

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155070	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2012
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NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date(s): July 30, 31, August 1, 2, 3, 7, 2012</p> <p>Facility number: 000028 Provider number: 155070 AIM number: 100275370</p> <p>Survey team: Donna Groan RN, TC Jennie Bartelt RN (7/30, 7/31, 2012) Diane Hancock RN (7/30, 7/31, 8/1, 8/2, 8/3, 2012) Vickie Ellis RN (7/30, 7/31, 8/1, 8/2, 8/3, 2012) Barbara Fowler RN (7/30, 7/31, 8/1, 8/2, 8/3, 2012) Amy Winger RN (7/30, 7/31, 8/1, 8/2, 8/3, 2012)</p> <p>Census bed type: SNF/NF: 103</p> <p>Census Payor type: Medicare: 17 Medicaid: 75 Other: 11 Total: 103</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	<p><u>Allegation of Compliance</u> Please accept the following plan of correction for the annual survey on July 30, 2012 – August 7, 2012. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. Green Valley Care Center respectfully requests consideration for a desk review and paper compliance for our 2012 Annual Survey</p>	

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

TITLE

(X6) DATE

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

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	<p>IAC 16.2.</p> <p>Quality review completed on August 12, 2012 by Bev Faulkner, RN</p>			

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F0157 SS=D	<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> <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 record review and interview, the facility failed to ensure the physician and family were notified of a significant weight loss for 1 of 3 residents sampled for weight loss in a</p>	F0157	<p>F-157</p> <p>1.To ensure adequate notification, Resident # 113's physician and family were again notified by the Director of Nursing</p>	09/05/2012	

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	<p>sample of 3 who met the criteria. (Resident #113)</p> <p>Finding includes:</p> <p>Resident #113's clinical record was reviewed on 8/1/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbances, rehabilitation, Parkinson's disease, diabetes mellitus II, gastroesophageal reflux disease, depression, schizophrenia, and paralysis agitans.</p> <p>Resident #113's weights were documented as follows: 6/13/12-193 pounds, 7/5/12-177 pounds, 7/12/12-178, 7/19/12-179. The weight loss from 6/13/12 to 7/5/12 was 8 percent.</p> <p>The physician saw the resident on 7/25/12. The progress note did not indicate any knowledge of the weight loss.</p> <p>Nurses' notes and dietary notes were reviewed and there was no indication the physician was notified of the weight loss.</p> <p>There was a dietary note, dated 7/12/12 at 3:44 p.m., regarding a nutrition review. The note indicated,</p>		<p>of the resident's recently experienced weight loss on August 2, 2012. At the time the resident's weight loss was initially identified, the resident was placed on our Nutritional Intervention Program (N.I.P.) and interventions were put in place to address the change in condition. At this time the resident's weight has been stable for more than 30 days, and is no longer triggering an acute weight loss.</p> <p>1.Residents that have experienced a significant weight loss have the potential to be affected by the alleged deficient practice. On August 21, 2012, an audit was completed by the Certified Dietary Manager (C.D.M.) of residents having experienced a 5 % weight loss in the past 30 days and of residents having experienced a 10% weight loss in the past 180 days. The audit was to ensure adequate physician and family notification regarding a significant weight loss and no other residents were affected.</p> <p>1.On August 21, 2012, Nurse Managers and the C.D.M. were in-serviced by the Director of Nursing (D.O.N.) on the importance of ensuring physician and family notification when a resident experiences a 5 % weight loss/gain in 30 days and/or a 10% weight loss/gain in180 days.</p>				

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	<p>"current weight 177 lbs and previous 178.3 lbs. Diet is regular CCHO [Controlled Carbohydrate]. Consumes 75-100% of meals and snacks in resident room. Noted to refuse breakfast most days. Eats in the dining room on occasion. No noted skin concerns or fluid problems. Will continue to monitor related to weight stability." Addendum: "Add snacks TID between meals."</p> <p>LPN #2 was interviewed on 8/2/12 at 10:45 a.m. She indicated nurses' notes or dietary notes should indicate physician notification of weight losses.</p> <p>Interview with Director of Nurses [DoN], Assistant Director of Nurses [ADoN], and Dietary Service Manager [DSM], on 8/2/12 at 3:30 p.m., indicated they did not know about notification of the physician regarding weight loss and would check on it. The DSM indicated they were following the resident in the Nutrition at Risk Program for 4 weeks.</p> <p>On 8/2/12 at 4:30 p.m., the DSM indicated she remembered having a conversation with the family about the weight. She was unable to say whether the physician was notified or not, but they were going to notify him</p>		<p>The N.I.P. committee will review the Weight Change Report during the weekly N.I.P. meeting, for the purpose of identifying residents who may be triggering an acute weight loss or gain. The Nurse Manager and/or C.D.M. will ensure that the physician and responsible parties have been notified for any residents found to be experiencing a 5 % weight loss/gain in the past 30 days or a 10% weight loss/gain in the past 180 days. The D.O.N. or designee will audit the Weight Change Report for any residents triggering an acute weight loss or gain to ensure the residents physician and responsible party have been notified. The audits will be completed weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. . Plan to be updated as indicated.</p>				

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	<p>now. She indicated the last weight 7/26/12 was 181 and they were going to see what the doctor wanted to do about the snacks.</p> <p>The Director of Nurses provided the policy and procedure for "Changes in Resident's Condition or Status (no date)," on 8/3/12 at 11:45 a.m. The policy and procedure included, but was not limited to, the following: "The facility will notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status." "Nursing services will be responsible for notifying the resident's attending physician when: b. There is a significant change in the resident's physical, mental, or emotional status... d. There is a need to alter the resident's treatment or medications significantly..." "Nursing services will be responsible for notifying the resident, his/her next of kin, or representative (sponsor) as each case may apply, when: b. There is a significant change in the resident's physical, mental, or emotional status."</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to ensure it provided services with reasonable accommodation of needs for 1 of 40 residents reviewed for room temperature, in the Census Sample of 40, in that the resident was dependent on others for setting of air conditioner temperature and it was observed to be set at 66 degrees or less, resulting in a cold room temperature. (Resident #26)</p> <p>Finding includes:</p> <p>On 7/30/12 at 3:09 p.m., Resident #26 was observed to be curled up in her bed with a bed spread over the resident, the blinds closed, and geri-sleeves [protective arm coverings] on. The room was cold and the air conditioner setting was set at 62 degrees Fahrenheit.</p> <p>On 7-31-12 8:29 a.m., the resident was observed seated in the hall outside her room after breakfast. The</p>	F0246	<p>F-246</p> <p>1. Upon notification of the surveyor's alleged concern, Resident # 26's air conditioning unit was adjusted to a temperature of 74 degrees by nursing staff to ensure compliance with state guidelines. Furthermore the resident was observed to be dressed in appropriate clothing to ensure warmth and comfort. Due to the resident's impaired cognition the resident was not able to verbalize a level of comfort. A label was placed on the resident's air-conditioning unit, directing staff to keep temperature level set between 71-81 degrees.</p> <p>1. Dependent residents have potential to be affected by the alleged deficient practice. On 8/2/2012, an audit was completed by nursing management for other residents determined to be dependent for care per the MDS assessment. The room temperatures of identified residents were observed and no concerns were noted. A label was also placed on these</p>	09/05/2012			

