

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2011
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NAME OF PROVIDER OR SUPPLIER LU ANN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 952 W WALNUT ST NAPPANEE, IN46550
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: November 14-18, 2011</p> <p>Facility number: 000317 Provider number: 155722 AIM number: 100274860</p> <p>Survey team: Honey Kuhn, RN, TC (November 14-17, 2011) Carol Miller, RN Shelly Miller-Vice, RN</p> <p>Census bed type: SNF?NF: 30 Total: 30</p> <p>Census payor type: Medicare: 2 Medicaid: 22 Other: 6 Total: 30</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/29/11 by Suzanne Williams, RN</p>	F0000		

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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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to report an incident and investigation of staff to resident abuse to the ISDH (Indiana State Department of</p>	F0225	1) The facility has in place policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident	12/22/2011	

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	<p>Health) in regard to 1 of 2 residents reviewed for allegations of abuse in a sample of 10. (Resident #11)</p> <p>Findings include:</p> <p>The DNS (Director Nursing Services) provided two facility investigations of abuse for review on 11/16/11 at 10:00 a.m. The DNS indicated she thought she had faxed information in regard to the provided investigation of staff to resident abuse, which occurred on 11/03/11, to ISDH. The DNS indicated she could not locate a fax confirmation and must have forgotten to do so.</p> <p>Review of the facility investigation indicated a thorough investigation had been completed in regard to LPN #13 verbally abusing Resident #11 on 11/03/11. The investigation resulted in the termination of employment of LPN #13 following a three day suspension.</p> <p>Review of a facility policy and procedure, provided by the Administrator following the entrance conference on 11/14/11, titled, "Abuse Prohibition Policy", dated 03/04/08, indicated: "Policy: It is the policy of LuAnn Nursing Home to provide a safe environment for the residents who reside here. To that end, the following policies</p>		<p>property. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate action must be taken. The facility failed to report an incident and investigation of staff to resident abuse to the ISDH. All residents have the potential to be affected by this deficient practice. II) On 11/17/11 Department Heads were advised of the deficient practice of not reporting an incident and investigation of staff to resident abuse to the ISDH. At the monthly nurse's meeting on 12/15/11 the nurses will be informed of the deficient practice. All staff will be informed of this deficient practice at the Annual All Staff Meeting on 12/16/11. All staff will also be reinforced of the need to report any signs of mistreatment, neglect, and abuse of residents and misappropriation of resident property so that an investigation can be completed. The policy of Reporting Abuse to State Agencies and Other Entities/Individuals will be reviewed. All staff receive information on abuse with their</p>		

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	<p>will be followed:...</p> <p>7. Reporting: ...All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law...."</p> <p>3.1-28(c) 3.1-28(e)</p>		<p>orientation. All staff are inserviced at least two (2) times yearly on abuse. If any specific needs arise throughout the year, they are addressed at that time. III) The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. IV) The results of all investigations will be reported to officials in accordance with state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. Appropriate staff will assist with the investigation. The DON will be responsible for completing the investigation and reporting reporting allegations of abuse to the Administrator, to the ISDH, APS, the Ombudsman, and any other appropriate agencies. The MDS Coordinator and SSD will be responsible to check with the DON to ensure that any investigations have been reported within 5 working days. Any investigations will be discussed at the monthly QA meeting. V) Administrator/DON/MDS Coordinator/SSD/all staff/QA Addendum F225</p> <p>Our policy and procedure Reporting Abuse to Facility</p>		

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			<p>Management states to "report any suspected abuse or incidents of abuse to the director of nursing services promptly" and "the administrator and director of nursing services must be promptly notified of suspected abuse or incidents of abuse".</p> <p>At the all staff meeting on 12/16/11, staff were reminded of what abuse is and the need to report any incidents of abuse or alleged abuse immediately to the director of nursing, the administrator, or the charge nurse.</p> <p>At the CNAs monthly meeting on 12/13/11 and 12/14/11, the CNAs were reminded of what abuse is and the necessity of reporting immediately. They were given a guideline of who to notify if the alleged abuse is by a staff nurse, the director of nursing, or the administrator.</p> <p>At the nurse's meeting on 12/15/11, nurses and QMAs were reminded that it is "Very important to report any possible abuse for investigation immediately. An initial report needs to be faxed within 24 hours and the investigation within 5 working days."</p> <p>An inservice "Verbal Abuse" was posted 12/21/11, and included "If you see someone abusing or possibly abusing a resident,</p>		

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F0226 SS=D	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 record review and interview, the facility failed to implement their abuse prevention policy and procedure regarding the failure to report an incident and investigation of staff to resident abuse to	F0226	<p>whether it is a staff member, a visitor or family, or another resident, this needs to be reported immediately. It must be reported to the Indiana State Department of Health (ISDH) within 24 hours, an investigation completed, and the investigation reported to the ISDH within 5 days. We also fax the results of the investigation to the Ombudsman and Adult Protective Services."</p> <p>At the monthly QA Committee meeting on 12/22/11, the need to report any abuse or suspected abuse immediately, the need to fax an initial report within 24 hours, and to fax the completed investigation within 5 working days was discussed.</p> <p>At the Department Head Meeting on 12/21/11, the need to report any abuse or suspected abuse immediately, the need to fax an initial report within 24 hours, and to fax the completed investigation within 5 working days was discussed.</p> <p>l) The facility has in place policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility failed to</p>	12/22/2011	

