

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2014
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NAME OF PROVIDER OR SUPPLIER ESSEX NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 301 W ESSEX ST LEBANON, IN 46052
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F000000	<p>This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00149088.</p> <p>Complaint IN00149088-Substantiated. Federal/state findings cited at F309 and F323.</p> <p>Survey Dates: July 7, 8, 9, 10, and 11, 2014.</p> <p>Facility Number: 000291 Provider Number: 155404 AIM Number: 100286710</p> <p>Survey Team: Lora Brettnacher, RN-TC Kewanna Gordon, RN Sherry Nagle-Smith, RN Vicki Nearhoof, RN</p> <p>Census Bed Type: SNF/NF: 29 Total: 29</p> <p>Census Payor Type: Medicare: 7 Medicaid: 22 Total: 29</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000		

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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F000157 SS=D	<p>16.2-3.1.</p> <p>Quality review completed 7/18/14 by Brenda Marshall, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>				

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of a resident's increased pain and/or the inability of the facility to obtain an X-Ray as ordered by the physician for 1 of 3 residents reviewed for physician notification after a fall (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 7/9/14/2014 at 1:35 P.M. Resident B had diagnoses which included but were not limited to advanced dementia, expressive dysphasia, decreased safety awareness, and a history of falls.</p> <p>A nurse's note dated 12/3/13 at 6:10 P.M., indicated Resident B had fallen and had a "tender" right knee and a skin tear to her right elbow. This note indicated a physician was called and had ordered a X-Ray to be obtained in the facility by the facility's mobile X-Ray service.</p> <p>A nurse's note dated 12/3/13 at 10:00 P.M., indicated, "Res [Resident] crying out in pain. Difficult to determine exact place pain is located due to res confusion (per norm [normal]). Note indications to R [right] hip and leg although difficult to</p>	F000157	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p>F-157</p> <p>(A)What corrective actions will be accomplished</p> <p>for those residents found to have been affected</p> <p>by the deficient practice:</p> <p>Resident B no longer resides in the facility.</p> <p>(B)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>All residents have been reviewed to assure that the physician has been made aware of any changes in condition. All X-ray orders will be reviewed each morning M-F to ensure that the facility procedures</p>	08/10/2014			

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	<p>determine...." This note indicated Tylenol [analgesic] 650 Milligrams was administered for pain.</p> <p>The record lacked documentation a physician was notified of Resident B's change in condition with increased pain.</p> <p>A nurse's note dated 12/4/14 at 1:45 A.M., indicated the nurse contacted the mobile X-ray company's answering service and the answering service indicated they were unsure if they would be able to provide services to Resident B until the next morning.</p> <p>A nurse's note dated 12/4/14 at 2:00 A.M. indicated the X-ray company notified the facility they would not be able to provide the X-ray service for Resident B until 8:00 A.M. on 12/4/13.</p> <p>The record lacked documentation the physician had been notified the mobile X-ray service would not be provided until 8:00 A.M. on 12/4/14 [fourteen (14) hours and 50 minutes after the physician had ordered the X-ray].</p> <p>A nurse's note dated 12/4/13 at 2:30 P.M., indicted Resident B was awake "holding" and "rubbing" her right upper outer leg and "crying" when the nurse attempted to examine her leg. This note</p>		<p>were followed.</p> <p>(C)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>All nurses will be in-serviced related to assuring that the resident's physician is notified of any changes. The in-service will specifically address those residents that have a change in pain level or if services are ordered that for some reason can't be performed. On weekends as well as off hours the charge nurse will notify the Director of Nurses of any change in a residents condition, and the DNS will ensure that proper physician notification has occurred. A Change in condition procedure was developed to provide staff with instructions on notifying the physician of changes in resident condition and how to proceed when the physician cannot be reached. A new procedure was developed to give Nursing personnel guidance with follow-up on X-Ray orders. All nurses have been inserviced on the new procedure.</p> <p>(D)How the corrective action(s) will be monitored to ensure the</p>		

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	<p>indicated her vitals were: temperature 99.2, blood pressure 162/100, pulse 102, respirations 20, skin color "pale." This note indicated the nurse called the physician's answering service and was "awaiting a return call."</p> <p>A nurse's note dated 12/4/14 at 3:15 A.M., [45 minutes after the call was placed to the physician's answering service] indicated the Nurse Practitioner called the facility and gave orders for Resident B to be sent to the emergency room for an evaluation of her pain.</p> <p>An untimed physical therapist progress and discharge note dated 12/7/13, indicated Resident B had been discharged from therapy due to a hospitalization after a fall on December 3, 2013 with a possible fractured hip and pelvis.</p> <p>A current care plan originally dated 10/25/13, indicated Resident B was at risk for pain related to arthritis and osteoporosis. Interventions indicated the physician would be notified if interventions were unsuccessful or if her current complaint was a significant change from her past experience of pain.</p> <p>During an interview on 7/9/14 at 2:12 P.M., Registered Nurse [RN] #5 indicated he was the nurse caring for</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>A Performance Improvement Tool has been initiated that will randomly review 5 residents related to any change of condition that warrants physician notification. The tool will assure that the physician was notified properly if indicated. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The QA Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit.</p> <p>Date of compliance:</p> <p>8-10-14</p>		

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	<p>Resident B when she fell on 12/3/13. RN #5 indicated the mobile X-ray company was supposed to respond within four hours. RN #5 stated, "I obviously wanted it done. She was crying out in pain... My shift was over at 10:00 P.M. I past it on to [nurse named]... It was difficult to determine rotation because she wouldn't let us rotate it. The notes indicated at 2:30 A.M., she was awake crying, rubbing her right outer leg...I got her pulse 8 hours earlier and her pulse was 90, blood pressure 90/60... The nurse's note indicated her pulse was 102 and blood pressure was 162/100. If she was in that much pain I would have called back every 15 minutes because [Physician named] might have got the call and fell back to sleep... I would have expected the nurse to call him back..."</p> <p>During an interview on 7/10/14 at 9:57 A.M., the Administer indicated he would have expected his staff to call the physician "again" to notify him the X-Ray he ordered had not been obtained and to inform him of Resident B's increased pain. He indicated if they were unable to reach the physician they should have sent her to the hospital to be evaluated.</p> <p>A policy titled "Change in a Resident's Condition Status" dated 7/9/14, and</p>			

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F000223 SS=E	<p>identified as a current policy by the Social Service Director on 7/10/14 at 8:27 A.M., indicated, "...Our facility shall promptly notify the resident, his or her Attending Physician...of changes in the resident's medical/mental condition... The Nurse Supervisor/Charge Nurse will notify the resident's Attending On-Call Physician when there has been...A significant change in the resident's physical/emotional/mental condition... A need to transfer the resident to a hospital...."</p> <p>3.1-5(a)(2)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal, physical, and/or mental abuse for 3 of 3 residents reviewed for abuse (Resident #32, #22, and #21).</p>	F000223	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of	08/10/2014

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	<p>Findings include:</p> <p>1. During an interview on 7/10/14 at 7:51 A.M., Registered Nurse (RN) #3 was interviewed during the Abuse Protocol Task. RN #3 stated, "Six months ago (Resident #32 named) told me (LPN #99 named) had been rough with her. When he turned her he pushed her too hard... I don't know if I told (Administrator named) or not. I was brand new. I didn't know what was going on." RN #3 indicated it was over a weekend and she had told her co-worker and assumed she would take care of it. RN #3 indicated she was aware she should have reported it to the Administrator.</p> <p>During an interview on 7/10/14 at 11:49 A.M., the Social Service Director (SSD) indicated she was not informed of Resident #32's allegations. The SSD indicated during a routine conversation with Resident #32 on 3/5/14 (Wednesday) Resident #32 informed her LPN #99 had pushed her during care. The SSD indicated at that time the Administrator was informed of the allegation and the abuse investigation began. The SSD indicated staff had not reported the allegation per the facility's policy.</p>		<p>correction is being submitted in good faith by the facility because it is the law. <u>F - 223</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>The employee was immediately suspended and after a thorough investigation was terminated.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All other residents at the facility have the potential to be affected. The SSD/designee interviewed all cognitively intact residents (contacted POA's of non cognitively intact residents) to inquire about potential abuse. No other resident's stated that any staff member had been verbally or physically abusive.</p> <p>(C)What measures will be put into place or what systemic changes will be made to</p>				

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	<p>During an interview on 7/10/14 at 11:50 A.M., the Administrator indicated once he was informed of Resident #32's allegations against LPN #99 he reported it to the appropriate entities, interviewed the staff accused and the Certified Nursing Assistant (CNA) who was on duty at the time, and interviewed interviewable residents. The Administrator indicated he did not thoroughly investigate the allegation of abuse by conducting staff interviews across all shifts before unsubstantiating the abuse allegation and allowing LPN #99 to return to work and provide resident care.</p> <p>Resident #32's record was reviewed on 7/10/14 at 8:16 A.M. Resident #32 had diagnoses which included, but were not limited to, Parkinson's disease, chronic kidney disease, schizophrenia, depression, anxiety, and muscle weakness. A non-scheduled Minimum Data Assessment Tool (MDS) dated 6/24/14, Resident #32 was cognitively intact with a Brief Interview Mental Status Score of 13 out of 15.</p> <p>An untimed social service note dated 3/5/14, indicated Resident #32 was queried by the SSD regarding "refusing care." The note indicated, "Resident</p>		<p>ensure this will not recur:</p> <p>The abuse policy was reviewed and found to be sufficient. All staff members were inserviced on abuse and neglect as well as reporting procedures. Each staff member understands how to recognize abuse and the importance of reporting allegations immediately to the administrator. Each charge nurse is responsible on their designated shift to ensure that any allegation of abuse is reported immediately to the administrator. Abuse training is conducted upon hire and at least annually thereafter. Abuse training is also conducted after any allegation of abuse occurs. The Administrator will conduct abuse investigations for all allegations of abuse to assure that they are completed within facility policy.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>This will be monitored by the Administrator or their designee, monthly for three months, then quarterly for three quarters, by interviewing a minimum of five residents R/T abuse. All positive responses will</p>	

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	<p>stated she does not like the CNA she has today. She stated she just doesn't like her because she is rude and she curses and argues with people. SSD asked resident if she has done that to her. Resident stated she had not but she has heard CNA doing it to others in the hall..."</p> <p>During an interview on 7/10/14 at 9:39 A.M., the SSD was queried regarding the allegations of verbal abuse by a CNA. The SSD indicated she had reported the allegation of verbal abuse to the Administrator.</p> <p>During an interview on 7/10/14 at 11:50 A.M., the Administrator was queried regarding knowledge of Resident #32's allegations of verbal abuse by a CNA. The Administrator indicated he had not been made aware of the allegations.</p> <p>2. During an interview on 7/10/14 at 8:55 A.M., Resident #22 indicated a nurse had been "rude" and "hateful" to him. He indicated he needed to be taken off the bed pan so he put on his call light. He indicated he waited for 10 or 15 minutes and when no one came in to help him he starting tapping on the bar above his bed to get "attention " because he thought they had "forgotten" me. Resident #22 stated, "(Licensed Practical Nurse (LPN) #99 named) came in and</p>		<p>be acted upon immediately. The interviews will be reviewed for compliance in the QA committee meetings.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>said, 'Stop that right now you hear me. What do you think we are your personal servant? I will not have that no more.' Resident #22 indicated a Certified Nursing Assistant with blond hair and bangs (name not known) were in the room when LPN #99 "treated" him that way. Resident #22 indicated on another occasion he had put his call light on because he needed to use the urinal "real bad." He indicted LPN #99 entered his room and he informed him he needed an aide because he needed to use the urinal. Resident #22 stated, "(LPN #99 named) said, 'What do you need an aide for? Here's your urinal.' " Resident #22 stated, " He threw the urinal on my bed and told me to use it." Resident #22 indicated LPN #22 walked out of his room without assisting him with his toileting needs. Resident #22 stated, "I do not put my light on unless I need it. I didn't appreciate it. I bit my tongue to keep from saying anything to him."</p> <p>Resident #22's record was reviewed on 7/11/14 at 11:26 A.M. Resident #22 had diagnoses which included, but were not limited to, heart failure, hypertension, and depression. A fourteen day scheduled Minimum Data Set Assessment Tool (MDS) dated 5/14/14, indicated Resident #22 was cognitively intact with a Brief Interview Mental</p>			

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	<p>Status (BIMS) score of 15 out of 15 and was totally dependent on the physical help of one staff for toileting which included using the urinal and bedpan.</p> <p>3. During an interview on 7/7/14 at 10:47 A.M., Resident #21's son indicated he and his brother visited the facility daily. When queried regarding knowledge of abuse towards his mother or other residents Resident #21's son indicated his brother had informed him when he arrived to visit their mom a few weeks ago he overheard a male nurse yelling at their mom telling her to 'shut up and be quiet.' His brother indicated to him he and the nurse "got into it." Resident #21's son indicated he was not sure if his brother had reported the incident to anyone.</p> <p>Resident #21's record was reviewed on 7/9/14 at 1:31 P.M. Resident #21 had current diagnoses which included, but were not limited to, diabetes, hypertension, stage four kidney disease, cardio pulmonary disease, morbid obesity, cellulitis, congestive heart disease, chronic carbon dioxide retention, chronic respiratory failure, and cellulitis.</p> <p>An Admission Minimum Data Assessment dated 5/13/14, indicated Resident #21 was cognitively impaired</p>			

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	<p>with a BIMS [Brief Interview Mental Status score] of 2.</p> <p>During an interview on 7/10/14 at 11:53 A.M., the Administrator indicated he had confirmed the male nurse Resident #21's son referred to was LPN #99. He indicated LPN #99 had come in and provided a statement. The Administrator indicated if he had done a thorough investigation the first time allegations were made against LPN #99 he might have avoided the other incidents. The Administrator stated, "Of course he denied it. It does not look could good for him."</p> <p>A policy titled, "Abuse Prevention" identified as a current policy by the Administrator on 7/10/14 at 10:15 A.M., indicated, "...It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...We have established policies and procedures that will provide facility personnel with the knowledge and training to ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program...All employees are required to attend our facility's resident rights and abuse prevention program in service training</p>			

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	<p>sessions prior to having any resident contact...Our facility will not condone any form of resident abuse... Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment...Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g., using derogatory language, rough handling of resident, ignoring residents while giving care...Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to the facility management immediately...All personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately...The following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. When it doubt, report it...Signs of Actual Physical Neglect:...Inadequate provision of care; caregiver indifferent to resident's personal needs...left alone, but needs supervision....All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...The</p>			

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	<p>individual conducting the investigation will, at a minimum...Interview the person's reporting the incident... interview any witnesses to the incident... interview the resident...interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident... Allegations of abuse are reported to the state survey agency with 24 hours...Abuse is defined as the willful infliction of injury...intimidation...deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental, and psychosocial well being. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance..."</p> <p>3.1-27(a)(1) 3.1-27(b)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>			

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	<p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of staff abuse to a resident was reported to State officials and/or thoroughly investigated for 1 of 3 residents (Resident #32) and failed to prevent further potential abuse for all residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview on 7/10/14 at 7:51 A.M., Registered Nurse (RN) #3 was interviewed during the Abuse Protocol Task. RN #3 stated, "Six months ago (Resident #32 named) told me (LPN #99 named) had been rough with her. When he turned her he pushed her too hard... I don't know if I told (Administrator named) or not. I was brand new. I didn't know what was going on." RN #3 indicated it was over a weekend and she had told her co-worker and assumed she would take care of it. RN #3 indicated she was aware she should have reported it to the Administrator.</p> <p>Resident #32's record was reviewed on 7/10/14 at 8:16 A.M. Resident #32 had diagnoses which included, but were not</p>	F000225	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F - 225</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>The employee was immediately suspended and after a thorough investigation was terminated.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All other residents at the facility have the potential to be affected. The SSD/designee interviewed all cognitively intact residents (contacted POA's of non cognitively intact residents) to</p>	08/10/2014