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	<p>room was checked, the room was cold and the air conditioner was set on 62 degrees.</p> <p>On 8/1/12 at 8:45 a.m., Resident #26 was observed laying in bed on an incontinent pad, on top of the bed spread. She had a light blanket. The room was cool; the air conditioner was set on 66 degrees.</p> <p>On 8/1/12 at 10:30 a.m., The resident was observed to be in bed with a light blanket on. The air conditioner was set on 66 degrees. The resident was dressed in light gown. She had geri-sleeves on. The room temperature was measured on top of the bed, at the foot of the bed, and was 68 degrees Fahrenheit.</p> <p>The resident's clinical record was reviewed on 8/1/12 at 10:31 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, rheumatoid arthritis, and hypertension.</p> <p>Resident #26 had a care plan, dated 12/18/09, for requiring extensive to total assist with ADL's related to confusion and rheumatoid arthritis. Interventions included, but were not limited to, the following: Assist me with all ADLs</p>		<p>resident's air-conditioning units, directing staff to keep temperature level set between 71-81 degrees.</p> <p>1. Department heads were in-serviced on 8/2/2012 by the Executive Director regarding state guidelines for resident room temperatures. The Maintenance Director adjusted the thermostat setting on these PTAC units to only allow the temperature to be set between 71-81 degrees. Staff will be in-serviced by the Staff Development Coordinator by August 24, 2012, regarding guidelines for maintaining resident room thermostats between 71-81 degrees for dependent residents to accommodate the resident's needs. The Maintenance Director will complete five (5) random temperature audits in dependent resident's rooms for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance</p>				

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	<p>Assist me with showers Assist me with hair and nail care Observe and report any potential problems Use caution during ADL's related to fragile skin and arthritis ...</p> <p>There was no indication in the care plan the resident preferred cooler temperatures.</p> <p>On 8-1-12 at 11:46 a.m., CNAs #3 and #4 were observed in Resident #26's room. They indicated they had just changed the resident's incontinence brief and she had been incontinent of urine. The resident repeated, "This is cold, this is cold right now." She stated, "awful cold out here." The CNAs gathered the trash. The room temperature measured 68 degrees Fahrenheit. The air conditioner was set on 66 degrees.</p> <p>On 8/1/12 at 1:49 p.m., Resident #26 was observed in bed with covers off to the side. She was constantly verbalizing, and mumbling. CNA #3 entered the room. She checked the resident and indicated she had been incontinent and needed changed. The resident stated, "I'm so cold, I'm so cold right here." As the brief was removed, she stated, "Oh that's</p>		improvement plan. Plan to be updated as indicated.		

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	<p>colder, that's colder." The CNA changed the resident's wet brief, washed her skin with wipes. The air conditioner continued to be set on 66 degrees and the air temperature measured 68 degrees. The CNA indicated, "We'll get you warmed up."</p> <p>The CNA picked up her bagged trash and was leaving the room on 8/1/12 at 2:00 p.m. CNA #3 was queried why the temperature on the air conditioner was set so low. She indicated, "No, somebody probably just came through and turned it down." At that time, she checked the air conditioner and turned it up to 72 degrees.</p> <p>On 8-2-12 at 8:34 a.m., the resident was seated in the dining room for an activity. When asked how she was doing, she stated, "It's awful cold." At that time, the resident's room was checked. The air conditioner was set on 64 degrees.</p> <p>On 8/2/12 at 4:45 p.m., the observed and recorded room temperatures were reviewed with the Director of Nurses [DoN]. He indicated he did not know why the room temperature would be set so cool.</p> <p>3.1-3(v)(1)</p>						

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F0257 SS=D	<p>483.15(h)(6) COMFORTABLE &amp; SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation, interview and record review, the facility failed to ensure comfortable room temperatures were maintained for 1 of 40 resident rooms observed, in the Census Sample of 40. (Resident #26's room)</p> <p>Finding includes:</p> <p>On 7/30/12 at 3:09 p.m., Resident #26 was observed to be curled up in her bed with a bed spread over the resident, the blinds closed, and geri-sleeves [protective arm coverings] on. The room was cold and the air conditioner setting was set at 62 degrees Fahrenheit.</p> <p>On 7-31-12 8:29 a.m., the resident was observed seated in the hall outside her room after breakfast. The room was checked, the room was cold and the air conditioner was set on 62 degrees.</p> <p>On 8/1/12 at 8:45 a.m., Resident #26 was observed laying on top of the bed spread. She had a light blanket. The</p>	F0257	<p>F-257</p> <p>1. Upon notification of the surveyor's alleged concern, Resident # 26's air conditioning unit was adjusted to a temperature of 74 degrees by nursing staff to ensure compliance with state guidelines. Furthermore the resident was observed to be dressed in appropriate clothing to ensure warmth and comfort. Due to the resident's impaired cognition the resident was not able to verbalize a level of comfort. A label was placed on the resident's air-conditioning unit, directing staff to keep temperature level set between 71-81 degrees.</p> <p>1. Dependent residents have potential to be affected by the alleged deficient practice. On 8/2/2012, an audit was completed by nursing management for other residents determined to be dependent for care per the MDS assessment. The room temperatures of identified residents were observed and no concerns were noted. A label was also placed on these resident's air-conditioning units, directing staff to keep</p>	09/05/2012			