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	<p>the ISDH (Indiana State Department of Health) in regard to 1 of 2 residents reviewed for allegations of abuse in a sample of 10. (Resident #11)</p> <p>Findings include:</p> <p>The DNS (Director Nursing Services) provided two facility investigations of abuse for review on 11/16/11 at 10:00 a.m. The DNS indicated she thought she had faxed information in regard to the provided investigation of staff to resident abuse, which occurred on 11/03/11, to ISDH. The DNS indicated she could not locate a fax confirmation and must have forgotten to do so.</p> <p>Review of the facility investigation indicated a thorough investigation had been completed in regard to LPN #13 verbally abusing Resident #11 on 11/03/11. The investigation resulted in the termination of employment of LPN #13 following a three day suspension.</p> <p>Review of a facility policy and procedure, provided by the Administrator following the entrance conference on 11/14/11, titled ,"Abuse Prohibition Policy", dated 03/04/08, indicated: "Policy: It is the policy of LuAnn Nursing Home to provide a safe environment for the residents who reside</p>		<p>follow our policy, Abuse Prohibition Policy, dated 03/04/08. The policy states that "All alleged/ suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals..." All residents have the potential to be affected by this deficient practice.</p> <p>II) On 11/17/11 Department Heads were advised of the deficient practice of not following our policy, Abuse Prohibition Policy, dated 03/04/08. At the monthly nurse's meeting on 12/15/11 the nurses will be informed of the deficient practice. All staff will be informed of this deficient practice at the Annual All Staff Meeting on 12/16/11. All staff will also be reformed of the need to report any signs of mistreatment, neglect, and abuse of residents and misappropriation of resident property so that an investigation can be completed. The policy of Reporting Abuse to State Agencies and Other Entities/Individuals will be reviewed. All staff receive information on abuse with their orientation. All staff are inserviced at least two (2) times yearly on abuse. If any specific needs arise throughout the year, they are addressed at that time. III) The results of all investigations will be reported to officials in accordance with our policy, Abuse Prohibition Policy, and state law, including the ISDH, within 5 working days</p>		

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	<p>here. To that end, the following policies will be followed:...</p> <p>7. Reporting: ...All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law...."</p> <p>3.1-28(a)</p>		<p>of the incident. If the alleged violation is verified, appropriate corrective action will be taken.</p> <p>IV) The results of all investigations will be reported to officials in accordance with our policy, Abuse Prohibition Policy, and state law, including the ISDH, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action will be taken. Appropriate staff will assist with the investigation. The DON will be responsible for reporting allegations of abuse to the Administrator, completing the investigation and reporting such to the ISDH, APS, the Ombudsman, and any other appropriate agencies. The MDS Coordinator and SSD will be responsible to check with the DON to ensure that any investigations have been reported within 5 working days. Any investigations will be discussed at the monthly QA meeting. V) Administrator/DON/MDS Coordinator/SSD/all staff/QA Addendum F226</p> <p>Our policy and procedure Reporting Abuse to Facility Management states to "report any suspected abuse or incidents of abuse to the director of nursing services promptly" and "the administrator and director of nursing services must be</p>		

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			<p>promptly notified of suspected abuse or incidents of abuse“.</p> <p>At the all staff meeting on 12/16/11, staff were reminded of what abuse is and the need to report any incidents of abuse or alleged abuse immediately to the director of nursing, the administrator, or the charge nurse.</p> <p>At the CNAs monthly meeting on 12/13/11 and 12/14/11, the CNAs were reminded of what abuse is and the necessity of reporting immediately. They were given a guideline of who to notify if the alleged abuse is by a staff nurse, the director of nursing, or the administrator.</p> <p>At the nurse's meeting on 12/15/11, nurses and QMAs were reminded that it is "Very important to report any possible abuse for investigation immediately. An initial report needs to be faxed within 24 hours and the investigation within 5 working days."</p> <p>An inservice "Verbal Abuse" was posted 12/21/11, and included "If you see someone abusing or possibly abusing a resident, whether it is a staff member, a visitor or family, or another resident, this needs to be reported immediately. It must be reported to the Indiana State Department of Health (ISDH)</p>		

