

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00119150.</p> <p>Survey Dates: November 12, 13, 14, 15, 16, 19, and 20, 2012</p> <p>Facility number: 011049 Provider number: 155670 AIM number: 200258520</p> <p>Survey team: Vickie Ellis, RN TC Barb Fowler, RN Amy Wininger, RN (November 12, 13, 14, 15, 16, & 19, 2012) Diane Hancock, RN (November 13, 14, 15, 16, 19 & 20, 2012)</p> <p>Census bed type: SNF/NF 106 Total: 106</p> <p>Census Payor type: Medicare: 26 Medicaid: 54 Other: 26 Total: 106</p>	F0000	<p>Attached you will find the completed Plan of Correction and attachments for our Annual Survey dated November 20, 2012. We 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) 473-4761. Sincerely, Lynn Renee Steinwachs 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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/28/12 by Suzanne Williams, RN</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F0225	1. Resident #29 had no	12/10/2012			

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	<p>review, the facility failed to report an allegation of resident to resident abuse, leading to a delay in investigation, for 1 of 3 allegations of abuse reviewed, in that a resident reported to a nurse she had been kicked by another resident and this was not reported to the Administrator and State Agency, and the investigation was delayed due to failure to report. (Resident #29)</p> <p>Finding includes:</p> <p>During an interview with Resident #29, she indicated a resident had entered her room, thinking it was the resident's own room, and when Resident #29 told her to leave, the other resident kicked her in the back. She indicated it hadn't hurt her and she told the nurse about it and they took the other resident out. She indicated they had set up the resident's wheelchair with a "wander pole" so she couldn't access other residents' rooms.</p> <p>Resident #29's clinical record was reviewed on 11/15/12 at 10:03 a.m. Nurses' notes included, but were not limited to, the following note on 11/1/12 at 1:33 p.m.: "Health Status Note. Late entry: Note Text: CNA reported to DNS [Director of Nursing</p>		<p>injuries from kick from another resident. Resident #29 had a weekly skin assessment scheduled and completed on 10/27/2012 without findings. Resident #29 had reported the event to LPN #1 at the time of the event. The other resident was removed from resident #29's room and a wander pole had been added to the other resident's wheelchair to prevent this resident accessing other resident's rooms without invitation.</p> <p>2. Other residents residing on 200 halls had the potential to be affected. LPN #1 was terminated from Kindred Angel River. All residents and families were interviewed without findings. The event was reported to ISDH.</p> <p>3. All staff were in-serviced on Abuse and What Constitutes Abuse with emphasis on reporting events for investigation to the ED.</p> <p>4. The IDT will complete resident and family interviews regarding any treatment that could be abuse quarterly and as needed. The results of the interviews will be reviewed in PI monthly and will be an on going practice of this facility. All events will be investigated for timeliness and reporting by the ED. The PI committee will determine if 100% compliance is achieved.</p>				

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	<p>Services] today that resident stated [name of resident] entered her room on 10/24 sometime between 11 a - 2 p and thought it was her room and her belongings and that [name of resident] kicked [Resident #29] in the back while she was sitting in w/c [wheelchair]. [Resident #29] states she told the nurse [LPN #1]."</p> <p>There was social service follow-up documentation in the progress notes on 11/2, 11/3, and 11/4/12 indicating the resident was having no emotional distress.</p> <p>There was a routine weekly skin check documented 10/27/12 with no skin issues noted, i.e. no bruises, skin tears, pressure areas.</p> <p>The resident's most recent Minimum Data Set [MDS] assessment, dated 9/18/12, indicated a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was alert and oriented without long or short term memory issues.</p> <p>The investigation materials, provided by the Director of Nurses on 11/15/12 at 3:00 p.m., were reviewed on 11/15/12 at 3:15 p.m. The materials indicated the resident alleging being kicked by another resident was</p>						

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	<p>reported to the State Agency on 11/1/12. The materials indicated the allegation had not been reported to the Administrator until 11/1/12. The investigation materials included the routine weekly skin assessment for Resident #29, dated 10/27/12. Also included was a new wandering assessment for the resident who had wandered into the room, dated 11/1/12. The "Wander Pole" had been placed on 11/1/12 and the resident's care plan had been revised to include the wander pole and interventions to prevent physically abusive behaviors by the resident. The investigation included routine questioning of residents that had been done in preparation for survey; these questions had been asked of residents on 10/30/12, regarding being fearful of other residents and/or staff.</p> <p>The Director of Nurses indicated, on 11/19/12 at 9:30 a.m., LPN #1 had been terminated following the incident for not following proper procedure regarding reporting of allegations of abuse.</p> <p>3.1-28(c) 3.1-28(d)</p>						

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure their policy and procedure for reporting allegations of abuse was followed, for 1 of 3 allegations of abuse reviewed, in that a resident reported to a nurse she had been kicked by another resident and this was not immediately reported to the Administrator and investigated. (Resident #29)</p> <p>Finding includes:</p> <p>During an interview with Resident #29, she indicated a resident had entered her room, thinking it was the resident's own room, and when Resident #29 told her to leave, the other resident kicked her in the back. She indicated it hadn't hurt her and she told the nurse about it and they took the other resident out. She indicated they had set up the resident's wheelchair with a "wander pole" so she couldn't access other residents' rooms.</p>	F0226	<p>1. Resident #29 had no injuries from kick from another resident. Resident #29 had a weekly skin assessment scheduled and completed on 10/27/2012 without findings. Resident #29 had reported the event to LPN #1 at the time of the event. The other resident was removed from resident #29's room and a wander pole had been added to the other resident's wheelchair to prevent this resident accessing other resident's rooms without invitation.</p> <p>2. Other residents residing on 200 halls had the potential to be affected. LPN #1 was terminated from Kindred Angel River. All residents and families were interviewed without findings. The event was reported to ISDH.</p> <p>3. All staff were in-serviced on Abuse and What Constitutes Abuse with emphasis on reporting events for investigation to the ED.</p> <p>4. The IDT will complete resident and family interviews regarding any treatment that could be abuse quarterly and as needed. The results of the interviews will be reviewed in PI monthly and will be an on going practice of this facility. All events will be</p>	12/10/2012			