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	<p>room was cool; the air conditioner was set on 66 degrees.</p> <p>On 8/1/12 at 10:30 a.m., The resident was observed to be in bed with a light blanket on. The air conditioner was set on 66 degrees. The room temperature was measured on top of the bed, at the foot of the bed, and was 68 degrees Fahrenheit.</p> <p>The resident's clinical record was reviewed on 8/1/12 at 10:31 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, rheumatoid arthritis, and hypertension.</p> <p>On 8-1-12 at 11:46 a.m., CNAs #3 and #4 were observed in Resident #26's room. The resident repeated, "This is cold, this is cold right now." She stated, "awful cold out here." The room temperature measured 68 degrees Fahrenheit. The air conditioner was set on 66 degrees.</p> <p>On 8/1/12 at 1:49 p.m., Resident #26 was observed in bed with covers off to the side. She was constantly verbalizing, and mumbling. CNA #3 entered the room. The resident stated, "I'm so cold, I'm so cold right here." As the incontinence brief was removed, she stated, "Oh that's</p>		<p>temperature level set between 71-81 degrees.</p> <p>1. Department heads were in-serviced on 8/2/2012 by the Executive Director regarding state guidelines for resident room temperatures. On 8/22/2012, the Maintenance Director adjusted the thermostat setting on these PTAC units to only allow the temperature to be set between 71-81 degrees. Staff will be inserviced by the Staff Development Coordinator by August 24, 2012, regarding guidelines for maintaining resident room thermostats between 71-81 degrees for dependent residents to accommodate the resident's needs. The Maintenance Director will complete five (5) temperature audits in dependent resident's rooms for four (4) weeks and continue weekly for 2 additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>				

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	<p>colder, that's colder." The CNA changed the resident's wet brief and washed her skin with wipes. The air conditioner continued to be set on 66 degrees and the air temperature measured 68 degrees. The CNA indicated, "We'll get you warmed up."</p> <p>The CNA was leaving the room on 8/1/12 at 2:00 p.m. CNA #3 was queried why the temperature on the air conditioner was set so low. She indicated, "No, somebody probably just came through and turned it down." At that time, she checked the air conditioner and turned it up to 72 degrees.</p> <p>On 8-2-12 at 8:34 a.m., the resident was seated in the dining room for an activity. When asked how she was doing, she stated, "It's awful cold." At that time, the resident's room was checked. The air conditioner was set on 64 degrees.</p> <p>8/2/12 4:45 p.m., the observed and recorded room temperatures were reviewed with the Director of Nurses [DoN]. He indicated he did not know why the room temperature would be set so cool. On 8/3/12 at 11:45 a.m., he indicated he could not locate a policy regarding room temperatures.</p>						

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	3.1-19(h)			

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure an accurate assessment of oral/dental status for 1 of 3 sampled residents who met the criteria for dental status. (Resident 77).</p>	F0272	F-272  1.Res. # 77 received a routine dental exam on August 23, 2012 at Hartman Dental Clinic and there were no areas of concern reported. On 8/17/2012 Res.	09/05/2012	

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	<p>Findings include:</p> <p>An observation was made on 7/31/12 at 09:30 A.M., of Resident #77. He had missing and broken teeth.</p> <p>Resident #77's clinical record was reviewed on 8/1/12 at 11:41 A.M. It included a document titled, "Initial Data Collection Tool/Nursing Services" dated 3/11/2010. The document indicated the resident had his own teeth, but some were loose and missing. The document did not include the specifics of which teeth were loose or missing.</p> <p>Resident #77's quarterly Minimum Data Set [MDS] Assessments, dated 2/9/12 and 4/26/12, were reviewed. The oral/dental status in the last full annual MDS assessment, dated 11/17/11 was as follows: "obvious or likely cavity or broken natural teeth."</p> <p>A monthly summary, dated 7/17/12, indicated Resident #77 needed total care with oral hygiene and had his own teeth.</p>		<p>#77's MDS assessments dated 2/9/12 and 4/26/12 were reviewed for accuracy by the MDS coordinator. Upon review of these assessments it was determined that the assessments were completed accurately. Section L of quarterly MDS assessments only requires the answering of 2 statements related to oral/dental status; (1) Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose); (2) Mouth or facial pain, discomfort or difficulty with chewing. The answering of 8 statements related to oral/dental status is only found in Section L of an Annual MDS assessment. Upon review of resident # 77's Annual MDS assessment dated November 17, 2011, Section L is marked accurately in accordance to the resident's current oral/dental status.</p> <p>1.All residents have potential to be affected by the alleged deficient practice. An audit of quarterly MDS assessments and oral assessments were completed within the last 90 days was reviewed by the MDS coordinators on August 22, 2012, to ensure the quarterly MDS assessments accurately reflected the resident's oral/dental status and no other residents were affected.</p> <p>1.On August 21, 2012, the MDS</p>		

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	<p>An oral assessment, dated 7/19/12, indicated Resident #77 had his own teeth with no dentures. Some upper and some lower teeth were missing. The assessment indicated from the diagram teeth #22 and #27 were missing.</p> <p>An oral assessment, dated 8/1/12, indicated Resident #77 had his own teeth with no dentures. Some upper and some lower teeth were missing. The assessment indicated from the diagram teeth #22 and #27 were missing.</p> <p>On 8/2/12 at 11:00 A.M., the Social Service Director indicated she could find no record where Resident #77 had seen a dentist since admission.</p> <p>3.1-31(c)(9)</p>		<p>coordinators were in-serviced by the Director of Nursing to validate understanding of the importance of ensuring that oral assessments are completed accurately. MDS coordinator(s) will bring newly completed oral assessments to the Mon-Fri stand-up meeting to be reviewed by the Interdisciplinary Team for completed accuracy in relation to oral/dental status. The Director of Nursing or designee will audit completed MDS assessments on a weekly basis for four (4) weeks and continue no less than two (2) additional months to ensure accuracy of the MDS assessment in relation to oral/dental status.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure care plans were reviewed and revised when changes occurred in the resident assessments, for 2 of 30 residents reviewed for care plans, in that care plans were not revised for a resident who was known to disable alarms and for a resident who lost weight. (Residents #152, #113)</p> <p>Findings include:</p> <p>1. Resident #113's clinical record was reviewed on 8/1/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, dementia with</p>	F0280	<p>F-280</p> <p>1. On August 2, 2012, resident # 113's care plan was updated by the Certified Dietary Manager to reflect the resident's recent weight loss; The Nourishment List was also updated to reflect the dietary recommendations for snacks three times a day between meals; Resident # 152's care plan was also updated to reflect the resident's history of self- disabling of alarms.</p> <p>1. All residents with fall interventions and residents with a significant weight loss have potential to be affected by the alleged deficient practice. On</p>	09/05/2012			

