

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: April 7, 8, 9, 10, 11, 14 and 15, 2014</p> <p>Facility number: 000325 Provider number: 155379 AIM number: 100274300</p> <p>Lora Swanson, RN-TC Christine Fodrea, RN (4/14, 4/15, 2014) Deb Kammeyer, RN (4/7, 4/8, 4/9, 4/10, 4/11, 4/14, 2014) Julie Wagoner, RN</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 8 Medicaid: 58 Other: 12 Total: 78</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 23, 2014, by Brenda Meredith, R.N.</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or correction does not constitute admission or agreement by the oprovider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of the federal and state law.</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 protect the dignity of of one resident by posting a sign in the residents restroom. The sign provided clinical information regarding the resident that could be observed by the other residents that shared the restroom with him. (Resident #52)</p> <p>Findings include:</p> <p>On 4-8-14 at 9:36 A.M., during an observation of Resident # 52's restroom, a typed note was posted on the wall across from the sink. The note stated "Please DO NOT throw away Catheter Bag!!!!!! These Cost Money!!!" This bathroom was shared by three other residents.</p>	F000241	<p>F 241 Dignity and respect of individuality</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: The sign in res # 52's bathroom was removed on 4.8.14.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 100% room and bathroom audit was conducted for signs regarding personal information completed on 5.1.14. 1 sign was removed that potentially may be perceived to be personal.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff member that posted sign was educated verbally on 4.8.14 and</p>	05/15/2014

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	<p>During an interview on 4-8-14 at 9:14 A.M., RN#1 indicated Resident #52 wore a Texas Catheter (a device to collect urine) only at nighttime and the note on the bathroom wall was regarding his catheter bag.</p> <p>During an interview on 4-9-14 at 2:40 P.M., the administer indicated she had no idea who put the sign in the resident's restroom. The administrator further indicated the facility had no policy regarding the storage and/or cleansing of the catheter bag or tubing.</p> <p>During an interview on 4-8-14 at 5:08 P.M. the administrator indicated the sign in the resident's bathroom was inappropriate.</p> <p>On 4-10-14 at 3:45 P.M., a review of policy titled "Resident Rights" undated and provided on 4/10/14 at 3:45 P.M. by the administrator indicated, "...3. Life Care will make every effort to assist each resident in exercising his/her rights to assure the resident is always treated with kindness, respect and dignity...."</p> <p>3.1-3(t)</p>		<p>education form completed with staff member on 5.2.14. All staff in service will be completed by May 15, 2014. Housekeeping Supervisor/Designee will audit resident rooms and bathrooms 2x/weekly x 6 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Housekeeping Supervisor/Designee will audit resident rooms and bathrooms 2x/weekly x 6 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a comprehensive nutritional assessment was completed for 1 of 3 residents reviewed for nutrition after 2 separate</p>	F000272	F 272 Comprehensive Assessments 1. What corrective action will be accomplished for those residents affected by the deficient practice: Resident # 84 and 85 was	05/15/2014

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	<p>episodes of significant weight loss. (Resident #84) In addition, the facility failed to ensure a comprehensive nutritional assessment for 1 of 1 residents fed with enteral feedings who was underweight, contained sufficient calories and nutriments to increase maintain and increase their weight. (Resident #85)</p> <p>Findings include:</p> <p>1. The record of Resident #85 was reviewed on 4/8/14 at 2:00 P.M. The record indicated Resident #85 was admitted to the facility on 03/07/13, with diagnoses, including but not limited to, open wound of the head, gout, tear film insufficiency, pneumonia, hypoglycemic, atrial fibrillation, anxiety stated, hemiplegia, secondary to bilateral middle cerebral artery infarcts, and calculus of the kidney.</p> <p>Review of the initial nursing assessment, completed on 03/07/13, indicated the resident's initial weight was documented on the Admission assessment as 162 pounds and the resident was receiving gastrostomy feedings.</p> <p>Review of resident weights, from Admission through September 2013 indicated the resident's weights ranged from 160 pounds - 170 pounds.</p>		<p>reviewed by dietician on April 21, 2014. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 100% audit of residents with significant weight loss within the last 6 months and residents with enteral feedings for correct caloric counts completed on 5.2.14. 6 residents had the potential to be affected that did not have sufficient documentation from registered dietician although facility had identified weight loss and implemented sufficient interventions. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Prior dietician no longer oversees facility and new dietician educated on 4.21.14 on significant weight loss and caloric intakes for enteral feeding documentation expectations. Dietary Manager/Designee will audit weekly x 6 months for dietician's documentation on significant weight loss and residents with enteral feedings. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Dietary Manager/Designee will audit weekly x 6 months for dietician's documentation on significant weight loss and residents with enteral feedings. All results will be submitted and reviewed at the Performance</p>	

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	<p>The dietician's assessment review notes, on 07/27/13 and 09/03/13 indicated the resident's weight was 164 and 163 pounds respectively and on the 09/03/13 assessment review she documented "Wt [weight] is stable and in acceptable range. No PrU [pressure ulcers] noted. Resident tolerates feeding well. Cont POC [plan of care]."</p> <p>On 09/01/13, the resident's weight had dropped 10 pounds to 160 pounds but this was not acknowledged by the dietician on her 09/03/13 assessment. She utilized the 08/04/13 weight of 163 pounds in her 09/03/13 assessment.</p> <p>On 10/05/13, the resident's weight was documented as 156 pounds. The dietician reassessed the resident on 10/07/13 and noted the September weight of 160 pounds and indicated a "slight weight loss trend [4.1 percent in 91 days] noted. Continues on ATB [antibiotic] for head infection...Nutrition dx [diagnosis] : Inadequate enteral intake avg [average] x 7 days...Nutrition prescription: 5% calorie increase. Nutrition intervention [sic] : Jevity 1.5 FS [full strength] at 103 ml [milliliters] /hr [hour]/GT [gastrostomy tube] /pump 22 hours. This provides an additional 165 cal [calories] /day. Monitoring and</p>		Improvement Meetings conducted monthly. 5. What date the systemic changes will be completed: May 15, 2014				

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	<p>evaluation: Resident to weigh 160 pounds without further loss."</p> <p>On 10/14/13, a dietary note from the dietician, indicated "Feeding increased to Jevity 1.5 @ 103 ml/hr x 22 hrs [hours]. per RD [Registered Dietitian] recommendations. No new wt [weight]. Will continue to monitor monthly." The dietician did not acknowledge the 10/05/13 weight of 156 pounds.</p> <p>The resident's weight was documented on 10/19/13 as 145 pounds. A reassessment by the dietician was completed on 10/22/13 due to the weight loss. The dietician indicated the 10/22/13 weight was 149 pounds, the tube feeding rate was Jevity 1.5 at 103 ml/hr/GT x 22 hours with 200 ml water flush every 6 hours. The dietician calculated a 4.5 % weight loss in the past 7 days, unplanned and recommended to increase the water flush to 360 ml 5x a day and to weigh the resident daily.</p> <p>A dietary note from the dietician, completed on 11/04/13, indicated the resident was "steadily regaining weight...His wt [weight] goal is 170 pounds...."</p> <p>The resident's weight was documented as follows:</p>			

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	<p>11/09/13 as 157 pounds 12/08/13 as 160 pounds 01/01/14 as 156 pounds.</p> <p>On 01/21/14, a dietary assessment review by the dietician indicated the resident's weight on 01/20/13 [sic] was 156 pounds. She indicated the following: "Res. wt. has remained stable, but is not making wt gain progress as care planned and is below desired wt... feeding increase indicated to promote wt. gain...Plan: Jevity 1.5 FS at 112 ml/hr/GT x 22 hrs daily with 400 ml flush 5x daily. This will provide 2465 ml, 3696 calories, 157 gram of protein, and 1873 ml of free water plus 2000 ml flush for a total of 3873 ml total water."</p> <p>A full dietary assessment, completed on 02/18/14, indicated the resident's energy needs were now calculated at 3692 calories a day and protein needs were calculated as 142 gm/day. The resident's albumin was now normal level at 3.8 and his BUN (blood urea nitrogen, lab test) was still elevated as 22. The resident was still on an antibiotic for his head wound infection, and had a new stage two pressure ulcer on his right hip. The resident's current weight was 156 pounds, his goal weight was 170 pounds, even though his ideal body weight was 190 pounds and his previous usual body</p>						