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F0242 SS=G	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. Based on observations, record reviews and interviews, the facility failed to provide choices of schedule of activities of daily living according to resident's personal desire and prior routine. Resident #1 was not able to begin her day before 9:00 am or participate in afternoon	F0242	<p>within 24 hours, an investigation completed, and the investigation reported to the ISDH within 5 days. We also fax the results of the investigation to the Ombudsman and Adult Protective Services."</p> <p>At the monthly QA Committee meeting on 12/22/11, the need to report any abuse or suspected abuse immediately, the need to fax an initial report within 24 hours, and to fax the completed investigation within 5 working days was discussed.</p> <p>At the Department Head Meeting on 12/21/11, the need to report any abuse or suspected abuse immediately, the need to fax an initial report within 24 hours, and to fax the completed investigation within 5 working days was discussed.</p> <p>l) All residents have the right to choose activities, schedules, and health care consistent with his or her interest. They have the right to make choices about aspects of his or her life in the facility that are significant to themselves. The facility failed to provide choices of</p>	12/15/2011	

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	<p>activities.</p> <p>This deficiency affected 1 of 10 residents reviewed for activities of daily living in the sample of 10 (Resident #1).</p> <p>Finding includes:</p> <p>The following observations were made of Resident #1 throughout the survey process:</p> <p>On 11/14/2011 at 10:30 a.m., Resident #1 was observed in the day room/dining area, well groomed, in her personal wheelchair and positioned at the edge of one of the dining tables.</p> <p>On 11/15/2011 at 9:10 a.m., Resident #1 was observed lying in bed in her room, with side rails up on each side, call light knotted around metal handrail, and with a perplexed expression on her face. There were no staff in her room. Resident #1 was interviewed at this time, concerning the time of day, and if breakfast and a.m. hygiene care were provided. When asked if she had been up out of her bed this morning, Resident #1 stated, with tears in her eyes, "not yet...."</p> <p>On 11/15/2011 at 9:40 a.m., Resident #1 was observed propelling herself in her personal wheelchair away from the direction of her own room. Wheelchair</p>		<p>schedule of activities of daily living according to a resident's personal desire and prior routine. All residents have the potential to be affected by this deficient practice.</p> <p>II) A resident preferences survey is being completed using the results of Section F of the MDS 3.0, the Social History completed on admission, and personal interviews with residents and/or families. This will be completed by 12/12/11. All CNAs will be advised of this deficient practice at their monthly meeting on 12/13/11 and 12/14/11, along with the results of the resident preferences survey. CNA's assignment sheets will be updated with the results of the resident preferences survey. Resident's health care plans will be updated accordingly. At the monthly nurse's meeting on 12/15/11 the nurses will be informed of the deficient practice and results of the resident preference survey.</p> <p>III) Two additional Hoyer pads were ordered 12/05/11 for resident #1's use to enable her to be transferred in and out of bed per her preferred schedule. A resident preference survey will be completed by 12/12/11. CNA's</p>		

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	<p>did not have feet-leg rest mechanical parts. Resident was smiling and said hello.</p> <p>On 11/15/2011 at 2:15 p.m., Resident #1 was observed in her room lounging in a recliner in front of television.</p> <p>On 11/15/2011 from 3:00 p.m. to 3:40 p.m., Resident #1's family was interviewed in her room with the resident present. The family member stated, "...I visit her (Resident #1) seven days a week in the afternoon...She (Resident #1) isn't argumentative... unless she's provoked... I think she (Resident #1) tells them (staff) what she (Resident #1) wants..." When interviewed about specific life-style preferences when more independent, the family member stated, "...she used to get up every morning at 5 a.m.; she loves being up early. She loves to be around other people. She is a very sociable person..." When interviewed about preferences that have changed in a significant way since moving to the facility, the family member stated, "(She) can't get up early mornings. She'd like to be up and about, close to 500 a.m." When interviewed about any concerns, the family member stated, "...misses getting up early..." When interviewed concerning the involvement of herself in the care-planning process stated, "I'm not sure</p>		<p>assignment sheets will be updated and care plans will be updated with the results of the survey. New admission preferences will be completed on admission and information placed on the CNA's assignment sheets. A Department Head meeting will take place within 3 days of admission and preferences discussed and how to best meet those preferences. A Resident Preference Worksheet will be completed by Social Services and placed in the chart to communicate preferences to appropriate staff.</p> <p>IV) Resident's personal preferences will be reviewed quarterly with the MDS 3.0 and appropriate staff informed, CNA's assignment sheets and health care plan updated accordingly. Preferences will be discussed at the monthly QA meeting.</p> <p>V) DON/SSD/AD/MDS Coordinator/all nursing staff</p>		

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	<p>I have ever been involved in the process..."</p> <p>On 11/16/2011 at 9:00 a.m. Resident #1 was observed lying in bed with right hand gripping metal side rails. Resident was interviewed at this time and asked why she stays in bed till 900 a.m. The resident stated, "...can't get up...poop first...."</p> <p>On 11/16/2011 at 9:45 a.m., Resident #1 was observed sitting in the day room in her personal wheelchair.</p> <p>On 11/16/2011 at 2:00 p.m., Resident #1 was observed lying in her bed in her own room with a clean gown covering her upper waist, front of chest and shoulder areas. Resident was grasping metal side rails with both right and left hands.</p> <p>On 11/17/2011 at 9:10 a.m., the door to Resident #1's room was observed closed. Audible voices were heard from behind closed door, and A.M. care was being completed.</p> <p>On 11/17/2011 at 10:50 a.m., Resident #1 was observed in the day room in her personal wheelchair passively involved in facility provided exercise program. Resident #1 was not actively involved.</p> <p>The record of Resident #1 was reviewed</p>						