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	<p>behavior disturbances, rehabilitation, Parkinson's disease, diabetes mellitus II, gastroesophageal reflux disease, depression, schizophrenia, and paralysis agitans.</p> <p>Resident #113's weights were documented as follows: 6/13/12-193 pounds, 7/5/12-177 pounds, 7/12/12-178, 7/19/12-179. The weight loss from 6/13/12 to 7/5/12 was 8 percent.</p> <p>Resident #113 had a care plan, dated 3/28/12, for being at risk for alteration in nutrition. Interventions included, but were not limited to, the following: Serve my diet, snacks, and supplements as ordered Monitor my food and fluid intakes Monitor my weight per facility protocol Provide me any assistance I may need at meals Offer fluids of choice frequently Observe for s/s dehydration</p> <p>There was also a care plan for being at risk for skin breakdown, dated 3/16/12, with interventions including, but not limited to, the following: Assess and document discolorations... Provide diet as ordered. Record food intake % at each meal Report decline in intake to physician</p>		<p>August 21-22, 2012, a care plan audit was completed by nursing management on residents who currently have orders for safety alarms and have a history of self-disabling alarms to ensure the care plans reflect this noted behavior. This audit also included a review of any resident's who are currently triggering for a 5% weight loss in the past 30 days and/or a 10% weight loss in the past 180 days. Care plans were updated as indicated by nursing management on August 21-22, 2012.</p> <p>1.Licensed nursing staff and the Certified Dietary Manager were in-serviced on August 21-23, 2012 by the Director of Nursing and/or Nursing Management regarding the facilities policy and procedure for updating care plans when a resident is non-compliant with their safety alarms and/or experience a change of condition related to a significant weight loss.</p> <p>1.The Director of Nursing or designee will audit the 24 hour report five (5) times per week for four (4) weeks and then weekly for no less than two (2) additional months to recognize any residents with a significant weight loss, and identify behaviors of non-compliance with safety alarms. The Director of Nursing or designee will then ensure the resident's care plan has been</p>		

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	<p>Offer food substitutes as needed Dietician to evaluate resident nutritional status quarterly and as needed</p> <p>Dietary notes included, but were not limited to, the following:</p> <p>7/9/12 3:01 p.m. "Resident receives a CCHO [controlled carbohydrate] diet. Resident consume 76% or more of his meals. Resident's weight is 193 (sic). Skin intact. Will continue to monitor." Written by the Dietary Service Manager [DSM].</p> <p>7/12/12 3:44 p.m. "[Nutrition] review, current weight 177 lbs and previous 178.3 lbs. Diet is regular CCHO. Consumes 75-100% of meals and snacks in resident room. Noted to refuse breakfast most days. Eats in the dining room on occasion. No noted skin concerns or fluid problems. Will continue to monitor related to weight stability." Addendum: "Add snacks TID [three times a day] between meals." This was written by the Registered Dietician.</p> <p>7/19/12 12:55 p.m. "...continue to monitor." Written by the DSM.</p> <p>7/26/12 4:27 p.m. "[Nutrition] review: Current weight 181.1 previous weight</p>		<p>updated to reflect this behavior or change of condition related to a significant weight loss by randomly auditing at least five (5) care plans per week for four (4) weeks and then weekly for no less than two (2) additional months.</p> <p>1. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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	<p>178.8. Consumes 100% meals 50-100% snacks..." Written by the DSM.</p> <p>The Dietary Service Manager [DSM] provided the "Nourishment Listing by Time" on 8/2/12 at 12:20 p.m. The list was reviewed at that time. The DSM indicated, at that time, anyone on a Controlled Carbohydrate diet were specifically listed on the nourishment list for bedtime snacks to ensure they received them, and that all residents were offered bedtime snacks whether or not they were on special diets. She indicated any resident with orders for snacks three times a day would be listed on the list. Review of the Nourishment Listing indicated Resident #113 was only planned for his routine bedtime snack, not for snacks three times a day as recommended by the dietitian.</p> <p>Interview with Director of Nurses [DoN], Assistant Director of Nurses [ADoN], and Dietary Service Manager [DSM], on 8/2/12 at 3:30 p.m., indicated they were following the resident in the Nutrition at Risk Program for 4 weeks. She further indicated she was unaware of the recommendation to add snacks three times a day between meals.</p>			

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	<p>There was no indication the care plan was revised to include actual weight loss and additional snacks related to the weight loss.</p> <p>2. Resident #152 's record was reviewed on 7/30/12 at 1445. Diagnoses included, but were not limited to, acute CVA [cerebral vascular accident] with left sided weakness, carotid artery stenosis, history of coronary artery disease, recurrent falls probably secondary to previous CVA, profound anxiety, and ischemic cardiomyopathy.</p> <p>The "Initial Data Collection Tool/Nursing Service," dated 7/17/12, indicated the resident had left sided weakness.</p> <p>The "Fall Risk Assessment," dated 7/17/12, indicated the resident was at risk for falls and the interventions were for a low bed and bilateral 1/2 side rails.</p> <p>The "Fall Risk Assessment , dated 7/23/12, indicated the resident was at risk for falls and the interventions were a low bed, bilateral 1/2 siderails, education regarding falls, and bed and chair alarms.</p> <p>The "Fall Risk Assessment, dated 7/27/12, indicated the resident was at risk for falls. The interventions were a</p>						

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	<p>low bed, bilateral 1/2 siderails, a fall mat, alarm to bed and chair, education regarding falls and ambulating with a walker.</p> <p>The MDS [Minimum Data Set], dated 7/16/12, indicated the resident had a cognitive score of 6 out of a total of 15. The score indicated the resident had some impaired mental awareness.</p> <p>On observation of Resident # 152 on 7/29/12 at 3:28 p.m., Resident # 152 was found with a scab and a bruise on his left forehead. The resident was found to be up in a wheelchair with an alarm attached to it and anti-tippers on the back of his wheelchair.</p> <p>On interview of the resident on 7/29/12 at 3:28 p.m., Resident #152 indicated he had fallen in his room, hitting his head on a black plug-in, which was in a wall outlet, and hurting his left rib cage area from striking the side of his bed. The resident indicated he had gotten out of bed on the right side and was ambulating around the foot of his bed to go to the bathroom when he fell striking his head and hurting his rib cage area.</p> <p>The resident's record review indicated</p>				

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	<p>the resident had fallen on 7/23/12, 7/26/12, and 7/27/12.</p> <p>The resident's nurses notes, dated 7/20/12 at 3:40 p.m., indicated the resident transferred with the assistance of 2 persons.</p> <p>The resident's nurses notes, dated 7/23/12 at 9:40 a.m., indicated the resident was found on the floor in his room lying on his left side with a skin tear, measuring 1.8 cm. [centimeter] x 2 cm., and a 4 cm. long abrasion to his left forehead. The nurses notes indicated the resident was ambulating to the bathroom and fell. The nurses notes indicated the resident's alarm had not gone off at the time of the incident, the alarm was checked, was on and functioning, but was unplugged at the time of the incident. The nurse's notes indicated the care plan had been updated at that time.</p> <p>The care plan for falls, dated 7/26/12, indicated the resident was at risk for injury from falls related to his CVA, impaired balance, weakness, psychotropic drug use, and a history of falls. The care plan indicated the resident was receiving physical therapy. The care plan interventions included the resident was to have a falls assessment (which the resident</p>			