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	<p>weight was 211 pounds.</p> <p>There was no explanation as to why the resident's caloric intake needs had increased from 2200 - 2950 calories/day and protein needs had increased from 88 - 110 gm/day to 3692 calories per day and 142 gm of protein per day. The resident's condition had not changed significantly during his stay at the facility.</p> <p>2. The clinical record for Resident #84 was reviewed on 04/11/13 at 11:00 A.M. Resident #84 was admitted to the facility on 07/06/12 with diagnosis, including but not limited to muscle weakness, hypertension, constipation, hyperlipidemia, dementia, esophageal reflux, difficulty walking, and vitamin D deficiency. The resident was readmitted to the on 03/04/14 with an additional diagnosis of status post traumatic fracture of the hip.</p> <p>The diet orders on readmission, on 03/07/14, indicated the resident was to have a regular diet. Prior to 03/07/14 the resident was on a finger food diet.</p> <p>The most recent nutritional assessment, completed by the dietician, was dated 08/26/13. The assessment indicated at the time of the assessment, the resident's</p>						

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	<p>weight was 104.6 pounds and her height was 60 inches, and her BMI was 20.4. The resident's laboratory tests indicated her hemoglobin was low at 11.1 and the resident was on an iron supplement. The assessment indicated the resident's weight was stable, she had a history of decreased appetite and required an appetite stimulant, and anemia. The nutrition/diet order and recommendations included a mechanical soft diet, orange juice with meals to increase iron absorption, and the goal for the resident's weight to remain "100 pounds without significant change" and to improve her hemoglobin and hematocrit levels.</p> <p>Resident #84's weight on 12/03/13, was documented as 102 pounds. Her weight on 01/05/15 had dropped and was 95 pounds (an approximate 7% weight loss in 30 days). Although the RAR (residents at risk) committee met and added the intervention of ice cream at 10:00 A.M. and 2:00 P.M., the dietician did not complete a reassessment of the resident's nutritional needs. The RAR committee indicated the resident's weight loss was 6.7% in the past month.</p> <p>On 01/09/14, the resident's Remeron medication, which was given to stimulate her appetite was reduced due to her falls. The resident was also put on a regular</p>			

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	<p>finger foods diet by the RAR committee.</p> <p>On 01/11/14, the resident's weight was down to 93 pounds.</p> <p>On 01/14/14, a 206 cookie was ordered to be given as a nutritional supplement at bedtime per the RAR committee.</p> <p>On 01/19/14, the resident's weight was down to 92 pounds.</p> <p>On 01/21/14, a RAR dietary note indicated the resident's weight loss of 1.1 pounds in the past week, the resident was documented as consuming an average of only 25 % of her meals and snacks. The committee recommended a speech therapy screen for finger food appropriateness, and an intervention to add a sandwich for all meals was added.</p> <p>On 01/26/14, the resident's weight was down to 89 pounds.</p> <p>On 01/28/14 per the RAR committee meeting, a healthshake at 9 am and 3 pm was added for supplements. There was still no assessment by the dietician despite the resident's continued significant and steady weight loss.</p> <p>A 02/16/14 Quarterly Nutrition Documentation assessment by Food</p>			

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	<p>Service Supervisor indicated the resident was on med pass, 206 cookie, finger foods, health shakes and magic cups. However, there was no documentation of medication pass supplements available as an interventions for January or February 2014. In addition, the magic cups were not documented as an intervention until 02/26/14.</p> <p>On 02/23/14, the resident's weight was down to 93 pounds.</p> <p>On 02/25/14, the ice cream was discontinued and magic cups were ordered.</p> <p>On 04/14/14 at 9:13 A.M., the Administrator and the FSS (Food Service Supervisor) were interviewed. The FSS indicated the resident was on med pass supplements until she was discharged to the hospital for fractured hip on 02/28/14, however, the medication administration records for January and February 2014, obtained and reviewed with the Nurse Consultant RN #25, on 04/14/14 at 3:10 P.M., indicated there was no medication pass supplement documented as administered. The Administrator indicated the dietician had not reassessed resident in 2014. NIP (nutrition intervention program) meetings and RAR reviewed her and that</p>			

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	<p>committee implemented their own interventions) When she went out to hospital had to obtain new orders for diet and nutrition.</p> <p>On 03/04/14, the resident was readmitted to the facility after having a fractured hip repaired. She was readmitted to the facility on a regular diet. Review of the laboratory studies from the acute care facility indicated, on 02/28/14, when the resident was admitted to the hospital, her hemoglobin was down to 8.6.</p> <p>On 03/06/14, the resident's weight was down to 91 pounds.</p> <p>On 03/15/14, the resident's weight was down to 89 pounds.</p> <p>On 03/22/14, the resident's weight was down to 87 pounds.</p> <p>On 04/01/14, the resident's weight was down to 86 pounds, (a significant weight loss of just over 5 % in less than 30 days).</p> <p>On 04/01/14 at 10:00 A.M., a high protein shake was added to the care plan for nutrition for Resident #84 by the RAR committee. In addition, Regular diet with finger foods was added to the care plan.</p>						

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	<p>On 4/11/14 from 9:30 A.M. - 11:00 A.M., Resident #84 was observed sleeping on the couch in the Alzheimer's unit lounge. Observation, on 04/11/14 at 11:00 A.M., of the refrigerator at the nurse's station on the dementia unit, indicated there was no magic cup or high protein shake with the resident's name on it in the refrigerator.</p> <p>On 4/11/14 at 12:30 P.M., the resident was served shrimp with tails on them, corn, and coleslaw. The resident was observed to take a few bites of her corn and a few bites of pudding. She picked up her shrimp, once but did not eat her shrimp. There was no carton of shake or magic cup on her tray. The resident was given a large glass of white milk partway through her meal.</p> <p>During an interview on 04/11/14 at 1:45 P.M. the FSS indicated the high protein shakes were chocolate flavored and delivered in a cup to the units.</p> <p>There was no reassessment by a dietician when the resident's weight significantly dropped in January 2014 and there was also no initial reassessment by the dietician when the resident was readmitted to the facility with a fractured hip on 03/04/14. Finally, there was no</p>			

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	<p>assessment by the dietician when the resident's weight loss was again noted to be significant on 04/01/14. There was also no intervention in place, except for the continued iron supplement the resident received, to increase iron absorption. The intervention to serve orange juice to increase iron absorption was not restarted after the resident was readmitted on 03/04/14, despite her low hemoglobin levels.</p> <p>3.1-31(c)(5) 3.1-31(d) 3.1-31(g)</p>			

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>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 observation, record review, and interviews, the facility failed to ensure 1 of 3 residents reviewed for assistance with activities of daily living who was provided oral hygiene supplies to brush her teeth.(Resident #115)</p> <p>Findings include:</p> <p>1. During an interview with alert and oriented Resident #115, conducted on 04/08/15 at 9:00 A.M., she indicated she would be able to brush her own teeth but she had never been offered the opportunity. The resident indicated she did not have a toothbrush at the facility and could not get in and out of her bed by herself.</p> <p>Interview with Resident #115, on 04/11/14 at 11:22 A.M., as she sat in her</p>	F000311	<p>F 311 TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Resident # 115 was given a toothbrush and toothpaste on 4.14.14. Care plan reflecting ADLS updated and resident given basin to assist with brushing.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 100% audit of resident supplies completed. All residents have oral care supplies.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ADL in service for all nursing staff will be completed by May 15, 2014. DON/Designee will audit oral care</p>	05/15/2014