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	<p>on 11/15/2011 at 10:25 a.m. and indicated Resident #1 had diagnoses, including but not limited to, mild mental retardation, morbid obesity and depressive disorder</p> <p>Restorative Monthly Documentation dated 10/24 2011, indicated "AROM (Active Range of Motion) exercise program offered 6 x (6 times)/wk (a week). Has weakness et (and) limitations in her R (right) arm et. (and) knees 2o (secondary to) arthritis. Able to move her legs et (and) feet during exercise but not fully extend or lift them. Encouraged to fully extend BUE (Bilateral Upper Extremities) et (and) left (L) arm to shoulder height et (and) lift R (Right) arm to chest height. Needs asst (assist) c (with) bathing, dressing et (and) grooming. Able to wash her hands et (and) face BID (twice a day) et (and) c (with) showers twice wkly (weekly) c (with) setup cues et (and) prepared items handed to her. Staff completes what she's unable to do. Hoyer lift used for transfers."</p> <p>Care Plan Summary, dated 8/31/2011, for "Activities" Indicated, "Problem: (Resident #1) has medical problems that currently are limiting her time out of bed. She is up an w/c (wheelchair) for a few hours each day. She refuses to come out of room. She continues to do self</p>				

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	<p>activities while in bed and when up in chair in room. and dining room." "Goal: (Resident #1's name) will have her activity needs met daily AEB (as evidenced by) she will continue to choose what activities she wants to be involved in and she will keep busy doing self activities she enjoys daily." "Intervention: Continue to invite and encourage her to come our of room for activities frequently...."</p> <p>Nurses notes reviewed indicated: "8/4/2011 at 12:30 p.m. resident continues to cry and kick legs when in her bed in the a.m. r/t (related to) wanting up. She is incontinent of bowel. Her normal bowel pattern is having a b.m. (bowel movement) in the morning. She is a hoyer lift d/t (due to) being unable to bear weight. (Residents name) is reminded daily the importance of keeping her skin clean and dry. She continues to have skin issues. Her understanding is poor and she's not easily redirected. She is gotten up once she is finished having a b.m."</p> <p>Medication administration records (MAR) were reviewed for Ativan (antianxiety) usage as a routine medication and as an as needed medication. Physician order and dosage administered indicated: Ativan 0.25 mg one by mouth twice daily as needed for anxiety. The</p>				

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	<p>Ativan was given as follows:</p> <p>8/9 at 9 a.m., 8/11 at 6 a.m., 8/12 at 10 a.m. 8/13 at 8:45 a.m. 8/14 at 6:30 a.m. 8/15 at 8:30 a.m. 8/16 at 8 a.m. 8/27 at 8 a.m. 8/28 at 8 a.m. 8/29 at 8:30 a.m. 8/30 at 8:30 a.m. 8/31 at 9 a.m.</p> <p>Ativan dosage increased to Ativan 0.5 mg one by mouth once daily as needed for anxiety on 9/5/2011.</p> <p>9/7 at 9:15 a.m. 9/11 at 9:30 a.m. 9/13 at 9 a.m. 9/14 at 5:30 a.m. 9/15 at 5:30 a.m. 9/16 at 5:30 a.m. 9/17 at 5 a.m. 9/18 at 5 a.m.</p> <p>On 9/18/2011, the MAR indicated Ativan PRN (as needed) was changed to routine time of 05:00 a.m. for the 0.5 mg by mouth once daily.</p> <p>The functional status of the MDS assessment dated 8/30/2011 indicated the following: Resident #1's bed mobility, dressing</p>				

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	<p>abilities, and personal hygiene required extensive assistance upon staff.</p> <p>Resident #1's transfer ability and toilet use were total dependence upon staff.</p> <p>Resident #1's ability to walk in her room and in the corridor indicated these activities did not occur during the assessment.</p> <p>Resident #1's functional status for bathing was coded total dependence upon staff for completion.</p> <p>Resident #1's balance during transitions and walking were coded for moving from seated to standing position, walking, turning around and moving on and off toilet as activity did not occur. Surface to surface transfer was coded not steady, only able to stabilize with human assistance.</p> <p>The CAA (Care Area Assessment) Summary for ADL (activity of daily living) dated 8/31/2011 indicated, "(Resident #1's name) needs assist with ADL's due to she has limitations right arm and knees related to arthritis. She is on a bathing program and needs extensive assist with bed mobility, dressing and personal hygiene. She is totally dependent with showers, toileting and transfers being lifted with hoyer lift. She is unable to bear weight. She is able to assist in bathing, dressing and grooming with task segmentation, and when items</p>				

