residents observed with an IV (intravenous access). (Resident #41). The facility also failed to ensure assessments were completed for 3 of 3 residents observed for nebulizer treatments. (Resident #166, #67 and #37)</p> <p>1. An Observation on 9/12/14 at 8:40 a.m., LPN #7 started Resident #166's breathing treatment at 8:40 a.m. At 8:42 a.m. LPN #7 left resident the residents room and continued to pass medications.</p> <p>On 9/12/14 at 9:03 a.m. LPN #7 went into Resident #166's room and discontinued the breathing treatment. LPN#7 assessed resident #166's blood pressure and walked out of the room.</p> <p>2. At 8:50 a.m. on 9/12/14 LPN #7 walking into Resident #67's room and started a breathing treatment and walked out of the residents room at 8:53 a.m.</p> <p>LPN #7 was observed walking to the medication cart and picking up the blood pressure cuff and returning to Resident #67's room. At 9:15 a.m. LPN #7 discontinuing the residents breathing treatment.</p>		<p>F328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>I. Residents # 41, #166, #67, #37 were all assessed for potential complications and none were found. Residents # 41, #166, #67, #37 orders and care plans reviewed and found to be appropriate.</p> <p>II. All residents receiving physician prescribed IV therapy and nebulizer treatments were identified and reviewed for appropriate assessments prior to administration of prescribed medications. Any concerns were addressed. LPN # 7 and RN #18 were provided education regarding administration of prescribed IV therapy and nebulizer treatment assessments.</p> <p>III. The systemic change includes: 1. All current licensed nursing staff received education regarding proper administration of IV medications and assessments. All current licensed nursing staff received education regarding assessments of residents prior to administration of prescribed nebulizer treatments. Licensed Nursing staff will have annual skills evaluation and education. Education will be provided to licenses nurses regarding the systemic change, and repeated annually and with any newly hired nurses.</p> <p>IV. The Director of Nursing or designee</p>				

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	<p>LPN #7 was not observed to assess the residents lung sounds. From the start of observation at 8:40 a.m. to 9:15 a.m. for Resident #166 and #67.</p> <p>3. On 9/9/2014 at 10:57 a.m., Resident #37 was observed holding a hand-held nebulizer with a treatment in progress. The unit nurse was at a medication cart half-way down the hall.</p> <p>On 9/11/2014 at 8:38 a.m., RN #18 was observed administering medications to Resident #43. RN #18 was observed to not wash his hands prior to preparing Resident #43's medications and used his bare fingers to remove the capsule to place in the Spiriva metered-dose inhaler as he prepped the medication. RN #18 checked off each medication as he dispensed it, prior to administering the medication. RN #18 entered Resident #43's room, handed him the Spiriva inhaler and the resident inhaled rapidly. RN #18 removed the nebulizer tubing and cup from an open plastic bag hanging on the wall. He dispensed the medication into the nebulizer cup and indicated to Resident #43, "Alright...I'll come back and check on ya' here in a bit." RN #18 returned to the med cart and began reviewing the Medication Administration Record (MAR). Three minutes later, he returned to Resident #43's room and listened briefly to his breath sounds and</p>		<p>will conduct random audits of residents receiving IV therapy and/or nebulizer treatments and observe assessment of IV therapy and/or nebulizer treatments by licensed nursing staff daily for 5 of 7 days a week for 4 weeks, then weekly for 3 months, then monthly x 9 months.</p> <p>The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the plan of action adjusted accordingly until 100% compliance is achieved.</p> <p>Date of completion: October 12, 2014</p>				

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	<p>assessed his lower extremities. RN #18 returned to the medication cart and began dispensing medications for another resident. At 8:45 a.m., RN #18 indicated, "I'm going to check on [Resident #43]," and stepped into the entry of Resident #43's room. Resident #43 indicated, "I think it's about out." RN #18 replied, "Still doing o.k....just a little bit more," and left the room. At 8:59 a.m., RN #18 returned to Resident #43's room, turned off the oxygen/nebulizer and returned the tubing and dispenser back into the plastic bag on the wall.</p> <p>On 9/11/14 at 4:20 p.m., LPN #7 indicated the procedure for nebulizer treatments was to "You wash hands....listen to lung sounds....do the treatment...wash the cup...let it dry.</p> <p>"Nebulizer Therapy Policy and Procedure was provided by the Director of Nursing (DON) and most recent DON, RN #20, on 9/11/2014 at 1:15 p.m. The procedure included, but was not limited to, "...4. Perform hand hygiene and don appropriate personal protective equipment (PPE)...8. Assess patient's breath sounds, respiratory rate, and heart rate prior to initiating therapy...14. Nebulize the solution for approximately 10 minutes or until all of the medication is gone. 15. Keep the nebulizer cup and</p>						