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	<p>Resident #29's clinical record was reviewed on 11/15/12 at 10:03 a.m. Nurses' notes included, but were not limited to, the following note on 11/1/12 at 1:33 p.m.: "Health Status Note. Late entry: Note Text: CNA reported to DNS [Director of Nursing Services] today that resident stated [name of resident] entered her room on 10/24 sometime between 11 a - 2 p and thought it was her room and her belongings and that [name of resident] kicked [Resident #29] in the back while she was sitting in w/c [wheelchair]. [Resident #29] states she told the nurse [LPN #1]."</p> <p>There was social service follow-up documentation in the progress notes on 11/2, 11/3, and 11/4/12 indicating the resident was having no emotional distress.</p> <p>The resident's most recent Minimum Data Set [MDS] assessment, dated 9/18/12, indicated Resident #29 had a Brief Interview for Mental Status [BIMS] score of 15/15, indicating she was alert and oriented without short or long term memory problems.</p> <p>The facility's investigation materials were reviewed on 11/15/12 at 3:15 p.m. The information indicated the allegation was reported to the State</p>		<p>investigated for timeliness and reporting by the ED. The PI committee will determine if 100% compliance is achieved.</p>		

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	<p>Agency on 11/1/12. The resident had a documented routine skin assessment dated 10/27/12 indicating no skin issues. Documentation in the investigation materials indicated they had done a new wandering assessment on the resident who had entered the room, dated 11/1/12. They had implemented the "wander pole" [a pole extending from the wheelchair that can be lowered and raised; it prevents the wheelchair from being able to enter resident rooms] on 11/1/12. They also revised the resident's care plan regarding wandering and physically abusive behaviors. The packet also included interviews with residents regarding care issues, dated 10/30/12; residents had been interviewed routinely in preparation for survey, not specifically about this incident.</p> <p>The policy and procedure regarding Abuse, dated 5/15/2003 and revised 8/31/2012, included, but was not limited to, the following: "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established</p>			

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	<p>procedures (including to the State survey and certification agency)."</p> <p>"Prohibitions on abuse apply to: ..."other patients."</p> <p>"Patients, with a personal history that renders them at risk for abusing other patients, are identified through:</p> <ol style="list-style-type: none"> Interviews with the family Chart review Behavior Monitoring logs MDS [Minimum Data Set] - Mood & Behavior Answers <p>Intervention strategies are developed to prevent and/or reduce occurrences, changes that would trigger abusive behavior are monitored, and interventions are reassessed on a regular basis."</p> <p>3.1-28(a)</p>			

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the correct wheelchair was utilized for a resident with positioning needs, for 1 of 4 residents observed to be transferred to their wheelchairs. (Resident #35).</p> <p>Findings include:</p> <p>On 11/14/12 at 2:01 p.m. Resident #35 was observed in his room, eyes closed, feet up, reclined back, and tab alarm in place in a Broda [a large wheelchair which reclines back and has neck support] wheelchair.</p> <p>On 11/15/12 at 9:20 a.m. an observation was made of Certified Nursing Assistant [CNA] #1 giving daily care and transferring the resident from the bed to a wheelchair. During this observation CNA #1 left the room to get the mechanical lift and the resident's wheelchair. CNA #1 indicated the resident's wheelchair was stored in the shower room at</p>	F0246	<p>1. Resident # 35 had no adverse effect. Resident # 35 had his name placed on the Broda chair for identification of equipment and the C.N.A. assignment sheet updated with the resident getting up in the Broda chair daily.</p> <p>2. All residents using a wheelchair or special chair for positioning have the potential to be affected. All wheelchairs or special chairs have been labeled. All C.N.A sheets and care plans have been updated</p> <p>3. All nursing and therapy staff have been in-serviced on labeling wheelchairs and special equipment. All C.N.A sheets and care plans have been updated.</p> <p>4. The IDT will complete weekly rounds X 3 months, then monthly X 3 months for accuracy in resident wheelchairs and resident plan of care. All findings will be reviewed in monthly PI meeting for 6 months or until 100% compliance has been achieved.</p>	12/10/2012	

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	<p>night. CNA #1 returned with a wheelchair and CNA #2 to assist with the transfer of Resident #35. Upon entering the room CNA #2 indicated to CNA #1 this was not the resident's usual wheelchair. CNA #1 then stated to CNA #2 "This is the problem with storing all the wheelchairs in the shower room at night. They get mixed up." The CNAs then transferred the resident to a black standard wheelchair, finished routine morning care and left the room.</p> <p>On 11/15/12 at 10:20 a.m. Resident #35 was observed sitting in his room in a black standard wheelchair.</p> <p>In an interview on 11/15/12 at 10:25 a.m. with LPN [Licensed Practical Nurse] #3, she indicated the residents' wheelchairs were identified by a small band on the wheelchair with each resident's name on it. LPN #3 made an observation at this time of the wheelchair Resident #35 was sitting in. The wheelchair did not have a band identifying who it belonged to.</p> <p>On 11/15/12 at 10:30 a.m., LPN #3 returned with Physical Therapist [PT] #1, who identified the resident was in the wrong wheelchair. PT #1 indicated the resident normally sat in</p>			

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	<p>a Broda wheelchair.</p> <p>Review on 11/15/12 at 3:15 p.m. of Resident #35's clinical record indicated the resident had diagnoses including, but not limited to, dementia and a history of falls.</p> <p>The Minimum Data Set [MDS] assessment dated 10/20/12, indicated the resident was not able to stabilize in order to transfer without human assistance.</p> <p>3.1-3(v)(1)</p>				

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F0272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess an edentulous resident using the resident assessment instrument [RAI] in 1 of</p>	F0272	1. Resident #78 had the RAI corrected to reflect the accurate assessment of dental care and the MDS modified and resubmitted. Resident # 78 has a dental appointment for	12/10/2012