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	<p>had), provided with a low/platform bed, his call light within reach, adequate glare-free lighting, safety teaching to the resident, provided and observe usage of adaptive devices, such as a walker or wheelchair, reminded and reinforcement of safety awareness, reminders to request assistance prior to ambulation, appropriate footwear, and notifying falls to the physician and responsible party.</p> <p>The nurses notes, dated 7/29/12, at 2:42 a.m., indicated the resident disengaged his alarms at times.</p> <p>During an interview with RN #1 on 8/2/12 at 11:20 a.m., RN #1 indicated the resident was alert but had periods of confusion and did unplug his alarms at times.</p> <p>During an interview with the DoN [Director of Nursing] on 8/2/12 at 2:45 p.m., he indicated the resident's care plan should have been revised after his fall and injury to indicate the resident did disengage his alarms at times.</p> <p>3.1-35(d)(2)(B)</p>				

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F0323 SS=D	<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 record review, observation and interview, the facility failed to ensure a cognitively impaired resident received supervision to prevent wandering into other resident rooms for 1 of 1 resident reviewed for wandering in a sample of 30.</p> <p>Findings include:</p> <p>The clinical record for Resident #30 was reviewed on 8/01/12 at 2:20 p.m. The resident was readmitted to the facility on 2/14/12. The resident's diagnoses included, but were not limited to: psychosis, drug induced psych disorder w/delusions, depressive disorder, and dementia with disturbance of behavior. A cognitive assessment, dated 7/17/12, indicated "mental alert, confused, ambulates independently."</p> <p>Review of the MDS (Minimum Data Set) Quarterly Assessment, dated 5/18/12, included, but was not limited to: severely impaired cognitively, and never or rarely made decision. No</p>	F0323	<p>F-323</p> <p>1.As stated in the Summary Statement of Deficiencies, resident # 30 was care planned for wandering behavior, and interventions were in place to provide supervision, activities and re-direction when the resident was displaying wandering behavior. Additionally, no harm was incurred by the resident allegedly wandering into another resident's room on July 27, 2012. On August 2, 2012 the facilities IDT team met and completed a review of Res. # 30's care plan and interventions. During the meeting on August 2, 2012, it was decided by the IDT team to move the resident to a room closer to the nurses' station, and apply a sensor alarm to the inside of the resident's door to provide additional supervision.</p> <p>1.Resident's displaying wandering type behavior and residing on the secured dementia unit have the potential to be affected by the alleged deficient practice. On August 23, 2012, an audit of residents residing on the Dementia Care unit displaying</p>	09/05/2012			

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	<p>behavior exhibited. Wandering occurred 1-3 days. Extensive assist with ADL's requiring one person assist.</p> <p>On 8/01/12 at 3 p.m., Resident #30 was observed with a CNA being assisted to the bathroom from the activity room.</p> <p>The Care Plan reviewed at this time, included, but was not limited to: "Onset 5/16/07, #6. Problem/Need - I am w/dx (with diagnosis) of dementia w/behaviors I do attempt to enter other res [resident] rooms and wanders on secured unit."</p> <p>Approach - "Observe me for an increase in restlessness, offer me housekeeping type activity as a diversion, offer me a rest period, offer me a magazine, secured unit for my safety at all times, added 7/21/12 will monitor resident's where about's Re direct out of other resident's rooms."</p> <p>"Goal will be easily redirected from other residents' rooms daily through the next 90 days 5/23/12, 8/17/12, added 7/21/12 Will re-direct to resident's own room."</p> <p>Nurse's Notes included, but were not limited to: 7/21/12 6:30 p.m. "Around</p>		<p>wandering type behaviors was completed by nursing management to ensure the resident was care planned for wandering type behaviors and that interventions were in place to address the residents wandering behavior.</p> <p>1. Staff on the Dementia Care Unit were in-serviced on August 20-24, 2012, regarding appropriate interventions to utilize when resident's attempt to wander into other residents rooms. The Director of Nursing and/or designee will complete random QA observations five (5) times a week for four (4) weeks, then three (3) times a week for no less than two (2) additional months on the Dementia Care unit to ensure staff are providing adequate supervision and redirection to residents displaying wandering type behaviors.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>				

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	<p>5:30 p.m. this resident was found in another resident's room in the bed. According to the CNA whom entered room [number] found this resident's pants removed, but her hipsters were still in place. Noted that the resident in room [number] had his hand under her hipster. This nurse was called to the room at this time nurse observed resident [number] having his hands on her breast. Immediately removed both residents from the situation. head to toe assessment completed without any reddness (sic) or marks noted...Will monitor resident's where about's at all times. as (sic) this resident has a history of wandering in and out of other residents room. At this time there is no abnormal behaviors."</p> <p>The Care Plan was updated Approach 7/21/12 "Will re-direct to resident's own room." The resident was also placed on 15 minute checks.</p> <p>Nurse's Note of 7/22/12 "06:57 p.m. Resident continues on every 15 minute checks. Noting no further incidents of wander [sic] into another resident's room and getting in the bed. Continues to wander but is being closely supervised."</p> <p>A Social Service Note, dated 7/ 23/12 03:47 p.m., indicated "both residents</p>			

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	<p>were placed on watch with staff members for next 72 hours. Resident #30 had no recall of incident."</p> <p>Nurse's Note of 7/24/12 4:34 a.m.,..."Resident remains on 15 minute checks related to incident of 7/21/12."</p> <p>A Post Fall Screening Tool, dated 7/27/12 at 6:35 a.m., indicated the resident was found sitting on the floor on the mat in another resident room in an upright position.</p> <p>Review of the nurses notes included, but was not limited to: "7/27/12 6:48 p.m., Res. cont. to wander in and out of rooms, but no behaviors. ambulating ad lid (sic), with gait steady. At 6:35 a.m., resident was found sitting on the mat in another resident's room in an up right position..."</p> <p>In interview with LPN #2 on 8/2/12 at 9:50 a.m., discussed interventions on care plan not working as resident was found in another resident room on 7/27/12 and the care plan had not been revised. Documentation was lacking the resident was being supervised to prevent entering other resident rooms.</p>			