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	<p>mask vertical during treatment. 16. Rinse the nebulizer cup after treatment with sterile or distilled water and allow it to air dry on a paper towel in a safe place...19. Reassemble and store in a treatment bag when dry...Assess therapy for efficacy noting breath sounds, respiratory rate and heart rate post treatment."</p> <p>During an interview with RN #20 (previous DON) on 9/11/2014 at 1:15 p.m., she inicated, "They [nurse] are supposed to stay with them [residents during nebulizer treatment]."</p> <p>4. On 9/11/2014 at 4:20 .m., LPN #7 was observed passing medications to Resident #41. Medications administered during the observation of Resident #41's medication pass included, but were not limited to, Gntamycin (antibiotic)120mg/100ml IV (intravenous infusion) via pump and DuoNeb nubulizer (breathing treatment).</p> <p>LPN #7 opened the plastic bag which held the IV bag and attached tubing. The end of the (capped) tubing landed on the floor and remained there as she prepared the pump and tubing. LPN #7 wiped the right forearm IV site with alcohol and injected 10ml (milliliters) of Normal</p>			

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F000356 SS=C	<p>Saline into the IV site. She did not draw back/check for blood return prior to the infusion. LPN #7 checked the resident's pulse, and indicated, "I'll start this [nebulizer] and then sceddadle [sic]." After placing the nebulizer mask on Resident #41, LPN #7 removed her gloves and indicated, "See ya later!" as she left the room.</p> <p>The IV Therapy Policy and Procedure, which included "IV secondary line drug infusion," was provided by the Clinical Operations Director on 9/12/2014 at 11:10 a.m. The procedure included, but was not limited to, "Perform hand hygiene...Put on gloves...Thoroughly disinfect the needleless connector with an antiseptic pad using friction, and allow it to dry...Maintaining sterility of the syringe tip, attach a syringe containing...normal saline to the needleless connector and aspirate for a positive blood return from the vascular access device to confirm patency...Remove and discard our gloves...Perform hand hygiene."</p> <p>3.1-47(a)(1) 3.1-47(a)(6)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p>						

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	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post the current staffing sheet for 1 of 1 building observations of posted staffing. This deficiency had to potential to affect all 144 residents in the facility.</p> <p>Findings include:</p>	F000356	<p>Facility is requesting Paper Compliance F 356 483.30(e) POSTED NURSING STAFFING INFORMATION</p> <p>I. All residents have potential to be affected by not having staffing information posted daily. Grievance log reviewed</p>	09/24/2014			

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	<p>During an observation on September 8, 2014 at 10:57 a.m. No staffing sheet was posted in the facility.</p> <p>During an observation on September 9, 2014 at 8:30 a.m. No staffing sheet was posted in the facility.</p> <p>During an observation on September 10, 2014 at 8:40 a.m. No staffing sheet was posted in the facility.</p> <p>During an interview on September 10, 2014 at 10:10 a.m., the Director of Nursing (DON) indicated, "Yes we have the staffing sheets." The Staffing Coordinator indicated, "I will get them and fill it out and post it....I have not posted it today. I do post it every day."</p> <p>On September 10, 2014 at 1:30 p.m., the Medical Records provided a copy of the current policy and procedure for "Posting of Licensed and Unlicensed Direct Care Staff" dated 8/31/2012. "Policy: Kindred Nursing Centers post the total number and actual hours worked of licensed and unlicensed nursing staff directly responsible for patient care in the center daily for each shift. The information is displayed in a prominent location, clearly visible and accessible by patients, family and staff. Compliance Guidelines 2.</p>		<p>and no concerns voiced regarding missing staffing information.</p> <p>II. All residents have potential to be affected. Permanent signage mounted to wall in visible area, at height visible by residents and visitors.</p> <p>III. Staffing Coordinator will post in permanent signage display on daily basis, on form with facility name, current date, total number of licensed and unlicensed staff per each shift worked, the total number of hours worked and resident census.</p> <p>IV. The Director of Nursing or designee will audit daily for 5 of 7 days weekly for 4 weeks, twice weekly for 1 month and monthly for 12 months to ensure accurate daily staffing information is posted.</p> <p>Date of Completion: September 24, 2014</p>	

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F000371 SS=E	<p>Direct Care Staffing for licensed and unlicensed staff is posted each at the beginning of each shift. 3. Information that is posted on a daily basis is: a. Center name b. Current Date c. The total number and actual hours worked for RNs (registered nurse), LPNs (licensed practical nurse), and CNAs (certified nurse aide) directly responsible for patient care per shift."</p> <p>3.1-13(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared under safe food handling conditions for 2 of 14 random residents observed in the main dinning hall (Resident #162 and #156) and food was served under sanitary conditions for 3 of 3 random residents observed (Resident #121, #83, #120,) and for 1 of 1 kitchens.</p> <p>Findings include:</p> <p>1. During an observation on 9/8/2014 at</p>	F000371	<p>Facility is requesting Paper Compliance F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>I. All residents who received meal service on 9/8/2014 were assessed and no complaints were noted. II. All residents who receive meal service from facility have potential to be affected. After investigation, the Registered Dietician and Dietary Manager found purchase of unpasteurized</p>	10/12/2014