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	<p>limited to, Parkinson's disease, chronic kidney disease, schizophrenia, depression, anxiety, and muscle weakness. A non-scheduled Minimum Data Assessment Tool (MDS) dated 6/24/14, Resident #32 was cognitively intact with a Brief Interview Mental Status Score of 13 out of 15.</p> <p>An untimed social service note dated 3/5/14, indicated Resident #32 was queried by the SSD regarding "refusing care." The note indicated, "Resident stated she does not like the CNA she has today. She stated she just doesn't like her because she is rude and she curses and argues with people. SSD asked resident if she has done that to her. Resident stated she had not but she has heard CNA doing it to others in the hall..."</p> <p>During an interview on 7/10/14 at 11:49 A.M., the Social Service Director (SSD) indicated she was not informed of Resident #32's allegations. The SSD indicated during a routine conversation with Resident #32 on 3/5/14 (Wednesday), Resident #32 informed her LPN #99 had pushed her during care. The SSD indicated at that time the Administrator was informed of the allegation and the abuse investigation began. The SSD indicated staff had not reported the allegation per the facility's</p>		<p>inquire about potential abuse. No other resident's stated that any staff member had been verbally or physically abusive.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The abuse policy was reviewed and found to be sufficient. All staff members were inserviced on abuse and neglect as well as reporting procedures. Each staff member understands how to recognize abuse and the importance of reporting allegations immediately to the administrator. Each charge nurse is responsible on their designated shift to ensure that any allegation of abuse is reported immediately to the administrator. Abuse training is conducted upon hire and at least annually thereafter. Abuse training is also conducted after any allegation of abuse occurs. The Administrator will conduct abuse investigations for all allegations of abuse to assure that they are completed within facility policy.</p>				

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	<p>policy.</p> <p>During an interview on 7/10/14 at 9:39 A.M., the SSD was queried regarding the allegations of verbal abuse by a CNA. She indicated she had reported the incident to the Administrator.</p> <p>During an interview on 7/10/14 at 11:50 A.M., the Administrator was queried regarding knowledge of Resident #32's allegations of verbal abuse by a CNA. The Administrator indicated his SSD had not reported the allegation to him. During this interview the Administrator indicated once he was informed of the allegations against LPN #99 he reported it to the appropriate entities, interviewed the staff accused and the Certified Nursing Assistant (CNA) who was on duty at the time, and interviewed interviewable residents. The Administrator indicated he did not thoroughly investigate the allegation of abuse by conducting staff interviews across all shifts before unsubstantiating the abuse allegation and allowing LPN #99 to return to work and provide resident care.</p> <p>A policy titled, "Abuse Prevention" identified as a current policy by the Administrator on 7/10/14 at 10:15 A.M., indicated, "...It is the policy of this</p>		<p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>This will be monitored by the Administrator or their designee, monthly for three months, then quarterly for three quarters, by interviewing a minimum of five residents R/T abuse. All positive responses will be acted upon immediately. The interviews will be reviewed for compliance in the QA committee meetings.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...We have established policies and procedures that will provide facility personnel with the knowledge and training to ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program...All employees are required to attend our facility's resident rights and abuse prevention program in service training sessions prior to having any resident contact...Our facility will not condone any form of resident abuse... Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment...Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g., using derogatory language, rough handling of resident, ignoring residents while giving care...Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to the facility management immediately...All personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately...The following are some examples of actual</p>			

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	<p>abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. When it doubt, report it...Signs of Actual Physical Neglect:...Inadequate provision of care; caregiver indifferent to resident's personal needs...left alone, but needs supervision....All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...The individual conducting the investigation will, at a minimum...Interview the person's reporting the incident... interview any witnesses to the incident... interview the resident...interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident... Allegations of abuse are reported to the state survey agency with 24 hours...Abuse is defined as the willful infliction of injury...intimidation...deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental, and psychosocial well being. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their</p>			

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F000226 SS=D	<p>hearing distance..."</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement its policy and procedure to ensure an allegation of staff abuse to a resident was reported to State officials and/or thoroughly investigated for 1 of 3 residents (Resident #32) and failed to prevent further potential abuse for all residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview on 7/10/14 at 7:51 A.M., Registered Nurse (RN) #3 was interviewed during the Abuse</p>	F000226	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F - 226</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p>	08/10/2014

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	<p>Protocol Task. RN #3 stated, "Six months ago (Resident #32 named) told me (LPN #99 named) had been rough with her. When he turned her he pushed her too hard... I don't know if I told (Administrator named) or not. I was brand new. I didn't know what was going on." RN #3 indicated it was over a weekend and she had told her co-worker and assumed she would take care of it. RN #3 indicated she was aware she should have reported it to the Administrator.</p> <p>Resident #32's record was reviewed on 7/10/14 at 8:16 A.M. Resident #32 had diagnoses which included, but were not limited to, Parkinson's disease, chronic kidney disease, schizophrenia, depression, anxiety, and muscle weakness. A non-scheduled Minimum Data Assessment Tool (MDS) dated 6/24/14, Resident #32 was cognitively intact with a Brief Interview Mental Status Score of 13 out of 15.</p> <p>An untimed social service note dated 3/5/14, indicated Resident #32 was queried by the SSD regarding "refusing care." The note indicated, "Resident stated she does not like the CNA she has today. She stated she just doesn't like her because she is rude and she curses and argues with people. SSD asked resident</p>		<p>The employee was immediately suspended and after a thorough investigation was terminated.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All other residents at the facility have the potential to be affected. The SSD/designee interviewed all cognitively intact residents (contacted POA's of non cognitively intact residents) to inquire about potential abuse. No other resident's stated that any staff member had been verbally or physically abusive.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The abuse policy was reviewed and found to be sufficient. All staff members were inserviced on abuse and neglect as well as reporting procedures. Each staff member understands how to recognize abuse and the importance of reporting allegations immediately to the</p>	

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	<p>if she has done that to her . Resident stated she had not but she has heard CNA doing it to others in the hall..."</p> <p>During an interview on 7/10/14 at 11:49 A.M., the Social Service Director (SSD) indicated she was not informed of Resident #32's allegations. The SSD indicated during a routine conversation with Resident #32 on 3/5/14 (Wednesday), Resident #32 informed her LPN #99 had pushed her during care. The SSD indicated at that time the Administrator was informed of the allegation and the abuse investigation began. The SSD indicated staff had not reported the allegation per the facility's policy.</p> <p>During an interview on 7/10/14 at 9:39 A.M., the SSD was queried regarding the allegations of verbal abuse by a CNA. She indicated she had reported the incident to the Administrator.</p> <p>During an interview on 7/10/14 at 11:50 A.M., the Administrator was queried regarding knowledge of Resident #32's allegations of verbal abuse by a CNA. The Administrator indicated his SSD had not reported the allegation to him. During this interview the Administrator indicated once he was informed of the allegations against LPN #99 he reported</p>		<p>administrator. Each charge nurse is responsible on their designated shift to ensure that any allegation of abuse is reported immediately to the administrator. Abuse training is conducted upon hire and at least annually thereafter. Abuse training is also conducted after any allegation of abuse occurs. The Administrator will conduct abuse investigations for all allegations of abuse to assure that they are completed within facility policy.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>This will be monitored by the Administrator or their designee, monthly for three months, then quarterly for three quarters, by interviewing a minimum of five residents R/T abuse. All positive responses will be acted upon immediately. The interviews will be reviewed for compliance in the QA committee meetings.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>it to the appropriate entities, interviewed the staff accused and the Certified Nursing Assistant (CNA) who was on duty at the time, and interviewed interviewable residents. The Administrator indicated he did not thoroughly investigate the allegation of abuse by conducting staff interviews across all shifts before unsubstantiating the abuse allegation and allowing LPN #99 to return to work and provide resident care.</p> <p>A policy titled, "Abuse Prevention" identified as a current policy by the Administrator on 7/10/14 at 10:15 A.M., indicated, "...It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...We have established policies and procedures that will provide facility personnel with the knowledge and training to ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program...All employees are required to attend our facility's resident rights and abuse prevention program in service training sessions prior to having any resident contact...Our facility will not condone any form of resident abuse... Preventing resident abuse is a primary concern for</p>			

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	<p>this facility. It is our goal to achieve and maintain an abuse free environment...Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g., using derogatory language, rough handling of resident, ignoring residents while giving care...Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to the facility management immediately...All personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately...The following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. When it doubt, report it...Signs of Actual Physical Neglect:...Inadequate provision of care; caregiver indifferent to resident's personal needs...left alone, but needs supervision....All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...The individual conducting the investigation will, at a minimum...Interview the person's reporting the incident... interview any witnesses to the incident...</p>			

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NAME OF PROVIDER OR SUPPLIER ESSEX NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 301 W ESSEX ST LEBANON, IN 46052
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F000242 SS=E	<p>interview the resident...interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident... Allegations of abuse are reported to the state survey agency with 24 hours...Abuse is defined as the willful infliction of injury...intimidation...deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental, and psychosocial well being. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance..."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure residents were assessed for and/or given a choice regarding their preferences related to bathing for 3 of 3 residents reviewed for choices (Resident #21, #38, and #33).</p> <p>Findings include:</p> <p>1. During an interview on 7/9/14 at 10:47 A.M., Resident #21's son indicated his mother did not receive the same number of baths or showers in a week based on her past preference. He stated, "She requires a bath every day because of her folds. She has an infection. That is why we bathed her everyday... She is supposed to get a sponge bath everyday. The aides told me they were only doing it three times a week. I came in one time at lunch and her eyes were matted shut. I asked them have you given her a bath and they said no she only got one three times a week." Resident #21's son indicated he had informed the facility his mom needed a full bed bath everyday.</p> <p>During an interview on 7/9/14 at 11:05 A.M., CNA (Certified Nursing Assistant) #11 and CNA #1 indicated Resident #21 was bathed three times a week.</p> <p>During an interview on 7/10/14 at 9:47 A.M., the Social Service Director</p>	F000242	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F - 242</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident 21 is no longer a resident of the facility, Resident #33 was reinterviewed and informed that the TUB in the (C) bathroom was not available for resident use. Her shower preferences will be honored. #38 were reinterviewed and his shower preferences will be honored.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents were</p>	08/10/2014			

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	<p>indicated Resident #21's son had informed her he wanted his mom to have a full bed bath daily because she could not take showers. She stated, "I was assured it was being done." She indicated she failed to document his wishes and the care plan had not been updated.</p> <p>Resident #21's record was reviewed on 7/9/14 at 1:31 P.M. Resident #21 had current diagnoses which included, but were not limited to, diabetes, hypertension, stage four kidney disease, cardio pulmonary disease, morbid obesity, cellulitis, congestive heart disease, chronic carbon dioxide retention, chronic respiratory failure, and cellulitis. The record lacked documentation Resident #21 had been provided daily bathes.</p> <p>An Admission Minimum Data Assessment dated 5/13/14, indicated Resident #21 had a BIMS [Brief Interview Mental Status score] of 3 and required total physical assistance of staff for bathing. This MDS indicated Resident #21 had indicated it was somewhat important to her to make choices regarding bathing and it was very important to her to have her family involved with her care.</p>		<p>reinterviewed for preferences to include showers and all preferences will be honored.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All residents will be assessed for preferences upon admission and with each comprehensive MDS assessment, and as indicated by the resident or their family. The shower schedule will be updated to reflect the resident preferences. Nursing staff will be in-serviced on assuring that the shower schedule is followed appropriately.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement Tool has been initiated that will randomly review 5 residents related to assuring that they receive showers that</p>	

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	<p>2. During an interview on 7/7/14 at 1:54 P.M., Resident #38 indicated he was not able to choose how many times a week. He stated, "No, they just say twice a week...I would take one every day if I could."</p> <p>An observation on 7/9/14 at 9:28 A.M., of a document titled "Shower List" posted on the wall by the nurse's station indicated Resident #38 received two showers a week.</p> <p>Resident #38's record was reviewed on 7/9/14 at 8:30 A.M. Resident #38 had diagnoses which included a history of a stroke with partial paralysis and hypertension. An admission MDS dated 2/22/14, indicated Resident #38 was cognitively intact with a BIMS score of 15 out of 15, was totally dependent on staff for bathing, and had indicated it was very important to him to make choices regarding bathing. The record lacked documentation Resident #38 had been provided three showers a week.</p> <p>During an interview on 7/9/14 at 8:59 A.M., the Social Service Director (SSD) indicated she assessed Resident #38's shower frequency preference on 6/27/14. She indicated he informed her he wanted three showers weekly.</p>		<p>meet their preference. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The QA Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>During an interview on 7/9/14 at 9:36 A.M., Certified Nursing Assistant #2 indicated it was her responsibility to make the CNA assignments for showers and shower frequency was determined by the residents' preference. She indicated she was not sure why Resident #38's shower preference had not been updated.</p> <p>3. During an interview on 7/7/14 at 2:14 p.m., Resident #33 indicated she was only offered showers, although she does enjoy soaking in the tub. She further indicated that the facility did have a tub, however, it was only available to residents who could not stand.</p> <p>During an interview on 7/9/14 at 9:03 a.m., the Social Services Director indicated there was not a bathtub in the facility. The Social Services Director then accompanied the surveyor to bathroom c where a tub, filled with shower chairs, was located. The Social Services Director indicated she did not believe the tub worked. She then inquired with the Director of Housekeeping who came into bathroom c, cleared the tub of equipment and demonstrated that the tub was functioning. The Social Services Director then indicated she had not given residents the ability to choose between bath or showers.</p>			

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F000244 SS=E	<p>Resident #33's record was reviewed on 7/8/14 at 1:30 P.M. A Minimum Data Set (MDS) assessment, dated 6/9/14, indicated Resident #33 had a Brief Interview for Mental Status (BIMS) score of 14/15. A review of the previous MDS records for resident #33 indicated she had not been assessed regarding " Daily activity Preferences," during her time at the facility.</p> <p>A policy titled "Resident Services" identified as a current policy by the Social Service Director on 7/10/14 at 8:27 A.M., indicated, "...It is the policy of this facility to assure that resident services are provided appropriately and the resident's needs are met in accordance with the facility standard and resident preferences...."</p> <p>3.1-3(u)(1)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting</p>			

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	<p>resident care and life in the facility. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 7 of 7 months reviewed for grievance resolution of the Resident council. This potentially affected all the residents who attended the Resident council.</p> <p>Findings include:</p> <p>Resident Council minutes were provided by the Activity Director (AD) on 7/7/14 at 10:45 a.m. The minutes indicated the following concerns by the Resident Council:</p> <ol style="list-style-type: none"> 1. Quieter in mornings - May, 2014 2. Call lights not being answered - December, 2013 & April, 2014 3. Missing items from laundry - February, 2014 4. More variety with menu - December, 2013; January, 2014; February, 2014; March, 2014; and April, 2014. 5. More activities - March, 2014; April, 2014; May, 2014; & June, 2014 <p>During an interview on 7/10/14 at 3:15 p.m., with the Resident Council President, she indicated the Activity Director (AD) took minutes for the Resident Council meetings but the facility staff did not respond to the</p>	F000244	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. . <u>F - 244</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>On 7/22/2014 a resident council meeting was held to assess the residents for any grievances. All Grievances have been addressed.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All Residents have the potential to be affected.</p> <p>All residents will be informed of the date of the next resident council meeting by giving each</p>	08/10/2014			