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	<p>are prepared and handed to her. She is encouraged to participate in AROM (active range of motion) with activities. Will proceed with care plan."</p> <p>The CAA Summary for Cognitive Loss dated 8/31/2011 indicated, "(Resident #1's name) has diagnosis of mild MR (mental retardation) and has some problems with memory. She has a BIMS (Brief Interview for Mental Status) score of 12 (impaired). Sight and hearing are adequate. She makes poor decisions related to picking fingernails making them bleed. She has glasses for distance but does not wear. Will proceed with care plan."</p> <p>The CAA Summary for Communication dated 8/31/2011 indicated, "(Resident #1's name) has some difficulty finding words and finishing thoughts. Speech is mumbling and talks quickly. She is difficult to understand at times. She has some difficulty with understanding related to Dx (diagnosis) mild MR (mental retardation). She is able to answer yes/no questions but not always appropriately. She will answer yes/no to same question asked at times. She is able to verbalize needs. Sight and hearing are adequate. Will proceed with care plan."</p> <p>The following interviews were conducted</p>				

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	<p>with staff concerning Resident #1 during the survey process: 11/16/2011 at 9:15 a.m. interviewed CNA #2, "...a.m. care is done at 9:30 a.m. because there are already 6 other residents being cleaned up on the night shift and we only have three CNAs on the day shift between both halls to do all the work..."</p> <p>On 11/16/2011 at 2:05 p.m., CNA #5 stated, "We just did her hygiene care... we used the hoyer lift to transfer her back to her bed..." Regarding the timeline of activities for Resident #1, CNA #5 stated, "...she (Resident #1) will stay in bed until tomorrow morning when she will be transferred back to her wheelchair with the hoyer lift after her breakfast... she does this twice a week on her shower days... she is up at approximately 9:30 a.m., then transferred back to her bed after her lunch approximately 2 p.m.... we (Lu Ann Nursing Facility) do this to keep her off her bottom because of her skin problems... the hoyer lift sling is sent to the laundry to get cleaned.... we (Lu Ann Nursing Facility) only have one (hoyer lift) sling so we have to clean it after her care..."</p> <p>On 11/17/2011 at 3:15 p.m., the DON (Director of Nursing) was interviewed and stated, "(Resident #1's name) is a challenge... we (facility) have tried</p>				

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F0315 SS=D	<p>different things to address her getting up and ready for her day... we (facility) used to get her up early, then she didn't want to do that...we've tried this, we've tried that... we've tried everything...."</p> <p>3.1-3(u)(1) 3.1-3(u)(2) 3.1-3(u)(3)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure a resident did not have an indwelling urinary catheter unless medically necessary.</p> <p>This deficiency affected 1 of 3 residents with indwelling urinary catheters in a sample of 10 (Resident #1).</p> <p>Findings include</p> <p>On 11/14/2011 at 9:10 a.m., Resident #1 was observed with an indwelling urinary catheter bag laying on the floor.</p> <p>The record of Resident #1 was reviewed</p>	F0315	<p>I) The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. The facility failed to ensure a resident did not have an indwelling urinary catheter unless medically necessary. All residents have the potential to be affected by this deficient practice.</p> <p>II) Any resident with a new order for a catheter or potential need for a catheter will be assessed to ensure that their clinical condition</p>	12/15/2011

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	<p>on 11/14/2011 at 10:00 a.m. and indicated Resident #1 had diagnoses, including but not limited to, acute kidney failure, cerebral palsy, depressive disorder, mild mental retardation, morbid obesity, and necrotizing fasciitis.</p> <p>Bladder status progress notes indicated; "8/29/2011 Continues c (with) an indwelling Foley catheter. Occasional irritation to skin folds- ... topical powder used prn... adequate fluid intake c (with) meals and meds ... UTI on 8/17/2011. Treated c (with) an antibiotic- no repeat u/a (urinalysis). No other pertinent labs." "3/16/2011 Continues to have Foley catheter. Area to groin is healed. Has many skin folds that irritate easily. Adequate fluid intake... asymptomatic of UTI (urinary tract infection)..." "12/21/2010 Continues c (with) indwelling catheter 2 o (secondary to) healing wound to per-area. Healing nicely et (and) only padded with gauze."</p> <p>Nurses note dated 9/7/2011 at 10:00 a.m. indicated, "routine cath (catheter) change performed with 20 French Foley. Clear lt (light) yellow urine return. Very anxious this morning- unable to satisfy needs."</p> <p>Nurses note dated 9/25/2011 at 9:30 a.m. indicated, "indwelling Foley catheter plugged and leaking large amount urine</p>		<p>demonstrates that catheterization is medically necessary. All catheter use must be medically necessary and comply with state and federally approved reasons. Nursing staff will be informed of this deficient practice and approved reasons for catheterization at the monthly nurse's meeting on 12/15/11.</p> <p>III) If a new catheter is ordered, appropriate documentation and/or testing will be obtained from the primary care physician or specialist. The documentation must comply with approved reasons for catheter use. Two catheters in use currently have approved documentation for use from their primary care physician. Two catheters in use meet state and federal guidelines. Appropriate documentation has been requested from the primary care physician for the remaining catheter in use. If a new admission has a catheter, appropriate documentation will be requested from the primary care physician, transferring facility, or hospital.</p> <p>IV) If a new catheter is ordered, appropriate documentation and/or testing will be obtained from the primary care physician or specialist. Any new catheter</p>		