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	<p>8:55 a.m., Resident #162 and Resident #156 were observed consuming soft fried eggs with liquid yellow yolk residue left on their plate.</p> <p>On 9/8/14 at 9:13 a.m. during the initial tour of the kitchen with the dietary manager (DM), Cook #14 was observed to be preparing soft fried eggs. No red "P" was observed on the four broken shells on the counter. One of ten eggs had visible cracks prior to the cook cracking open and frying for soft serve.</p> <p>Cook #14 indicated the eggs were being prepared for the residents whom want soft fried eggs. Cook #14 indicated she was not aware of the non-pasteurized eggs being a problem since the eggs were cooked.</p> <p>DM indicated the eggs being used were not pasteurized. DM indicated she could not explain why there was no thermometer in the second milk refrigerator or how long it had been missing. DM indicated that all cans dented were to be returned to the manufacture for credit and not to be used for residents. DM indicated two trays of 18 eggs each minus 15 eggs disposed of were served soft serve to residents. DM indicated she normally only orders pasteurized eggs.</p>		<p>shell eggs to be isolated incident.</p> <p>III. Cook # 14 and all dietary employees who may order food for resident meal service have received education regarding purchasing pasteurized shell eggs from facility approved vendors only and to ensure that products ordered are pasteurized. Cook # 14 and Dietary employees who may prepare meals for residents have received education regarding ensuring labeling of pasteurized shell eggs and if labeling is not present, the product delivery is to be rejected and not accepted into the kitchen. Dietary Manager replaced all thermometers in refrigerators immediately and purchased extra as back up to replace any broken or missing thermometers immediately. All dietary employees received education regarding infection control practices and guidelines to prevent food borne illness.</p> <p>Facility staff have been educated on proper infection control practices while serving food in the dining room.</p> <p>IV. Dietary Manager or designee will audit orders of shell eggs to ensure that pasteurized shell eggs are on order and in quantity sufficient to serve current resident census daily for 30 days, weekly for 60 days, and monthly for 6 months.</p>				

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	<p>Record review on 9/8/2014 at 10:30 a.m., indicated the non-pasteurized eggs were delivered on 9/15/2014.</p> <p>2. On 9/8/14 at 9:13 a.m., during the initial tour of the kitchen with the Dietary Manager (DM), the following was observed:</p> <p>a. In the milk refrigerator identified as the cow refrigerator, Dietary Manager (DM) was only able to located a broken piece of the original thermometer. No other thermometer was found in the refrigerator. The refrigerator temperatures were within normal limits and temperatures log sheet was current and up to date.</p> <p>Cook #14 indicated the broken thermometer was removed earlier that morning and no thermometer was replaced.</p> <p>b. In the second milk refrigerator identified as the plain milk refrigerator, the DM was unable to locate a thermometer after looking under every milk basket and the entire area inside the refrigerator. The refrigerator temperatures were within normal limits and temperatures log sheet was current and up to date.</p>		<p>Dietary Manager or designee will audit refrigerator temperatures and presence of working thermometers in refrigerators twice daily.</p> <p>Executive Director will ensure audits are complete daily for 30 days, weekly for 60 days and monthly for 6 months.</p> <p>The SDC/designee will audit dining room observation for proper infection practices while serving food.</p> <p>The results of these audits will be presented to the monthly Performance Improvement Committee. The committee will determine when the audits can be discontinued.</p> <p>Date of Completion: October 12, 2014</p>				

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	<p>c. On the top of the second milk refrigerator in the back storage area, was a clear plastic container of sugar, the left outside of the container was speckled from the top ridge to the bottom with a sticky brown liquid.</p> <p>d. In the dry storage area located in the can good rack was a large ripe olive can, the can had a large dent in the side. The dent was one inch from the top to three inches down by four inches wide.</p> <p>e. An interview on 9/8/2014 at 8:37 a.m. with the DM and Cook:</p> <p>3. On 9/8/14 at 11:28 a.m., CNA #3 was observed touching Resident #121's shoulder, then she reached over and pulled Resident #83's sandwich out of the wax paper wrap with her bare hands, CNA #3 then handed the sandwich to resident #83. No hand gel or hand washing was observed between touching the resident and handling the sandwich by CNA #3.</p> <p>4. On 9/8/14 at 11:31 a.m., observation of LPN #7 and CNA #3 reached under the arms of Resident #120 to lift the resident up in her wheelchair, then without hand washing or hand gel LPN #7 assisted Resident #47 with her meal.</p>						

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F000411 SS=D	<p>A Policy and Procedure for "Production, Purchasing, Storage" provided by District Director for Clinical Operations indicated, but was not limited to, "Food Handling Guideline: ...All accounts have access to pasteurized shell eggs. Pasteurized shell eggs are the only approved shell egg for ALL accounts with Assisted Living or Skilled Nursing Areas. They are the only eggs that are permitted to be cooked to a soft state. "Storage Temperatures: ... Each mechanically refrigerated unit storing potentially hazardous food shall be provided with a numerically scaled indicating thermometer.</p> <p>3.1-21(i)(1) 3.1-21(1)(3)</p> <p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost</p>						