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	<p>wheelchair waiting on her insulin shot, indicated she had not been given a toothbrush or toothpaste yesterday or this morning to allow her to brush her bottom teeth. She indicated she did not know who her aide was today.</p> <p>The clinical record for Resident #115 was reviewed on 04/11/14 at 11:35 A.M. Resident #115 was admitted to the facility on 03/13/14 with diagnosis, including but not limited to, obesity, bipolar disorder, status post knee replacement with post surgical infection.</p> <p>Interview with CNA #25, the aide assigned to care for Resident #115, on 04/14/14 at 8:50 A.M., indicated she had not offered a toothbrush and oral hygiene supplies to Resident #115 during AM care. She indicated she was going to offer her a toothbrush after breakfast. When asked to locate a toothbrush for Resident #115 in her room, CNA #25 looked in the resident's 3 drawer stand, the bathroom, and a basin of miscellaneous supplies on the resident's over bed table and could not locate a toothbrush. CNA #25 indicated she did not usually take care of Resident #115 and could not find a toothbrush for her. She indicated she would have to go get her a new one.</p>		<p>supplies in resident rooms and interview alert and oriented residents 2x/weekly for 4 weeks then weekly for 5 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: DON/Designee will audit oral care supplies in resident rooms and interview alert and oriented residents 2x/weekly for 4 weeks then weekly for 5 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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	<p>Resident #115 was observed on 04/11/14 at 11:45 A.M. in her room. Resident had at least 7 natural teeth on her bottom gum. She was edentulous on the top. Resident indicated she did not have dentures and no one had offered to brush her teeth or obtained a toothbrush for her since she had been admitted to the facility. She indicated her family did not have a ride to the facility and lived in another town and could not bring her own supplies, clothes , etc to her for her to use.</p> <p>The current care plans for Resident #115, reviewed on 04/14/14 at 11:30 A.M. had no plan to address the resident's activities of daily living or personal hygiene, including oral care, needs.</p> <p>Her Monthly flow record for April 2014 regarding the CNA documentation for personal hygiene indicated the resident's self-performance varied from independent to total dependence.</p> <p>3.1-38(a)(2)(A) 3.1-38(b)(1)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure oral care was provided for 2 of 4 residents reviewed for activities of daily living (ADL's) who required staff assistance to complete grooming and/or oral care needs. (Resident #85 and #51)</p> <p>Findings include:</p> <p>1. Resident #85's record was reviewed on 4/8/14 at 2:00 P.M. and indicated the resident was admitted to the facility on 03/07/13, with diagnoses, including but not limited to, open wound of the head, gout, tear film insufficiency, pneumonia, hypoglycemia, atrial fibrillation, anxiety stated, hemiplegia, secondary to bilateral middle cerebral artery infarct, and calculus of the kidney.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, completed on 02/15/14, indicated the resident required extensive staff assistance of two staff for personal hygiene needs.</p>	F000312	<p>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Resident # 85's facial and nasal hair trimmed on 4.15.14. Care plan updated to reflect dependency on ADLs, including oral care and frequency. Resident # 51 was given a new toothbrush on 4.14.14. Resident's old toothbrushes removed from his drawer and toothbrush charger was removed. Nursing staff set up oral care items for Resident # 51.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All dependent residents and residents that need assistance with oral care that were identified as needing staff assistance with oral care were reviewed for oral care supplies, proper oral care plan and oral care provided. Residents needing assistance with grooming were reviewed and are receiving assistance</p>	05/15/2014

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	<p>The initial care plans, dated 03/08/14, included a plan to address the resident's ADL Self-care deficit. The interventions included explain all procedures and purpose prior to performing task and encourage self-performance, provide the amount of assistance/supervision that is required, total assist with ADL's, all staff bed mobility, transfers, bathing, full side rails. There was no specific plan to address the resident's oral hygiene needs.</p> <p>Observation of Resident #85, on 04/07/14 at 3:15 P.M., indicated the resident was lying in his bed. His head was positioned near the center of the bed but the left upper bed rail. He had a white helmet type apparatus on his head with gauze wrapped around the top of his head and under his chin. He was noted to have a straggly, untrimmed beard with several long hares from his nares. There was white crusty substance around his lips and dried white flakes in his beard on his chin. The resident was noted to also be drooling thick saliva. No staff were in the room at the time of the observation.</p> <p>On 04/08/14 at 9:30 A.M., Resident #85 was observed in his bed with his head down by the bottom of the left upper bed rail. The resident's mouth was noted to have thick white build up of mucous</p>		<p>according to individualized care plans.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ADL in service for all nursing staff will be completed by May 15, 2014. DON/Designee will audit oral care supplies in resident rooms and observe teeth and facial and nasal hair on dependant residents 2x/weekly for 4 weeks then weekly for 5 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: DON/Designee will audit oral care supplies in resident rooms and observe teeth and facial and nasal hair on dependant residents 2x/weekly for 4 weeks then weekly for 5 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly. 5. What date the systemic changes will be completed: May 15, 2014</p>				

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	<p>around his lips and dry flakes were noted in his untrimmed beard. The resident was noted again, on 04/08/14 at 1:00 P.M., in the same position and condition, except his head wrap was now noted to be partially off of his head and his sheet was not covering him completely.</p> <p>04/09/14 9:00 A.M., Resident #85 was observed in his bed. His hospital type gown was falling down, his body had slipped down in the bed. His head was located over near the bottom of left upper side rail. His beard was noted to be untrimmed and again had a large amount of crust white flakes. He also again had a large amount of white crust around his lips.</p> <p>Resident #85 was observed on 04/09/14 at 3:15 P.M., lying in his bed uncovered, his hospital gown was exposing his incontinence brief. The resident's left leg was noted to be contracted at the knee and resting on the inside of the resident's right thigh with skin against skin. The resident's back was noted to be arched to the left and the resident's head was noted to be beside the left upper bedrail. The resident's beard was untrimmed and had a large amount of dry crust flakes in it.</p> <p>On 04/11/14 at 9:30 A.M., during the</p>			

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	<p>observation of reposition, CNA #26, was noted to obtain a toothette sponge, mouthwash, and lip balm and provided oral hygiene care for Resident #85. He was unable to participate and/or assist in any portion of the task. He was also noted to be nonverbal.</p> <p>Observation of Resident, on 04/15/14 at 10:10 a.m., indicated the resident's beard and been trimmed and he had been provided oral care. CNA #27 and unit manager LPN #28 indicated the resident's wife had requested his beard be trimmed. CNA #27 indicated it had taken two staff to complete the task and she requested the task be added another shift's duties. It was unclear why routine beard care and oral hygiene were not already on a planned program.</p> <p>2. During an interview, with alert and oriented Resident #51, conducted on 04/08/14 at 1:36 P.M., he indicated he had not had help brushing his teeth in about three months. He indicated if he asked staff would probably help him but they were too busy and did not remember to assist him to brush his teeth.</p> <p>The clinical record for Resident #51 was reviewed on 04/10/14 at 9:35 A.M. Resident #51 was admitted to the facility on 08/31/10 with diagnoses, including</p>			

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	<p>but not limited to, Louis-Bar syndrome, recurrent bowel obstruction, hypertension, hyperlipidemia, history of asthma, and congestive heart failure.</p> <p>Resident #51 was observed, on 04/10/14 at 7:40 A.M., propelling his electric wheelchair back from the dining room. Interview with the resident, on 04/10/14 at 7:55 A.M. indicated he had eaten his breakfast at around 7:00 A.M. The resident indicated no one had assisted or brushed his teeth this morning with morning care.</p> <p>Resident #51 was observed, on 04/11/14 at 8:15 A.M., seated in his electric wheelchair across from the nurses station. Interview with Resident #51 indicated no one helped his brush his teeth this morning. He indicated he did not bring it up either or request his teeth be brushed.</p> <p>The most recent Quarterly review of the MDS assessment, completed on 01/15/14, indicated Resident #51 required the extensive staff assistance of two for personal hygiene needs. Additionally, the MDS indicated Resident #51's BIMS (Brief Interview for Mental Status) was 15, indicating Resident #51 was oriented and able to answer questions appropriately.</p>			

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	<p>The current care plan related to activities of daily living, initiated on 02/21/11, indicated the resident required staff assist of one with ADL's and staff were to set up items for upper body grooming and encourage the resident.</p> <p>The ADL documentation for April 2014, completed by the CNAs, indicated personal hygiene assistance had ranged from limited physical assistance of staff to total dependence on staff.</p> <p>Observation of the resident's room, with the resident, on 04/11/14 at 8:17 A.M., indicated a small charger, identified by the resident as his toothbrush charger, was located on the floor underneath and behind his bed with the cord wrapped around the bedframe. There was no toothbrush in or around the charger. The charger also had dust on it.</p> <p>Interview with CNA #26, on 04/11/14 at 8:20 A.M., indicated she had helped get the resident out of bed but had not finished his A.M. care. She indicated she did not offer to assist him to brush his teeth this morning. When asked to locate his tooth brush, the CNA went to his room and looked in the three drawer dresser. The top dresser drawer, which was packed with various hygiene items,</p>			

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	<p>did have two regular toothbrushes uncovered and a battery operated toothbrush wrapped in a dirty plastic bag. The CNA confirmed all of the toothbrushes were buried in the drawer, dry and had not been used this morning.</p> <p>Interview with CNA #29, on 04/11/14 at 8:35 A.M., indicated she had not assisted Resident #51 to brush his own teeth. She indicated she would expect the resident to be able to brush his own teeth. When asked if she would expect the resident to be able to get into the bathroom, turn on the sink by himself and brush his own teeth, she indicated "yes." The resident overheard the conversation and indicated, "I can't get into the bathroom, there's a chair in the bathroom and I would need help putting the toothpaste onto the toothbrush." Observation of the bathroom for Resident #51 indicated there was a large geri chair with foot pedals located in the bathroom, blocking access to the sink.</p> <p>3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(b)(1)</p>			