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	<p>38 sampled residents whose RAI was reviewed for dental care. (Resident # 78)</p> <p>Findings include:</p> <p>On 11/14/12 at 9:45 a.m., Resident #78's record was reviewed. Resident #78 had diagnoses including, but not limited to, anemia, depressive disorder, and congestive heart failure [CHF].</p> <p>During initial tour on 11/13/12 at 10:40 a.m., Resident #78 was observed to be lying in bed with no teeth in place. Resident #78 indicated she did not have any dentures.</p> <p>On 11/15/12 at 10:35 a.m., Resident #78 was observed again to be edentulous and without any dentures.</p> <p>The quarterly RAI for Resident #78, dated 7/25/12, indicated the resident did not have any dental issues present.</p> <p>The annual RAI for Resident #78, dated 10/9/12, indicated the resident had no issues related to her dental status.</p> <p>The "Annual Patient Nursing Evaluation", dated 11/7/12 at 10:30</p>		<p>dentures.2. All residents had the potential to be affected. An audit was completed of all residents for accuracy with the RAI and the resident's dental assessment. 3. In-servicing was completed with the nurses in the MDS department.4. The DNS/Designee will audit 5 MDS assessments for accuracy in assessing weekly X 3 months, then monthly X 3 months. All findings will be reviewed in monthly PI until 100% compliance is achieved as determined by the PI committee.</p>				

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	<p>a.m., indicated the resident had an oral mucosa without lesions or ulcerations, good oral hygiene, did not have any partial dentures, did not have full plate dentures, did not have any of the following oral/mouth problems: difficulty or pain with swallowing/chewing, facial/mouth pain, altered consistency of meals or fluids, pocketing or holding food in mouth or cheek, or loss of liquids or solids from her mouth while eating or drinking.</p> <p>The Medical Nutrition Therapy Assessment dated 10/15/12 at 5:12 p.m., indicated Resident #78 received a mechanical soft diet with no liquid restrictions. The assessment indicated the resident had no oral health issues or biting or chewing difficulty. The assessment indicated the resident did have a history of dysphagia.</p> <p>Interview with RN #1 on 11/15/12 at 3:23 p.m., indicated Resident #78 had not had teeth for a very long time and the RAI dated 10/9/12 was not correct. RN #1 reviewed the MDS [Minimum Data Set] from 7/25/12 and indicated it was not correct.</p> <p>Interview with Resident #78 on 11/16/12 at 9:40 a.m. indicated the</p>			

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	resident had not had any dentures for a "long time." 3.1-31(c)(9)			

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F0279 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 ensure 1 of 3 residents reviewed for rehabilitation, in the sample of 20 who met the criteria for rehabilitation, had a care plan developed for restorative nursing care following the discontinuation of therapies. (Resident #39)</p> <p>Finding includes:</p> <p>Resident #39's clinical record was reviewed on 11/14/12 at 2:20 p.m. The resident was re-admitted to the</p>	F0279	<ol style="list-style-type: none"> Resident #39 has a care plan in place for her restorative nursing plan. All residents with a restorative nursing plan had the potential to be affected. An audit has been completed of all residents with a restorative nursing plan for a care plan. Any findings have been corrected. All nurses have been in-serviced on care plans and developing care plans for restorative nursing plans. The DNS/Designee will audit any resident's plan of care with a restorative nursing plan initiated and then weekly with change in 	12/10/2012	

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	<p>facility following hospitalization, on 9/25/12. The resident's diagnoses included, but were not limited to, cervicalgia, congestive heart failure, atrial fibrillation, anxiety state, hypothyroidism, generalized osteoarthritis, and vitamin deficiency.</p> <p>Physician's orders and therapy notes indicated Occupational Therapy and Physical Therapy were discontinued on 11/7/12.</p> <p>Discharge recommendations from Physical Therapy, dated 11/7/12, indicated "FMP [Functional Maintenance Plan]/Restorative Aide for: Walking with RW [rolling walker] X 100 [feet] with CGA [contact guard assistance]."</p> <p>An "Occupational Therapy Restorative Care Therapy Referral to Nursing," dated 11/7/12, indicated "Active ROM [range of motion] bilateral upper extremities 2 sets of 15 repetitions. Transfer SBA [stand-by assistance]."</p> <p>There was no care plan in place for the restorative ambulation or range of motion.</p> <p>Care plans were reviewed again on</p>		restorative plan of care x 6 months. All findings will be reviewed in monthly PI and the PI committee will determine when 100% compliance is achieved.				

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	<p>11/16/12 at 11:52 a.m. There continued to be no care plan in place for the therapy recommendations for ambulation and active range of motion exercises.</p> <p>The lack of care plan was reviewed with the Administrator and Nurse Consultant on 11/16/12 at 3:30 p.m. On 11/19/12 at 10:00 a.m., the Administrator indicated there had been no care plan in place, but one had been developed.</p> <p>3.1-35(a)</p>			

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for rehabilitation, in the sample of 20 who met the criteria for rehabilitation, was provided with on-going restorative nursing care to maintain or improve her abilities, in that therapy was discontinued and a restorative care plan was not initiated. (Resident #39)</p> <p>Finding includes:</p> <p>Resident #39's clinical record was reviewed on 11/14/12 at 2:20 p.m. The resident was re-admitted to the facility following hospitalization, on 9/25/12. The resident's diagnoses included, but were not limited to, cervicgia, congestive heart failure, atrial fibrillation, anxiety state, hypothyroidism, generalized osteoarthritis, and vitamin deficiency.</p> <p>Physician's orders and therapy notes indicated Occupational Therapy and Physical Therapy were discontinued on 11/7/12.</p>	F0311	<p>1. Resident #39 has a restorative nursing plan implemented and care plan updated.2. All residents discontinued from therapy and who met the criteria for an on-going restorative nursing care have the potential to be affected. An audit of all residents discharged from therapy in the past 30 days has been completed to ensure a restorative nursing plan has been initiated.3. All nursing staff and therapy have been in-serviced on Restorative nursing care.4. The DNS/Designee will review with the therapy program director once weekly any resident discharging from therapy and meeting criteria for restorative nursing care to ensure a plan is implemented and staff educated on the restorative program. This will be an on-going practice of this facility. Audit results will be reviewed monthly in monthly PI meeting and the PI committee will determine when 100% compliance is achieved.</p>	12/10/2012	