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	<p>group's concerns and there was not any follow up from the facility.</p> <p>During an interview with the AD on 7/10/14 at 3:45 p.m. she indicated that she took minutes for the meetings and wrote the grievances for department heads. The Activity Director indicated that she made notes to different department heads and let the department heads handle their own grievances.</p> <p>The record lacked documentation of the grievances being addressed by the AD and facility.</p> <p>No other information was provided by exit on 7/11/14 at 3:30 p.m.</p> <p>3.1-3(l)</p>		<p>resident a copy of the activity calendar. Activity staff will also continue to ask each resident individually if they would like to attend the resident council meeting, prior to the meeting time.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The Prior months Grievance resolution forms will be reviewed at the following resident council meeting. The Activity Supervisor will keep a copy of the forms in the resident council book for one year. An in-service will be conducted for all department heads related to assuring that if a grievance is identified specific to their departments that the grievance is acted on with proper documented resolution.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Administrator will review all resident council concern forms within 7 days of the resident council meeting to ensure that all</p>		

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well being for 2 of 3 residents reviewed for activities (Resident #38 and #37).</p>	F000248	<p>concerns have been acted upon. All resident council minutes will be reviewed each month following the resident council meeting to ensure that all concerns have been addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p> <p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the</p>	08/10/2014

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	<p>Findings include:</p> <p>1. During an interview on 7/7/14 at 1:59 P.M. Resident #38 indicated the facility did not provide activities as often as he would like, including on weekends and evenings. He stated, "I like music. They don't play my type. I like rock and roll. They never turn on my radio or give me anything to do. There isn't anything to do in the evenings or on the weekends. They only have stuff until 1:30 P.M. most days. I told (Activity Director/Social Service Director named) I needed something to do. She posted this calendar. I told her those activities were not for me."</p> <p>Observations were made of the two "activity cabinets" located in the dining room on 7/10/14 at 2:00 P.M. The cabinets contained the following: Bingo cards, puzzles, stuffed animals, board games, and VCR tapes. The cabinets did not contain cards, a CD player, or music.</p> <p>Resident #38's record was reviewed on 7/9/14 at 8:30 A.M. Resident #38 had diagnoses which included a history of a stroke with partial paralysis and hypertension.</p> <p>An admission MDS dated 2/22/14,</p>		<p>facility because it is the law.</p> <p><u>F - 248</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident#37 and #38 were reassessed for activities of interest, preferences and abilities via "initial activity evaluation; form (Briggs FGS-933). Resident #37's family was also contacted to clarify if any additional activity preferences could be identified. Their activity careplans were reviewed and amended as needed.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents of the facility have the potential to be affected. All residents will be reviewed for activity preferences with POA input as needed. The activity director will complete new activity preference forms on each resident.</p>				

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	<p>indicated Resident #38 was cognitively intact with a BIMS score of 15 out of 15. This MDS indicated Resident #38 was dependant on staff for ambulation, it was very important for him to listen to music, keep up with the news, participate with groups of people, and his favorite activities.</p> <p>A care plan dated 6/10/14, indicated Resident #38 was dependent on staff for activities, cognitive stimulation, social interaction related to his physical limitations. A goal indicated he would maintain involvement in cognitive stimulation, and social activities as he desired. Interventions to meet this goal indicated staff would assist and escort him to activity functions. Staff would arrange for community activities. Staff would assure that the activities the resident attended were compatible with his physical and mental capabilities; compatible with his known interest and preferences, and compatible with his individual needs and abilities; and age appropriate. His interest were: TV, games, cards, crafts/arts, football, music, cooking, working on a computer, fishing, being outdoors, parties, and community outings.</p> <p>Resident #38's activity attendance records for June and July 1-5, 2014 indicated:</p>		<p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>Activity preference forms will be completed on new admissions and reviewed at least annually. The Activities Department has been in-serviced related to assuring that the activities conducted meet the needs and preference of the residents.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents related to participation in activities and verbal satisfaction with activities. The Activity Director, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p>				

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	<p>Resident #38 did not attend out of room activities on June 1, 2, 4, 5, 7, 8, 14, 18, 19, 20, 24, 25, or 30, 2014, Resident #38 did not attend out of room activities on July 2, 4, or 5, 2014.</p> <p>The record lacked documentation the activities Resident #38 had been assessed to enjoy were being consistently offered and/or provided.</p> <p>During an interview on 7/8/14 at 2:40 P.M., Resident #38 stated, "Will you see what you can do about getting me outside. I am bored."</p> <p>During an interview on 7/9/14 9:45 A.M., the Social Service/Activity Director indicated Resident #38 had a difficult time adjusting to living in the facility. She indicated Resident #38 enjoyed being outside and they took him outside once in awhile. She indicated the facility scheduled one evening activity a month but activity staff were not available in the evening. She indicated the evening staff have movies to play and they are programmed to play in all the residents' rooms. She stated, "There is a cabinet out there with a CD player and different types of music. I encourage him all the time if he gets bored in the evening to go out in the dining room get some friends</p>		(E) Date Certain: 8-10-2014				

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	<p>and hang out there... I am here 5 to 7 days a week and I have an activity assistant who is here from 9:30 to 3:30 P.M. No one is here in the evenings for activities.... He has the mind frame of a eighteen or twenty year old. He tells you he is bored no matter what...It has been very hard for him to adapt. He does like baseball...I would be completely miserable if my life changed so drastically... He use to be so mobile... He does not qualify for outside services... His family visits and I think they are looking at other facilities with a younger group..."</p> <p>During an interview on 7/11/14 at 2:30 P.M., Resident #38 stated, "I am bored as (curse word used). They are playing bingo. I cant play bingo. What can I do?"</p> <p>2. Resident # 37 was observed on 7/8/14 at 9:54 a.m. wheeling himself into room 15 and 18, which were not his room.</p> <p>Resident #37 was observed on 7/8/14 at 2:17 p.m. ambulating in wheelchair and came from behind and started patting with his hand SSD (Social Services Designee) buttocks by nurses' station.</p> <p>The Resident was observed on 7/8/14 at 2:36 p.m. ambulating in wheelchair and</p>			

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	<p>roaming into residents' room #5.</p> <p>Resident #37 was observed on 7/9/14 8:56 a.m. wheeling/ambulating his wheelchair into Residents ' room #18.</p> <p>On 07/09/14 p.m., Resident #37 attempted to go outside. Residents at the door stopped him.</p> <p>Resident #37 was observed on 07/09/14 1:33 p.m. in his wheelchair, he grabbed the water cart and water pitcher which spilled onto floor.</p> <p>Resident #37 was observed on 7/10/14 8:25 a.m. in dining room eating breakfast.</p> <p>Resident #37 was observed on 7/10/14 9:12 a.m. went into unstaffed-unlocked-open door at the administrative nursing office.</p> <p>Record review was done on 7/8/14 at 9:00 a.m. Diagnoses included, but were not limited to,dementia, MR (Mental Retardation), Recent Pneumonia, urinary retention/UTI (urinary tract infection), scoliosis, constipation and delusional disorders.</p> <p>The care plan was reviewed on 7/8/14 at 9:00 a.m.</p>			

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	<p>The Care Plan Focus was "The resident has impaired cognitive function r/t DX (diagnosis) Mental Retardation, Dementia with behavioral disturbances. Goal: The resident will be able to participate in simple decisions and making 1 basic needs known on a daily basis through the review date 9/21/14.</p> <p>Interventions included: "Provide a program of activities that accommodates the resident's abilities such as he likes to sit across from the nurses station and look at magazines, books and play with the items he brought with him from his 'busy box.' He comes into staff's offices and likes to sit in there while they work. Engage the resident in simple structured activities that avoid overly demanding tasks."</p> <p>The resident was screened for his Level II on 12/31/2013. It indicated the following: "Level II The applicant/resident:(13) has a developmental disability. (20) Has medical needs (20b) long term Nursing facility services: (22) The applicant/resident does meet PASRR (Pre-Admission Screening and Resident Review) Level II criteria for: (23) Admission to a nursing facility Criteria (28) Nursing services for medical</p>			

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	<p>needs (29) Geriatric medical issues."</p> <p>Additionally, the Diagnostic and Evaluation Assessment (D&E) indicated: "(Resident's name) previously had a Behavioral Support Plan (BSP) in place developed by Opportunities for Positive Growth. Collateral BSP was dated 7/23/2011 but group home staff reported that his current BSP remains essentially the same with emphasis on replacement behaviors. Targeted behaviors included:</p> <ul style="list-style-type: none"> - Emotional outbursts-yelling, cursing which can lead to slapping and hitting; recent frequency of verbal outbursts reported as 3-4 times weekly; no recent physical attack; reported antecedent at times is frustration when not understood. - Not using walker for ambulation; recent frequency reported as 3-4 times daily. <p>Proactive strategies include: -Assist (Resident's name) in self-calming strategies - Assist (Resident's name) in increasing his communication of his feelings, wants and needs - Provide a structured routine that includes activities that increase his enjoyment and independence - Keep him busy and provide choices - Provide positive reinforcement Reactive interventions include: - Use a calm voice - Redirect to a safe place - Time to calm down - Verbal reminders to use walker. "</p>			

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	<p>(Resident's name) previous goals included but were not limited to: "(Resident's name) will place a handkerchief in his right pocket every day. (Resident's name) will pick out a penny from a group of 2 coins. (Resident's name) will put lotion on his feet after his shower to desensitize. (Resident's name) will go on a community outing two times per month to a location and place of his interest and will make a purchase. (Resident's name) will pick out his shirt and socks each morning. (Resident's name) will use hand sanitizer on his hands prior to consuming a meal. (Resident's name) will have meaningful days. (Resident's name) will receive his receipt after making a purchase. (Resident's name) will not need a medication before attending a podiatry appointment. (Resident's name) will have independent hygiene skills. (Resident's name) will independently put away his laundry. (Resident's name) will independently shave his face. (Resident's name) will wash his hands before meals. (Resident's name) will recognize coins. (Resident's name) will use a handkerchief</p>			

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	<p>to wipe his saliva. (Resident's name) will change his shirt when wet."</p> <p>The recommendations included on the D& E included, but were not limited to:</p> <p>(Resident's name) may benefit from continued opportunities for leisure activities that promote cognitive and sensory stimulation, socialization, and community awareness. (Resident's name) may benefit from continued monitoring of his mood and behavior for any psychological or behavioral consults needed. These were not included in his care plan.</p> <p>The SSD was interviewed on 7/9/14 at 2:10 p.m. She indicated Resident # 37 had no behaviors being tracked. SSD indicated that staff can't do anything about wandering. She indicated that Resident #37 didn't go in others rooms, just roamed the hall. SSD was asked about him grabbing other residents, running over feet, running into other people, grabbing other people's buttocks and attention seeking. The SSD agreed it was a behavior, but didn't know how to address it. SSD indicated that Resident #37 wouldn't stay in activities.</p> <p>A policy titled "Activity Programs"</p>						

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	<p>identified as current by the SSD on 7/10/14 at 8:27 A.M., indicated, "Activity programs designed to meet the needs of each resident are available on a daily basis... Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs... Actives are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs... Weather permitting, at least one activity a month is held away from the facility... Weather permitting, outdoor activities are held on a regular basis...At least one evening activity is offered per week, depending on population needs... At least two group activities per day are offered on Saturday, Sunday and holidays... Creative and expressive activities, such as arts and crafts, ceramics, painting, drama, creative writing, poetry and music, are available on a regular basis to meet the needs of residents... Social activities are scheduled to increase self esteem, to stimulate interest and friendships, and to provide fun and enjoyment...."</p> <p>3.1-33(a) 3.1-33(c)</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to implement a management plan for maladaptive behaviors for 1 of 1 resident reviewed for behavior management. (Resident # 37)</p> <p>Findings include:</p> <p>Resident # 37 was observed on 7/8/14 at 9:54 a.m. wheeling his self into rooms # 15 and 18, which were not his room.</p> <p>Resident #37 was observed on 7/8/14 at 2:17 p.m. ambulating in wheelchair and came from behind and started patting with his hand SSD (Social Services Designee) buttocks by nurses' station.</p> <p>The Resident was observed on 7/8/14 at 2:36 p.m. ambulating in wheelchair and roaming into residents' room #5.</p> <p>Resident #37 was observed on 7/9/14 8:56 a.m. wheeling/ambulating his wheelchair into Residents ' room #18.</p> <p>On 07/09/14 p.m., Resident #37</p>	F000250	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F – 250</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>A new careplan was implemented for #37 communication deficits which is the root cause of the touching behavior. The careplan addresses staff interventions for inappropriate touching. A plan of care was in place at the time of the survey for resident #37 related to wandering. Staff was made aware of the new careplan.</p> <p>(B)How will you identify other</p>	08/10/2014
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	<p>attempted to go outside. Residents at the door stopped him.</p> <p>Resident #37 was observed on 07/09/14 1:33 p.m. in his wheelchair, he grabbed the water cart and water pitcher which spilled onto floor.</p> <p>Resident #37 was observed on 7/10/14 8:25 a.m. in dining room eating breakfast.</p> <p>Resident #37 was observed on 7/10/14 9:12 a.m. went into unstaffed-unlocked-open door at the administrative nursing office.</p> <p>The SSD was interviewed on 7/9/14 at 2:10 p.m. She indicated Resident # 37 had no behaviors being tracked. SSD indicated that staff can't do anything about wandering. She indicated that Resident #37 didn't go in others rooms, just roamed the hall. SSD was asked about him grabbing other residents, running over feet, running into other people, grabbing other people's buttocks and attention seeking. The SSD agreed it was a behavior, but didn't know how to address it. SSD indicated that Resident #37 wouldn't stay in activities.</p> <p>Record review was done on 7/8/14 at 9:00 a.m. Diagnoses included, but were</p>		<p>residents having potential to be affected and what corrective action will be taken:</p> <p>All other non-verbal residents were assessed and all other non-verbal residents have a careplan in place to address their deficits. Resident # 37 had a new level II completed. The Level II stated that the resident did not require specialized services.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All residents will be assessed upon admission, and all appropriate plans of care will be initiated. The Social Services Director has been in-serviced on assuring that residents that may have communication deficits or other behaviors identify a management plan as part of the plan of care. Speech therapy will be requested as needed. Behavior tracking sheets are utilized by all facility staff to document behaviors as they occur. Interventions are presented on the forms for the staff to use during behavior interventions. The IDT team reviews the behavior tracking tool each morning to determine if the interventions in place were effective. Revisions of the</p>				

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	<p>not limited to, dementia, MR (Mental Retardation), recent pneumonia, urinary retention/UTI (urinary tract infection), scoliosis, constipation and delusional disorders.</p> <p>The care plan was reviewed on 7/8/14 at 9:00 a.m.</p> <p>The Care Plan Focus was "The resident has impaired cognitive function r/t DX (diagnosis) Mental Retardation, Dementia with behavioral disturbances. Goal: The resident will be able to participate in simple decisions and making 1 basic needs known on a daily basis through the review date 9/21/14.</p> <p>Interventions included: "Provide a program of activities that accommodates the resident's abilities such as he likes to sit across from the nurse 's station and look at magazines, books and play with the items he brought with him from his 'busy box.' He comes into staff's offices and likes to sit in there while they work. Engage the resident in simple structured activities that avoid overly demanding tasks."</p> <p>The resident was screened for his Level II on 12/31/2013. It indicated the following: "Level II The applicant/resident:(13) has</p>		<p>careplan interventions are completed for any intervention to be found ineffective. The Social Services Director will be responsible for ensuring that interventions are updated timely.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents with identified behaviors to assure that there is a management plan as part of the plan of care. The Administrator, or designee, will randomly complete the tool monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p>		

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	<p>a developmental disability. (20) Has medical needs (20b) long term Nursing facility services: (22) The applicant/resident does meet PASRR (Pre-Admission Screening and Resident Review) Level II criteria for: (23) Admission to a nursing facility Criteria (28) Nursing services for medical needs (29) Geriatric medical issues."</p> <p>Additionally, the Diagnostic and Evaluation Assessment (D&E) indicated: "(Resident's name) previously had a Behavioral Support Plan (BSP) in place developed by Opportunities for Positive Growth. Collateral BSP was dated 7/23/2011 but group home staff reported that his current BSP remains essentially the same with emphasis on replacement behaviors. Targeted behaviors included: - Emotional outbursts-yelling, cursing which can lead to slapping and hitting; recent frequency of verbal outbursts reported as 3-4 times weekly; no recent physical attack; reported antecedent at times is frustration when not understood. - Not using walker for ambulation; recent frequency reported as 3-4 times daily. Proactive strategies include: -Assist (Resident's name) in self-calming strategies - Assist (Resident's name) in increasing his communication of his feelings, wants and needs - Provide a structured routine that includes activities</p>			