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F000314 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, record review, and interviews, the facility failed to ensure 1 of 1 residents reviewed for pressure ulcers received appropriate treatment to prevent the reoccurrence and worsening of pressure ulcers. (Resident #85)</p> <p>Findings include:</p> <p>1. Resident #85's record was reviewed on 4/8/14 at 2:00 P.M. and indicated the</p>	F000314	<p>F 314 TREATMENT TO PREVENT/HEAL PRESSURE SORES</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Resident # 85's cloth pad and draw sheet removed and replaced with thin paper pad allowing air mattress to be more effective. Positioning devices are available and are being utilized for resident.</p> <p>2. How other residents having the potential to be affected by the</p>	05/15/2014			

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	<p>resident was admitted to the facility on 03/07/13, with diagnoses, including but not limited to, open wound of the head, gout, tear film insufficiency, pneumonia, hypoglycemic, atrial fibrillation, anxiety stated, hemiplegia, secondary to bilateral middle cerebral artery infarct, and calculus of the kidney.</p> <p>A progress note, dated 12/23/13 indicated the resident's wounds had healed.</p> <p>However, a note, dated 01/28/14, indicated the resident again had a stage 2 pressure ulcer on the right hip. A follow up note, dated 02/04/14, indicated the pressure ulcer on the right hip had healed.</p> <p>There was a care plan, initiated on 04/04/14 for an open area to the right hip. The interventions were measure weekly, treatment as ordered, and monitor et (and) notify the MD of acute changes. There was an additional care plan, initiated on 04/07/14 for a Stage IV (Pressure Ulcer) to the right hip with interventions to measure weekly, treatment as ordered, air mattress, and turn and reposition frequently.</p> <p>A pressure ulcer status record, initiated on 04/04/14, indicated the resident had a 2 x 2.5 cm (centimeter) stage 2 pressure ulcer to the right hip which was pink in</p>		<p>same deficient practice will be identified and what corrective action will be taken:</p> <p>Whole house audit completed indicating 8 residents have the potential of worsening areas.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing in service on proper positioning and prevention of pressure ulcers to be completed by May 15, 2014. DON/Designee to audit residents with pressure ulcers for correct positioning, preventative measures and treatments 5x/week x 1 month then weekly x 5 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: DON/Designee to audit residents with pressure ulcers for correct positioning, preventative measures and treatments 5x/week x 1 month then weekly x 5 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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	<p>color.</p> <p>There was a care plan, initiated on 04/04/14 for an open area to the right hip. The interventions were measure weekly, treatment as ordered, and monitor and notify the MD of acute changes. There was an additional care plan, initiated on 04/07/14 for a Stage IV to the right hip with interventions to measure weekly, treatment as ordered, air mattress, and turn and reposition frequently.</p> <p>Observation of Resident #85, on 04/07/14 at 3:15 P.M. indicated the resident was lying in his bed. His head was positioned near the center of an air filled bed near the bottom of the left upper bed rail. His back was twisted so his right hip was against the draw sheet and quilted cloth incontinence pad beneath him. His legs were flexed at the knee with his left leg overtop his right leg. The left leg was resting on the inside of his right thigh. His right foot was pressed into the air mattress of the bed. There were no positioning pillows or cushions in the bed with the resident and no protection on his feet. He was dressed in a hospital type gown and had a soft white helmet type apparatus with gauze on his head.</p> <p>On 04/08/14 at 9:30 A.M., Resident #85</p>						

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	<p>was observed in his bed with his head down by the bottom of the left upper bed rail. The resident's hips were again twisted so that his right hip was against the quilted incontinence pad and draw sheet underneath him. His legs were again left on top of right. There were again no positioning devices in the bed. The resident was noted again on 04/08/14 at 1:00 P.M. in the same position and condition, except his head wrap was now noted to be partially off of his head and top sheet was not covering him completely.</p> <p>04/09/14 9:00 A.M., Resident #85 was observed in his bed. His hospital type gown was falling down, his body had slipped down in the bed. His head was located over near the bottom of left upper side rail. His right hip was noted to again be directly against the draw sheet and the incontinence pad underneath him. His legs were in the same position.</p> <p>Resident #85 was observed on 04/09/14 at 3:15 P.M., lying in his bed uncovered, his hospital gown was exposing his incontinence brief. The resident's left leg was noted to be contracted at the knee and resting on the inside of the resident's right thigh with skin against skin. The resident's back was noted to be arched to the left and the resident's head was noted</p>						

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	<p>to be beside the bottom of the left upper bedrail. The resident's right hip was again against the incontinence pad and draw sheet underneath him. There were no positioning aides or pillows noted in the bed with the resident.</p> <p>On 04/11/14 at 9:30 A.M., during the observation of repositioning for Resident #85, performed by CNA #26 and #29, pillows were obtained from a linen room along with pillow cases, two incontinence pads partially overlapping each other both overtop a draw sheet were observed. The resident was pulled up in bed with the draw sheet, centered, and two pillows and a wedge cushion, located in his closet in his room, were utilized to position the resident in his bed on his left side.</p> <p>The wound care for Resident #85 was observed on 04/11/14 from 11:40 a.m. - 11:50 a.m. Upon entering the room, with RN #22 and CNA #26, Resident #85 had was noted to have remained in the same position he had been placed earlier on 04/11/14 at 9:30 A.M. Both staff washed their hands and donned gloves. and rolled the resident to his back. RN removed soft helmet and removed soiled head bandages. The head bandages, and pillow case underneath the resident's head were soiled with large amount of green tinged serious exudate. RN #22</p>			

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	<p>removed her gloves and put on clean gloves. She then took a gauze dressing and sprayed wound cleanser and dabbed the large wound with the gauze. Then without changing her gloves she put the cap back on the wound cleaner can, opened two packages of Calgical alginate placed them against the wound and then put ABD dressings and kerlex to secure dressing in place. Then she washed her hands. Next after washing her hands and repositioning the resident, the nurse donned gloves and removed the dressing from the resident's right hip wound. An Irregularly shaped golf ball sized open area pink on edges with the center approximately 1 inch by 2 inch area with thick yellow slough with a streak of eshcar looking tissue down the middle was observed. The nurse without changing her gloves, cleaned the wound with saline wound cleaner and put protestant cream around the wound and put a mepilex border dressing. Interview with the RN #22 indicated she did not know how long the resident had the hip wound with the treatment. She indicated she was going to tell the wound nurse the resident needed a new treatment.</p> <p>Interview with the wound nurse, RN #30, on 04/14/14 at 10:30 A.M. , indicated on 04/07/14 when she had assessed the wound for Resident #85's hip she had</p>			

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	<p>noted two small Stage 2 pink wounds. She indicated she had been informed by RN #22 of the changes in the wound. She indicated she was not surprised the two separate Stage two wounds had opened together into one larger wound. An assessment of the wound, completed on 04/14/14 indicated the wound was now "unstageable," measured 4.5 by 4 centimeters and was an area of yellow slough and brown necrotic and a reddish brownish drainage. She indicated the brown necrotic area was 2 cm x .8 cm inside the pink area with slough. She indicated the resident had an appointment with the wound clinic on 04/14/14.</p> <p>A 04/13/14 note to the physician indicated the following: "Res with intact outer filled blister to right heel. Ok to begin allyvn heel cup and change every 2 days and prn?" Documentation from the wound clinic, dated 04/14/14, indicated recommendation of offloading boots for the resident's right heel blister and changed the dressing on the right hip wound to alginate absorptive silver dressing daily and cover with mepilexborder.</p> <p>Observation of Resident, on 04/15/14 at 10:10 a.m., indicated the resident had a gauze dressing on his right heel. Interview with LPN #28 indicated it was</p>			

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	<p>"for protection." She later indicated maybe it was placed by the wound clinic and she did not know why it was there.</p> <p>Interview with CNA #27, on 04/15/14 at 10:08 A.M., indicated she repositioned Resident #85 with pillows behind his back. She indicated if pillows were not used or the right side rail was not used, the resident would twist himself onto his right hip and would not stay positioned in bed correctly. There were two pillows behind the resident's back, a draw sheet, a quilted incontinence pad underneath resident. There was also a wedge cushion behind the resident's knees.</p> <p>Interview with the Unit Manager, on 04/11/14 at 3:00 P.M. indicated the nursing staff repositioned Resident #85 frequently but he would move himself in bed and would not stay appropriately positioned. However, there was no explanation as to why the cloth incontinence pads and draw sheet were continually observed beneath the resident on 04/07/14 - 04/10/14 and there were no positioning devices or pillows utilized to prevent the resident from twisting onto his right hip until 04/10/14. Finally, on 04/11/14, when positioning devices and frequency of positioning was observed, the resident was observed to be properly positioned throughout the day and was</p>			