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	<p>or damaged dentures to a dentist. Based on observation, interview and record review, the facility failed to provide prompt referral of residents with lost or broken dentures to a dentist for 3 of 3 residents reviewed for dental services (Residents #33, #102, and #155).</p> <p>Findings include:</p> <p>I. Resident #155 was observed to be edentulous (lacking teeth) during random observations on 9/8, 9/9, 9/10, 9/11 and 9/12, 2014. During an observation and attempted interview on 9/9/2014 at 10:57 a.m., the resident was non-verbal and did not respond to questions. The resident's husband indicated, "She has nothing but gums...."</p> <p>The CNA Assignment Sheet, provided by the Director of Nursing (DON) on 9/10/2014 at 11:55 a.m., indicated that Resident #155 had dentures.</p> <p>During another interview with Resident #155's husband on 9/10/2014 at 1:40 p.m., he indicated, "They've [dentures] been broken and in there [bedside table] for as long as I've been here...for 3 months. She's been gumming her food. I know she's not getting enough to eat. Something needs to be done."</p>	F000411	<p>Facility is requesting Paper Compliance F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>I. Residents #33, #102 and #155 have been referred to ancillary dental services for assessment.</p> <p>II. All residents will have oral assessment completed and residents identified as needing dental services will be referred to ancillary dental services for assessment.</p> <p>III. Systemic changes:</p> <ol style="list-style-type: none"> All newly admitted residents who are assessed and found to have missing teeth or no teeth and without dentures/partials or dentures/partials that are broken, chipped or missing teeth or do not fix properly will be referred to ancillary dental service for exam and same discussed with resident or responsible party. Residents with dental needs will be placed on list for next available appointment for ancillary dental services by Medical Records. Nursing staff to inform Medical Records of ancillary service needs by filling out form and sending to Medical Records as soon as possible. If current resident noted to have loose, missing or broken 	10/12/2014			

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	<p>Resident #155's clinical record was reviewed on 09/10/2014 at 10:46 a.m. Diagnoses included, but were not limited to, dementia, congestive heart failure, anxiety and generalized pain.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/1/2014, indicated "Resident is rarely/never understood...Cognitive Skills for Daily Decision Making - severely impaired." MDS further indicated that Resident #155 required "extensive assistance" and "total dependence" for personal hygiene. MDS indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. F. Mouth or facial pain, discomfort or difficulty with chewing: No."</p> <p>Quarterly MDS assessments dated 4/9/2014 and 1/14/2014 indicated that same regarding Resident #155's dental status.</p> <p>The 10/16/2014 Annual MDS assessment indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. B. No natural teeth or tooth fragments (edentulous): No. ...F. Mouth or facial pain or difficulty chewing: No. G. Unable to examine: No. Z. None of the above: Yes."</p>		<p>dentures/partials, staff to fill out concern form and interdisciplinary team will review on next business day to ensure that resident is referred to ancillary dental service on next available appointment.</p> <p>5. Residents who are found to have broken, missing or no dentures and refuse to have assessment or treatment by ancillary dental services will be identified. Resident and/or responsible party will be offered and provided education regarding oral services, attending physician will be notified and a care plan updated as needed to reflect refusal of services.</p> <p>6. The licensed nursing staff have been provided education on oral assessments and referral for ancillary dental services.</p> <p>7. Social Services will be educated on the referral process for ancillary services.</p> <p>IV. The Director of Nursing or designee will audit new admissions, quarterly and annual assessments for accuracy daily 5 days of 7 days weekly for 30 days, weekly for 3 months and monthly for 6 months. Any concerns will be addressed immediately and corrected. The results of these audits will be presented to the Performance Improvement Committee monthly. The committee will determine when the audits can be discontinued after 6 months of completion.</p>	

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	<p>A 3/12/2013 Total Care Consent Form indicated that the resident was "approved" for "On-site Dentistry."</p> <p>Resident #155's 9/7/2014 Readmission Assessment indicated that she did not have any "missing teeth" and was not "edentulous/no natural teeth/tooth fragments." The assessment further indicated that the resident had "full plate dentures" and that the full upper plate "fit" and was not "loose/ill-fitting; broken/chipped." The assessment indicated that the lower full plate "fit" and was not "loose/ill-fitting; broken/chipped."</p> <p>LPN #17 indicated on 9/10/14 at 1:43 p.m. that she was frequently assigned to care for Resident #155 and stated, "All I knew is she didn't have any dentures. I didn't know she had any broken ones [dentures]."</p> <p>Resident #155 was observed on 9/10/2014 at 1:48 with the Clinical Operations Director. She opened the resident's second bed-side table drawer, pulled out a denture container, opened the lid, and observed two halves of a plate of broken dentures.</p> <p>MDS Coordinator #1, RN #20 (most recent DON), the DON, and Social</p>		Date of completion: October 12, 2014				