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	<p>that increase his enjoyment and independence - Keep him busy and provide choices - Provide positive reinforcement reactive interventions include: - Use a calm voice - Redirect to a safe place - Time to calm down - Verbal reminders to use walker. "</p> <p>(Resident's name) previous goals included but were not limited to: "(Resident's name) will place a handkerchief in his right pocket every day. (Resident's name) will pick out a penny from a group of 2 coins. (Resident's name) will put lotion on his feet after his shower to desensitize. (Resident's name) will go on a community outing two times per month to a location and place of his interest and will make a purchase. (Resident's name) will pick out his shirt and socks each morning. (Resident's name) will use hand sanitizer on his hands prior to consuming a meal. (Resident's name) will have meaningful days. (Resident's name) will receive his receipt after making a purchase. (Resident's name) will not need a medication before attending a podiatry appointment. (Resident's name) will have independent hygiene skills.</p>			

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	<p>(Resident's name) will independently put away his laundry.</p> <p>(Resident's name) will independently shave his face.</p> <p>(Resident's name) will wash his hands before meals.</p> <p>(Resident's name) will recognize coins.</p> <p>(Resident's name) will use a handkerchief to wipe his saliva.</p> <p>(Resident's name) will change his shirt when wet."</p> <p>The recommendations included on the D& E included, but were not limited to:</p> <p>(Resident's name) may benefit from continued opportunities for leisure activities that promote cognitive and sensory stimulation, socialization, and community awareness.</p> <p>(Resident's name) may benefit from continued monitoring of his mood and behavior for any psychological or behavioral consults needed.</p> <p>Interview with the SSD on at 07/09/2014 2:10 p.m. indicated the facility was unable to find the D&E and would have to have it faxed to them. She indicated the QMRP (Qualified Mental Retardation Professional) had reviewed the recommendations, but not notes were available for review.</p>			

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	A policy entitled, "Essex Nursing and Rehabilitation Mood and Behavior Program," received from the SSD, on 7/10/14 at 3:00 p.m., indicated, "Any mood and/or behavior that can be harmful to any resident in any manner, such as sexual, verbal, mental, or physical abuse, must be immediately reported to the Administrator and/or designee, in an effort to confirm that staff completing the form followed the facility abuse prohibition policy mandating immediate reporting. The Social Service and/or will collect the Mood and Behavior Communication Memos during scheduled days of work and review all occurrences with the interdisciplinary team during the morning clinical meeting. Review of the team will be acknowledged via the signature on the bottom of the memo of the designated member of the interdisciplinary team. Should a mood/behavior be e identified as 'new' or 'worsening' for the resident, an Evaluation of New or Worsening Mood or Behavior assessment will be initiated by social services or nursing and completed by the interdisciplinary team, in an attempt to identify any intrinsic or extrinsic factors which may be causing or precipitating the new or worsening mood(s) or behavior(s). Medical conditions will be addressed/evaluated as ordered by the physician and the resident			

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F000279 SS=D	<p>and/or responsible party will be notified, as indicated. A written plan of care will be developed by social services and the interdisciplinary team to address the mood(s) and/or behavior(s), including interventions to address any noted intrinsic and/or extrinsic factors precipitating the mood(s) and/or behavior(s).</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on record review and interview, the facility failed to develop comprehensive care plans for 2 of 2 residents in the sample. (#23 and #37)</p> <p>Findings include:</p> <p>1. During a review of Resident # 23 ' s chart on 7/8/14 at 1:01 p.m., no care plans were found for resident ' s psychotropic medication Zyprexa, which was prescribed for the resident to address her diagnosis of depression in order to assist with mood stabilization. Resident #23 ' s diagnosis included but were not limited to bipolar, depressive disorder, and anxiety.</p> <p>During an interview with the MDS Coordinator, on 7/9/14 at 12:56 p.m., she indicated she could not locate a care plan regarding resident #23 ' s psychotropic medication. She indicated she usually did a care plan for any resident on psychotropic medication, however, she had failed to do so on this resident ' s record. She indicated that the items that she should care plan for are, including but not limited to, behavior monitoring, gradual dose reduction, and side effects related to the medication.</p> <p>2. Resident # 37 was observed on 7/8/14 at 9:54 a.m. wheeling him self into rooms # 15 and 18, which were not his room.</p>	F000279	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F - 279</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #23 had a psychotropic care plan implemented. #37 careplan was updated to include a communication deficit which is the root cause of the attention seeking behavior.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents will be assessed upon admission for psychotropic drug use and appropriate careplans will be initiated. All new orders will be reviewed during morning clinical meeting and plans of care</p>	08/10/2014			

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	<p>Resident #37 was observed on 7/8/14 at 2:17 p.m. ambulating in wheelchair and came from behind and started patting with his hand SSD (Social Services Designee) buttocks by nurses' station.</p> <p>The Resident was observed on 7/8/14 at 2:36 p.m. ambulating in wheelchair and roaming into residents' room #5.</p> <p>Resident #37 was observed on 7/9/14 8:56 a.m. wheeling/ambulating his wheelchair into Residents ' room #18.</p> <p>On 07/09/14 p.m., Resident #37 attempted to go outside. Residents at the door stopped him.</p> <p>Resident #37 was observed on 07/09/14 1:33 p.m. in his wheelchair, he grabbed the water cart and water pitcher which spilled onto floor.</p> <p>Resident #37 was observed on 7/10/14 8:25 a.m. in dining room eating breakfast.</p> <p>Resident #37 was observed on 7/10/14 9:12 a.m. went into unstaffed-unlocked-open door at the administrative nursing office.</p> <p>The SSD was interviewed on 7/9/14 at</p>		<p>initiated as indicated.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All new orders will be reviewed for new psychotropic medication during morning clinical meeting and plans of care initiated during the meeting as indicated. The MDS Coordinator will be in-serviced related to assuring that the care plans are updated appropriately based on any resident condition or condition change.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents related assuring that the plan of care identifies the resident's current condition. The tool ensures that the care plan reflects the current condition of the resident, and assures that the careplan has been updated to reflect any changes in the resident's condition. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and</p>		

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	<p>2:10 p.m. She indicated Resident # 37 had no behaviors being tracked. SSD indicated that staff can't do anything about wandering. She indicated that Resident #37 didn't go in others rooms, just roamed the hall. SSD was asked about him grabbing other residents, running over feet, running into other people, grabbing other people's buttocks and attention seeking. The SSD agreed it was a behavior, but didn't know how to address it. SSD indicated that Resident #37 wouldn't stay in activities.</p> <p>Record review was done on 7/8/14 at 9:00 a.m. Diagnoses included, but were not limited to, diagnosis include but not limited to dementia, MR (Mental Retardation), Recent Pneumonia, urinary retention/UTI (urinary tract infection), scoliosis, constipation and delusional disorders.</p> <p>The care plan was reviewed on 7/8/14 at 9:00 a.m.</p> <p>The Care Plan Focus was "The resident has impaired cognitive function r/t DX (diagnosis) Mental Retardation, Dementia with behavioral disturbances. Goal: The resident will be able to participate in simple decisions and making 1 basic needs known on a daily basis through the review date 9/21/14.</p>		<p>quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p>				

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	<p>Intervention: Provide a program of activities that accommodates the resident's abilities such as he likes to sit across from the nurse ' s station and look at magazines, books and play with the items he brought with him from his "busy box." He comes into staff's offices and likes to sit in there while they work.</p> <p>Intervention: Engage the resident in simple structured activities that avoid overly demanding tasks.</p> <p>The resident was screened for his Level II on 12/31/2013. It indicated the following: "Level II The applicant/resident:(13) has a developmental disability. (20) Has medical needs (20b) long term Nursing facility services: (22) The applicant/resident does meet PASRR (Pre-Admission Screening and Resident Review) Level II criteria for: (23) Admission to a nursing facility Criteria (28) Nursing services for medical needs (29) Geriatric medical issues."</p> <p>Additionally, the Diagnostic and Evaluation Assessment (D&E) indicated: "(Resident's name) previously had a Behavioral Support Plan (BSP) in place developed by Opportunities for Positive Growth. Collateral BSP was dated</p>			

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	<p>7/23/2011 but group home staff reported that his current BSP remains essentially the same with emphasis on replacement behaviors. Targeted behaviors included:</p> <ul style="list-style-type: none"> - Emotional outbursts-yelling, cursing which can lead to slapping and hitting; recent frequency of verbal outbursts reported as 3-4 times weekly; no recent physical attack; reported antecedent at times is frustration when not understood. - Not using walker for ambulation; recent frequency reported as 3-4 times daily. <p>Proactive strategies include: -Assist (Resident's name) in self-calming strategies - Assist (Resident's name) in increasing his communication of his feelings, wants and needs - Provide a structured routine that includes activities that increase his enjoyment and independence - Keep him busy and provide choices - Provide positive reinforcement Reactive interventions include: - Use a calm voice - Redirect to a safe place - Time to calm down - Verbal reminders to use walker. "</p> <p>(Resident's name) previous goals included but were not limited to: "(Resident's name) will place a handkerchief in his right pocket every day. (Resident's name) will pick out a penny from a group of 2 coins. (Resident's name) will put lotion on his</p>			

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	<p>feet after his shower to desensitize. (Resident's name) will go on a community outing two times per month to a location and place of his interest and will make a purchase. (Resident's name) will pick out his shirt and socks each morning. (Resident's name) will use hand sanitizer on his hands prior to consuming a meal. (Resident's name) will have meaningful days. (Resident's name) will receive his receipt after making a purchase. (Resident's name) will not need a medication before attending a podiatry appointment. (Resident's name) will have independent hygiene skills. (Resident's name) will independently put away his laundry. (Resident's name) will independently shave his face. (Resident's name) will wash his hands before meals. (Resident's name) will recognize coins. (Resident's name) will use a handkerchief to wipe his saliva. (Resident's name) will change his shirt when wet."</p> <p>None of those goals were included in his current care plan.</p> <p>The recommendations included on the</p>			

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	<p>D& E included, but were not limited to:</p> <p>(Resident's name) may benefit from continued opportunities for leisure activities that promote cognitive and sensory stimulation, socialization, and community awareness.</p> <p>(Resident's name) may benefit from continued monitoring of his mood and behavior for any psychological or behavioral consults needed.</p> <p>These recommendations were not included in the care plan.</p> <p>Interview with the SSD on at 07/09/2014 2:10 p.m. indicated the facility was unable to find the D&E and would have to have it faxed to them. She indicated the QMRP (Qualified Mental Retardation Professional) had reviewed the recommendations, but not notes were available for review.</p> <p>A policy entitled, " Care Planning-Interdisciplinary Team, " received from the MDS Coordinator, on 7/9/14 at 3:15 p.m., indicated, " Each resident care plan shall be reviewed at least quarterly. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status. The Care Planning/Interdisciplinary Team is</p>						

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F000280 SS=E	<p>responsible for the periodic review and updating of care plans."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>3. During a review of Resident #3 ' s chart on 7/9/14 at 9:34 a.m., a notation in the nursing notes, dated 7/4/14 at 6 a.m., indicated the resident had a fall from his bed to the floor. The noted indicated the DON had been informed of the residents fall. Upon reviewing the resident's chart for follow up regarding his fall, no Interdisciplinary team review was found in the resident's record.</p>	F000280	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p>F - 280</p>	08/10/2014	

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	<p>During an interview on 7/9/14 at 11:42 p.m. the MDS coordinator indicated she participated in the interdisciplinary team meetings at the facility along with all of the department heads. She indicated they were usually conducted each morning during the week. She indicated she was unaware of Resident #3 's fall on 7/4/14 and no interdisciplinary team meeting had been conducted in regard to the residents fall on that date. She indicated interdisciplinary team meetings were supposed to be conducted the following day after a resident had a fall.</p> <p>A record entitled, " Interdisciplinary Team Process " , received from the Executive Director on 7/9/14 at 2:06 p.m., indicated, a daily clinical meeting should occur daily Monday through Friday. The document further indicated, " Residents who fall will be reviewed daily during this clinical meeting ...An IDT [SIC] intervention note should be written at this time in the clinical record. "</p> <p>4. Resident # 37 was observed on 7/8/14 at 9:54 a.m. wheeling himself into rooms # 15 and 18, which were not his room.</p> <p>Resident #37 was observed on 7/8/14 at 2:17 p.m. ambulating in wheelchair and came from behind and started patting with his hand SSD (Social Services</p>		<p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #19 is no longer a resident of the facility. #3, #15, #37 careplan was updated.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents of the facility have the potential to be affected. All careplans will be reviewed by the Interdisciplinary team and updated as needed.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All careplans will be reviewed at least quarterly to ensure it is up to date and that out of date interventions and diagnoses are removed. The care plans will be updated as needed based on any changes in the resident's conditions. The MDS coordinator has been inserviced</p>	

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	<p>Designee) buttocks by nurses' station.</p> <p>The Resident was observed on 7/8/14 at 2:36 p.m. ambulating in wheelchair and roaming into residents' room #5.</p> <p>Resident #37 was observed on 7/9/14 at 8:56 a.m. wheeling/ambulating his wheelchair into Residents' room #18.</p> <p>On 07/09/14 p.m., Resident #37 attempted to go outside. Residents at the door stopped him.</p> <p>Resident #37 was observed on 07/09/14 at 1:33 p.m. in his wheelchair, he grabbed the water cart and water pitcher which spilled onto floor.</p> <p>Resident #37 was observed on 7/10/14 at 8:25 a.m. in the dining room eating breakfast.</p> <p>Resident #37 was observed on 7/10/14 at 9:12 a.m. went into unstaffed-unlocked-open door at the administrative nursing office.</p> <p>The SSD was interviewed on 7/9/14 at 2:10 p.m. She indicated Resident # 37 had no behaviors being tracked. SSD indicated that staff can't do anything about wandering. She indicated that Resident #37 didn't go in others rooms,</p>		<p>on assuring that the careplans are updated appropriately.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents related to assuring that the care plans identify the resident's current condition. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p>		

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	<p>just roamed the hall. SSD was asked about him grabbing other residents, running over feet, running into other people, grabbing other people's buttocks and attention seeking. The SSD agreed it was a behavior, but didn't know how to address it. SSD indicated that Resident #37 wouldn't stay in activities.</p> <p>Record review was done on 7/8/14 at 9:00 a.m. Diagnoses included, but were not limited to, diagnosis include but not limited to dementia, MR (Mental Retardation), Recent Pneumonia, urinary retention/UTI (urinary tract infection), scoliosis, constipation and delusional disorders.</p> <p>The care plan was reviewed on 7/8/14 at 9:00 a.m.</p> <p>The Care Plan Focus was "The resident has impaired cognitive function r/t DX (diagnosis) Mental Retardation, Dementia with behavioral disturbances. Goal: The resident will be able to participate in simple decisions and making 1 basic needs known on a daily basis through the review date 9/21/14.</p> <p>Interventions included, but were not limited to: "Provide a program of activities that accommodates the resident's abilities such as he likes to sit</p>			