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F000323 SS=E	<p>not noted to end up in the extremely poor position he was repeatedly noted to be in on 04/07/14 - 04/09/14.</p> <p>3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to provide a safe environment for residents, related to power strips that were not properly attached to the wall and had medical devices plugged into them, for 5 of 43 resident rooms that had power strips in their room. (Rooms 205, 210, 216, 219 and 226)</p> <p>Findings include:</p> <p>On 4/14/14 from 2:00 P.M. to 3:15 P.M., an environmental tour was conducted of the facility with the Maintenance Director, the Environmental Services Director, and the Director of Nursing, during which the following was</p>	F000323	<p>F 323 FREE OF ACCIDENT HAZARDS</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Rm # 205, 210, 216, 219, and 226 power strips have been reattached to the wall or removed. Medical equipment plugs has been relocated to wall outlet.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 8 additional power strips were identified not being attached to the wall.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	05/15/2014

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	<p>observed:</p> <p>At 2:05 P.M., Resident room 205 was observed with a power strip not securely attached to the wall, the plug in part of the strip was hanging down in front of the base board heater. The power strip had a fan, television, oxygen concentrator and IV (intravenous) pump plugged into it. Interview with the Maintenance Director at this time indicated power strips were okay to use but they should be secured to the wall and medical equipment should not be plugged into it. The Maintenance Director further confirmed that this power strip was not attached properly to the wall.</p> <p>At 2:10 P.M., Resident room 210 was observed with a power strip on the floor in front of the resident's dresser. The Maintenance Director indicated the power strip should not be left in that position.</p> <p>At 2:15 P.M., Resident room 216 bed 3 was observed to have a power strip on the floor underneath the bed.</p> <p>At 2:30 P.M., Resident room 219 bed 1 was observed to have a power strip on the floor with a gastrostomy feeding pump (delivers liquid nourishment), a nebulizer machine (delivers inhalation medication),</p>		<p>Maintenance Director educated on power strip location and appropriate use of strips conducted on May 2, 2014. Maintenance Director/designee will audit power strips 3 x/ weekly for 6 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Maintenance Director/designee will audit power strips 3 x/ weekly for 6 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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F000325 SS=D	<p>and a suction machine plugged into it.</p> <p>At 2:35 P.M., Resident room 219 bed 3 was observed to have a power strip not securely attached to the wall, the plug in part of the strip was hanging loosely from the wall. The power strip had a fan, a power wheelchair charger and the resident's bed plugged into it. Interview with the Maintenance Director at this time indicated a resident bed should never be plugged into a power strip. The Maintenance Director further indicated beds should be directly plugged into a wall outlet.</p> <p>At 2:45 P.M., Resident room 226 bed 1 was observed to have a power strip on the floor not attached to the wall.</p> <p>On 4/15/14 at 12:45 P.M., an interview with the Administrator indicated the facility does not have a policy regarding the usage of power strips in resident rooms, The Administrator further indicated they follow the CMS (Centers for Medicare and Medicaid Services) guidelines.</p> <p>3.1-19(c)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive</p>				

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	<p>assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interviews, the facility failed to ensure a comprehensive nutritional assessment was completed for 1 of 3 residents reviewed for nutrition after 2 separate episodes of significant weight loss. (Resident #84) In addition, the facility failed to ensure a comprehensive nutritional assessment for 1 of 1 residents fed with enteral feedings who was underweight, contained sufficient calories and nutrients to increase maintain and increase their weight. (Resident #85)</p> <p>Findings include:</p> <p>1. The record of Resident #85 was reviewed on 4/8/14 at 2:00 P.M. The record indicated the resident was admitted to the facility on 03/07/13, with diagnoses, including but not limited to, open wound of the head, gout, tear film insufficiency, pneumonia, hypoglycemic, atrial fibrillation, anxiety stated, hemiplegia, secondary to bilateral middle cerebral artery infarcts, and calculus of the kidney.</p>	F000325	<p>F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Resident # 84 and 85 was reviewed by dietician on April 21, 2014.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 100% audit of residents with significant weight loss within the last 6 months and residents with enteral feedings for correct caloric counts completed on 5.2.14. 6 residents had the potential to be affected that did not have sufficient documentation from registered dietician although facility had identified weight loss and implemented sufficient interventions.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Prior dietician no longer oversees facility and new dietician educated</p>	05/15/2014

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	<p>Review of the initial nursing assessment, completed on 03/07/13, indicated the resident's initial weight was documented on the Admission assessment as 162 pounds and the physician's orders indicated the resident received no nutrition by mouth and was to receive gastrostomy feedings.</p> <p>The dietician's assessment review notes, on 07/27/13 and 09/03/13 indicated the resident's weight was 164 and 163 pounds respectively and on the 09/03/13 assessment review she documented "Wt [weight] is stable and in acceptable range. No PrU [pressure ulcers] noted. Resident tolerates feeding well. Cont POC [plan of care]."</p> <p>On 05/06/13 the resident's weight was documented as 170 pounds and on 09/01/13 the resident's weight had dropped 10 pounds to 160 pounds, a 5.8 percent weight loss, but this was not acknowledged by the dietician on her 09/03/13 assessment. She utilized the 08/04/13 weight of 163 pounds in her 09/03/13 assessment.</p> <p>On 10/05/13, the resident's weight was documented as 156 pounds. The dietician reassessed the resident on 10/07/13 and noted the September weight</p>				<p>on 4.21.14 on significant weight loss and caloric intakes for enteral feeding documentation expectations. Dietary Manager/Designee will audit weekly x 6 months for dietician's documentation on significant weight loss and residents with enteral feedings.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Dietary Manager/Designee will audit weekly x 6 months for dietician's documentation on significant weight loss and residents with enteral feedings. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>		

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	<p>of 160 pounds and indicated a "slight weight loss trend (4.1 percent in 91 days) noted. Continues on ATB [antibiotic] for head infection...Nutrition dx [diagnosis] : Inadequate enteral intake avg [average] x 7 days...Nutrition prescription: 5% calorie increase. Nutrition intervention [sic]: Jevity 1.5 FS [full strength] at 103 ml [milliliters]/hr [hour]/ GT[gastrostomy tube]/pump 22 hours. This provides an additional 165 cal [calories]/day. Monitoring and evaluation: Resident to weigh 160 pounds without further loss."</p> <p>On 10/14/13, a dietary note from the dietician, indicated "Feeding increased to Jevity 1.5 @ 103 ml/hr x 22 hrs [hours]. per RD [Registered Dietitian] recommendations. No new wt [weight]. Will continue to monitor monthly." The dietician did not acknowledge the 10/05/13 weight of 156 pounds, nor did she recommend to increase the calories despite the actual weight loss.</p> <p>The resident's weight was documented on 10/19/13 as 145 pounds, a 14.9 percent weight loss. A reassessment by the dietician was completed on 10/22/13 due to the weight loss. The dietician indicated the 10/22/13 weight was 149 pounds, the tube feeding rate was Jevity 1.5 at 103 ml/hr/GT x 22 hours with 200</p>			

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	<p>ml water flush every 6 hours. The dietician calculated a 4.5 % weight loss in the past 7 days, unplanned and recommended to increase the water flush to 360 ml 5x a day and to weigh the resident daily.</p> <p>A dietary note from the dietician, completed on 11/04/13, indicated the resident was "steadily regaining weight...His wt (weight) goal is 170 pounds...."</p> <p>The resident's weight was documented as follows: 11/09/13 as 157 pounds 12/08/13 as 160 pounds 01/01/14 as 156 pounds.</p> <p>On 01/21/14, a dietary assessment review by the dietician indicated the resident's weight on 01/20/13 [sic] was 156 pounds. She indicated the following: "Res. wt. has remained stable, but is not making wt gain progress as care planned and is below desired wt... feeding increase indicated to promote wt. gain...Plan: Jevity 1.5 FS at 112 ml/hr/GT x 22 hrs daily with 400 ml flush 5x daily. This will provide 2465 ml, 3696 calories, 157 gram of protein, and 1873 ml of free water plus 2000 ml flush for a total of 3873 ml total water."</p>			

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	<p>A full dietary assessment, completed on 02/18/14, indicated the resident's energy needs were now calculated at 3692 calories a day and protein needs were calculated as 142 gm/day. The resident's albumin was now normal level at 3.8 and his BUN (Blood Urea Nitrogen, lab test)) was still elevated as 22. The resident was still on an antibiotic for his head wound infection, and had a new Stage two pressure ulcer on his right hip. The resident's current weight was 156 pounds, his goal weight was 170 pounds, even though his ideal body weight was 190 pounds and his previous usual body weight was 211 pounds.</p> <p>There was no explanation as to why the resident's caloric intake needs had increased from 2200 - 2950 calories/day and protein needs had increased from 88 - 110 gm/day to 3692 calories per day and 142 gm of protein per day. The resident's condition had not changed significantly during his stay at the facility.</p> <p>Based on the Harris-Benedict equation (formula to determine caloric needs), Resident #85 initially required 2080 calories/day to maintain his admission weight prior to adding additional calories for his Total Energy Expenditures which would include his Basal Energy</p>			