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	<p>Services Director (SSD) were interviewed on 9/11/14 at 11:45 a.m. MDS Coordinator #1 indicated, "We only answer A & F [questions] quarterly. We just look at their mouth. If their dentures aren't in, we check that they're o.k. We don't look in their drawer." RN #20 indicated that she could not recall, nor provide documentation related to, how long ago Resident #155's dentures were broken. She stated, "The staff that were here say she threw them and they broke on the floor....It was quite a while ago. I don't know when." When queried as to what happened after the incident was reported to management and/or how it was followed up, RN #20 indicated, "Because he [husband] didn't want to pay for the lowers, they thought he wouldn't want to pay for the broken uppers." The SSD indicated via Point-Click-Care in the nurses station computer that Resident #155's son was her Power of Attorney (POA), not her husband. RN #20 further indicated that Medical Records is responsible for scheduling dental appointments.</p> <p>During an interview with Medical Records on 9/12/2014 at 9:45 a.m. She indicated that she did not know how long Resident #155's dentures had been broken, how they were broken, or who broke them.</p>						

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	<p>Resident #155's daughter was interviewed on 9/11/2014 at 2:11 p.m. She indicated that her brother was POA. She indicated, "I just knew they [dentures] were gone. Someone said she threw them on the floor and broke them. I thought they were going to get her new ones. They said she got mad and threw them on the floor. She was so proud of them [dentures]...thought they were really pretty and really nice and really took care of them. She never would have thrown them on the floor."</p> <p>2. Resident #102's daughter was interviewed on 9/09/2014 at 2:13 p.m. She indicated, "She has some [bad] teeth...she needs to see a dentist, but the one they want to send her to is all the way in (name of city), which I'm not crazy about. They're supposed to get back to me on a local one [dentist]."</p> <p>Resident #102's clinical record was reviewed on 09/10/2014 at 10:08 a.m. Diagnoses included, but were not limited to, history of CVA (stroke), aphasia, and depressive disorder.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/2/2014, indicated "Resident is rarely/never understood...Cognitive Skills for Daily</p>			

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	<p>Decision Making - severely impaired." MDS further indicated that Resident #102 required "extensive assistance" and "total dependence" for personal hygiene. MDS indicated, "A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. F. Mouth or facial pain, discomfort or difficulty with chewing: No."</p> <p>The resident's most recent Dental Exam, dated 5/7/2014, indicated that Resident #102 had 7 lower teeth, 3 of which were "mobile." The record further indicated, "...is edent [no teeth] upper with no appl [appliance/dentures] in place, referral written in past for extraction of mobile teeth...."</p> <p>On 9/10/2014 at 11:40 a.m., Resident #102's teeth were observed with MDS Coordinator #2. Resident #102 was observed to have no top teeth and few brown-grey bottom teeth with foul odor. MDS Coordinator #2 indicated, "She did [have dentures]...I want to say they don't fit or....[trailed off]."</p> <p>The CNA Assignment Sheet, provided by the DON on 9/10/2014 at 11:55 a.m., indicated that Resident #102 had dentures.</p> <p>Resident #102 was observed on</p>						

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	<p>9/10/2014 at 1:45 p.m. with the Clinical Operations Director. She opened the resident's top bed-side table drawer, pulled out a denture container dated 9/1/14, opened the lid, and indicated it contained "upper dentures." No lower dentures were observed in the resident's mouth or in her room.</p> <p>Resident #102's sister was interviewed on 9/10/2014 at 11:55 a.m. She indicated, "They did make an appointment with a dentist, but I didn't want to take her all the way to [different city]. She's always had a partial on the bottom...three teeth. Her teeth are loose on the bottom. I don't know if they fit [dentures] or not.</p> <p>3. The clinical record for Resident #33 was reviewed on 9/10/2014 at 1:25 p.m. The resident diagnoses included, but were not limited to dementia, anxiety, congestive heart failure and restless leg syndrome. Resident #33's chart lacked a dental care plan.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 7/15/2014, indicated the resident had no oral or dental problems. A patient nursing evaluation part 3 dated 4/30/2014, indicated Resident # 33 had a full plate dentures.</p> <p>During an interview on 9/9/14 at 10:31 a.m. Resident #33's daughter indicated</p>						

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	<p>that Resident #33 had her upper dentures, but the facility lost her lower dentures a while ago. Resident #33's daughter indicated that the facility dentist had fit Resident #33 for lower dentures, but have not heard anything regarding the dentures.</p> <p>During an interview on 9/10/2014 at 1:41 p.m. RN #9 indicated Resident #33 was readmitted to the facility on 7/8/2014 when she returned to the facility she did not have her lower dentures, the behavioral unit lost her dentures. RN #9 indicated the family was notified regarding her dentures.</p> <p>During an interview on 9/12/2014 at 9:08 a.m. The MDS coordinator #1 indicated Resident #33 returned from the behavioral unit on 7/8/2014. I do not see in the nurses notes that Resident #33's family was notified that her lower dentures were lost.</p> <p>During an observation on 9/10/2014 at 2:00 p.m., Resident #33 was observed to only have upper dentures.</p> <p>A nurse note dated 7/18/2014, indicated during a care plan meeting with Resident #33's daughter, she requested that Resident #33 see the facility dentist, regarding the lost of Resident #33</p>			