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F000309 SS=G	<p>across from the nurse ' s station and look at magazines, books and play with the items he brought with him from his 'busy box.' He comes into staff's offices and likes to sit in there while they work. Engage the resident in simple structured activities that avoid overly demanding tasks."</p> <p>The care plan had not been updated to reflect interventions to deal with the attention seeking behaviors.</p> <p>A policy entitled, "Care Planning-Interdisciplinary Team," received from the MDS Coordinator, on 7/9/14 at 3:15 p.m., indicated, "...Each resident care plan shall be reviewed at least quarterly. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status. The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans...."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to provide pain management for a resident who experienced severe pain after a fall with a possible fractured hip/pelvis by failing to administer pain medication as ordered and failing to assess efficacy of administered pain medication for 1 of 1 resident reviewed for pain management (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 7/9/14/2014 at 1:35 P.M. Resident B had diagnoses which included but were not limited to advanced dementia, expressive dysphasia, decreased safety awareness, and a history of falls.</p> <p>A care plan dated 10/25/13, indicated Resident B had a communication problem due to expressive aphasia, hearing deficit, weak or absent voice, and advanced dementia. A goal indicated her needs would be met daily. An intervention indicated staff was to anticipate and meet her needs.</p> <p>A care plan, dated 10/25/13, indicated Resident B was at risk for pain related to</p>	F000309	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F – 309</u></p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p style="padding-left: 40px;">Resident B is no longer a resident of the facility</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p style="padding-left: 40px;">All other residents have the potential to be affected. A new pain assessment will be conducted for each resident. Any resident found to be experiencing uncontrolled pain will have their physician notified immediately with proper interventions</p>	08/10/2014

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	<p>arthritis and osteoporosis. Interventions indicated the physician would be notified if interventions were unsuccessful or if her current complaint was a significant change from her past experience of pain.</p> <p>A physician's order dated 10/3/13, indicated an order for, "Acetaminophen 325 MG [milligrams] tablet Tylenol 325 MG tablet. Take 2 Tablets (650 MG) by mouth every 4 hours as need for pain." The record indicated Resident B had complaints of a " tender knee" on 12/3/13 at 6:10 p.m. and pain medication was not administered until 10:00 p.m. (3 hours and 50 minutes after her first complaint of pain).</p> <p>A nurse's note dated 12/3/13 at 10:00 P.M., indicated, "Res [Resident] crying out in pain. Difficult to determine exact place pain is located due to res confusion (per norm [normal]). Note indications to R [right] hip and leg although difficult to determine...." This note indicated Tylenol [analgesic] 650 Milligrams was administered for pain. The medication record lacked documentation to indicate efficacy of pain medication was assessed and the medication administration record lacked evidence additional doses of pain medication were administered prior to obtaining an order at 3:15 a.m. on 12/4/14 to transfer the resident to the</p>		<p>implemented.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>A pain medication administration procedure will be developed to provide guidance for the nursing staff to ensure that pain medication is administered timely and describe where to monitor the efficacy of the medication. All nurses will be re-educated on signs and symptoms of pain in verbal and non-verbal residents as well as providing timely pain medication administration. Nursing will utilize the PRN Pain Medication Tracking, that was initiated on 7/1/2014 which documents the efficacy of the pain medication.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents related to assuring that resident pain is controlled appropriately. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified</p>		

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	<p>emergency room for evaluation of pain.</p> <p>A document titled "Pain Management Flow Sheet" dated for December 2013, indicated Resident B had the following symptoms of pain: guarding, crying/whining, and rubbing body part.</p> <p>A nurse's note dated 12/4/13 at 2:30 A.M., indicted Resident B was awake "holding" and "rubbing" her right upper outer leg and "crying" when the nurse attempted to examine her leg. This note indicated her vitals were: Temperature 99.2, Blood Pressure 162/100, Pulse 102, Respirations 20, skin color "pale." This note indicated the nurse called the physician's answering service and was "awaiting a return call."</p> <p>A nurse's note dated 12/4/14 at 3:15 A.M., [45 minutes after the call was placed to the physician's answering service] indicated the Nurse Practitioner called the facility and gave orders for Resident B to be sent to the emergency room for an evaluation of her pain.</p> <p>During an interview on 7/9/14 at 2:12 P.M., Registered Nurse [RN] #5 indicated he was the nurse caring for Resident B when she fell on 12/3/13. RN #5 stated, "...She was crying out in pain...The notes indicated at 2:30 A.M.,</p>		<p>issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>she was awake crying, rubbing her right outer leg...I got her pulse 8 hours earlier and her pulse was 90, blood pressure 90/60... The nurse's not indicated her pulse was 102 and blood pressure was 162/100. If she was in that much pain I would have called back every 15 minutes because [Physician named] might have got the call and fell back to sleep... I would have expected the nurse to call him back..."</p> <p>During an interview on 7/10/14 at 9:57 A.M., the Administrator indicated he expected his staff to call the physician "again" if the physician had not called back within a reasonable amount of time. He indicated because Resident B had been in so much pain he would have expected the nurse to attempt to call the physician back after 15 minutes and/or send her out to the emergency room.</p> <p>A policy titled "Pain Management" and identified as a current facility policy by the Social Service Director on 7/10/14 at 8:27 A.M., indicated, "...This facility is committed to providing an environment and program to assist each resident to attain and or maintain his/her highest physical, mental, and psychosocial well being. It is the policy of this facility to monitor residents for signs and symptoms of pain and when identified, provide</p>			

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	<p>necessary assessment and interventions according to the IDT plan of care, to achieve the highest practicable...The resident will be assessed for pain... Upon the development of new symptoms or chronic pain that has not been previously assessed... Medication (s) received, refused and response to PRN (as needed) pain medication will be documented on the Mediation Administration Record (MAR). Pain status and the effects of treatment will be monitored... Documentation regarding pain management status and pharmacological treatment may be found on Pain Management Flow sheet, nursing notes and/or MAR...The resident's physician shall be consulted for additional instructions if pain is not relieved by currently ordered treatment...."</p> <p>This Federal tag relates to Complaint IN00149088.</p> <p>3.1-37(a)</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, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received incontinent care for 1 of 3 residents reviewed for activity of daily living, cleanliness and grooming (Resident #21).</p> <p>Findings include:</p> <p>During an observation on 7/9/14 at 9:45 A.M., Resident #21 was observed sitting in a wheel chair in her room with a Hoyer lift sling under her. Two flies were observed on her stomach and one fly was observed on her leg. A strong odor of urine and feces was noted in the room. Certified Nursing Assistant #12 and the Maintenance Director were in Resident #21's room attending to her roommate 's broken bed.</p> <p>During an observation on 7/9/14 at 10:50 A.M., Resident #21 was observed sitting in her wheel chair in her room. Flies were observed swarming around her.</p>	F000312	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F - 312</u></p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #21 is no longer a resident of the facility.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All other incontinent residents have the potential to be affected. Incontinent assessments will be performed</p>	08/10/2014

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	<p>Resident #21 stated, "Shoo Wee. It stinks in here." A strong odor of urine and feces was noted around resident #21.</p> <p>During an observation on 7/9/14 at 11:05 A.M., CNA (Certified Nursing Assistant) #11 and CNA #1 removed the foot pedals from Resident #21's wheel chair, positioned the Hoyer lift around the wheel chair, attached the lift to the sling under Resident #21, and began to lift Resident #21 from the wheel chair. Flies swarmed around Resident #21 and the saturated lift pad underneath her. The lift pad was saturated and strong feces odor was noted when Resident #21 was lifted out of her wheel chair. The cushion in the wheel chair was saturated. CNA #11 stated, "I am sure her shorts are soaked because the pad is. CNA #11 repositioned Resident #21 onto her right side. Fecal matter was noted all over her buttocks and on her shorts.</p> <p>During an interview on 7/9/14 at 9:45 A.M. CNA #12 was informed of Resident #21's incontinent status. CNA #12 indicated she would take care of her.</p> <p>During an interview on 7/9/14 at 10:47 A.M., Resident #21's son indicated his mother did not receive the assistance with toileting that she needed. He stated, "No she does not. When I come in she is</p>		<p>for all residents. All residents are receiving appropriate incontinence care.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>At the time of admission, quarterly, or with a significant change, the resident will be assessed for continent status. Based on the assessment, a plan of care will be established for the resident. Services will be provided based on the plan of care. All nursing staff will be in-serviced related to the provision of proper continence care for each resident. The C.N.A assignment sheet has been modified to include information on toileting check and change schedules. A Nursing Observation form has been implemented to document to check call light placement and loose side rails per shift, will occur as part of daily routine rounds by the nurses. The nurses are responsible for assuring that the residents receive appropriate services on their designated shifts and will be observing for any issues during their routine rounds.</p>				

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	<p>soaking wet." He indicated when he arrived that morning he found her in a "wet and dirty diaper." He stated, "She told me she was dirty. They told me they would get to it but I doubt they will change her before we leave."</p> <p>During an interview on 7/9/14 at 10:53 A.M., the acting DON was informed Resident #21 needed changed before transportation took her out of the building to be moved to a new facility. The DON indicated she would have someone take care of her.</p> <p>During an interview on 7/9/2014 at 10:55 A.M., CNA #11 indicated she had just "clocked in" and was not aware of the last time Resident #21 had been checked for incontinence or had been provided incontinent care. At this time CNA #11 informed Resident #21 her transportation was there to take her to another facility. CNA #11 began to push Resident #21 out into the hallway. At this time CNA #11 was informed Resident #21 was incontinent and needed care. CNA #11 indicated she would get help and provide incontinent care to Resident #21.</p> <p>Resident #21's record was reviewed on 7/9/14 at 1:31 P.M. Resident #21 had current diagnoses which included, but were not limited to, diabetes,</p>		<p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>In addition to daily nursing monitoring, A Performance Improvement tool will be initiated that will randomly review 5 residents related to provision of incontinence services. The tool will look for assessment as well as identification of needed services to include toileting and incontinence care. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p>				

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	<p>hypertension, stage four kidney disease, cardio pulmonary disease, morbid obesity, cellulitis, congestive heart disease, chronic carbon dioxide retention, chronic respiratory failure, and cellulitis.</p> <p>A care plan dated 5/19/14, indicated Resident #21 was incontinent of bowel and bladder, required total assistance from staff for care, was at risk for complications of incontinence including skin irritation, breakdown, urinary tract infections, and falls. A goal indicated Resident #21 would be free from complication form incontinence. Interventions to meet this goal included staff would check, change, and provide incontinent care for Resident #21 as needed.</p> <p>An Admission Minimum Data Assessment dated 5/13/14, indicated Resident #21 had a BIMS [Brief Interview Mental Status score] of 2, required the physical assistance of two staff for bed mobility and transfers, and required total physical assistance of staff for toileting needs.</p> <p>A policy titled "Resident Services" identified as a current policy by the Social Service Director on 7/10/14 at 8:27 A.M., indicated, "...It is the policy of this facility to assure that resident services are</p>			

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F000323 SS=E	<p>provided appropriately and the resident's needs are met in accordance with the facility standard and resident preferences... Incontinent resident will have the assistance necessary provided by the staff based on their ADL [Activity of Daily Living] needs."</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(2)(C)</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, record review, and interview, the facility failed to ensure a resident was provided a call light to call for assistance to prevent falls, ensure staff were available to monitor and assist residents, and failed to ensure side rails were safely attached to a bed to prevent injury. This deficient practice affected 3 of 4 residents reviewed for accidents (Resident #21, #32, and #38).</p> <p>Findings include:</p>	F000323	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F - 323</u></p> <p>-</p>	08/10/2014

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	<p>1. During an observation on 7/9/14 at 9:45 A.M., Resident #21 was observed sitting in a wheel chair in her room. The call light was on the bed and not positioned within Resident #21's reach.</p> <p>During an observation on 7/9/14 at 10:50 A.M., Resident #21 was observed sitting in her wheel chair in her room. The call light was on the bed and not positioned within Resident #21's reach.</p> <p>During an observation on 7/9/14 at 11:05 A.M., Resident #21 was observed sitting in her wheel chair in her room. The call light was on the bed and not positioned within Resident #21's reach.</p> <p>Resident #21's record was reviewed on 7/8/14 at 1:31 P.M. Resident #21 had current diagnoses which included, but were not limited to, diabetes, hypertension, stage four kidney disease, cardio pulmonary disease, morbid obesity, cellulitis, congestive heart disease, chronic carbon dioxide retention, chronic respiratory failure, and cellulitis.</p> <p>A care plan dated 5/29/14, indicated Resident #21 had a self care deficit and was at risk for falls. Interventions to prevent falls and injury included staff were to encourage Resident #21 to use</p>		<p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #21 no longer resides in the facility.</p> <p>Resident #32 is receiving services in accordance with the plan of care. The nurses have been reminded to assure that they are relieved appropriately during breaks.</p> <p>Resident #38 bed rail has been corrected.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents have been reviewed and assured that the call light is in place. Routine rounds will occur to assure that this is an on-going practice.</p> <p>All nurses received training related to assuring that they are relieved appropriately during their break times.</p> <p>All residents with side rails have been reviewed to assure that they all function properly.</p>	

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	<p>the call bell for assistance and to ensure call light cord was placed in her hand.</p> <p>A fall risk assessment dated 6/3/14, indicated Resident #21 was at high risk for falls.</p> <p>A nurse's note dated 7/2/14 at 3:00 P.M., indicated Resident #21 had fallen out of her chair and sustained an injury which required sutures.</p> <p>During an interview on 7/7/14 at 10:47 A.M., Registered Nurse (RN) #3 indicted Resident #21 had fallen within the last thirty days. She stated, "She fell out of her wheel chair last week and had to get ten sutures..."</p> <p>During an interview on 7/9/14 at 11:15 A.M., Certified Nursing Assistant (CNA)#1 indicated Resident #21 had fallen out of her chair recently. She indicated they had to get her a bigger chair because she would "wiggle" around and "slide down" in the chair. CNA #1 indicated Resident #21 could use a call light but she had to put it in her pocket so she could get to it.</p> <p>2. During an observation on 7/10/14 at 7:55 A.M., Resident #32 was observed in bed positioned on her back with the head of the bed flat. Her oxygen tubing was</p>		<p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All staff will be in-serviced related to assuring that call lights are in reach of the resident when in their bed or room chair in accordance with facility policy. A Nursing Observation form has been implemented to document to check call light placement and loose side rails per shift, will occur as part of daily routine rounds by the nurses.</p> <p>Nurses have been in-serviced related to assuring that the proper process is followed if the nurses are leaving the facility for break times so that proper notification is made to assure coverage of the building. All staff will be in-serviced related to assuring that if a side rail is identified to be in need of repair that maintenance be notified appropriately so that the proper repair/correction can occur. Maintenance will assure that side rail functioning is monitored as part of preventive maintenance program.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance</p>		

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	<p>on her stomach. She indicated she was having difficulty breathing. Staff was not observed in the hall ways or at the nurse 's station at this time with the exception of a house keeping staff who indicated the nurse responsible for providing care to Resident #32 was outside of the building.</p> <p>During an observation on 7/10/14 at 7:56 A.M., Registered Nurse (RN) #3 and a Certified Nursing Assistant (CNA) were observed sitting outside smoking. When queried if there was another nurse inside RN #3 replied, "Nope, just me." RN #3 was informed of Resident #21's condition. RN #3 entered the building and went to Resident #21's room. She was observed to put Resident #21's oxygen tubing in her nostrils and elevated the head of the bed. RN #3 proceeded to get the oxygen saturation monitor from the nursing station. She returned to Resident #21's room and obtained her Resident #21's oxygen saturation level. During an observation on 7/10/14 at 7:59 A.M., Resident #21's oxygen saturation was 83 percent.</p> <p>Resident #32's record was reviewed on 7/10/14 at 8:16 A.M. Resident #32 had diagnoses which included, but were not limited to, Parkinson's disease, chronic kidney disease, schizophrenia, depression, anxiety, and muscle</p>		<p>Improvement tool will be initiated that will randomly review 5 residents related to call light placement. This tool will also assure that at the time of review that a nurse is present on the floor. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. An additional Performance Improvement tool will randomly review 5 resident side rails to assure that they are functioning properly. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The tools will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tools.</p> <p>(E) Date Certain: 8-10-2014</p>		