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	<p>around insertion site., catheter removed. Foley catheter 20 French/30 cc balloon inserted. Clear amber urine returning. Tolerated procedure well."</p> <p>Nurses note dated 10/18/2011 at 1:00 p.m. indicated, "Mod (moderate) amt (amount) of urinary leakage. Unable to irrigate c (with) NS (normal saline). Foley (changed) c (with) #20 French/ 30 cc S (without) difficulty. Immediate return of clear lt (light) yellow urine."</p> <p>Nurses notes dated 10/26/2011 at 10:00 a.m. indicated, "...noted red rash and abd (abdominal) fold. areas raised et (and) firm others 'blotchy'. (no) itching or pain. (Physician's name) was notified."</p> <p>Care Plan Summary reviewed 11/15/2011 at 3:00 p.m. indicated on "2/3/2011 red/irritated abd folds healed 5/1/2011."</p> <p>Care Plan Summary reviewed 11/15/2011 at 3:00 p.m. indicated on "8/17/2011 UA obtained, 2+ bacteria.... 8/22/2011 cephalixin as ordered for UTI." Initialed date for review dated 8/31/11.</p> <p>Physician's progress notes reviewed 11/16/2011 at 10:00 a.m. indicated " 9/1/2011 Assessment. 5. Urinary Tract infection has resolved (Physicians name)."</p>		<p>orders or admissions with catheters will be discussed at the weekly department head meeting and investigate if appropriate documentation and/or testing is in place.</p> <p>V) DON/MDS Coordinator/Nurses</p>		

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	<p>The MDS (Minimum Data Set) assessment dated 8/30/2011 was reviewed on 11/18/2011 at 8:30 a.m. Section H bladder and bowel function indicated appliance of indwelling catheter. Urinary toileting program was coded indicating a trial of a toileting program had not been attempted. Urinary continence was not rated.</p> <p>The CAA (Care Area Assessment) Summary dated 8/31/2011 was reviewed 11/18/2011 at 8:30 a.m. Noted under indwelling foley catheter was, "(Resident #1's name) has #20F/30cc indwelling foley catheter. Output is done every shift and prn (as needed). Temperature is done daily. Catheter changed monthly and as needed. UD (urinary drainage) bag changed 2x (two times) month. Catheter may be irrigated with N/S (normal saline) as needed. 8-17-11 she was treated for UTI (urinary tract infection) Will proceed with care plan."</p> <p>The CAA Summary dated 8/31/2011 was reviewed 11/18/2011 at 8:30 am. Noted under pressure ulcers/ skin was, "(Resident #1's name) is at risk for skin breakdown due to incontinence and diagnosis of PVD (peripheral vascular disease). She does not have any pressure ulcers. She has two half side rails on bed to assist with bed mobility. She is</p>				

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	<p>extensive to dependent with ADL's. She has a foley catheter placed. She uses desitin cream every shift and after each incontinent episode. She uses anti-dandruff shampoo. She has granulex spray to bilateral heels and nystop powder PRN to irritation under abdominal folds and under breasts. She has triamcinolone cream for skin rash PRN. Skin will be addressed with individual care plan. Will not proceed with care plan."</p> <p>On 11/16/2011 at 2:00 p.m., Resident #1's abdominal folds were observed during shower hygiene care with slight irritated areas noted bilaterally at iliac (hip bone) areas. Perineum (between legs of private area) was clear of redness and or wound activity. No opened areas were visualized.</p> <p>On 11/16/2011 at 2:15 p.m. CNA #4 was interviewed regarding the reason Resident #1 had an indwelling urinary catheter. CNA #4 stated, " I'm really new here... I don't know the residents very well....I'm really not sure...."</p> <p>On 11/16/2011 at 3:00 p.m. the DON (Director of Nursing) was interviewed in regard to reason for continued indwelling urinary catheter for Resident #1, and stated, "... she has had such a bad history of infections...." DON stated time of healing of abdominal wounds had been</p>						

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	approximately , "... close to a year..." 3.1-41(a)(1)				

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F0334 SS=D	<p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes</p>			

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	<p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to ensure a resident was offered and vaccinated with the Pneumonia vaccine.</p> <p>This deficiency affected 1 of 10 residents reviewed for the Pneumonia vaccine in a sample of 10 (Resident # 20).</p> <p>Findings include:</p> <p>1. The record of Resident #20 was reviewed on 11/15/11 at 1:00 p.m., indicated Resident #20 had diagnoses, including but not limited to, Huntington chorea.</p> <p>The "...Annual Mantoux and Vaccine Record" Form for Resident #20 indicated</p>	F0334	<p>I) The facility will offer each resident a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. The facility failed to ensure a resident was offered and vaccinated with the pneumonia vaccine. Six residents were affected by this deficient practice.</p> <p>II) Nurse's will be informed of this deficient practice at the monthly nurse's meeting on 12/15/11. The Admission Data Sheet will be reviewed and the importance of obtaining information from the resident and/or family or POA regarding the pneumonia vaccine</p>	12/15/2011			