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	<p>In interview with the Director of Nursing (DON) on 8/2/12 at 10:40 a.m., he indicated they monitor her and re-direct her out of the room. They try to engage her in activities, and observe her. "We try to be proactive not reactive."</p> <p>On 8/2/12 at 11:25 a.m., Resident #30 was observed in the activity/restorative dining room paging through a magazine.</p> <p>On 8/3/12 at 9 a.m., the DON indicated Resident #30 was being moved closer to the nurses' station. The Maintenance Director was in the room and was observed attaching a motion sensor above the doorway.</p> <p>3.1-45(a)(2)</p>			
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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for nutrition/weight loss, in a sample of 3 who met the criteria for nutrition/weight loss, had the weight loss reported to the physician and received additional snacks as recommended by the Dietitian. (Resident #113)</p> <p>Finding includes:</p> <p>Resident #113's clinical record was reviewed on 8/1/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbances, rehabilitation, Parkinson's disease, diabetes mellitus II, gastroesophageal reflux disease, depression, schizophrenia, and paralysis agitans.</p> <p>Resident #113's weights were</p>	F0325	<p>1.To ensure adequate notification, Resident # 113's physician and family were again notified by the Director of Nursing of the resident's recently experienced weight loss on August 2, 2012. At the time the resident's weight loss was initially identified, the resident was placed on our Nutritional Intervention Program (N.I.P.) and interventions were put in place to address the change in condition. At this time the resident's weight has been stable for more than 30 days, and is no longer triggering an acute weight loss.</p> <p>1.Residents that have experienced a significant weight loss have the potential to be affected by the alleged deficient practice. On August 21, 2012, an audit was completed by the Certified Dietary Manager (C.D.M.) of residents having</p>	09/05/2012			

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	<p>documented as follows: 6/13/12 193 pounds, 7/5/12 177 pounds, 7/12/12 178, 7/19/12 179. The weight loss from 6/13/12 to 7/5/12 was 8 percent.</p> <p>The physician saw the resident on 7/25/12. The progress note did not indicate any knowledge of the weight loss.</p> <p>Nurses' notes and dietary notes were reviewed and there was no indication the physician was notified of the weight loss.</p> <p>Resident #113 had a care plan, dated 3/28/12, for being at risk for alteration in nutrition. Interventions included, but were not limited to, the following: Serve my diet, snacks, and supplements as ordered Monitor my food and fluid intakes Monitor my weight per facility protocol Provide me any assistance I may need at meals Offer fluids of choice frequently Observe for s/s dehydration</p> <p>There was also a care plan for being at risk for skin breakdown, dated 3/16/12, with interventions including, but not limited to, the following: Assess and document discolorations... Provide diet as ordered. Record food</p>		<p>experienced a 5 % weight loss/gain in the past 30 days and of residents having experienced a 10% weight loss in the past 180 days. The audit was to ensure adequate physician and family notification regarding a significant weight loss. The audit also included a review of dietary recommendations received in the past 30 days to ensure all dietary recommendations had been adequately followed through and new orders received as indicated.</p> <p>1. On August 21, 2012, Nurse Managers and the C.D.M. were in-serviced by the Director of Nursing (D.O.N.) on the importance of ensuring physician and family notification when a resident experiences a 5 % weight loss/gain in 30 days and/or a 10% weight loss/gain in 180 days.</p> <p>The N.I.P. committee will review the Weight Change Report during the weekly N.I.P. meeting, for the purpose of identifying residents who may be triggering an acute weight loss or gain. The Nurse Manager and/or C.D.M. will ensure that the physician and responsible parties have been notified for any residents found to be experiencing a 5 % weight loss/gain in the past 30 days or a 10% weight loss/gain in the past 180 days. The N.I.P. committee will also review dietary recommendations received within the past 7 days to ensure</p>		

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	<p>intake % at each meal Report decline in intake to physician Offer food substitutes as needed Dietician to evaluate resident nutritional status quarterly and as needed</p> <p>Dietary notes included, but were not limited to, the following:</p> <p>7/9/12 3:01 p.m. "Resident receives a CCHO [controlled carbohydrate] diet. Resident consume 76% or more of his meals. Resident's weight is 193. Skin intact. Will continue to monitor." This note was written by the Dietary Services Manager (DSM).</p> <p>7/12/12 3:44 p.m. "[Nutrition] review, current weight 177 lbs and previous 178.3 lbs. Diet is regular CCHO. Consumes 75-100% of meals and snacks in resident room. Noted to refuse breakfast most days. Eats in the dining room on occasion. No noted skin concerns or fluid problems. Will continue to monitor related to weight stability." Addendum: "Add snacks TID [three times a day] between meals." This was written by the Registered Dietician (RD)</p> <p>7/19/12 12:55 p.m. "...continue to monitor." Written by the DSM.</p>		<p>adequate follow through and new orders received as indicated. The D.O.N. or designee will audit the Weight Change Report for any residents triggering an acute weight loss or gain to ensure the residents physician and responsible party have been notified. Additionally, the audit will review received dietary recommendations within the past 7 days to ensure adequate follow through and new orders have been received as indicated. The audits will be completed weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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	<p>7/26/12 4:27 p.m. "[Nutrition] review: Current weight 181.1 previous weight 178.8. Consumes 100% meals 50-100% snacks..." Written by the DSM.</p> <p>LPN #2 was interviewed on 8/2/12 at 10:45 a.m. She indicated nurses' notes or dietary notes should indicate physician notification of weight losses.</p> <p>The Dietary Service Manager [DSM] provided the "Nourishment Listing by Time" on 8/2/12 at 12:20 p.m. The list was reviewed at that time. The DSM indicated, at that time, anyone on a Controlled Carbohydrate diet were specifically listed on the nourishment list for bedtime snacks to ensure they received them, and that all residents were offered bedtime snacks whether or not they were on special diets. She indicated any resident with orders for snacks three times a day would be listed on the list. Review of the Nourishment Listing indicated Resident #113 was only planned for his routine bedtime snack, not for snacks three times a day as recommended by the dietitian.</p> <p>Interview with Director of Nurses [DoN], Assistant Director of Nurses [ADoN], and Dietary Service Manager</p>			

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	<p>[DSM], on 8/2/12 at 3:30 p.m., indicated they did not know about notification of the physician regarding weight loss and would check on it. The DSM indicated they were following the resident in the Nutrition at Risk Program for 4 weeks. She further indicated she was unaware of the recommendation to add snacks three times a day between meals.</p> <p>On 8/2/12 at 4:30 p.m., the DSM indicated she remembered having a conversation with the family about the weight. She was unable to say whether the physician was notified or not, but they were going to notify him now. She indicated the last weight 7/26/12 was 181 and they were going to see what the doctor wanted to do about the snacks.</p> <p>The policy and procedure for Registered Dietician Consultation [no date] was provided by the Director of Nurses on 8/3/12 at 11:45 a.m. The policy and procedure included, but was not limited to, the following guidelines: "RD [Registered Dietician] will review recommendations with nursing management and /or executive director of the facility and leave written recommendations." "Resident's physician will be notified</p>						