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	<p>weakness. A non-scheduled Minimum Data Assessment Tool (MDS) dated 6/24/14, Resident #32 was cognitively intact with a Brief Interview Mental Status Score of 13 out of 15.</p> <p>A care plan dated 6/20/14, indicated Resident #32 had been more confused than usual and nursing was to check her oxygen saturations, assist her to sit up in bed or in her wheel chair to ease her respiratory status and allow for lung volume, and to frequently check on her to assure oxygen was in place.</p> <p>During an interview on 7/10/14 at 7:59 A.M., RN #3 indicated Resident #21 had "real high" carbon dioxide levels and the physician wanted her oxygen saturation to be maintained over 85 percent. She indicated Resident #21 had a history of removing her oxygen tubing. She indicated there were two CNAs in the building besides the CNA that was outside with her however, they were in the dining room serving breakfast.</p> <p>During an interview on 7/10/14 at 8:15 A.M., with the Administrator and RN 3, RN #3 indicated the Administrator was a nurse and she was supposed to inform him when she went out to smoke but she failed to do so. The Administrator indicated he was in the kitchen and was</p>			

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	<p>not aware she had left the building.</p> <p>3. During an observation on 7/8/14 at 10:08 A.M., Resident #38 was observed in his bed. A half side rail was observed on the side of the bed away from the wall. The side rail was observed loosely attached to the bed with a large gap between the side rail and the mattress. The Maintenance Director measured the gap between the bed and the side rail. The gap was observed to measure 4.5 inches wide.</p> <p>During an interview on 7/8/14 at 10:08 A.M., The Maintenance Supervisor indicated the side rail was "loose" and easily pulled out to a gap of 4.5 inches. He indicated the gap should not be more than 3.25 inches or 3.5 inches. He stated the side rail only had one "joint" and he would fix it.</p> <p>During an observation on 7/9/14 at 8:22 A.M. with the Maintenance Supervisor present, Resident #38's side rail was observed loosely attached to the bed. The Maintenance Supervisor measured the gap between the bed and side rail. The gap measured 4 1/8 inch wide.</p> <p>During an interview on 7/9/14 at 8:22 A.M., The Maintenance Supervisor stated, "We tightened it yesterday. This</p>			

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	<p>is the best it is going to be. All we can do is keep checking it and tightening it. It is supposed to have 4 inch gap. We have adapted it to fit this bed. It is the best we can do."</p> <p>During an interview on 7/9/14 at 8:25 A.M., the Maintenance Supervisor indicated the Administrator would order a new bed for Resident #38.</p> <p>A policy title "Bed Safety" and identified as a current policy by the Social Service Director on 7/11/14 at 2:15 P.M., indicated, "...Our facility shall provide a safe sleeping environment for the resident... The resident's sleeping environment shall be assessed by the interdisciplinary team considering the resident's safety... To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches...Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; Review that gaps within the bed system are within the dimensions established by the FDA (Note The review shall consider situations that could be caused by the resident's weight,</p>			

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F000364 SS=D	<p>movement or bed position)... Ensure that when bed system components are worn and need to be replaced, components meet manufacturer specifications..."</p> <p>This Federal tag relates to Complaint IN00149088.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review the facility failed to provide meals that the residents found to be palatable for 3 of 3 residents in the survey sample. (#12, #33, #38) Findings include: 1. During an interview on 7/8/14 at 12:00 p.m., Resident #12 indicated, "the food does not taste good here; I am tired of the same thing repeatedly. " During an interview on 7/10/14 at 9:00 a.m., Resident # 38 indicated, he did not eat breakfast most times because the food is was not good. He indicated he only ate</p>	F000364	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F – 364</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p>	08/10/2014

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	<p>breakfast on occasions when pancakes were served. He indicated, lunch and dinner were generally cold and many times the portions were not large enough, and if he did not like what was served and asked for more they usually did not have extra food available.</p> <p>During an interview on 7/10/14 at 2:35 p.m., Resident #33 indicated, she did not like the lunch today, and felt the chicken was greasy. She did not eat her breakfast because she did not like it.</p> <p>During a dining observation on 7/10/14 at 8:42 a.m., at the end of dining service it was noted that Resident #33 only drank a small amount of apple juice and none of her meal, and Resident #38 refused breakfast.</p> <p>A test tray was requested following resident meal service on 7/10/14 at 12:15 p.m. The temperature of the carrots on the tray was 149 degrees, the ground chicken was 156 degrees and the chocolate pudding dessert was 69 degrees.</p> <p>During an interview with Dietary Aide #9 on 7/10/14 at 12:20 p.m., she indicated the temperature for cold foods should have been be at 41 degrees or below and</p>		<p>Residents #12, #33, and #38 are being served food at the appropriate temperatures and in a palatable manner. See systems below that have been implemented and monitoring.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents are being served food at appropriate temperatures and in a palatable manner.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The facility is now utilizing top and bottom insulated plate base/dome coverings. This will assure that food temperatures maintain proper heat settings for the room trays. For cold temperatures, the food items will remain refrigerated until they are to be served. All dietary staff has been in-serviced related to assuring that procedure is followed appropriately and that food is served at appropriate temperatures. The Dietary Manager will be working with the residents related to food likes/dislikes in an attempt to accommodate their preferences.</p>				

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	<p>hot foods should have been above 150 degrees. She indicated she put the pudding in the refrigerator in the a.m. and scooped it into its pie shells just before meal service.</p> <p>2. During an interview on 7/7/2014 at 2:03 P.M., Resident #38 indicated the food was not served at the proper temperatures. He indicated he asked staff to do something about it but "nothing had changed."</p> <p>Resident #38's record was reviewed on 7/9/14 at 8:30 A.M. Resident #38 had diagnoses which included a history of a stroke with partial paralysis and hypertension. An admission MDS (Minimum Data Assessment Tool) dated 2/22/14, indicated Resident #38 was cognitively intact with a BIMS (Brief Interview Mental Status) score of 15 out of 15.</p> <p>A review of a document entitled, " Food Temperature Log-Lunch, " received from the Dietary Manager on 7/10/14 at 3:02 p.m., indicated, hot vegetables should have been at a temperature between 160-175 degrees, ground meats should have been at a temperature between 165-185 degrees, and cold desserts</p>		<p>Food temperatures will be taken before the first tray is served, at the approximate middle of tray service, and at the end of tray service for each meal. In addition the Dietary Manager will select 5 meals each week to have a room test tray added to the room cart. The test trays will incorporate at least 1 breakfast, 1 lunch and 1 dinner, and will include at least 1 weekend meal. The cook on duty will place a test tray on the room cart and test the temperature of that tray after all other trays are delivered.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 meals by utilizing a test tray to monitor temperatures. These 5 meal reviews will occur weekly x3, monthly x3, and quarterly x3. This tool will also randomly interview 5 residents related to assuring that they are identifying their food as being at proper temperatures. The Dietary Manager, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the</p>		

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F000371 SS=E	<p>should have been at less than 40 degrees. 3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on interview, observation, and record review, the facility failed to follow the established hand washing policies during food preparation. This practice had the potential to affect 4 of 4 residents participating in the beverage activity held in the dining room.</p> <p>During a continuous observation of kitchen staff on 7/10/14 from 9:40 a.m. until 10:15 a.m. Resident # 37 wheeled himself to the gated entry of the kitchen. He had his fingers in his mouth and large amounts of saliva saturating his hands. He put his hands on the latch, the top rails and the bars of the gated entry to the kitchen while waiting for staff to come to address his needs. After tending to</p>	F000371	<p>regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p> <p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. - <u>F - 371</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Residents #23, #33, #37, and #11 are receiving services in a manner that is within acceptable</p>	08/10/2014

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	<p>Resident #37 needs the Dietary Manager and Dietary Aide #9 were seen exiting the kitchen without disinfecting the gated entry. Activities Assistant #8 entered the kitchen through the gated entryway. She put on a hairnet and sanitized her hands with hand gel. She started to prepare beverages for a scheduled activity in the dining room. She was called to the gated entry of the kitchen to assist a resident, at this time she touched the top rail of the gated entry. After addressing the resident in the hallway she returned to the food prep area and continued preparing the drinks. She picked up a carafe with her bare hands by the rim and pour spout. She then poured the liquid into the carafe for service. She then picked up a wet towel from the countertop and used it to wipe down a food service cart. She then placed the used towel on the counter. She went to the drying rack and picked up a modified cup by its inner liner and placed it on her cart for service. She then left the kitchen at which time she wheeled the food service cart through the facility to gather residents for the activity. At this time Resident #23 asked Activities Assistant #8 to push her wheel chair to the dining room for the activity. Activities Assistant #8 pushed the wheel chair and the cart to the dining room and as she maneuvered around the corner she dropped the newspaper she was carrying</p>		<p>parameters of infection control. Please see below for systems implemented and means of monitoring.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents are receiving services in a manner that is within acceptable parameters of infection control.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All staff has been in-serviced related to proper infection control protocol which includes proper hand washing. The Gait leading into the kitchen has been removed. The Activity staff has been in-serviced related to proper infection control techniques to utilize when preparing and serving food and/or drinks for the activity programming. Infection control related to the identified deficiency will be monitored through the Performance Improvement process.</p>	

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	<p>onto the floor. She picked the newspaper up from the floor and continued into the dining room where she served resident #'s 23, 33, 37, and 11. During this observation Activities Assistant #8 did not sanitize her hands anymore after her initial entry into the kitchen.</p> <p>During an interview with the Dietary Manager on 7/10/14 at 10:30 a.m., she indicated the Activities staff always entered the kitchen to prepare items for activities. She indicated, they get trained to put their hairnet 's on and wash their hands when they enter the kitchen. She indicated they did not receive any formal training. When asked about the towel that was used by Activities Assistant #9, the Dietary Manager indicated she did not know of a towel that was left on the counter. She indicated, towels are kept in the red and green buckets in the sink. She indicated the solution inside of the green bucket was a food safe cleaner and the red bucket indicated the solution inside is safe for surfaces. She indicated that Activities Assistant #9 should know what the difference between the buckets was.</p> <p>During an interview with Dietary Assistant #9 on 7/10/14 at 10:55 p.m., she indicated she was taught by the Social Services Director how to make</p>		<p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>In addition to routine observation by the Dietary Manager of meal preparations, a Performance Improvement tool will be initiated that will observe for areas of infection control related to dietary and activity services. The tool will assure that services are provided within acceptable parameters of infection control. The Dietary Manager, or designee, will complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p>	

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F000406 SS=D	<p>drinks and get supplies from the kitchen. When asked about hand washing she stated, " I forgot that this morning. " She indicated she should have washed her hands in the sink upon entering the kitchen. When asked about the towel on the counter she stated, " It comes from the buckets in the sink, there are two buckets, they have some type of stuff in them that they soak in. There is not a difference between the buckets, they did not really explain that to me. "</p> <p>A review of the policy entitled, " Hand Washing and Glove Use for Food Workers-Questions and Answers, " received from the Dietary Manager on 7/10/14 at 3:15 p.m., indicated, " All employees involved with food preparation must wash their hands and exposed portions of their arms with soap and waterAvoid touching food contact surfaces of dishes, utensils, and equipment. "</p> <p>3.1-21(i)(3)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy,</p>			

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	<p>speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure specialized rehabilitative services were provided for a resident with an intellectual disability (Resident #37).</p> <p>Findings include:</p> <p>Resident # 37 was observed on 7/8/14 at 9:54 a.m. wheeling himself into rooms #15 and 18, which were not his room.</p> <p>Resident #37 was observed on 7/8/14 at 2:17 p.m. ambulating in wheelchair and came from behind and started patting with his hand SSD (Social Services Designee) buttocks by nurses' station.</p> <p>The Resident was observed on 7/8/14 at 2:36 p.m. ambulating in wheelchair and roaming into residents' room #5.</p> <p>Resident #37 was observed on 7/9/14 at 8:56 a.m. wheeling/ambulating his wheelchair into Residents ' room #18.</p>	F000406	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F - 406</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #37 has been assessed and interventions have been implemented to meet this resident's individual needs. A new level II was obtained to accurately reflect the resident's current needs. The Identified recommendations have been added to the plan of care.</p> <p>(B)How will you identify other</p>	08/10/2014	

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	<p>On 07/09/14 at 1:05 p.m., Resident #37 attempted to go outside. Residents at the door stopped him.</p> <p>Resident #37 was observed on 07/09/14 at 1:33 p.m. in his wheelchair, he grabbed the water cart and water pitcher which spilled onto floor.</p> <p>Resident #37 was observed on 7/10/14 at 8:25 a.m. in dining room eating breakfast.</p> <p>Resident #37 was observed on 7/10/14 at 9:12 a.m. went into unstaffed-unlocked-open door at the administrative nursing office.</p> <p>Resident #37 was not observed during the survey dates engaged in any training activities to encourage his highest level of functioning.</p> <p>The SSD was interviewed on 7/9/14 at 2:10 p.m. She indicated Resident #37 had no behaviors being tracked. SSD indicated that staff can't do anything about wandering. She indicated that Resident #37 didn't go in others rooms, just roamed the hall. SSD was asked about him grabbing other residents, running over feet, running into other people, grabbing other people's buttocks and attention seeking. The SSD agreed it</p>		<p>residents having potential to be affected and what corrective action will be taken:</p> <p>All residents have been reviewed to assure that if they have specialized needs that they receive appropriate services to attain their highest level of functioning. Residents with identified level II recommendations have been identified and their plan of care have been modified as needed.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>At the time of admission, quarterly, or with a significant change, residents are assessed for any specialized needs. Based on that assessment, interventions will be implemented that will assist the resident to attain their highest level of functioning. If needed, outside resources will be utilized to assist the facility in establishing the plans. Based on the decided interventions, the plan of care will be updated appropriately. The Social Services Director will be in-serviced related to assuring that proper interventions are in place with those residents with specialized needs.</p>				

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	<p>was a behavior, but didn't know how to address it. SSD indicated that Resident #37 wouldn't stay in activities.</p> <p>Resident #37 's record was reviewed on 7/8/14 at 9:00 a.m. Resident #37 had diagnoses which included, but were not limited to, dementia, MR (Mental Retardation), recent Pneumonia, urinary retention/UTI (urinary tract infection), scoliosis, constipation and delusional disorders.</p> <p>The care plan was reviewed on 7/8/14 at 9:00 a.m. The Care Plan Focus was "The resident has impaired cognitive function r/t DX (diagnosis) Mental Retardation, Dementia with behavioral disturbances. Goal: The resident will be able to participate in simple decisions and making 1 basic need known on a daily basis through the review date 9/21/14. Interventions included, but were not limited to: "Provide a program of activities that accommodates the resident's abilities such as he likes to sit across from the nurse ' s station and look at magazines, books and play with the items he brought with him from his 'busy box.' He comes into staff's offices and likes to sit in there while they work. Engage the resident in simple structured activities that avoid overly demanding tasks." The care plan lacked</p>		<p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents (if applicable) related to provision of specialized services to assist the residents in attaining their highest level of functioning. The Administrator, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p>				

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F000441 SS=E	<p>interventions to assist Resident #37 with attaining his highest possible level of functioning.</p> <p>3.1-23(a)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p>			

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the infection control program was followed to prevent Resident # 37 from contaminating the environment during 2 of 2 random observations, failed to ensure contaminated objects were cleaned properly, failed to do tracking for the month of June, 2014 concerning the possible transmission of infections, and failed to implement an infection control person during the absence of the primary staff. This deficiency had the potential to affect 29 of 29 resident living in the facility.</p> <p>Findings include:</p> <p>1. During an observation on 07/09/2014 at 1:33 p.m. Resident #37 sucked his thumb and continuously drooled. He wore a clothing protector to maintain a dry shirt and wandered in his wheelchair</p>	F000441	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><u>F - 441</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident #37 has been reviewed. The facility will be sanitizing areas of possible contamination more frequently. If the resident is observed to contaminate a surface the area will be sanitized at that time to assist with the</p>	08/10/2014