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	<p>the Pneumonia vaccine was blank.</p> <p>The Physician's Order Sheet dated 6/2008 for the resident did not indicate if the Physician either wanted or did not want the resident to have the Pneumonia vaccine.</p> <p>On 11/17/11 at 12:30 p.m. an interview with the Director Of Nursing (DON) in regard to the residents Pneumonia vaccine and the DON indicated she did not find any documentation in the resident's chart to indicate the resident had received the pneumonia vaccine. The DON indicated the nurse who transcribed the orders for 6/2008 should had clarified with the resident's Physician if he wanted the resident to have the Pneumonia vaccine.</p> <p>On 11/18/11 at 9:30 a.m. the Physician's Order indicated the resident "may have the pneumovax."</p> <p>3.1-13(a)</p>		<p>will be discussed.</p> <p>III) Information regarding the pneumonia vaccine will be obtained or attempted to be obtained on admission. If the resident has not had a pneumonia vaccine or if the pneumonia vaccine was given before age 65, an order for a pneumonia vaccine will be obtained unless medically contraindicated. The resident and /or POA will be informed of the benefits and potential side effects of the immunization. The resident and/or POA have the right to refuse the pneumonia vaccine after education is given.</p> <p>IV) The Admission Data Sheet will be completed for all admissions. If it is unknown whether the pneumonia vaccine was received, the ICN (Infection Control Nurse) will investigate whether the immunization was received at a physician's office or hospital. New admissions will be discussed at the weekly Department Head Meeting regarding whether information regarding the pneumonia vaccine has been obtained.</p> <p>V) ICN/Staff Nurses</p>		

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observations, record reviews and interview, the facility failed to ensure a clean floor in the storage area of the kitchen.</p> <p>This deficiency affected 28 of 30 residents who receive meals in the facility.</p> <p>Findings include:</p> <p>On 11/14/2011 at 10:30 a.m. during the kitchen sanitation tour with the Certified Dietary Manager (CDM), the storage room floor was observed with salt packets, sugar packets, plastic graduated medication cups, plastic coffee cups, paper napkins, grainy dirt and a wooden unset mouse trap.</p> <p>On 11/14/2011 at 10:45 a.m., the CDM was interviewed in regard to the debris on the floor. CDM indicated the kitchen floor was dirty and difficult to access for cleaning. CDM indicated, "...It's dirty? ... well ... it's hard to get down there..."</p> <p>On 11/15/2011 at 4:15 p.m., during observation, the kitchen storage floor remained dirty, salt and sugar packets had</p>	F0371	<p>I) The facility will store, prepare, distribute, and serve food under sanitary conditions. The facility failed to ensure a clean floor in the storage area of the kitchen. Twenty-nine out of 31 residents have the potential to be affected by this deficient practice.</p> <p>II) On 11/14/11 all dietary staff were informed of this deficient practice. On 11/15/11 the floor of the storage area was cleaned. The cleaning schedule, the Cleaning Schedule Policy, and the Floor Cleaning Policy have been revised. The cleaning schedules will include an area for initials for accountability of dietary staff in cleaning. A dietary staff meeting is scheduled for 12/13/11 where revised policies and cleaning schedules will be discussed. A master signature log will be utilized and kept with the completed cleaning schedules by the CDM.</p> <p>III) The cleaning schedule, Cleaning Shedule Policy, and the</p>	12/13/2011

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	<p>been removed and wooden mouse trap repositioned and reset.</p> <p>On 11/15/2011 at 5:00 p.m., the CDM was interviewed in regard to cleaning schedules of storage room floors and date and time of most recent cleaning. CDM indicated cleaning of the floor was done daily. CDM provided the October 2011 cleaning schedule for the kitchen. The CDM was interviewed in regard to what check marks located beside specific chores indicated in documentation. CDM stated, "...that means those were done...."</p> <p>On 11/16/2011 at 8:45 a.m. CDM provided the November 2011 cleaning schedule and cleaning schedule policy and procedure for the dietary department.</p> <p>3.1-21(i)(3)</p>		<p>Floor Cleaning Policy have been revised. All dietary staff will be informed of the revised policies procedures on 12/13/11. The ICN will do a random check of the floor of the storage area at least weekly.</p> <p>IV) The CDM will monitor the cleaning schedule at least 5 days a week to ensure the policy is being followed. The CDM will do random spot checks of areas to be cleaned at least 3 days a week. The ICN will do a random check of the floor of the storage area at least weekly. This will be discussed at the monthly QA meeting.</p> <p>V) CDM/Dietary Staff/ICN</p>		