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	<p>Discharge recommendations from Physical Therapy, dated 11/7/12, indicated "FMP [Functional Maintenance Plan]/Restorative Aide for: Walking with RW [rolling walker] X 100 [feet] with CGA [contact guard assistance]."</p> <p>An "Occupational Therapy Restorative Care Therapy Referral to Nursing," dated 11/7/12, indicated "Active ROM [range of motion] bilateral upper extremities 2 sets of 15 repetitions. Transfer SBA [stand-by assistance]."</p> <p>The RN Assessment Coordinator was interviewed on 11/16/12 at 10:10 a.m. She indicated restorative programs were documented in the CNA books. The CNA documentation was reviewed at that time. There was no documentation of an ambulation program or active range of motion program.</p> <p>There was no care plan in place for the restorative ambulation or range of motion.</p> <p>CNA #6 and CNA #7 were interviewed on 11/16/12 at 10:13 a.m. Both indicated Resident #39 was still receiving therapy, and they did not do</p>			
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	any walking or exercising with her. 3.1-38(a)(2)(B)				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure oral care was given in 2 of 2 residents reviewed for oral care in a sample of 6 who met the criteria for activities of daily living and oral care. [Resident #35, #78].</p> <p>Findings include:</p> <p>1. A record review of Resident #35's clinical record was done on 11/15/12 at 3:11 p.m. The minimum data set [MDS] assessment dated 10/20/12, indicated the resident needed assistance of one person with personal hygiene.</p> <p>In an interview on 11/13/12 at 12:55 p.m. with the resident's daughter, the daughter indicated the facility seemed to take good care of the resident with the exception of brushing his teeth.</p> <p>On 11/15/12 at 9:20 a.m. an observation was made of Certified Nursing Assistant [CNA] #1 giving routine morning care to Resident #35.</p>	F0312	<p>1. Resident #35 and #78 have been provided oral care. Resident #78 has items placed in her room to assist in providing oral care. Resident #35 has brushing teeth added to the C.N.A. assignment sheet.</p> <p>2. All residents needing assistance with dental/oral care have the potential to be affected. An audit of all residents personal hygiene items related to dental/oral care has been completed and any resident without supplies have had them placed in their room. All C.N.A. assignment sheets have been updated to include dental/oral care.</p> <p>3. All nursing staff have been in-serviced on Dental/Oral care.</p> <p>4. The DNS/IDT will complete rounds daily for 5 days a week to ensure Dental/oral care has been provided for 2 months, then three times a week for 2 months, then weekly X 2 months. The results of the audit will be reviewed in monthly PI and the PI committee will determine when 100% compliance has been achieved.</p>	12/10/2012			

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	<p>During this observation, CNA #1 gave the resident a partial bath, clothed the resident, transferred the resident from the bed to the wheelchair, and shaved the resident. During care, CNA #1 asked the resident if he wished to have his teeth brushed now or after lunch. The resident replied, "now is as good a time as any." CNA #1 continued with care by changing the bed linens. After changing the linens, she exited the room and indicated she was finished with the resident's care. CNA #1 was not observed to brush the resident's teeth at any time during morning care.</p> <p>In an interview with CNA #5 on 11/16/12 at 9:35 a.m., CNA #5 indicated she sometimes assists Resident #35 in routine morning care. CNA #5 indicated the resident's oral care would be done in the morning when assisting him with getting dressed and out of bed.</p> <p>2. On 11/14/12 at 9:45 a.m., Resident #78's record was reviewed. Resident #78 had diagnoses including, but not limited to, anemia, depressive disorder, and congestive heart failure [CHF].</p> <p>The MDS [Minimum Data Set assessment], dated 10/9/12, indicated the resident's BIMS [Basic Interview</p>				

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	<p>for Mental Status] to be 7 of 15 indicating the resident to have memory issues. The MDS assessment for functional status indicated the resident required extensive assist of one person for personal hygiene which included oral care.</p> <p>The MDS assessment, dated 7/25/12, indicated the resident required extensive assistance of one person for personal hygiene.</p> <p>During initial tour on 11/13/12 at 10:40 a.m., Resident #78 was observed to be lying in bed with no teeth in place. Resident #78 indicated she did not have any dentures and her mouth was dry.</p> <p>Observation of Resident #78 on 11/15/12 at 9:49 a.m., indicated the resident was edentulous and did not have any dentures.</p> <p>The CNA [certified nursing assistant] assignment sheet obtained from CNA #3 on 11/14/12 at 3:05 p.m., indicated Resident #78 had dentures and required the assistance of 1 person for transfers and used a wheelchair for mobility.</p> <p>The "CNA Monthly Record" for</p>				

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	<p>August, 2012, September, 2012, and October, 2012, documented the resident received oral care 2 times during a 24 hour time period in the morning and evening.</p> <p>During morning care of Resident #78 on 11/15/12 at 10:35 a.m., CNA #4 offered to take the resident into the bathroom to brush her teeth. Resident #78 indicated she did not have teeth or dentures. CNA #4 indicated she could not find any supplies for oral care in the resident's room or bathroom. When queried, CNA #4 indicated she did not know if the resident had dentures as she did not have teeth and proceeded to brush the resident's hair. CNA #4 left the resident's room and provided no oral care to the resident. No supplies for oral care were obtained for the resident.</p> <p>Interview with Resident #78 on 11/16/12 at 9:50 a.m., indicated she had not had dentures for a long time and had not received oral care. The resident indicated she did not have mouthwash, oral swabs, or any other items to assist in the cleaning of her mouth.</p> <p>Interview with CNA #8 on 11/16/12 at 9:40 a.m., indicated oral care is to be</p>				

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	<p>provided to edentulous residents using mouth swabs with toothpaste or mouthwash on them and cleaning out the resident's mouth.</p> <p>3.1-38(a)(3)(C)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review the facility failed to ensure care was provided for 1 of 2 residents reviewed for pressure ulcers, in a sample of 2 who met the criteria for review of pressure ulcers. (Resident #188)</p> <p>Findings include:</p> <p>On 11/13/12 at 8:00 a.m., Resident #188 was observed lying in bed on his right side.</p> <p>The clinical record was reviewed on 11/14/12 at 11:05 a.m.</p> <p>A Physician history and physical, dated 11/03/12, indicated Resident #188 was admitted to the hospital for a perineal and buttock abscess.</p> <p>The admission orders, dated</p>	F0314	<p>1. Resident #188 has been receiving his sitz bath 2-3 times a day. PI was completed with nurses not providing care to resident #188 on 11/07/2012 thru 11/15/2012.</p> <p>2. All residents with a pressure ulcer have the potential to be affected. An audit of the TAR for all residents with a pressure ulcer was completed for verification that care has been provided.</p> <p>3. All nurses have been in-serviced on pressure ulcers with emphasis on providing care as ordered.</p> <p>4. The DNS/Designee will audit pressure ulcer treatments 3 x a week for verification that treatments were provided for 2 months, then 2 x a week for 2 months, then weekly x 2 months. Meeting All findings will be reviewed in monthly PI, the PI committee will determine when 100% compliance.</p>	12/10/2012			