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	<p>throughout the facility. Resident #37 grabbed the water cart and water pitcher which spilled onto the floor. The water cart was located at the entrance to the main dining room. Staff #8, who observed the resident at the cart, failed to sanitize the cart or get a new water pitcher.</p> <p>2. During observation of the soiled/clean utility room on 7/9/14 at 1:30 p.m., resident bedpans, wash basins and urinals were propped against each other on a white towel.</p> <p>Observation of soiled / clean utility room on 7/9/2014 at 1:30 p.m. indicated resident bedpans, wash basins and urinals were propped against each other on a white towel. The towel was discolored with spots of light grey. Small black flecks were scattered on top of the towel. Maintenance Supervisor indicated that resident care equipment was sanitized by the CNA (Certified Nurse Aide) then allowed to air dry on the towel. When questioned on the procedure for disinfecting resident supplies, CNA #2 on 7/10/14 at 8:50 a.m. and CNA #1 on 7/10/2014 at 2:50 p.m. indicated that the equipment was cleaned and rinsed in hopper, placed in sink, then sprayed with Virex. CNA #1 and CNA #2 further indicated Virex was left on for at least</p>		<p>spread of possible infection.</p> <p>Equipment is being sanitized appropriately in accordance with the manufacture's guidelines. The staff is utilizing clean towels to dry sanitized equipment.</p> <p>The June infection control log has been updated. The DON was out of the office and the log was completed as soon as she returned. There were no previous months that were identified as not being logged appropriately.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents have the potential to be affected by the practice. Please see systems changes below to address the infection control area identified.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>All staff has been in-service related to proper hand washing. In addition, the in-service included proper sanitizing of possible or observed contaminated areas to assist with</p>		

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	<p>two minutes, and then equipment was rinsed and allowed to air dry on towel.</p> <p>Facility policy and procedure presented by Administrator on 7/10/2014 at 2:10 p.m. stated: "Staff will rinse all bedpans and urinals in the soiled utility room in the hopper. The bedpans and urinal will be placed in the left side of the double sink and sprayed with Virex. Staff will wait at least 2 minutes before rinsing. The bedpans and urinals will be placed on a clean towel to air dry before being put away. "</p> <p>On 7/10/2014 at 3:30 p.m. manufacturer instructions on container of Virex was reviewed with Maintenance Supervisor. Instructions for disinfecting equipment was to pre-clean equipment, spray with Virex, let set for ten minutes, then air dry.</p> <p>3. During an observation on 7/10/14 at 9:11 a.m. Registered Nurse (RN) #10 was observed preparing medications, during this time Resident #37, who was observed to have his fingers in his mouth and large amounts of saliva coming from his mouth, wheeled himself up to RN #10 who was standing at her med cart. She pushed his wheel chair back from her. The resident wheeled forward again and reached into the med drawer and touched</p>		<p>preventing the spread of infection. The areas of the facility that are known to have possible contamination more frequently have been placed on an increased sanitizing schedule. In addition, nursing has been in-serviced related to sanitizing patient care equipment in correlation with the manufacture's guidelines. Also in relation to the infection control log, an alternative person has been designated to complete the log in the absence of the DON.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly reviews for areas of infection control. The tool will look for sanitation of areas that have been observed to be contaminated, increased sanitizing of areas that have a higher probability of contamination, proper sanitizing of patient care equipment, and proper tracking utilizing the infection control log. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality</p>				

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	<p>the medicine cards. RN #10 took Resident #33 's saliva saturated hands into hers and removed them from her med cart. She then returned to preparing medications for Resident #33. She retrieved a med cup and placed Resident #33 's medications inside it. She then sanitized her hands as she entered Resident #33 's room and gave her the contaminate cup.</p> <p>During an interview with the Administrator on 7/10/14 at 4:00 p.m., he indicated that tracking and trending of the facilities infection control information was the responsibility of the Director of Nursing, who was out on leave. He indicated he did not realize she had not passed the responsibility on to a coworker during her absence.</p> <p>During a review of the infection control book on 7/10/14 at 1:30 p.m., it was noted that tracking of infection control information had not been completed for the month of June.</p> <p>A review of the policy entitled, " Hand Washing and Glove Use for Food Workers-Questions and Answers, " received from the Dietary Manager on 7/10/14 at 3:15 p.m., indicated, " All employees involved with food preparation must wash their hands and</p>		<p>Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p>	

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F000465 SS=F	<p>exposed portions of their arms with soap and waterAvoid touching food contact surfaces of dishes, utensils, and equipment. "</p> <p>A review of the policy entitled, "Handwashing," received from the Administrator on 7/10/14 at 2:52 p.m., indicated, "Handwashing should be performed: As promptly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them....As promptly and thoroughly as possible between resident contacts....".</p> <p>A review of the policy entitled, " Infection Control, " received on 7/10/14 at 11:45 from the MDS coordinator, indicated the facility should, " Maintain records of incidents and corrective actions related to infections</p> <p>3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and</p>	F000465	Neither signing nor submission of this plan of	08/10/2014

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	<p>record review, the facility failed to provide maintenance and housekeeping services to keep facility clean and in good repair.</p> <p>Findings include: During initial tour on 7/7/2014 at 8:50 a.m. and environmental tour on 7/9/2014 at 1:20 p.m. with Maintenance Supervisor the following was observed:</p> <ol style="list-style-type: none"> 1. Floor tile in hallways, resident rooms and common areas appeared dull and dirty, were discolored light yellow and had numerous thin and thick black lines. Housekeeping Supervisor stated lines were scratches and scuff marks. 2. Ceramic floor tile in Bathrooms A, B, C and D had dirt and dust residue. Dirt build-up was noted on tile grout and around edges of flooring in all the bathrooms. Tile was chipped on lower part of east wall in Bathroom D exposing sharp edges. 3. In Bathrooms A, B, C and D, bolts anchoring the toilets to the floor were of varying lengths and rust-colored. Bolts had exposed 		<p>correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F - 465</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>No specific residents were identified. Below find the areas that were identified related to corrections.</p> <p>The floor tiles in resident rooms, bathrooms, and near ice machine have either been cleaned (including grout) or replaced.</p> <p>The bolts anchoring the toilets have been replaced.</p> <p>The floor drains and clean-out plugs have been cleaned.</p> <p>Ceiling vent was painted.</p> <p>Lint trap in dryer and surrounding area cleaned</p> <p>The soiled/clean utility room floor has been cleaned as well as the sink area and hopper. The cabinets have also been repaired.</p>	

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	<p>sharp threads and tops.</p> <p>4. Floor drains and clean-out plugs in Bathrooms A, B, C and D and in the soiled laundry had dirt and dust residue. A paper towel was inserted in the clean-out plug in Bathroom A and what appeared to be part of a plastic glove per Maintenance Supervisor statement was inserted in the clean-out drain in the soiled laundry.</p> <p>5. Paint was chipped and flaking on ceiling vent in Bathroom D.</p> <p>6. In the clean laundry, the lint trap in the dryer near the wall was full of lint to the extent that lint was hanging down from the trap. Underneath lint trap on floor of dryer nearest door was covered with lint. Laundry worker indicated that the traps are supposed to be cleaned every two hours, but she did not have time today. At 2:50 PM on 7/7/2014, the lint traps were still full of lint and had not been cleaned. One laundry dryer was spinning with clothes with no person in attendance in the laundry room.</p>		<p>Concrete floor has been painted in laundry room</p> <p>The grout around the toilet has been replaced</p> <p>Ceiling tiles have been addressed</p> <p>Return air vents have been cleaned</p> <p>The cover in the shower drain has been replaced and the toilet has been leveled</p> <p>The window in dining room has been addressed</p> <p>The fan in the nurses' station has been cleaned</p> <p>The beauty shop chair and dryer has been cleaned</p> <p>Wheelchair scale has been cleaned</p> <p>Drywall in room 7 has been repaired</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All resident areas have been reviewed and repairs and cleaning have occurred if there were areas identified.</p>	

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	<p>7. Floor in the soiled / clean utility room had an accumulation of dust and dirt residue with a build-up of dirt around floor edges. The stainless steel sink was dull in appearance, marred and water-stained with a film of extraneous matter. The sink faucets were crusted with a white flaky substance. Two mop buckets under the sink had an accumulation of dust and dirt over the top and sides of the bucket.</p> <p>8. Hopper in soiled / clean utility room had several dark brown spots inside and outside with a light yellow ring around inside of bowl.</p> <p>9. Edges of doors on cabinets in the soiled / clean utility room were worn with wood fiber particles of board exposed. West cabinet door was missing a handle and bottom hinge was not attached to door making door unstable when opened.</p> <p>10. Paint was chipped and concrete had gouges in the floor of soiled laundry area. Floor appeared rust-colored in several areas, especially around floor drain.</p>		<p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The Housekeeping Department and Laundry Department have all been in-serviced related to following of the cleaning schedules to include all resident areas, laundry areas, common areas, and utility room areas. The Maintenance Director has been in-serviced related to identifying areas that may need repair and assuring that all facility areas are in good working orders. The Administrator or designee will be making rounds throughout the facility to assure that the building is clean and in good repair daily.</p> <p>Any identified issues will be addressed promptly. The Maintenance directors Preventative Maintenance program will be used to ensure that the building and equipment are in good repair.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 facility areas related to</p>	

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	<p>11. Part of grout at base of toilet in Bathroom C was missing. Remainder of grout was noted to be discolored grey.</p> <p>12. Ceiling tile near the west exit door was discolored yellow. Maintenance supervisor indicated that the discoloration was from a roof leak this past winter. Return air vents in ceiling near door had an accumulation of dust.</p> <p>13. Cover on shower floor drain in Bathroom C was broken and not secure, exposing open drain. Toilet was leveled with a thin-wedge shaped piece of plastic exposing a gap between floor and base of toilet.</p> <p>14. Small portion of hard material of the north window sill in dining room was cracked exposing a sharp edge.</p> <p>15. Floor fan in nurses' station had an accumulation of dust .</p> <p>16. Beautician chair and floor dryer in Bathroom A had an accumulation of dust and hair residue.</p> <p>17. Wheelchair scale stored in</p>		<p>cleanliness and good repair. The Administrator, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: 8-10-2014</p>	

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	<p>Bathroom A had dirt and dust residue.</p> <p>18. Part of a tile was missing on floor near ice machine stored in a room on the north hall.</p> <p>19. Several areas of drywall in Room 7 are either marred, peeled or missing exposing gypsum.</p> <p>On 7/9/2014 during environmental tour, Maintenance Supervisor indicated that the pest control contractor had been contacted, but would not be at facility until 7/10/2014.</p> <p>Interview with Maintenance Supervisor, on 7/9/2014 at 2:00 p.m., indicated that facility had no preventive maintenance policy.</p> <p>Interview with Housekeeping Supervisor on 7/9/2014 at 2:15 p.m. indicated that facility had no policy on routine floor maintenance. Housekeeping Supervisor also indicated that facility had no policy and procedure on routine or deep cleaning of resident rooms, cleaning of resident bathrooms or cleaning of common areas. Housekeeping Supervisor presented a " Deep Cleaning List " and " Housekeeping Quality</p>			

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F000469 SS=E	<p>Assurance Checklist " on 7/9/2014 at 2:45 p.m. Housekeeping Supervisor stated lists were used as guides for deep cleaning one room a day per a schedule and for cleaning every room daily.</p> <p>Administrator presented a pest control contract and policy statement on 7/9/2014 at 8:30 a.m. that he indicated was current. Policy indicated pest control services would be provided (usually on a weekly basis except for special circumstances) and as needed.</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview and record review, the facility failed to maintain 2 of 18 resident rooms (Rooms 7 and 8) free of flies and 1 of 4 resident bathrooms (Bathroom A) free of ants.</p> <p>Findings include: During initial tour on 7/7/2014 at 8:50 a.m., room observations on 7/7/2014</p>	F000469	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p>	08/10/2014

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	<p>from 1:29 p.m. -2:23 p.m. and environmental tour on 7/9/2014 at 1:20 p.m. the following was observed:</p> <p>1. Flies were noted swarming around Residents 32 (Room 7), 37 (Room 8) and 38 (Room 8). Flies were noted on abdomen and leg of Resident 21 (Room 7). At 10:50 a.m. on 7/7/2014 flies were still noted swarming around Resident 21. Resident #21 stated "flies are terrible."</p> <p>2. On 7/7/2014 in Bathroom A numerous small black ants were noted crawling on floor drain cover and covering approximately two inches on one side of floor tile surrounding cover. On 7/9/2014 several ants were still noted crawling on floor drain cover.</p> <p>During an interview on 7/9/2014 at 1:20 p.m., the Maintenance Supervisor indicated that the pest control contractor had been contacted, but would not be at facility until 7/10/2014.</p> <p>Administrator presented a pest control contract and policy statement on 7/9/2014 at 8:30 a.m. that he indicated was current. Policy indicated pest control services would be provided (usually on a weekly basis except for special circumstances) and as needed.</p>		<p>F - 469</p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>The Pest control company came to the facility on 7/28/14 and sprayed for Ants. The pest control company has also installed a new glue board in the fly attracter at the employee entrance and a fly attractor has been ordered for the front door as well. A new more effective model has been ordered to be placed at the employee entrance door.</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All other rooms in the facility were inspected by the Housekeeping and Maintenance supervisors as well as the Administrator and no other issues with Ants or Flies were observed. Also pest Control Company was here and found no issues related to ants.</p> <p>(C)What measures will be put into place or what systemic changes will be made to</p>		

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	3.1-19(f)(4)		<p>ensure this will not recur:</p> <p>The pest control company visits monthly or as needed. They will be replacing the glue boards routinely as needed during their visits. The Maintenance Director will also have a supply of glue boards that he can install in between the pest control visits. The Maintenance Director is responsible for working with the pest control company to assure that ants/flyes are controlled.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 resident rooms related to the presence of ants/flyes. The Director of Maintenance, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain:</p>		

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F000508 SS=D	<p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to timely obtain radiology services ordered by a physician for 1 of 1 Residents reviewed for radiology services (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 7/9/14/2014 at 1:35 P.M. Resident B had diagnoses which included but were not limited to advanced dementia, expressive dysphasia, decreased safety awareness, and a history of falls.</p> <p>A nurse's note dated 12/3/13 at 6:10 P.M., indicated Resident B fell and had a "tender" right knee and a skin tear to her right elbow. The note indicated the physician was notified and an order was received for a mobile X-ray to be obtained in the facility.</p> <p>A nurse's note date 12/3/13 at 9:30 P.M., indicated the nurse "re-called" the</p>	F000508	<p>August 10, 2014</p> <p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F – 508</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Resident B no longer resides in the facility</p> <p>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</p> <p>All residents are now receiving</p>	08/10/2014

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	<p>contracted mobile X-ray company.</p> <p>A nurse's note dated 12/4/14 at 1:45 A.M., indicated the nurse again contacted the mobile X-ray company's answering service and the answering service indicated they were unsure if they would be able to provide services to Resident B until the next morning.</p> <p>A nurse's note dated 12/4/14 at 2:00 A.M. indicated the X-ray company notified the facility they would not be able to provide the X-ray service for Resident B until 8:00 A.M. on 12/4/13.</p> <p>The record lacked documentation the physician had been notified the mobile X-ray service would not be provided until 8:00 A.M. on 12/4/14 [fourteen (14) hours and fifty (50) minutes after the physician had ordered the X-ray].</p> <p>During an interview on 7/10/14 at 9:57 A.M., the Administrator indicated he would have expected his staff to notify the physician if the mobile X-ray was not obtained within four hours or earlier if the resident had been in pain.</p> <p>3.1-49(g)</p>		<p>x-ray services in a timely manner as needed.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>A new procedure has been implemented related to the provision of timely services related to radiology. The procedure identifies the time frame that services are allowed to respond before notifying the physician for additional orders. There is a 2 hour timeframe for STAT orders, If the service is not obtained within the 2 hours the physician will be contacted for additional information. The nurses have been in-serviced related to the new procedure. In addition, a new x-ray company has started in the provision of services to the facility.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>A Performance Improvement tool will be initiated that will randomly review 5 residents that had x-ray orders (if applicable) to assure that radiology services are performed in a timely manner and</p>		