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	<p>Expenditure x the Activity Factor x the Stress Factor. His initial caloric needs would need to range above 3744 calories/day to maintain his Admission weight. This would include stress factors on admission, which continued through his stay, such as, open wounds, infections, and the surgery he had endured just prior to his admission to the facility.</p> <p>The 2011 Indiana Diet Manual indicated the facility should "Provide sufficient calories, adjust formula based on weight loss....individuals...who have unintentional weight loss may need additional kilocalories to cease weight loss and/or regain lost weight...."</p> <p>2. The clinical record for Resident #84 was reviewed on 04/11/13 at 11:00 A.M. Resident #84 was admitted to the facility on 07/06/12 with diagnosis, including but not limited to muscle weakness, hypertension, constipation, hyperlipidemia, dementia, esophageal reflux, difficulty walking, and vitamin D deficiency. The resident was readmitted to the on 03/04/14 with an additional diagnosis of status post traumatic fracture of the hip.</p> <p>The diet orders on readmission, on 03/07/14, indicated the resident was to</p>						

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	<p>have a regular diet. Prior to 03/07/14 the resident was on a finger food diet.</p> <p>The most recent nutritional assessment, completed by the dietician, was dated 08/26/13. The assessment indicated at the time of the assessment, the resident's weight was 104.6 pounds and her height was 60 inches, and her BMI (Body Mass Index) was 20.4. The resident's laboratory tests indicated her hemoglobin was low at 11.1 and the resident was on an iron supplement. The assessment indicated the resident's weight was stable, she had a history of decreased appetite and required an appetite stimulant, and anemia. The nutrition/diet order and recommendations included a mechanical soft diet, orange juice with meals to increase iron absorption, and the goal for the resident's weight to remain "100 pounds without significant change" and to improve her hemoglobin and hematocrit levels.</p> <p>Resident #84's weight on 12/03/13 was documented as 102 pounds. Her weight on 01/05/15 had dropped and was 95 pounds (an approximate 7% weight loss in 30 days). Although the RAR [residents at risk] committee met and added the intervention of ice cream at 10:00 A.M. and 2:00 P.M., the dietician did not complete a reassessment of the</p>			

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	<p>resident's nutritional needs. The RAR committee indicated the resident's weight loss was 6.7% in the past month.</p> <p>On 01/09/14 the resident's Remeron medication, which was given to stimulate her appetite was reduced due to her falls. The resident was also put on a regular finger foods diet by the RAR committee.</p> <p>On 01/11/14 the resident's weight was down to 93 pounds.</p> <p>On 01/14/14 a 206 cookie was ordered to be given as a nutritional supplement at bedtime per the RAR committee.</p> <p>On 01/19/14 the resident's weight was down to 92 pounds.</p> <p>On 01/21/14, a RAR dietary note indicated the resident's weight loss of 1.1 pounds in the past week, the resident was documented as consuming an average of only 25 % of her meals and snacks. The committee recommended a speech therapy screen for finger food appropriateness, and an intervention to add a sandwich for all meals was added.</p> <p>On 01/26/14, the resident's weight was down to 89 pounds.</p> <p>On 01/28/14, per the RAR committee</p>			

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	<p>meeting, a healthshake at 9 am and 3 pm was added for supplements. There was still no assessment by the dietician despite the resident's continued significant and steady weight loss.</p> <p>A 02/16/14 Quarterly Nutrition Documentation assessment by Food Service Supervisor indicated the resident was on med pass, 206 cookie, finger foods, health shakes and magic cups. However, there was no documentation of medication pass supplements available as an interventions for January or February 2014. In addition, the magic cups were not documented as an intervention until 02/26/14.</p> <p>On 02/23/14, the resident's weight was down to 93 pounds.</p> <p>On 02/25/14, the ice cream was discontinued and magic cups were ordered.</p> <p>On 4/14/14 at 9:13 A.M., the Administrator and FSS (Food Service Supervisor) were interviewed. The FSS indicated the resident was on med pass supplements until she was discharged to the hospital for fractured hip on 02/28/14, however, the medication administration records for January and February 2014, obtained and reviewed with the Nurse</p>			

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	<p>Consultant RN #25, on 04/14/14 at 3:10 P.M., indicated there was no medication pass supplement documented as administered. The Administrator indicated the dietician had not reassessed resident in 2014. NIP (nutrition intervention program) meetings and RAR reviewed her and that committee implemented their own interventions) When she went out to hospital had to obtain new orders for diet and nutrition.</p> <p>On 03/04/14, the resident was readmitted to the facility after having a fractured hip repaired. She was readmitted to the facility on a regular diet. Review of the laboratory studies from the acute care facility indicated, on 02/28/14, when the resident was admitted to the hospital, her hemoglobin was down to 8.6.</p> <p>On 03/06/14, the resident's weight was down to 91 pounds.</p> <p>On 03/15/14, the resident's weight was down to 89 pounds.</p> <p>On 03/22/14, the resident's weight was down to 87 pounds.</p> <p>On 04/01/14, the resident's weight was down to 86 pounds, (a significant weight loss of just over 5 % in less than 30 days).</p>						

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	<p>On 04/01/14 at 10:00 A.M., a high protein shake was added to the care plan for nutrition for Resident #84 by the RAR committee. In addition, Regular diet with finger foods was added to the care plan.</p> <p>Resident #84 was observed sleeping on the couch in the Alzheimer's unit lounge from 9:30 A.M. - 11:00 A.M. Observation, on 04/11/14 at 11:00 A.M., of the refrigerator at the nurse's station on the dementia unit, indicated there was no magic cup or high protein shake with the resident's name on it in the refrigerator.</p> <p>On 04/11/14 at 12:30 P.M., the resident was served shrimp with tails on them, corn, and coleslaw. The resident was observed to take a few bites of her corn and a few bites of pudding. She picked up her shrimp, once but did not eat her shrimp. There was no carton of shake or magic cup on her tray. The resident was given a large glass of white milk partway through her meal.</p> <p>During an interview on 4/11/14 at 1:45 P.M., the FSS indicated the high protein shakes were chocolate flavored and delivered in a cup to the units.</p> <p>There was no reassessment by a dietician</p>			

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F000371 SS=F	<p>when the resident's weight significantly dropped in January 2014, and there was also no initial reassessment by the dietician when the resident was readmitted to the facility with a fractured hip on 03/04/14. Finally, there was no assessment by the dietician when the resident's weight loss was again noted to be significant on 04/01/14. There was also no intervention in place, except for the continued iron supplement the resident received, to increase iron absorption. The intervention to serve orange juice to increase iron absorption was not restarted after the resident was readmitted on 03/04/14, despite her low hemoglobin levels.</p> <p>3.1-46(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>			

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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interviews, the facility failed to ensure one of three kitchen staff prepared and served food properly regarding thawed/partially cooked meat and washing tomatoes prior to use in 1 of 1 kitchens. This potentially affected 76 of 77 residents who resided in the facility. In addition, the facility failed to ensure 4 of 12 residents served in the memory unit dining were served food in a sanitary manner regarding handwashing. (Resident #52, Resident #84, Resident #67, and Resident 116)</p> <p>Findings include:</p> <p>1. On 4-7-14 at 12: 24 P.M., in the Martin Hall (Memory unit) dining area, CNA #3 was observed washing her hands for 5 seconds after assisting Resident #52 to the restroom. CNA #3 then walked to the dining area and was observed serving Resident #84 and Resident #67 their lunch.</p> <p>On 4-11-14 at 11:22 A.M., CNA #3 was observed taking Resident #116 to the restroom and closed the door. She exited</p>	F000371	<p>F 371 FOOD PROCURE, STORE/PREPARE/SERVE 1.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice: Food is being thawed and raw vegetables are being handled correctly. Employee #20 and 21 were educated on proper food handling on 4.21.14. CNA #3 was educated and a handwashing competency was completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: In service on food handling, infection control, handwashing and proper thawing techniques for dietary staff will be completed by May 15, 2014. Infection control inservice for all staff will be completed by May 15, 2014. Audit will be completed by Dietary Manager for thawing and food handling 5x/week x 1 month then weekly x 5 months. DON/Designee will complete handwashing audit 5x/week x 1 month then weekly x 5 months to conducted on</p>	05/15/2014