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	<p>11/07/12, indicated the diagnoses included, but were not limited to, decubitus ulcer/cellulitis [a pressure ulcer with infection]. The admission orders further indicated an order for, "Sitz bath [a bath used to soak the peri-anal region] BID [twice daily] with dry ABD [type of dressing]." The admission orders further indicated Resident #188 had three stage II wounds on the coccyx measuring 3.2 X 2.0 X 0.3; 2.0 X 1.0 X 0.1; and 3.0 X 1.0 X 0.1.</p> <p>During an interview on 11/16/12 at 3:00 p.m., the DNS [Director of Nursing Services] indicated the resident had been admitted around 7:00 p.m. on 11/07/12.</p> <p>An untimed telephone order dated 11/07/12, indicated an order for "Sitz Baths BID."</p> <p>The November TAR [treatment administration record] included an undated entry for "Sitz bath BID with ABD Dsg" and included a handwritten note "see new orders." This entry on the TAR lacked any documentation a Sitz bath had been performed.</p> <p>A Physician's Report of Consultation dated 11/14/12, included a recommendation of "2-3 X [times]</p>						

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	<p>daily Sitz bath."</p> <p>A Physician's telephone order dated 11/14/12 at 12:25 p.m., included, but was not limited to, an order for "2-3X daily Sitz bath."</p> <p>The November TAR included an entry dated 11/14/12 for "2-3X daily Sitz bath." The entry lacked any documentation a Sitz bath had been performed.</p> <p>A Sitz bath was observed to be performed on 11/15/12 at 10:47 a.m. by LPN #2. During an interview with Resident #188 on 11/15/12 at 11:05 a.m., he indicated he could not feel the Sitz bath. He further indicated, at that time, he had not had a Sitz bath before.</p> <p>The admission MDS [Minimum Data Set Assessment] was in progress and not available for review. The Admission Nursing Assessment dated 11/07/12, indicated Resident #188 was alert and oriented to person, place, and time.</p> <p>A Care Plan dated 11/09/12 for actual impairments to skin integrity included, but was not limited to, an intervention dated 11/12/12, of "Tx [treatment] as ordered."</p>				

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	<p>During an interview with the DNS on 11/16/12 at 9:45 a.m., she indicated there was no documentation that Resident #188 had received a Sitz bath from 11/07/12 until 11/15/12.</p> <p>During an interview on 11/16/12 at 10:50 a.m., PT #2 indicated she had recommended a treatment for the wound of Resident #188. She further indicated, at that time, it was not intended for the Sitz baths to be discontinued, and she had communicated that to the nursing staff.</p> <p>3.1-40(a)(2)</p>			

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the resident was not taking any unnecessary antibiotics in 1 of 10 residents reviewed for unnecessary medications. (Resident #35)</p> <p>Findings include:</p> <p>A review on 11/14/12 at 2:24 p.m. of Resident #35's clinical record was done. The clinical record identified the resident had a diagnosis of, but</p>	F0329	<p>1. Resident #35 has had the Cipro discontinued.</p> <p>2. All residents receiving an antibiotic have the potential to be affected. An audit of all residents on an antibiotic has been completed for justification for the use of the antibiotic, and to ensure all antibiotics have a discontinue date.</p> <p>3. All nurses have been in-serviced on the policy for Antibiotic Resistance Review with emphasis on discontinue dates and justification for antibiotic use.</p> <p>4. The DNS/Designee will audit</p>	12/10/2012

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	<p>not limited to, frequent urinary tract infections [UTI].</p> <p>The resident's admission orders dated 9/21/12, upon return to the facility from the hospital, indicated an order for Cipro [an antibiotic] 500 milligram [mg] by mouth two times a day for UTI.</p> <p>The medication administration records [MAR] for the resident indicated the resident received Cipro 500 mg 1 pill by mouth two times a day from 9/21/12 until 11/19/12.</p> <p>Resident #35 had a doctor's order dated 10/24/12 for Keflex (antibiotic) 500 mg 1 tab by mouth 3 times a day for 7 days.</p> <p>Resident #35 had a doctor's ordered dated 10/27/12 for Rocephin 500 mg intramuscularly every 24 hours for 5 days.</p> <p>Resident #35 had a doctors order dated 10/29/12 for Omnicef (antibiotic) 300 mg 1 tab by mouth 2 times a day for 7 days.</p> <p>The MAR indicated the resident was given the Keflex antibiotic 10/24/12 through 10/27/12. It was discontinued and the Rocephin</p>		<p>all antibiotic orders 5 x a week for 3 months, then weekly x 3 months. Results of the audits will be reviewed in the monthly PI meeting until 100% compliance is achieved as determined by the PI committee.</p>				

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	<p>antibiotic was started on 10/27/12 and given through 10/31/12. It was discontinued and Omnicef was given from 11/1/12 through 11/7/12. During this time the resident continued on the Cipro 500 mg 1 tab by mouth 2 x a day.</p> <p>No record was found in which the facility had notified the doctor of the resident continuing on the Cipro for 58 days.</p> <p>In an interview with RN [registered nurse] #3 on 11/14/12 at 2:47 p.m., she indicated the resident was on the Cipro as a prophylactic.</p> <p>In an interview with the DNS [Director of Nursing Services] on 11/16/12 at 3:00 p.m., she indicated there was no documentation of the nurse contacting the physician regarding the Cipro.</p> <p>A fax was sent to the primary doctor by the DNS on 11/16/12 requesting instructions regarding the Cipro. The fax included the Resident had a UTI in October while on the Cipro. A reply from the doctor to stop the Cipro was faxed back on 11/16/12 at 9:15 a.m. The resident continued to receive the Cipro until 11/19/12.</p>			