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F000441 SS=E	<p>dentures.</p> <p>Dental Services Policy and Procedure was provided by the DON on 9/11/2014 at 1:15 p.m. The Policy indicated, "Emergency Dental Services: Services needed to treat...broken or otherwise damaged teeth....The center [facility] refers patients with lost or damaged dentures to a dentist as soon as the dentures are lost or damaged, within reason. Referral does not mean that the patient must see a dentist at that time, but does mean that an appointment (referral) is made or that the center is aggressively working to replace the dentures....If any patient is unable to pay for needed dental services, the center should attempt to find alternative funding sources or an alternative dental delivery system."</p> <p>3.1-24(a)(2) 3.1-24(a)(3)</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</p>						

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	<p>Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 that staff washed their hands when indicated and according to accepted professional practice for 7 of 7 random observations of hand washing (Residents #41, #43, #137, #142, #150 #159, and #192) The facility also failed to maintain IV equipment in a sanitary manner for 1 of 1 IV observations. (Residents #41)</p>	F000441	<p>The facility is requesting Paper ComplianceF 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS I.</p> <p>Residents have been assessed for signs of adverse effects and none were noted. RN # 18, LPN #7, LPN #18 have received education regarding proper hand washing techniques and maintaining sanitary technique when passing medications and providing care with residents with IV therapy. II. Facility Licensed</p>	10/12/2014

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	<p>Findings include:</p> <p>1. On 9/11/2014 at 8:38 a.m., RN #18 was observed administering medications to Resident #43. RN #18 was observed to not wash his hands prior to preparing Resident #43's medications and used his bare fingers to remove the capsule to place in the Spiriva metered-dose inhaler as he prepped the medication. RN #18 administered Resident #43's medications and returned 3 minutes later to listen briefly to his breath sounds and assess his lower extremities, touching his bare skin. As he exited the room, RN #18 scratched his nose. RN #18 returned to the medication cart and began dispensing medications for Resident #159 without washing his hands. After dispensing Resident #159's medications, he entered her bathroom and washed his hands for 8 seconds. At 8:59 a.m., RN #18 returned to Resident #43's room, turned off the oxygen/nebulizer and returned the tubing and dispenser back into the plastic bag on the wall. He entered the resident's bathroom and washed his hands for 6 seconds before returning to the medication cart to begin dispensing medications to another resident.</p> <p>2. On 9/11/2014 at 4:20 p.m., LPN #7 was observed passing medications. LPN #7 did not wash her hands prior to</p>		<p>Nursing staff will complete a skill competency observation regarding proper hand washing techniques and maintaining sanitary technique when passing medications, when serving meals in dining room and when providing care for residents with IV therapy. III. Facility staff have been offered education regarding hand washing and infection control practices per facility policy. Facility staff will complete skill competency no less than yearly. Newly hired facility staff will receive education and complete skill competency. Licensed Nursing staff will complete a skill competency regarding maintaining sanitary technique when passing medications upon hire and no less than yearly. Any concerns will be addressed. IV. The Staff Development Coordinator or designee will monitor for medications being passed in a sanitary manner and proper hand washing techniques with 1 nurse 5 days a week for 4 weeks, then 3 observations per week for 4 weeks then 1 observation a week for 4 weeks then monthly thereafter for a total of 6 months of monitoring. The results of the audits will be reported monthly to the Performance Improvement Committee. The committee will determine if the audits can be discontinued. Date of completion: October 12, 2014</p>		

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	<p>preparing or administering medication to Resident #159, nor did she wash her hands prior to dispensing or administering medications to Resident #41. As LPN #7 was dispensing medications at the medication cart, she was observed to remove a box of DuoNeb (Ipratropium bromide and albuterol sulfate), which contained plastic packets with individual unit-dose vials of the solution. An open packet containing individual unit-dose vials dropped to the floor. LPN #7 picked up the packet, replaced it in the box, and placed it back in the medication cart. She did not wash her hands prior to continuing to dispense Resident #41's medications. LPN #7 donned a clean pair of gloves and administered Resident #41's nasal spray, followed by the Spiriva hand-held meter dose inhaler. She then opened the plastic bag which held an IV bag of antibiotics and tubing. The end of the (capped) tubing landed on the floor and remained there as she prepared the pump and tubing. LPN #7 wiped the IV site with alcohol, did not allow it to dry, and injected 10 ml (milliliters) of Normal Saline into the IV access site in Resident #41's right forearm. The end of the IV was then dragged across the floor as LPN #7 pulled the tubing toward her to remove the cap, and insert the tubing into Resident #41's right forearm IV access</p>			

