

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/16/2016
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NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 10, 11, 14, 15, 16, and 17, 2016.</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Census bed type: SNF/NF: 26 Total: 26</p> <p>Census payor type: Medicare: 4 Medicaid: 13 Other: 9 Total: 26</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/20/16 by 29479.</p>	F 0000	<p>Preparation and/ or execution of this plan of correction in general, or any corrective actions set forth herein, in particular, does not constitute an admission or agreement by Rockville Nursing and Rehabilitation Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws.</p> <p>Rockville Nursing and Rehabilitation Center desires this plan of correction to be considered the facility's allegation of compliance effective 04/15/2016.</p>	
F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</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>in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident was dressed in a manner to maintain dignity for 1 of 1 resident reviewed for dignity (Resident #5).</p> <p>Finding includes:</p> <p>On 3/10/16 at 12:00 p.m., Resident #5 was observed walking into the dining room holding up his green sweat pants. The green sweat pants appeared to be very loose on the resident.</p> <p>On 3/10/16 at 12:15 p.m., Resident #5 was observed walking to his table in the dining room holding a newspaper and his green sweat pants fell down to the floor (around his ankles).</p> <p>On 3/15/16 at 10:05 a.m., Resident #5 was observed walking in the hallway holding up in navy blue sweat pants. The sweat pants appeared to be loose on the resident.</p> <p>During an interview on 3/10/16 at 2:38 p.m., Resident #5 indicated he was humiliated today a lunchtime because his pants fell down in the dining room and was afraid other residents had seen it</p>	F 0241	<p>It is the standard of this facility to promote care for residents in a manner that enhances each resident's dignity and respect in full recognition of his or her individuality. No other resident was affected by this alleged deficient practice. I: Immediately after the incident and prior to the survey team identifying the concern about R. #5's sweatpants falling to the floor, Social Service Designee met with R. to understand the incident, and allow R. to express his feelings about being "humiliated", providing comfort and support. R. had purchased the sweatpants the day before, insisting on their purchase despite them being too large for him, as they contained a drawstring he could adjust. Resident insists that he continue to wear the green sweatpants that appear to be too big for him. R. receives assistance with dressing, but R. does toilet himself independently. R. will be offered suspenders to use in addition to the drawstring waist band to control the size around his waist to reduce the risk of his pants falling down. II: All residents will be monitored daily for loose fitting clothing by all staff. III: Residents with loose fitting clothing will be brought to the</p>	04/15/2016

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	<p>happen. He further indicated some of his pants were loose on him due to him losing some weight.</p> <p>During an interview on 3/16/16 at 9:48 a.m., CNA # 8 indicated she had noticed one pair of Resident #5's pants were loose on him. She further indicated he needed assistance at times with dressing.</p> <p>During an interview on 3/16/16 at 10:17 a.m., Social Service Director (SSD) indicated the green sweat pants had been purchased the day prior to the incident . She further indicated she tried to tighten the drawstring on the sweat pants so they would not be so big on the resident.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 1/18/16, indicated the resident had no cognitive impairment and required one person physical assist with dressing.</p> <p>The facility policy titled, "Resident Rights," identified as current and provided by MDS Coordinator on 3/17/16 at 9:20 a.m., indicated... "A resident has the right be be treated with respect and dignity in recognition of individuality and preferences...."</p> <p>3.1-3(t)</p>		<p>attentionof the facility Social Service Designee. That R. will be assisted by Social Service Designee to obtain newclothing, or assist resident to ensure clothing does not become a dignity issuefor the resident, such as providing the resident with suspenders. IV: Administrator will monitor residents forloose clothing or clothing that may be a dignity issue daily during walkingrounds. This will continue daily for 4weeks, weekly for 2 months, and weekly until 100% compliance is achieved. Results will be presented to the QualityAssurance (QAPI) committee monthly.</p>				

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F 0248 SS=E Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being for 4 of 4 residents reviewed for activities (Residents #11, #13, #3 and #26).</p> <p>Findings include:</p> <p>1. Upon entering the facility on 3/10/16 at 9:15 a.m., there were no activities observed in the dining room, which also served as the facility activity area.</p> <p>On 3/11/16 at 9:35 a.m., Resident #11 was observed sitting in her room reading</p>	F 0248	<p>It is the standard of this facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>All residents had the potential to be affected by this alleged deficient practice.</p> <p>I: Residents #11, #13, #3 &amp; #26 were all reassessed for their activity preferences and abilities.</p> <p>II: All residents will be reassessed for their activity preferences</p>	04/15/2016