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	<p>within (7) days of the RD recommendations to determine if the physician agrees to follow the recommendations."</p> <p>"If recommendations are considered necessary for the resident, the nurse will complete an order and implement interventions to complete the recommendations, i.e., physician order, lab requisition, communication with central supply on availability of product, etc."</p> <p>"Once the resident's physician agrees or declines recommendation, the nurse will document in the resident's plan of care and update if indicated..."</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>				

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F0412 SS=D	<p><b>483.55(b)</b> <b>ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b></p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to ensure routine dental checkups were provided for 1 of 3 sampled residents who met the criteria for dental service. (Resident 77)</p> <p>Findings include:</p> <p>An observation was made on 7/31/12 at 09:30 A.M., of Resident #77. He had missing and broken teeth. Resident #77's quarterly Minimum Data Set [MDS] Assessments, dated 2/9/12 and 4/26/12, were reviewed. The oral/dental status in the last full annual MDS assessment, dated 11/17/11, was as follows: "obvious or likely cavity or broken natural teeth."</p>	F0412	<p>F 412</p> <p>1. 1. Upon assessment of the resident # 77's current oral/dental status. There is no oral/dental concerns noted, and there is no evidence that the resident incurred any harm related to the alleged deficient practice. Resident #77 had a routine dental exam on August 23, 2012 at Hartman Dental Clinic and no areas of concern were reported.</p> <p>2. 2. All residents have potential to be affected by the alleged deficient practice. Chart reviews were completed by Social Services on August 20-21, 2012 for residents to ensure routine dental checkups were provided in accordance with 483.75(h) for dental services.</p> <p>3. 3. Social Services was re-educated by the Director of Nursing on August 22, 2012</p>	09/05/2012	

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	<p>Resident #77's clinical record was reviewed on 8/1/12 at 11:41 A.M. It included a document titled Initial Data Collection Tool/Nursing Services and dated 3/11/2010. The document indicated the resident had his own teeth, but some were loose and missing. The document did not include the specifics of which teeth were loose or missing.</p> <p>An annual nutrition data collection /assessment, dated on 11/15/11, for Resident #77 was documented as the resident required a mechanically altered diet next to the assessment of chewing ability.</p> <p>A monthly summary, dated 7/17/12, indicated Resident #77 needed total care with oral hygiene and had his own teeth.</p> <p>An oral assessment, dated 7/19/12 and 8/1/12, indicated Resident #77 had his own teeth with no dentures. Some upper and some lower teeth were missing with the numbers 22 and 27 printed on the assessment indicating from the diagram teeth #22</p>		<p>regarding provision and tracking of resident dental services. The E.D. executed a contract with Primesource Dental Services to provide ongoing routine dental services within the facility on August 20, 2012. All residents requiring dental checkups in accordance with 483.75(h) had dental appointments scheduled by Social Services by August 24, 2012.</p> <p>Social Services or designee will audit resident charts to ensure routine dental services have been provided according to state guidelines at least five (5) times weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. 4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>				

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	<p>and #27 were missing.</p> <p>In interview on 8/1/12 at 2:46 P.M. with the Social Services Director, she indicated it was her responsibility to schedule dental appointments if residents needed it. In the interview she indicated the facility did not currently have a dentist who comes to the facility, but the facility was trying to get one. She indicated the "Residents of the facility had to be sent out to see a dentist."</p> <p>On 8/2/12 at 11:00 A.M., the Social Service Director indicated she could find no record where Resident #77 had seen a dentist since his admission.</p> <p>In an interview on 8/3/12 at 12:30 P.M., the Director of Nursing [DoN] indicated he could not find a facility policy for routine dental exams.</p> <p>3.1-24(a)(1)</p>				

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F0441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p><b>A. Based on interview and record</b></p>	F0441	F 441			09/05/2012	

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	<p>review, the facility failed to ensure an effective facility infection control program by not keeping a record of TB [tuberculosis] skin tests [a series of 2 injections done to detect if a person has TB] in 5 of 10 employees reviewed for receiving a TB skin test. (CNA #5, #6, #7, #8, and LPN # 1)</p> <p>B. Based on observation and record review, the facility failed to ensure it implemented infection control policies to prevent potential transmission of infection during observations of care for 1 of 5 sampled residents observed during care, in that gloves were not changed and hands washed between soiled and clean activities. (Resident #1)</p> <p>Findings include:</p> <p>A.1. A record review on 8/2/12 at 3:30 P.M., of employee files indicated the following employees did not receive their complete TB screening:</p> <ol style="list-style-type: none"> <li>1. CNA #5 hired on 5/8/12 had no record of a TB screening.</li> <li>2. CNA #6 hired on 4/25/12 had no record of a TB screening.</li> <li>3. CNA #7 hired on 6/1/12 had no record of the 2nd TB screening.</li> <li>4. LPN [Licensed Practical Nurse] #1 hired on 5/17/12 had no record of TB</li> </ol>		<ol style="list-style-type: none"> <li>1. 1. Upon review of the alleged incident as cited in the Summary Statement of Deficiencies, no harm was incurred by the resident related to the alleged deficient practice. CNAs #1 and #2 were re-educated by the Staff Development Coordinator on hand washing and the proper removal of contaminated gloves during resident care. Additionally, the facility has ensured via documentation that C.N.A.'s #5, #6, #7, #8 and L.P.N. #1 are in compliance with state guidelines and the facility policy related to TB skin testing. A new 2-step PPD series of injections or chest x-rays were initiated and compliance will be achieved by August 31, 2012.</li> <li>2. 2. All residents requiring assistance with personal care are at risk to be affected. On August 1, 2012, nursing administration initiated a 2-step PPD injection series on applicable associates to ensure compliance with State guidelines.</li> <li>3. 3. Nursing staff were provided re-education with return demonstration by the Staff Development Coordinator and Unit Managers on August 20-24, 2012, regarding hand washing and the proper removal of contaminated gloves during resident care. The Staff Development Coordinator was</li> </ol>				