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F0441 SS=D	<p>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. Based on observation, record review and interviews, the facility failed to follow their Policy and Procedure in regard to changing gloves during wound care, for 1 of 1 resident observed for wound care, in</p>	F0441	<p>1) The facility has an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development</p>	12/15/2011

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	<p>a sample of 10. (Resident #9)</p> <p>Findings include:</p> <p>The record of Resident #9 was reviewed on 11/15/11 at 8:30 a.m. Resident #9 was admitted to the facility on 06/09/09 with diagnoses including, but not limited to, HTN (hypertension), COPD (chronic obstructive pulmonary disease), PVD (peripheral vascular disease), and FTT (failure to thrive). The resident was under the services of hospice and was receiving treatment for a chronic ulcer to the coccyx area.</p> <p>On 11/16/11, at 10:45 a.m., LPN #3 was observed during a wound dressing change for Resident #9, who resided in a private room with no bathroom or sink. Upon entering the room, LPN #3 set up her supplies for the dressing change and put on clean gloves while CNA #7 assisted Resident #9 to her (R) right side. LPN #3 proceeded to place a clean towel atop the mattress and then placed the urinary catheter drainage bag on the towel. LPN #8 then removed the old dressing from the coccyx wound, which contained a moderate amount of tan colored, malodorous drainage, and discarded her gloves. LPN #8 put on clean gloves and proceeded to clean and pack the wound. LPN #8 again discarded her gloves, put</p>		<p>and transmission of disease and infection. The facility failed to follow our Policy and Procedure in regard to changing gloves during wound care. All residents have the potential to be affected by this deficient practice.</p> <p>II) Nurse's have been informed individually of this deficient practice. The CDC was contacted on 12/02/11 for guidance on glove change and handwashing during dressing changes when no water or sinks are available in rooms. Staff spoke with Carlos, a Public Health Specialist. He had no specific guidelines but directed facility to two documents. "Handwashing: Clean Hands Save Lives" states "If soap and water are unavailable, use an alcohol-based hand sanitizer that contains at least 60% alcohol to clean hands". "Guideline for Hand Hygiene in Health-Care Settings" from the CDCs <i>Morbidity and Mortality Weekly Report</i>, October 25, 2002 states "Use of waterless antiseptic agents (e.g., alcohol-based solutions) was recommended ... in situations where sinks were not available." The policies and procedures for Handwashing and Using Gloves have been revised according to guidelines from these documents. The revised policies and procedures will be discussed with CNAs during their monthly</p>		

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	<p>on clean gloves and applied the new top dressing to the wound. LPN #8 did not wash her hands or apply sanitizer to her hands between glove changes.</p> <p>The Infection Control Nurse was interviewed on 11/15/11, at 4:15 p.m., in regards to Infection Control practices, including, but not limited to, the fact that 9 of 28 resident rooms do not have a sink for handwashing. When queried in regards to hand washing or sanitation, the Infection Control Nurse indicated the facility does not have hand sanitizers in the room for resident safety issues. The Infection Control Nurse indicate those residents without hand washing facilities in their rooms had access in the hallway for both staff and residents. No trends for spread of infections were noted with review of the Infection Control monitoring tools.</p> <p>Review of an undated Policy and Procedure, titles, "Using Gloves", provided by the DNS (Director Nursing Services) on 11/17/11 at 10:00 a.m., indicated: "Rationale: 1) Wear clean, non-sterile gloves when touching blood, body fluids (sic), secretions, excretions, and contaminated items. 2) Put on clean gloves before touching</p>		<p>meeting on 12/13/11 and 12/14/11 and nurses will be advised of changes in policies and procedures at the monthly nurses meeting on 12/15/11.</p> <p>III) The revised policies and procedures will be discussed with CNAs during their monthly meeting on 12/13/11 and 12/14/11 and nurses will be advised of changes in policies and procedures at the monthly nurses meeting on 12/15/11. All CNAs and nurses will be required to carry hand sanitizer that contains at least 60% alcohol to clean their hands per revised policies.</p> <p>IV) CNAs will be monitored randomly by a nurse on a weekly basis for 30 days then monthly to ensure they are changing gloves, washing hands, and/or using hand sanitizer appropriately. Nurses will be monitored by the ICN during a dressing change on a weekly basis to ensure they are changing gloves, washing hands, and/or using hand sanitizer appropriately. The results will be discussed at the monthly QA meeting.</p> <p>V) ICN/Staff Nurses/CNAs/QA</p>		

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	<p>mucous membranes and non-intact skin.</p> <p>3) Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms.</p> <p>4) Remove gloves promptly after use, and wah (sic) hands immeditey (sic) before touching non-contaminated items and environmental srfaces (sic) and before going to another resident."</p> <p>The DNS was interviewed on 11/17/11 at 10:30 a.m. The DNS indicated staff could not wash their hands in the nine rooms without a sink prior to leaving the room.</p> <p>3.1-18(I)</p>		Committee		