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	<p>According to Nursing Spectrum Drug Handbook 2010, Cipro should be given for UTI's 500 mg-1000 mg daily for 7-14 days in mild to severe complicated infections. There were no indications for Cipro to be used as a prophylactic.</p> <p>A policy titled Antibiotic Resistance Review and dated 8/31/11 indicated the "physicians are asked to justify the indication for using antibiotics" and "the antibiotic is ordered for the shortest period possible while still being effective."</p> <p>The policy also indicated "physicians are requested to prescribe antibiotic therapy only when likely to be beneficial to the patient" and "physicians are asked to discontinue all antibiotics."</p> <p>3.1-48(a)(2)</p>			

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 14 residents observed during medication pass, in that medications were not given before meals or with meals as ordered/recommended, and medications were omitted. Eight [8] medication errors were observed during 51 opportunities for error. This resulted in an error rate of 15.68 %. (Residents #9, #7, #1)</p> <p>Findings include:</p> <p>1. On 11/15/12 at 8:38 a.m., LPN #4 was observed administering medications to Resident #9. The resident's breakfast tray was on her overbed table and had been eaten. The medications administered included, but were not limited to, the following: Pantoprazole (Protonix) [proton pump inhibitor to reduce stomach acid] DR 40 mg [milligrams], one tablet Prilosec OTC [over the counter] [proton pump inhibitor to reduce stomach acid]20 mg one tablet</p>	F0332	<p>1.Resident #9 has an MD order obtained to administer Protonix, Prilosec, and Levothyroxine PO with breakfast per resident's preference. RN #1 received PI in written form for omission of a medication without consent of the resident # 7 and administering calcium PO without before a meal. RN #1 received written PI for administering PO medications without a meal and omission of potassium tabs without resident #1's consent. 2.All residents with medications ordered have the potential to be affected. All licensed nurses will complete a medication administration skills validation. 3.All licensed nurses will be in-serviced on medication administration. 4.The DNS/Designee will complete medication administration skills validations with 5 nurses three times a week x 1 month, then twice a week for 1 month, then once a week for 4 months. Results of the medication administration skills validation will be reviewed in monthly PI until 100% compliance is determined by the PI committee.</p>	12/10/2012			

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	<p>Levothyroxine [thyroid supplement medication] 75 mcg [micrograms], one tablet</p> <p>The medications were administered orally with water.</p> <p>Resident #9's clinical record was reviewed on 11/15/12 at 9:20 a.m. The physician's orders had been signed on 10/8/12. The physician's orders included, but were not limited to, the following: Protonix 40 mg po [by mouth] daily Prilosec 20 mg po daily [also known as omeprazole] Levothyroxine Sodium 75 mcg po daily</p> <p>The PharMerica 2011 specialized long-term care nursing drug handbook, stored at the facility's nurses' station, was reviewed on 11/16/12 at 9:25 a.m. The drug handbook indicated the following: Pantoprazole tablet "Should be swallowed whole, do not crush or chew. Best if taken before breakfast." Omeprazole oral: "Best if administered before breakfast." Levothyroxine oral administration: "Administer in the morning on an empty stomach, at least 30 minutes before food."</p>				

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	<p>2. On 11/15/12 at 4:37 p.m., RN #1 was observed administering medications to Resident #7. The medications included, but were not limited to, the following: Calcium with D 600/400, one tablet [mineral and vitamin supplement].</p> <p>During the medication administration, the Medication Administration Record [MAR] was incidentally observed. An inhaled medication, Atrovent [to help with breathing], was observed on the MAR, scheduled for 4:00 p.m. RN #1 continued on her medication pass without administering the inhaled medication.</p> <p>At 5:10 p.m. on 11/15/12, RN #1 was interviewed regarding the Atrovent inhaled medication for Resident #7. She indicated, "she usually refuses it; she'll take it at bedtime, but not now." This RN had signed off the medication as given on 11/13/12 and 11/14/12 at the 4:00 p.m. time. There was no documentation indicating the resident had ever refused the medication from 11/1/12 through 11/15/12. The RN had not obtained the medication from the medication cart, had not offered the medication to the resident, and did not give the medication.</p>				

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	<p>The resident had not received her evening meal as of 5:15 p.m.</p> <p>Resident #7's clinical record was reviewed on 11/16/12 at 8:55 a.m. The physician's orders, signed 10/8/12, included, but were not limited to, the following: Caltrate-600 Plus 600 mg/400 IU [international units] po bid with meals Atrovent 0.03% spray 1 inhalation QID [four times a day]</p> <p>3. RN #1 was observed to administer medications to Resident #1 on 11/15/12 at 4:51 p.m. The medications included, but were not limited to, the following: Calcium with D 600/400, one tablet by mouth [mineral and vitamin supplement] Ferrous Sulfate 325 mg, one tablet by mouth [iron supplement]</p> <p>Resident #1's clinical record was reviewed on 11/16/12 at 9:02 a.m. The physician's orders, signed on 11/9/12, included, but were not limited to, the following: Caltrate D po [by mouth] BID [twice a day] with meals Feosol [iron supplement] 325 mg po BID with meals</p> <p>Resident #1 did not have her meal as</p>						

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	<p>of 5:15 p.m. on 11/15/12.</p> <p>The physician's orders also included an order for K tabs [potassium supplement] 20 meq [milliequivalents] po BID [twice a day] with meals. The MAR was reviewed, at that time, and indicated the medication was scheduled for 5:00 p.m. It had not been given when the evening medication pass was observed.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>				

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F0412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on on observation, interview, and record review, the facility failed to provide a resident who was edentulous with dental services in 1 of 3 residents reviewed for dental services of 3 who met the criteria for dental services. (Resident #78)</p> <p>Findings include:</p> <p>On 11/14/12 at 9:45 a.m., Resident #78's record was reviewed. Resident #78 was admitted on 4/8/10 with diagnoses including, but not limited to, anemia, depressive disorder, and congestive heart failure [CHF].</p> <p>During initial tour on 11/13/12 at 10:40 a.m., Resident #78 was observed to be lying in bed with no teeth in place. Resident #78 indicated she did not have any dentures.</p>	F0412	<p>1. Resident #78 has a dental appointment on 12/10/2012 to be fitted for dentures.</p> <p>2. All residents who are in need of dental services are at risk. The SSD and nursing completed a dental/oral assessment of all residents to identify residents needing dental/oral care and dental services have been arranged in agreement with their plan of care.</p> <p>3. All nursing staff, SSD, therapy and department managers have been in-serviced on policies and procedures for residents who need dental services.</p> <p>4. The SSD/Designee will audit all residents on admission, readmission, Quarterly, with significant change in dental or oral needs to determine follow up with dental services. All concerns will be reviewed by SSD related to dental or oral concerns weekly and dental services offered and documented with follow up on the concern form. An audit will be</p>	12/10/2012			