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F000441 SS=F	<p>restroom and assisted resident to the dining area. She returned to the restroom and washed her hands for 7 seconds. Then CNA #3 went to the beverage cart and poured Resident #116 a glass of water and juice. She placed these items in front of the resident and sanitized her hands with Purell alcohol sanitizing gel.</p> <p>During an interview, on 4-14-14 at 9:35 A.M., the administrator indicated staff members should wash their hands for 15 seconds when they are serving residents in the dining area or may use an alcohol based gel.</p> <p>On 4-14-14 at 9:45 A.M., a review of a policy titled "Hand Hygiene" with a revision date of 9-18-2009, indicated Handwashing "...3. Wash well under running water for a minimum of 15 seconds, using a rotary motion and friction...."</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>		<p>random shifts and weekends. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audit will be completed by Dietary Manager for thawing and food handling 5x/week x 1 month then weekly x 5 months. DON/Designee will complete handwashing audit 5x/week x 1 month then weekly x 5 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly. 5. What date the systemic changes will be completed: May 15, 2014</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>1. Based on observation and interview, the facility failed to ensure 1 of 1 licensed staff (RN #22) observed applying pressure ulcer treatments for 1 of 1 residents with pressure ulcers (Resident #85) changed her gloves appropriately.</p> <p>2. Based on observation, record review and interview, the facility failed to ensure indwelling urinary catheter tubing and</p>	F000441	F 441 INFECTION CONTROL 1. What corrective action will be accomplished for those residents affected by the deficient practice: Staff member #22 received individual education on proper infection control and a nursing competency on wound care was completed. Resident # 39's catheter tubing and catheter is being maintained in proper position in a dignity bag. Resident # 52's drainage bag disposed on 4.9.14. 3 staff	05/15/2014

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	<p>collection bag was properly positioned for 1 of 1 residents observed with an indwelling catheter. (Resident #39)</p> <p>3. Based on record review, interview and observation, the facility failed to properly cleanse, store, or provide a new catheter bag for 1 of 1 residents using a Texas catheter. (Resident #52)</p> <p>4. Based on interview and record review, the facility failed to follow their policy regarding tuberculin testing prior to employment for three employees reviewed for completion of tuberculin skin tests. This had the potential to affect 78 of 78 residents in the facility.</p> <p>Findings include:</p> <p>1. During an observation of a dressing change for Resident #85, conducted on 04/11/14 at 11:40 a.m. - 11:50 A.M., RN #22 washed her hands and donned gloves. She removed a soft helmet and soiled head bandages from Resident #85's head. The head bandages, and pillow case were soiled with large amount of green tinged serious exudate. RN #22 removed her gloves and put on clean gloves. She then took a gauze dressing and sprayed wound cleanser and dabbed the large head wound with the gauze. Then</p>		<p>members identified to not have had their full series of mantoux has started series over. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents that have current wound treatment orders are at risk for being affected. All residents with catheters are at risk for being affected. No other residents with Texas catheters have been identified. 15 staff members were identified to not have supporting documentation of tuberculosis testing completed timely. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurse competencies are to be completed by May 15, 2014. In service for nursing staff on infection control to include proper positioning of catheter bags and tubing and single use of catheter bags. Staff Development Coordinator educated on mantoux policy and procedure. Education to be completed by May 15, 2014 for all staff on infection control. SDC will continue handwashing competencies for all new staff. SDC/Designee will perform nursing competencies on wound care for new nursing staff and quarterly x 6 months. DON/Designee will audit catheter tubing, proper bagging and texas</p>				

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	<p>without changing her gloves, she put the cap back on the wound cleaner can, opened two packages of Calgical alginate dressing and placed them against the wound and then put an absorbent dressings and kerlex gauze to secure the dressings in place. RN #22 then washed her hands. Interview with RN #22 indicated the resident did have "something" [some kind of organism] growing in his head wound and recently had cultured the drainage. Next after washing her hands and repositioning the resident, RN #22 then donned gloves and removed the dressing from the resident's right hip wound. There was an irregularly shaped golf ball sized open area with pink tissue on the edges and in the center was an approximately 1 inch by 2 inch area with thick yellow slough with a streak of dark brown thick looking tissue. The nurse without changing her gloves, cleaned the wound with saline wound cleaner, using the same can she had contaminated during the head wound dressing change, put a protective cream around the wound edges and put a mepilex border dressing on the wound..</p> <p>2. The clinical record for Resident #39 was reviewed on 04/10/14 at 9:47 A.M. Resident #39 was admitted to the facility on 07/02/12, with diagnoses, including but not limited to, diabetes mellitus, BPH</p>		<p>catheters 5 x/week x 1 month then 3x/week x 5 months. SDC/Designee will audit all new employees 1st step and 2nd step mantoux weekly x 1 month then 2 x a month for 5 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: SDC/Designee will perform nursing competencies on wound care quarterly x 6 months. DON/Designee will audit catheter tubing, proper bagging and texas catheters 5 x/week x 1 month then 3x/week x 5 months. SDC/Designee will audit all new employees 1st step and 2nd step mantoux weekly x 1 month then 2 x a month for 5 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly. 5. What date the systemic changes will be completed: May 15, 2014</p>		

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	<p>(benign prostatic hyperplasia), dementia with behavioral disturbances, hypertension, and constipation. Resident also had a history of a hip fracture with repair, obstructive uropath with renal failure, and depression.</p> <p>On 04/07/14 at 3:00 P.M., the catheter tubing for Resident #39 was noted not in dignity bag, with the tubing dragging the floor. An unidentified nursing staff member assisted the resident to lay down in his bed, however, the catheter bag was still noted to be touching the floor mat beside the resident's bed the urine in the bag was visible from the hallway</p> <p>On 04/08/14 at 12:55 P.M., Resident #39 was observed sitting in his wheelchair in his room. The resident was observed to roll over his catheter tubing, which was lying against the floor, with his wheelchair.</p> <p>On 04/09/14 at 3:00 P.M., Resident #39 was observed lying in his bed asleep. The resident's catheter tubing and bag were fastened to his low bed frame, not in a dignity bag and both the bottom of the collection bag and some of the tubing were resting on the floor mat.</p> <p>On 04/10/14 at 7:40 A.M., Resident #39 was observed lying in his bed awake,</p>			

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F000456 SS=D	<p>drinking a glass of juice. The resident's catheter bag was positioned on the far side of his low bed but closer observation indicated the tubing and the top of the bag were out of the dignity bag and were touching the floor mat.</p> <p>Resident #39, who was in his wheelchair by the nurse's station, was awakened by staff and invited to an activity for coffee on 04/10/14 at 9:42 A.M. The resident however, declined and indicated he just wanted to go lie down. CNA #23 was notified and indicated she would lay him down after she answered a call light on the west hall. CNA #23 came back at 9:50 A.M. and pushed resident to his room to assist him to lay down. After she laid the resident down his catheter collection bag was noted to be on the floor mat beside the bed near the window.</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure resident care equipment was maintained in a safe operating condition, related to 2 of 3 suction machines had outdated service stickers on them and 1 suction machine did not have any stickers on it indicating</p>	F000456	<p>F 456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: Suction machine in R. 219 was removed due to order discontinued.</p> <p>2. How other residents having</p>	05/15/2014

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	<p>the last date of service.</p> <p>Findings include:</p> <p>On 4/14/14 from 2:00 P.M. to 3:15 P.M., an environmental tour was conducted of the facility with the Maintenance Director, the Environmental Director and the Director of Nursing, during which the following was observed:</p> <p>At 2:40 P.M., resident room 219 bed 1 was observed to have a suction machine at the bedside. The suction machine was observed with no cover over the top of it. A layer of dust was observed over the top of the machine. There was no suction tubing observed, and a cap was missing where the suction tubing would have attached to the canister. A sticker on the side of the machine indicated last serviced: 10/2012 next service due 10/2013. Interview with the Maintenance Director indicated he was unsure when the machine was last serviced and was not even aware a suction machine was in this room.</p> <p>At 3:00 P.M., a suction machine was observed on a cart beside the nurses station for the East and West hallways. The DON (Director of Nursing) removed the cover from the machine and indicated there was not a sticker on the machine</p>		<p>the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All other suction machines are stored and inspected timely. All suction machines were inspected and date of inspection placed on machine.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An in service was given to Maintenance Director on proper storage, cleaning, inspecting and labeling of all suction machines in facility. Central Supply Clerk to track machines and inform maintenance of placement to ensure inspections occur. Housekeeping Supervisor/Designee to audit all suction machines monthly x 6 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Housekeeping Supervisor/Designee to audit all suction machines monthly x 6 months. All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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F000465 SS=E	<p>anywhere to indicate when the machine was last serviced.</p> <p>At 3:05 P.M., a suction machine was observed on a cart in the main dining room. The Maintenance Director removed the plastic cover and located a service sticker on the side of the machine that indicated the last service was 10/2012 and the next service due was 10/2013. The Maintenance Director indicated that he inspects and tests the machines monthly and was unsure if an outside company was supposed to service the machines.</p> <p>On 4/15/14 at 11:00 A.M., interview with the Administrator indicated the Maintenance Director was to check the machines monthly however he was unaware that a suction machine was kept in room 219 bed 1.</p> <p>3.1-19(bb)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and</p>	F000465	F 465 SAFE/FUNCTIONAL/SANITARY/COM	05/15/2014			