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	<p>site. LPN #7 removed the gloves and listened to Resident #41's chest, who was observed to be wearing an isolation mask throughout the observation. The IV alarm sounded, and LPN #7 donned clean gloves, removed the tubing from the Resident's IV site, and primed the tubing into the trash can. She then removed one alcohol swab from her pocket and wiped the end of the IV tubing, followed by the right forearm IV access site with the same alcohol swab and immediately connected the needless connector/tubing, not allowing the alcohol to dry. She then checked the resident's pulse, and indicated, "I'll start this [nebulizer] and then scedaddle [sic]." After placing the nebulizer mask on Resident #41, LPN #7 removed her gloves and indicated, "See ya later!" as she left the room. Outside the room, she indicated, "She [Resident 41] has e-Coli and staph in her lungs...." LPN #7 was then observed removing the blood glucose monitor from the medication cart and entering Room 2, indicating "It's time to check your blood sugar." She did not wash her hands or use hand gel.</p> <p>A Physician's order dated 9/11/2014 indicated, "Clarification: Contact Isolation d/t [due to] e.coli and staff in respiratory tract." An over-the-door storage system containing personal</p>						

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	<p>protective equipment (masks, gowns, gloves) was observed on the outside of Resident #41's room during multiple observations since the survey entrance date of 9/8/2014.</p> <p>3. During a clean dressing change on 9/11/14 at 10:33 a.m. (Licensed Practical Nurse) LPN #18 washed hands for 17 seconds, removed Resident #192 boot and sock. LPN #18 applied clean gloves and removed old dressing with her scissors. LPN #18 laid the scissors on Resident #192 bed. LPN #18 removed gloves and washed her hands for 15 seconds. LPN #18 applied clean gloves. LPN #18 opened normal saline and poured into a 4 x 4 gauge package. LPN #18 removed a 4 x 4 gauge and cleansed Resident #192 right heel and discarded the used 4 x 4 gauge in a trash bag. LPN #18 opened a 4 x 4 gauge and dried Resident #192 right heel. LPN #18 removed gloves and washed hands for 11 seconds, and applied new gloves. LPN #18 opened a Betadine wipe and applied to Resident #192 right heel. LPN #18 opened a mexiplex and placed on Resident #192 right heel, covered right heel with kerlix. LPN #18 cut the kerlix with the scissors she previously used to remove the old dressing. LPN #18 secured the kerlix with tape. LPN #18 removed gloves and placed Resident #192's sock on right foot, replaced boot,</p>			

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	<p>threw the garage away and washed hands. LPN #18 placed the scissors back in her pocket without cleaning the scissors.</p> <p>4. During an observation on 9/11/14 at 12:00 p.m. (Certified Nurse Aide) CNA #4 was observed to rub Resident #137's back. CNA #4 was observed to remove a cup from the kitchen and pour coffee for Resident #142 and Resident #150, no hand washing or hand sanitizer was observed.</p> <p>Nebulizer Therapy Policy and Procedure was provided by the Director of Nursing (DON) and most recent DON, RN #20, on 9/11/2014 at 1:15 p.m. The procedure included, but was not limited to, "...4. Perform hand hygiene and don appropriate personal protective equipment (PPE)..."</p> <p>The IV Therapy Policy and Procedure was provided by the Clinical Operations Director on 9/12/2014 at 11:10 a.m. The procedure included, but was not limited to, "Perform hand hygiene...Put on gloves...Thoroughly disinfect the needle less connector with an antiseptic pad using friction, and allow it to dry...Maintaining sterility of the syringe tip, ...Remove and discard your gloves...Perform hand hygiene."</p>			

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	<p>Oral Medication Administration Policy and Procedure was provided by the DON on 9/11/2014 at 1:15 p.m. The Procedure included, but was not limited to, "1. Hands are washed before administering medication....9. Removes medication properly from container or blister pack without touching the medication....24. Remains with the resident/patient and confirms that the medication has been taken...."</p> <p>Hand Hygiene/Hand washing Policy and Procedure was provided by the DON on 9/11/2014 at 1:15 p.m. Rationale indicated, "Hand washing is the single most important procedure for preventing the spread of infection....Hand hygiene is to be performed: ...Before taking part in a medical or surgical procedure; Before donning gloves for working with food; After touching...contaminated items, whether or not gloves are worn; Between tasks and procedures on the same patient when contaminated with body fluids to prevent cross-contamination of different body sites; If moving from a contaminated-body site to a clean body site during patient care; Before and after food preparation; ...After coughing, sneezing, or blowing the nose; ...After removal of medical/surgical or utility gloves; Intermittently after gloves are removed, between patient contacts, and</p>						

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F000514	<p>when otherwise indicated to avoid transfer of microorganisms to other patients or environments; After touching bare parts of the body other than clean hands and clean, exposed portions of arms...." The Procedure indicated, "...2. Rub hands together with vigorous friction for 20 seconds...."</p> <p>Transmission-Based Precautions Policy and Procedure was provided by the Clinical Operations Director on 9/12/2014 at 11:10 a.m. Contact Precautions included, but were not limited to, "...2. Appropriate personal protective equipment is used per Standard Precautions. 3. Hand Hygiene - is the most important method of control to prevent transmission....4. a. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails)....5. a. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces....d. Remove gown and perform hand hygiene before leaving the patient's environment...."</p> <p>3.1-18(j) 3.1-18(l) 483.75(l)(1)</p>			