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F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee</p>		<p>that the new procedure was followed appropriately. The Director of Nursing, or designee, will randomly complete the tool weekly x3, monthly x3, and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee at the regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p> <p>(E) Date Certain: August 10, 2014</p>		

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	<p>except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview, and record review, the facility failed to identify and implement a process for quality improvement for staff non-compliance related to failure of staff to implement residents' individual activity preferences, abuse identification and reporting, addressing residents' grievances made known through the Resident Council Group minutes, housekeeping/maintenance concerns, and the lack of infection control tracking and trending. This deficient practice had the potential to affect 29 of 29 residents in the facility.</p> <p>Findings include:</p> <p>A. Resident #32's record was reviewed on 7/10/14 at 8:16 A.M. Resident #32 had diagnoses which included, but were not limited to, Parkinson's disease, chronic kidney disease, schizophrenia, depression, anxiety, and muscle weakness. A non-scheduled Minimum Data Assessment Tool (MDS) dated 6/24/14, Resident #32 was cognitively intact with a Brief Interview Mental</p>	F000520	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>F - 520</u></p> <p>-</p> <p>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</p> <p>Each of the areas identified have been addressed previously in the plan of correction. Please refer to those specific areas for interventions for compliance. Each area now has a Performance Improvement tool that will be utilized for monitoring to assure ongoing compliance which will be reviewed by the QA committee.</p> <p>(B)How will you identify other</p>	08/10/2014

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	<p>Status Score of 13 out of 15.</p> <p>An untimed social service note dated 3/5/14, indicated Resident #32 was queried by the SSD regarding "refusing care." The note indicated, "Resident stated she does not like the CNA she has today. She stated she just doesn't like her because she is rude and she curses and argues with people. SSD asked resident if she has done that to her. Resident stated she had not but she has heard CNA doing it to others in the hall..."</p> <p>During an interview on 7/10/14 at 11:49 A.M., the Social Service Director (SSD) indicated she was not informed of Resident #32's allegations. The SSD indicated during a routine conversation with Resident #32 on a Monday morning, Resident #32 informed her LPN #99 had pushed her during care. The SSD indicated at that time the Administrator was informed of the allegation and the abuse investigation began. The SSD indicated staff had not reported the allegation per the facility's policy.</p> <p>During an interview on 7/10/14 at 9:39 A.M., the SSD was queried regarding the allegations of verbal abuse by a CNA. The SSD indicated she had reported the incident to the Administrator.</p>		<p>residents having potential to be affected and what corrective action will be taken:</p> <p>All residents could potentially be affected. The QA interdisciplinary committee will be routinely identifying quality areas on an ongoing basis with ongoing recommendations for quality improvement. For items identified as needing improvement are identified through the Performance improvement tools or staff observations, an action plan will be initiated to communicate the problem to the QA committee.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</p> <p>The QA committee will meet monthly x3 Then at least quarterly thereafter to review all current Performance Improvement Tools, action plans and any other area of concern with recommendations for improvement. As part of the process, if areas of improvement are needed, recommendations will be made with interventions and means of monitoring established. The QA committee will be reviewing the outcomes of any recommendations at the next scheduled meeting, but at least</p>				

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	<p>During an interview on 7/10/14 at 11:50 A.M., the Administrator was queried regarding knowledge of Resident #32's allegations of verbal abuse by a CNA. The Administrator indicated he had not been made aware of the allegations.</p> <p>During an interview on 7/10/14 at 7:51 A.M., Registered Nurse (RN) #3 was interviewed during the Abuse Protocol Task. RN #3 stated, "Six months ago (Resident #32 named) told me (LPN #99 named) had been rough with her. When he turned her he pushed her too hard... I don't know if I told (Administrator named) or not. I was brand new. I didn't know what was going on." RN #3 indicated it was over a weekend and she had told her co-worker and assumed she would take care of it. RN #3 indicated she was aware she should have reported it to the Administrator.</p> <p>A policy titled, "Abuse Prevention" identified as a current policy by the Administrator on 7/10/14 at 10:15 A.M., indicated, "...It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...We have established policies and procedures that will provide facility personnel with the knowledge and training to ensure each resident is treated with individual</p>		<p>quarterly. The Administrator/designee is responsible for assuring that the QA committee is functioning in a manner that promotes quality within the facility.</p> <p>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Administrator, or designee, will be reviewing the minutes of any QA meeting to assure that areas that have been identified with recommendations are being addressed appropriately by the interdisciplinary team.</p> <p>(E) Date Certain: August 10, 2014</p>	

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	<p>respect and dignity. The following guidelines outline the components of our Abuse Prevention Program...All employees are required to attend our facility's resident rights and abuse prevention program in service training sessions prior to having any resident contact...Our facility will not condone any form of resident abuse... Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment...Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g., using derogatory language, rough handling of resident, ignoring residents while giving care...Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to the facility management immediately...All personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately...The following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. When it doubt, report it...Signs of Actual Physical Neglect:...Inadequate provision</p>			

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	<p>of care; caregiver indifferent to resident's personal needs...left alone, but needs supervision....All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...The individual conducting the investigation will, at a minimum...Interview the person's reporting the incident... interview any witnesses to the incident... interview the resident...interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident... Allegations of abuse are reported to the state survey agency with 24 hours...Abuse is defined as the willful infliction of injury...intimidation...deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental and psychosocial well being. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance..."</p> <p>B. Resident Council minutes were provided by the Activity Director (AD) on 7/7/14 at 10:45 a.m. The minutes indicated the following concerns by the Resident Council:</p>			

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	<p>1. Quieter in mornings - May, 2014</p> <p>2. Call lights not being answered - December, 2013 & April, 2014</p> <p>3. Missing items from laundry - February, 2014</p> <p>4. More variety with menu - December, 2013; January, 2014; February, 2014; March, 2014; and April, 2014.</p> <p>5. More activities - March, 2014; April, 2014; May, 2014; & June, 2014</p> <p>During an interview on 7/10/14 at 3:15 p.m., with the Resident Council President, she indicated the Activity Director (AD) took minutes for the Resident Council meetings but the facility staff did not respond to the group's concerns and there was not any follow up from the facility.</p> <p>During an interview with the AD on 7/10/14 at 3:45 p.m. she indicated that she took minutes for the meetings and wrote the grievances for department heads. The Activity Director indicated that she made notes to different department heads and let the department heads handle their own grievances.</p> <p>The record lacked documentation of the grievances being addressed by the AD and facility.</p>			

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	<p>No other information was provided by exit on 7/11/14 at 3:30 p.m.</p> <p>C. During initial tour on 7/7/2014 at 8:50 a.m. and environmental tour on 7/9/2014 at 1:20 p.m. with Maintenance Supervisor the following was observed:</p> <ol style="list-style-type: none"> 1. Floor tile in hallways, resident rooms and common areas appeared dull and dirty, were discolored light yellow and had numerous thin and thick black lines. Housekeeping Supervisor stated lines were scratches and scuff marks. 2. Ceramic floor tile in Bathrooms A, B, C and D had dirt and dust residue. Dirt build-up was noted on tile grout and around edges of flooring in all the bathrooms. Tile was chipped on lower part of east wall in Bathroom D exposing sharp edges. 3. In Bathrooms A, B, C and D, bolts anchoring the toilets to the floor were of varying lengths and rust-colored. Bolts had exposed sharp threads and tops. 						

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	<p>4. Floor drains and clean-out plugs in Bathrooms A, B, C and D and in the soiled laundry had dirt and dust residue. A paper towel was inserted in the clean-out plug in Bathroom A and what appeared to be part of a plastic glove per Maintenance Supervisor statement was inserted in the clean-out drain in the soiled laundry.</p> <p>5. Paint was chipped and flaking on ceiling vent in Bathroom D.</p> <p>6. In the clean laundry, the lint trap in the dryer near the wall was full of lint to the extent that lint was hanging down from the trap. Underneath lint trap on floor of dryer nearest door was covered with lint. Laundry worker indicated that the traps are supposed to be cleaned every two hours, but she did not have time today. At 2:50 PM on 7/7/2014, the lint traps were still full of lint and had not been cleaned. One laundry dryer was spinning with clothes with no person in attendance in the laundry room.</p> <p>7. Floor in the soiled / clean utility room had an accumulation of dust</p>			

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	<p>and dirt residue with a build-up of dirt around floor edges. The stainless steel sink was dull in appearance, marred and water-stained with a film of extraneous matter. The sink faucets were crusted with a white flaky substance. Two mop buckets under the sink had an accumulation of dust and dirt over the top and sides of the bucket.</p> <p>8. Hopper in soiled / clean utility room had several dark brown spots inside and outside with a light yellow ring around inside of bowl.</p> <p>9. Edges of doors on cabinets in the soiled / clean utility room were worn with wood fiber particles of board exposed. West cabinet door was missing a handle and bottom hinge was not attached to door making door unstable when opened.</p> <p>10. Paint was chipped and concrete had gouges in the floor of soiled laundry area. Floor appeared rust-colored in several areas, especially around floor drain.</p> <p>11. Part of grout at base of toilet in</p>			

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	<p>Bathroom C was missing. Remainder of grout was noted to be discolored grey.</p> <p>12. Ceiling tile near the west exit door was discolored yellow. Maintenance supervisor indicated that the discoloration was from a roof leak this past winter. Return air vents in ceiling near door had an accumulation of dust.</p> <p>13. Cover on shower floor drain in Bathroom C was broken and not secure, exposing open drain. Toilet was leveled with a thin-wedge shaped piece of plastic exposing a gap between floor and base of toilet.</p> <p>14. Small portion of hard material of the north window sill in dining room was cracked exposing a sharp edge.</p> <p>15. Floor fan in nurses ' station had an accumulation of dust.</p> <p>16. Beautician chair and floor dryer in Bathroom A had an accumulation of dust and hair residue.</p> <p>17. Wheelchair scale stored in Bathroom A had dirt and dust residue.</p>			

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	<p>18. Part of a tile was missing on floor near ice machine stored in a room on the north hall.</p> <p>19. Several areas of drywall in Room 7 were marred, peeled or missing exposing gypsum.</p> <p>On 7/9/2014 during environmental tour, Maintenance Supervisor indicated that the pest control contractor had been contacted, but would not be at facility until 7/10/2014.</p> <p>Interview with Maintenance Supervisor, on 7/9/2014 at 2:00 p.m., indicated that facility had no preventive maintenance policy.</p> <p>Interview with Housekeeping Supervisor on 7/9/2014 at 2:15 p.m. indicated that facility had no policy on routine floor maintenance. Housekeeping Supervisor also indicated that facility had no policy and procedure on routine or deep cleaning of resident rooms, cleaning of resident bathrooms or cleaning of common areas. Housekeeping Supervisor presented a " Deep Cleaning List " and " Housekeeping Quality Assurance Checklist " on 7/9/2014 at</p>			

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	<p>2:45 p.m. Housekeeping Supervisor stated lists were used as guides for deep cleaning one room a day per a schedule and for cleaning every room daily.</p> <p>Administrator presented a pest control contract and policy statement on 7/9/2014 at 8:30 a.m. that he indicated was current. Policy indicated pest control services would be provided (usually on a weekly basis except for special circumstances) and as needed.</p> <p>D. During an observation on 7/10/14 at 9:11 a.m. Registered Nurse (RN) #10 was observed preparing medications. During this time, Resident #37 was observed with his fingers in his mouth and large amounts of saliva coming from his mouth. Resident #37 wheeled himself up to RN #10 who was standing at her med cart. She pushed Resident #3's wheel chair away from her. He wheeled forward again and reached into the med drawer and touched the medicine cards. She took his saliva saturated hands into hers and removed them from the med cart. She then returned to preparing medications for Resident #33. She retrieved a med cup and placed Resident #33's medications inside it. She then sanitized her hands as she entered Resident #33's room and gave her the contaminated cup of medications to</p>			

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	<p>Resident #33, who took the cup to her mouth and swallowed her medications.</p> <p>During an observation on 07/09/2014 at 1:33 p.m. Resident #37 sucked his thumb and continuously drooled. He wore a clothing protector to maintain a dry shirt and wandered in his wheelchair throughout the facility. Resident #37 grabbed the water cart and water pitcher which spilled onto the floor. The water cart was located at the entrance to the main dining room. Staff #8, who observed the resident at the cart, failed to sanitize the cart or get a new water pitcher.</p> <p>During a review of the infection control book on 7/10/14 at 1:30 p.m., it was noted that tracking of infection control information had not been completed for the month of June.</p> <p>During an interview with the Administrator on 7/10/14 at 4:00 p.m., he indicated that tracking and trending of the facilities infection control information was the responsibility of the Director of Nursing, who was out on leave. He indicated he did not realize she had not passed the responsibility on to a coworker during her absence.</p> <p>During observation of the soiled/clean</p>						

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	<p>utility room on 7/9/14 at 1:30 p.m., resident bedpans, wash basins and urinals were propped against each other on a white towel. The towel was discolored with spots of light grey. Small black flecks were scattered on top of the towel. Maintenance Supervisor indicated that resident care equipment was sanitized by the CNA (Certified Nurse Aide) then allowed to air dry on the towel. When questioned on the procedure for disinfecting resident supplies, CNA #2 on 7/10/14 at 8:50 a.m. and CNA #1 on 7/10/2014 at 2:50 p.m. indicated that the equipment was cleaned and rinsed in hopper, placed in sink, then sprayed with Virex. CNA #1 and CNA #2 further indicated Virex was left on for at least two minutes, and then equipment was rinsed and allowed to air dry on towel.</p> <p>Facility policy and procedure presented by Administrator on 7/10/2014 at 2:10 p.m. stated: "Staff will rinse all bedpans and urinals in the soiled utility room in the hopper. The bedpans and urinal will be placed in the left side of the double sink and sprayed with Virex. Staff will wait at least 2 minutes before rinsing. The bedpans and urinals will be placed on a clean towel to air dry before being put away. "</p> <p>On 7/10/2014 at 3:30 p.m. manufacturer</p>			

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	<p>instructions on container of Virex was reviewed with Maintenance Supervisor. Instructions for disinfecting equipment was to pre-clean equipment, spray with Virex, let set for ten minutes, then air dry.</p> <p>A review of the policy entitled, " Hand Washing and Glove Use for Food Workers-Questions and Answers, " received from the Dietary Manager on 7/10/14 at 3:15 p.m., indicated, " All employees involved with food preparation must wash their hands and exposed portions of their arms with soap and waterAvoid touching food contact surfaces of dishes, utensils, and equipment. "</p> <p>A review of the policy entitled, "Handwashing," received from the Administrator on 7/10/14 at 2:52 p.m., indicated, "Handwashing should be performed: As promptly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them....As promptly and thoroughly as possible between resident contacts....".</p> <p>A review of the policy entitled, " Infection Control, " received on 7/10/14 at 11:45 from the MDS coordinator, indicated the facility should, " Maintain</p>			

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	<p>records of incidents and corrective actions related to infections.</p> <p>During an interview on 7/10/14 at 2:30 P.M., The Administrator indicated the Quality Assessment and Assurance (QAA) committee met monthly to discuss issues that triggered in the facility. He indicated the QAA committee had not identified concerns with activity attendance or residents concerns with the lack of activities provided on weekends and evenings, housekeeping/maintenance concerns, system problems with responding to and acting on residents' grievances voiced through the resident council committee, system problems with the reporting and investigation of abuse allegations, system problems with infection control and the lack of tracking and trending. The Administrator indicated his Director of Nursing had been off on sick leave for a few months and a lot of these issues she dealt with and were not assigned to other staff when she left.</p> <p>3.1-52(b)(2)</p>			

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