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	<p>record review, the facility failed to provide a safe and clean resident environment related to, holes in the walls of resident rooms, stained floor tile in restrooms, urine odors in resident restrooms, a stained privacy curtain, a suction machine was uncovered and dusty, a feeding pump pole and the flooring underneath had a dried brown substance on it, a toilet seat riser had a dried brown substance on it. This had the potential to affect 7 of 21 residents residing on the South hallway, 1 of 3 residents residing on the Skilled hallway, 2 of 13 residents residing on the East hallway, and 10 of 17 residents residing on the West hallway.</p> <p>Findings include:</p> <p>On 4/14/14 from 2:00 P.M. to 3:15 P.M., an environmental tour was conducted with the Maintenance Director, the Environmental Director, and the Director of Nursing, during which the following was observed:</p> <p>1. South Hallway:</p> <p>At 2:05 P.M., the shared restroom for Room 325 and 324 was observed with a brown dried substance on the right arm of a toilet seat riser, this same dried substance was observed on the seat riser</p>		<p>FORTABLE ENVIRONMENT</p> <p>1. What corrective action will be accomplished for those residents affected by the deficient practice: 325 restroom cleaned and privacy curtain in room 312 removed on 4.14.14. Flooring in 316, 212 and 216 are scheduled to be replaced by a contractor on May 8, 2014. Rm. 219 floor was mopped under tube feeding pole on 4.14.14. TF pole was replaced on 4.14.14. Suction machine was discontinued for non-use on 4.14.14. Rm. 209 and 325 holes in bathroom repaired 5.5.14. Paint touch ups and dents in rm. 210 and 212 were completed on 5.5.14.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Whole house bathroom audit completed on 4.30.14 identified 1 toilet not clean. Whole house curtain audit completed on 4.30.14 identified multiple curtains with small stains. Curtains have been removed and washed and facility continues to follow deep clean protocol of removing and washing curtains as scheduled. Whole house audit of IV poles, no others identified. Whole house audit for room/restroom repairs and paint completed on 5.1.14 identified touch up painting needed in multiple rooms and 7 rooms needing</p>	

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	<p>on 4/7, 4/8, 4/9, 4/10 and 4/11. Also observed was 2 small holes approximately dime sized in the wall on the right side of the toilet.</p> <p>During an interview on 4/14/14 at 2:05 P.M., the Environmental Director indicated he was unsure how long the dried substance was on the toilet seat riser and could not believe it was left in this condition. He further indicated the toilet seat risers are to be cleaned daily when the rooms are cleaned.</p> <p>At 2:10 P.M., the shared restroom for Room 316 and 317 was observed to have a strong urine odor and the tile on the floor around the toilet was stained with a brown/rust color.</p> <p>During an interview on 4/14/14 at 2:10 P.M., the Environmental Director indicated that this restroom was a focus room for cleaning and that the restroom was cleaned 2 times a day. He further indicated due to the urine seeping under the tile, the tile needed to be replaced. He also indicated the facility was working on having the tile replaced in a few of the bathrooms but was unsure when that was going to happen.</p> <p>2. Skilled Hallway:</p>		<p>dry wall repair. Whole house audit on flooring completed on 5.2.14 identified 16 bathrooms with potential tiles needing replaced due to staining, peeling or chipping.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An in service was given to Maintenance Director on scheduling and completing painting and repairs of all resident rooms and bathrooms. Housekeeping in service on cleaning expectations to be completed on May 9, 2014. Executive Director/Designee will audit paint and repairs on 5 rooms weekly x 6 months. Housekeeping Supervisor/Designee will audit cleanliness of floors, curtains and toilet risers 2x/week for 1 month then weekly for 5 months. Housekeeping Supervisor/Designee will audit suction machines monthly x 6 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Executive Director/Designee will audit paint and repairs on 5 rooms weekly x 6 months. Housekeeping Supervisor/Designee will audit cleanliness of floors, curtains and toilet risers 2x/week for 1 month then weekly for 5 months. Housekeeping Supervisor/Designee will audit suction machines monthly x 6 months.</p>	

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	<p>At 2:12 P.M., Room 312, the privacy curtain between Bed 1 and Bed 3 was observed with a large dark stain on it.</p> <p>During an interview on 4/14/14 at 2:12 P.M., the Maintenance Director indicated the stain appeared to be some sort of body fluid. The Environmental Director indicated that the privacy curtains are to be inspected with each room cleaning and he should be notified if the curtains need to be replaced or laundered. He further indicated he was unsure the last time the curtain was laundered.</p> <p>3. West Hallway:</p> <p>At 2:15 P.M., the shared restroom for Room 209 and 210 was observed to have a hole approximately quarter sized in the wall below the sharps container (a container that holds biohazard material).</p> <p>At 2:17 P.M., Room 210 was observed to have a large area at the bottom edge of the door approximately 3" high that was missing paint exposing the metal. The wall behind the door had multiple pea size gouges in the paint exposing the wall board underneath it.</p> <p>At 2:20 P.M., the shared restroom for Room 212 and 213 was observed to have a strong urine odor. There was peeling</p>		<p>All results will be submitted and reviewed at the Performance Improvement Meetings conducted monthly.</p> <p>5. What date the systemic changes will be completed: May 15, 2014</p>	

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	<p>paint in several areas and multiple pea sized dings in the wall above the baseboard in the restroom.</p> <p>During an interview on 4/14/14 at 2:20 P.M., the Environmental Director indicated this room was also a focus room and that it was cleaned 2 times a day. The Maintenance Director indicated that he does not have a specific schedule for repairs. He indicated that any staff can write in the maintenance book any repairs that they see need to be completed. He further indicated that he tries to prioritize what needs fixed according to the acuity of the situation.</p> <p>4. East Hallway:</p> <p>At 2:35 P.M., Room 216 bed 3 was observed to have a large indent approximately 4 inches by 1 inch deep in a floor tile located underneath the resident's bed.</p> <p>During an interview on 4/14/14 at 2:55 P.M., the Maintenance Director indicated the tile had an indented area in it.</p> <p>At 2:55 P.M., Room 219 bed 1 was observed to have a pole with a feeding pump and liquid nourishment in a bag hanging from the pole. A dried brown substance was observed down the side of</p>			
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	<p>the pole and at the bottom of the pole. A pattern of multiple brown drip marks was also observed on the tile flooring underneath the pole. This was also observed on 4/7 and 4/8/14. A suction machine was also observed at the bedside. The machine was uncovered and had dust on the top of the machine and the canister.</p> <p>During an interview on 4/14/14 at 2:55 P.M., the Director of Nursing indicated the suction machine should have a cover over it and that it is the responsibility of the nursing department to clean the feeding pump pole and was unsure at this time when that was completed. The Environmental Director indicated that this room was just swept and mopped today and the room was cleaned daily.</p> <p>On 4/15/14 at 10:00 A. M, an interview with the Administrator indicated that the staff had identified the odor in Room 212 and 317 and had decided that the tile would need replaced. She further indicated that a company was coming on Friday to give a quote for new flooring. When asked to provide a work order and a time line for repairs no documentation was available to review.</p> <p>On 4/15/14 at 11:30 A.M., review of the "Cleaning/Sanitizing, Disinfection, &</p>			

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	<p>Sterilization" policy, last updated May 2004, and received from the DON, indicated "Purpose: To provide supplies and equipment that are adequately cleaned, disinfected, or sterilized...Respiratory therapy equipment that touches mucous membranes should be subjected to sterilization before each use...."</p> <p>On 4/15/14 at 12:30 P.M., review of the "Daily Resident Room Cleaning" effective February 2012, and received from the Environmental Director, indicated "...All areas that are touched daily by our residents and staff are to wiped down daily as we clean...It is the responsibility of the housekeeper to inspect daily the condition of the privacy curtains on their halls and if found soiled to report that to their supervisor. The supervisor will then assign someone to change out said curtain...Scrape the floors around edges and thresholds and sweep and mop the entire floor including the bathroom. Be sure to do this under beds...."</p> <p>On 4/15/14 at 12:35 P.M., review of the "Bathroom Cleaning Procedure" undated, and received from the Environmental Director, indicated "...Toilet seat risers must be thoroughly scrubbed daily...Sweep and mop the floor utilizing</p>			

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	the microfiche cleaning system...." 3.1-19(f)			