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SS=D	<p>RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to complete documentation of Neurological Checks for 1 of 3 resident reviewed for Clinical Records (Resident #153).</p> <p>Findings include:</p> <p>The clinical record for Resident #153 was reviewed on 09/11/2014 at 9:30 a.m. The admission MDS (Minimum Data Set) assessment, dated 8/26/14, indicated Resident #153 had diagnoses including but not limited to chronic respiratory failure, chronic airway obstruction, congestive heart failure, chronic kidney disease stage III, atrial fibrillation, and hypertension. The resident was hard of hearing, had no hearing aids, does not speak, was usually understood and understands others, had a BIMS (Brief</p>	F000514	<p>Facility is requesting Paper Compliance F 514 483.75(I)(1) RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>I. Resident # 153 has been assessed and no issues noted. LPN # 10 received education regarding documentation in resident records to ensure completeness.</p> <p>II. All residents currently residing in the facility who have sustained an unwitnessed fall or fall with head injury are potentially at risk. Residents records who have sustained a fall within the last 30 days will be reviewed for missing documentation and licensed nursing staff noted to have missing documentation will receive 1:1 education regarding documentation.</p>	10/12/2014	

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	<p>Interview of Mental Status) score of 15, indicating no cognitive impairment, needs extensive assistance with bed mobility, transfers, dressing, toileting and locomotion on and off the unit with a one person physical assist.</p> <p>Review of the progress notes, dated 08/23/2014 with a time listed as "1630" (4:30 p.m.), indicated an Incident Note by LPN (Licensed Practical Nurse) #10 in which the resident stated, on paper, she slid to the floor.</p> <p>Review of the Clinical Assessment Report - Post Fall Evaluation, dated 08/23/2014 with a time listed as "16:30" [sic] (4:30 p.m.), provided by MDS Coordinator #1, indicated the fall was unwitnessed.</p> <p>Review of the Neurological Assessment, dated 08/23/2014 through 08/26/2014, provided by the office Receptionist, listed no assessment values for the hours of "1215" (12:15 p.m.), and "1615" (4:15 p.m.), on 08/24/2014, and was initialed by LPN #10.</p> <p>Record review of the Policy and Procedure for Fall Response and Management, with a release date of 02/28/2014, provided by the Clinical Operations Director, , indicated under</p>		<p>III. Licensed nursing staff have been offered education regarding documentation requirements per facility fall policy. Unit Manager or designee will audit fall documentation daily to ensure accuracy and completeness. Interdisciplinary Team will review fall incidents for completeness and accuracy daily, excluding weekends and holidays.</p> <p>IV. The Director of Nursing or designee will audit fall documentation 5 of 7 days weekly for 30 days, weekly for 60 days and monthly for 6 months. Any issues will be identified and immediately corrected. The results of audits will be reported to the monthly Performance Improvement Committee. The Committee will determine if the audits can be discontinued.</p> <p>Date of completion: October 12, 2014</p>				

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	<p>item #12, on the list of Procedures to " Monitor neurological assessments with vital signs. Notify the physician if any change from the baseline is noted."</p> <p>Record review, on 09/12/2014 at 11:50 a.m., of the Progress Notes, dated 08/24/2014, provided by the Clinical Operations Director, indicated at "13:41" [sic] (1:41 p.m.), resident's vital signs and neurological checks were within normal limits. No values for vital signs were noted.</p> <p>An interview, on 09/11/2014 at 2:38 p.m., with MDS Coordinator #1, in regards to the procedure following a fall, she indicated the nurse assesses the resident, gets them up, and initiates a protection intervention such as personal safety equipment, this could be a chair or bed alarm, notifies the DON (Director of Nursing), and if there needs to be a different kind of personal safety equipment like a low bed they would use that. The nurse would call the family and doctor, and monitor the resident for 72 hours and documenting in the progress notes. If the resident hits their head, staff has to perform neurological checks until the doctor orders to discontinue them. Neurological checks would be charted on a form in the chart. For an unobserved fall, if the resident is not alert and</p>				

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	<p>oriented, staff assumes they hit their head. If the resident is alert and oriented and does not have a diagnosis of Dementia or Altered Mental Status, staff just asks the resident if they hit their head.</p> <p>An interview, on 09/11/2014 at 2:40 p.m., with RN #9, the unit manager, indicated that all unwitnessed falls require neurological checks to be done for 72 hours.</p> <p>An interview, on 09/12/2014 at 12:07 p.m., with MDS Coordinator #1, indicated the initials on the Neurological Assessment form under the "1215" (12:15 p.m.) and "1615" (4:15 p.m.) time columns were the initials of LPN #10, who was not working today and unavailable for interview.</p> <p>Review of the Policy and Procedure for Neurological Evaluation, dated "10/31/10 R", provided by MDS Coordinator #1, listed under Procedure, item number 2., fourth bullet, Neurological Evaluations should be performed and documented "Every 4 hours until physician states it is no longer necessary or in 72 hours if patient's condition is stable and showing no signs and symptoms of neurological injury. "</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-50(a)(1)				