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	<p>On 11/15/12 at 10:35 a.m. during care, Resident #78 indicated she had no teeth or dentures. CNA #4 who was providing care indicated she did not know if the resident had dentures.</p> <p>During record review on 11/14/12 at 9:45 a.m., no documentation was located indicating Resident #78 had been seen by a dentist.</p> <p>Interview with SS [Social Services Specialist] #1 on 11/15/12 at 11:55 a.m. indicated the resident had dentures but she does not know what became of them. SS #1 indicated there was a "story behind the resident's dentures" but she could not remember what it was. SS #1 indicated when residents are admitted, the resident or family sign a "Health Services Consent Form" which indicate if they prefer on-site dental care. SS #1 indicated the family probably requested no dental services for the resident when she was admitted, but she was unable to provide any documentation. SS #1 indicated the facility has a dentist who they refer residents to and who comes to the facility to visit residents when they request.</p> <p>On 11/15/12 at 2:15 p.m., SS #1 indicated she could not find any</p>		<p>completed weekly X 3 months, then monthly X 3 months. All findings from the audit will be reviewed in the monthly PI meeting until 100% compliance is achieved as determined by the PI committee.</p>		

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	documentation as to what happened to the resident's dentures or why the resident had not been seen by a dentist. 3.1-24(a)(1)				

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F0431 SS=B	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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, interview and record review, the facility failed to ensure medications were disposed of when discontinued or the residents</p>	F0431	<p>1.Residents # 132, 104, 202, 12, 64, 70, 16, 201, 118, and 103 had no adverse affects. Resident # 16 has expired.</p> <p>2.All residents with discontinued</p>	12/10/2012			

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	<p>were discharged, in that medications for discharged residents and/or medications that had been discontinued were still being stored in medication rooms on 2 of 2 units (100 and 200 units). This affected 10 residents who had medications stored in the medication rooms and/or medication carts for 1 to 4 months. (Residents #132, #104, #202, #12, #64, #70, #16, #201, #118, #103)</p> <p>Findings include:</p> <p>1. On 11/14/12 at 3:05 p.m., a 100 Unit medication cart was observed during a narcotic count. The following medications, either discontinued or belonging to discharged residents, were observed to be in the cart: Resident #16 had a bottle of Roxanol [oral liquid narcotic] and Ativan Intensol [antianxiety medication]. LPN #7 indicated the resident had died awhile ago. Resident #201 had a Fentanyl medication patch [narcotic medication]. LPN #7 indicated the resident had been discharged. Resident #118 had Clonazepam [anti-anxiety] 2 mg tablets and Oxycodone/Acetaminophen [narcotic pain medication] tablets and had been discharged. Resident #103 had Zolpidem 5 mg</p>		<p>medications or discharged from the facility have the potential to be affected. An audit of all medication carts and medication rooms has been completed for discontinued medications or medications that had been ordered for a discharged resident and those medications have been disposed of in accordance with state regulations.</p> <p>3. All licensed nurses have been in-serviced on the policy and procedure for Medication Discontinuation and Return to Pharmacy.</p> <p>4. The DNS/Designee will audit all med rooms and med carts once weekly for medications that need to be properly disposed of in accordance with state regulations X 6 months. All findings will be reviewed in monthly PI meeting until 100% compliance is achieved as determined by the PI committ</p>				

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	<p>tablets [sleeping medication] and had been discharged.</p> <p>Review of the resident discharge dates, on 11/19/12 at 2:15 p.m. indicated the following: Resident #16 died 10/16/12. Resident #201 was discharged 8/23/12. Resident #118 was discharged 11/2/12. Resident #103 was discharged 10/24/12</p> <p>LPN #7 indicated, at that time, the Director of Nurses had to destroy all narcotics.</p> <p>2. The 100 Unit medication room was observed on 11/16/12 at 10:35 a.m. RN #2 indicated two pharmacies they used would not take unused medications back, so they often were in the medication room for awhile. Observed in the 100 Unit medication room were medications belonging to the following residents, who were discharged: Resident #132, discharged on 10/12/12 Resident #104, discharged on 9/5/12 Resident #202, discharged on 7/16/12 Resident #12, discharged on 7/2/12</p>						

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	<p>3. The 200 Unit medication room was observed on 11/16/12 at 11:00 a.m. The following residents, who were discharged and/or had discontinued medications, had medications stored in the medication room on the counter: Resident #64, medication discontinued 8/22/12 according to the disposition record attached to the medication. Resident #70, discharged 9/24/12, medication discontinued 8/7/12 according to disposition record attached to the medication. Resident #16, discharged 10/18/12</p> <p>According to RN #3, at that time, the medications were for residents who had been discharged.</p> <p>4. The policy and procedure for Medication Discontinuation and Return to Pharmacy, dated 10/31/09, included, but was not limited to, the following: "Remove the discontinued medication from the medication cart and/or medication room. a. Where allowed under state law, return unopened medications (e.g., Unit-dose packages) that were originally supplied in sealed containers to the issuing pharmacy with the proper paperwork within a</p>						

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	<p>timely manner.</p> <p>b. Otherwise, store the medication in the designated secured area for drugs awaiting destruction and destroy according to State regulations."</p> <p>3.1-25(o) 3.1-25(p) 3.1-25(q) 3.1-25(r)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to</p>	F0441	1.LPN #5 and LPN #6 received written PI for failure to follow	12/10/2012			