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	<p>screening.</p> <p>5. CNA #8 hired on 11/18/96 had no annual TB screening.</p> <p>In an interview on 8/2/12 at 4:40 P.M., with the Regional Business Office Manager, she indicated the facility realized "there was a problem with not having a record of all the TB skin tests given to employees."</p> <p>In an interview on 8/2/12 at 4:50 P.M., the DoN [Director of Nursing] indicated there was no record, other than employee files, of the employees who had received their TB skin test.</p> <p>At 11:45 A.M., on 8/3/12, the DoN provided a document titled, "Associate Physical Assessment" and dated as revised on 05/03/2005. The document indicated it was the facility policy for all new associates to complete a physical assessment which included a two-step TB skin test or documentation of having one.</p>		<p>educated by the Director of Nursing on August 8, 2012, regarding the facility policy for completing PPD screening and ensuring the injection series or chest x-ray is provided to associates as indicated. The Staff Development Coordinator will ensure that all newly hired associates are pre-screened to receive the 2-step PPD injection series or a Chest x-ray as applicable. The Director of Nursing or designee will randomly audit the proper removal of contaminated gloves during resident care at least eight (8) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The Director of Nursing or designee will review the completed files for all newly hired associates to ensure the associate was pre-screened and received as indicated a 2-step PPD injection series or annual PPD as indicated weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4. 4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as</p>	

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	<p>B. 1. On 8/1/12 at 9:22 a.m., CNAs #1 and #2 were observed to transfer Resident #1 to bed and check and change her incontinence brief. The resident was observed to be incontinent of urine and a moderate amount of feces. CNA #1 wore gloves and used commercial wipes to cleanse the resident's skin of urine and feces. Fecal matter was observed on gloves. The CNA wore the same gloves to put a clean brief on the resident, handle the resident's clean clothes, and handle the resident's wheelchair. She then removed the gloves and transferred the resident with assistance of CNA #2, and put the foot rests back on. It was not until those activities were finished that she washed her hands.</p> <p>B.2. The policy and procedure for Standard Precautions, dated 7/18/11, was provided by the Director of Nurses on 8/3/12 at 11:55 a.m. The policy regarding Personal Protective Equipment (PPE) Use, including gloves, included, but was not limited to, the following: "Follow hand hygiene recommendations immediately or as soon as feasible after removal of gloves or other PPE." "Remove PPE after it becomes contaminated and before leaving the work area." "Wear appropriate gloves when it can be</p>		indicated.				

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	<p>reasonably anticipated that there may be contact with blood or other potentially infectious materials, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised..."</p> <p>3.1-18(b)(1) 3.1-18(b)(6)</p>			

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F9999	<p><b>STATE FINDINGS</b></p> <p>1. 3.1-14 PERSONNEL</p> <p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employees received dementia training within 30 days of hire for the Alzheimer's unit for 2 of 2 employees currently working the secured unit whose records were reviewed for</p>	F9999	<p>F 9999</p> <p>1. CNA #5 and #7 were provided 6 hours of dementia training on August 22, 2012 by the Certified Dementia Practitioner.</p> <p>2. Employee files were reviewed by nursing management on August 13, 2012 for staff assigned to the Dementia Care Unit to ensure proper dementia training was provided and additional training provided as indicated.</p> <p>3. Staff requiring additional dementia training will be trained by the Certified Dementia Practitioner by Aug 31, 2012; education to include but not limited to review of the needs and/or preferences of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. The Staff Development Coordinator will ensure required training is provided to staff who have regular contact with residents; Staff shall have a minimum of six (6) hours of dementia specific training within six (6) months of initial employment, or within (30) days for personnel assigned to the Dementia Care Unit, and three (3) hours annually thereafter. The Director of Nursing or designee</p>	09/05/2012			

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	<p>dementia training in a sample of 10. (CNA #5,#7) Findings include:</p> <p>The employee files were reviewed on 8/2/12 between 2 p.m. and 4:30 p.m., and the following was noted:</p> <ol style="list-style-type: none"> <li>CNA #5 with a hire date of 5/8/12 lacked dementia training in the file.</li> <li>CNA #7 with a hire date of 6/1/12 lacked dementia training in the file.</li> </ol> <p>In interview with the Director of Nursing (DON) on 8/2/12 at 4:45 p.m., he indicated both employees were currently working on the Alzheimer's unit and had not had the demenia training.</p> <p>In interview with the DON on 8/3/12 at 11:50 a.m., he indicated he did not know if he had a policy on dementia training and that staff on the unit should have the training. He indicated they should have 6 hours within 30 days of hire and the facility uses the state guidelines.</p>		<p>will audit newly hired employee files weekly for one month and continue weekly for no less than two (2) additional months.</p> <p>4. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p> <p>5. September 6, 2012</p> <p>F 9999</p> <p>1.The lights were changed in room 311,313, and 317 on August 2, 2012 by the Maintenance Director to exceed state lighting requirements.</p> <p>1.All resident bathrooms were audited on August 22, 2012, by the Maintenance Director to ensure light intensity was sufficient and lighting exceeded state guidelines of 20 Foot-Candles at the mirror shelf and sink.</p> <p>1.The Maintenance Director will measure the light intensity in</p>				

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	<p>2. 3.1-19 ENVIRONMENTAL AND PHYSICAL STANDARDS</p> <p>(dd) Each facility shall have natural lighting augmented by artificial illumination, when necessary, to provide light intensity and to avoid glare and reflective surfaces that produce discomfort and as indicated in the following table: Toilet and bathing facilities-20 Foot-Candles.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on observation and interview,</p>		<p>foot-candles at the mirror shelf and sink in at least five (5) resident bathrooms weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>1. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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	<p>the facility failed to ensure resident bathrooms had required lighting for 3 of 37 resident rooms observed for lighting. (Rooms #317, #311, #313) This deficient practice potentially affected 5 residents residing in the rooms.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 8/1/12 at 2:37 p.m., Room 317's bathroom was checked for lighting levels using a light meter. At the level of the mirror shelf, the light meter registered 10 foot-candles. At the sink level, the meter registered less than 10 foot-candles.</li> <li>On 8/1/12 at 2:40 p.m. Room 311's bathroom was checked for lighting levels. At the level of the mirror shelf, the light meter registered 10 foot-candles. At the sink level, it measured less than 10 foot-candles.</li> <li>On 8/1/12 at 2:42 p.m., Room 313's bathroom was checked for lighting levels. At the level of the mirror shelf, the light meter registered 10 foot-candles. At the sink level, it measured less than 10 foot-candles.</li> <li>This information was reviewed with the Administrator on 8/3/12 at 1:30 p.m. He indicated he was unaware</li> </ol>			

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	the bathroom lighting failed to meet the required foot-candles of light and it would be fixed.			