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	<p>ensure 2 of 5 nurses observed and/or interviewed were sanitizing blood glucometers between residents, in order to prevent potential blood borne pathogen transmission. This had the potential to affect 9 residents who received blood glucose checks on the 100 unit hall 3 and 200 unit hall 3. (LPN #5, LPN #6)</p> <p>B. Based on observation, interview, and record review, the facility failed to provide proper handwashing and glove use in 2 of 4 residents observed receiving personal care. (Residents #78, #89)</p> <p>Findings include:</p> <p>A1. On 11/15/12 at 11:40 a.m., LPN #5 was at her medication cart. A blood glucometer was on top of the cart. She indicated she was done with her blood sugar checks at that time. She was interviewed regarding blood glucometer use. She indicated she used alcohol wipes to wipe off glucometer between residents if she couldn't find any other wipes. She looked through the drawers and could not find any other type of sanitizing wipes.</p> <p>Review of the Medication Administration Records for this</p>		<p>policy and procedures for cleaning blood glucometers between residents. Residents #78 and #89 had no adverse affect.</p> <p>2.9 residents had the potential to be affected from incorrect sanitizing of the blood glucometer. All residents had the potential to be affected from incorrect hand washing and glove use. All nurses will complete a skills validation on sanitizing the blood glucometers. All staff will complete a skills validation on hand washing.</p> <p>3.All staff have been in-serviced on Hand washing / Hand Hygiene. All nurses have been in-serviced on policy and procedure for Blood Glucose Monitoring System Calibration and Cleaning.</p> <p>4.The DNS/Designee will complete infection control rounds twice a week for 3 months then once a week for 3 months. The DNS/Designee will complete skills validation on blood glucometer sanitizing three times a week for 1 month, then twice a week for 1 month, then once a week for 4 months. All results of audits and rounds will be reviewed immediately with staff and monthly in PI meeting. The PI committee will determine when compliance is achieved and determine if further monitoring is needed.</p>				

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	<p>nurse's hall, on 11/19/12 at 10:40 a.m., indicated there were 7 residents who received blood glucose checks.</p> <p>A2. On 11/15/12 at 4:22 p.m., LPN #6 was observed at her medication cart. A blood glucometer was laying on top of her cart. She indicated she had already done her 2 blood glucose checks. She indicated she usually stored the meter in her top drawer. When queried, she indicated she would wipe off the meter with alcohol pads and pulled a couple of pre-packaged alcohol pads out of her pocket. She checked her cart and indicated there weren't any other type of wipes to use on her cart.</p> <p>A3. The policy and procedure for the Blood Glucose Monitoring System Calibration and Cleaning, dated 10/31/10, was provided by the Director of Nurses on 11/16/12 at 1:40 p.m. The procedure for cleaning the glucometer indicated the following: "Clean the outside of the meter with a 10% bleach solution moistened wipes in-between each resident and as needed. Allow contact with bleach solution for 1-minute. Follow with a cloth dampened with water to remove residual bleach."</p>						

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	<p>B. On 11/14/12 at 9:45 a.m., Resident #78's record was reviewed. Resident #78 had diagnoses including, but not limited to, anemia, depressive disorder, and congestive heart failure [CHF].</p> <p>The MDS [Minimum Data Set] assessment, dated 10/9/12, for functional status indicated the resident to be an extensive assist of 1 person for bathing and personal hygiene.</p> <p>The CNA assignment sheet, obtained on 11/14/12 at 3:05 p.m. from CNA #3, indicated Resident #78 to be incontinent and have a shower on Tuesdays and Fridays on the day shift.</p> <p>CNA #4 was observed to be giving care to Resident #78 on 11/15/12 at 10:35 a.m. CNA #4 placed gloves on and unfastened Resident #78's gown and her bra. The CNA handed a wet washcloth to the resident to wipe her face. CNA #4 obtained liquid body soap from the resident's dresser drawer and applied soap to the wet washcloth, laid it on a towel with a non-soapy washcloth, and placed the liquid soap bottle into the resident's dresser drawer. CNA #4 washed under Resident #78's left axilla and</p>			

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	<p>down her left arm. She rinsed off the left axilla and arm and dried them. She obtained the resident's deodorant from the resident's dresser drawer and rubbed the deodorant onto her gloved hand before applying it under the resident's left axilla. CNA #4 proceeded around the bed and performed the same procedure to her right axilla and underarm but did not apply deodorant. CNA #4 obtained the resident's soap from her dresser drawer and placed it on the wet washcloth. CNA #4 removed her night gown. The CNA obtained a clear, plastic bag from the trash can, after removing the trash liner, which was in the trash can, and placed the dirty linen in it. CNA #4 removed her gloves and indicated she needed to obtain more linens. CNA #4 returned to Resident #78's room and indicated she had to obtain supplies from 2 different locations. CNA #4 applied clean gloves and unfastened the resident's soiled brief. She assisted with turning the resident to her left side. She placed a clean disposable diaper under the resident's soiled diaper and washed the resident's right buttock. While washing Resident #78's right buttock, CNA #4 indicated the resident was urinating and placed the soiled washcloth between the resident's legs. After the resident had</p>			

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	<p>completed urinating, CNA #4 obtained a clean washcloth and continued to wash and dry the resident's right buttock. A clean disposable diaper was placed under the resident and the resident was turned onto her back. CNA #4 washed the resident's bilateral groin areas. She removed her soiled gloves, applied clean ones, and rewashed the resident's bilateral groin areas which were still soiled. CNA #4 removed her dirty gloves and reapplied clean ones. She fastened the resident's disposable diaper, refastened the resident's bra, and placed a clean dress on the resident. CNA #4 removed the soiled pad from under the resident. CNA #4 removed her gloves and placed the resident's socks and shoes on her. Resident #78 was assisted into her wheelchair by CNA #4. CNA #4 indicated she would disposed of dirty linen and return to assist Resident #78 with combing her hair. CNA #4's gloves were removed and her hands washed. Upon returning to Resident #78's room, CNA #4 obtained Resident #78's brush and brushed her hair with no gloves on. Resident #78's roommate (Resident #89) requested to ambulate to the bathroom. Without handwashing, CNA #4 assisted Resident #89 to the</p>						

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	<p>bathroom after brushing Resident #78's hair.</p> <p>Interview with CNA #4 on 11/15/12 at 11:35 a.m. indicated the facility did not use hand sanitizer as there were no sanitizers in the resident's rooms or in the halls. She indicated residents are given partial baths if they do not receive showers, and it is listed on the CNA assignment sheet which days they receive a shower.</p> <p>The DNS [Director of Nursing Services] provided a document titled Hand Hygiene/Handwashing on 11/16/12 at 1:41 p.m. which indicated it was the facility's policy to wash hands between patient contact. It is also the policy to wash hands between tasks and procedures on the same patient when contaminate with body fluids to prevent cross-contamination of different body site.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>				