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	<p>a book. The activity calendar did not indicate planned activities until 10:30 a.m. each day.</p> <p>On 3/11/16 at 1:55 p.m., Resident #11 was observed sitting in her room watching television. The activity calendar did not indicate planned afternoon activities until 2:30 p.m. each day.</p> <p>On 3/14/16 2:33 p.m., Resident #11 was observed seated at a table in the dining room. The activity calendar indicated an activity, titled "Best Baseball Cap," was scheduled at this time. The planned activity had not begun. The staff were observed assisting residents to the activity room and setting up for the activity at this time.</p> <p>On 3/15/16 at 9:50 a.m., Resident #11 was observed in her room reading a book. The activity calendar did not indicate planned activities until 10:30 a.m. each day.</p> <p>On 3/15/16 at 1:50 p.m., Resident #11 was observed in her room reading a book. The activity calendar did not indicate planned afternoon activities until 2:30 p.m. each day.</p> <p>On 3/16/16 at 8:58 a.m., Resident #11 was observed sitting in the dining room. No activity was scheduled nor occurring at this time. She was not provided</p>		<p>andabilities.</p> <p>III: The activity calendar will be revised to include more varied activities and times. The activity calendar will be reviewed monthly by administrator prior to posting. All staff will be in service on resident activity preferences, assistance needed to activities and independent activities for residents on 4/8/16. Documentation will be completed for program attendance and 1:1 activities. Administrator or designee shall observe resident's participation in activities daily and document observations on the Activity Audit Tool.</p> <p>IV: Administrator or designee shall observe resident's participation in activities and document observations on the Activity Audit Tool daily while on duty for 4 weeks, weekly for 2 months. Results will be presented to the Quality Assurance (QAPI) committee monthly.</p>		

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	<p>activities for cognitive stimulation.</p> <p>On 3/16/16 10:55 a.m., Resident #11 was observed sitting in the dining room, drinking coffee, while the AD (Activity Director) was observed reading a newspaper out loud.</p> <p>On 3/16/16 at 2:05 p.m., Resident #11 was observed sitting in her room. There was no activity occurring at this time.</p> <p>During a stage 1 interview on 3/11/16 at 9:49 a.m., Resident #11 indicated the facility did not offer many activities; some days there were no activities. She indicated she enjoyed reading books, but would like more activities, because she was bored.</p> <p>Resident #11's record was reviewed on 3/11/16 at 12:23 p.m. Resident #11 had diagnoses which included, but were not limited to, depression and dementia. A Minimum Data Set (MDS) assessment, dated 8/19/15, indicated Resident #11 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and required supervision of oversight, encouragement and cueing of staff for locomotion on the unit. The assessment also indicated it was very important for Resident #11 to have books, newspapers, and magazines to read, and also very important for her to keep up with the</p>			

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	<p>news, to do things with groups of people, and to do her favorite activities.</p> <p>An activity care plan, dated 12/7/15, indicated Resident #11 required reminders to attend group activities of interest. A goal indicated she would enjoy group activities of interest to her level of satisfaction through the next assessment date. Approaches indicated the facility would invite her to games, provide her with the assistance needed, remind her of music, cards, bingo, dominos, and socials, and respect her right to choose activities.</p> <p>An activity calendar document for March, 2016, was reviewed on 3/17/16 at 10:45 a.m. Six activities were scheduled each day starting at 10:30 a.m., 11:00 a.m., 11:30 a.m., 2:30 p.m., 3:30 p.m., and 4:30 p.m. No additional activities were scheduled for evenings after 4:30 p.m., during the weekdays. Saturday evening activities included at 6:30 p.m., "Saturday Night Movie" and Sunday evening activities included at 6:30 p.m., "Puzzles."</p> <p>2. On 3/11/16 at 2:01 p.m., Resident #13 ambulated self to room with wheelchair and sat in room yelling "hey" or "help." When questioned, Resident #13 stopped yelling, denied any pain and indicated she was doing "alright." Resident continued</p>			

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	<p>to yell "hey" or "help" until 2:25 p.m., when staff assisted the resident to the dining room. The resident was not provided objects or items to engage in a meaningful activity</p> <p>On 3/14/16 at 1:35 p.m. to 2:20 p.m., Resident #13 was observed sitting in a wheelchair in her room yelling, "Hey" or "Help." The resident was not provided objects or items to engage in a meaningful activity</p> <p>On 3/15/16 at 9:05 a.m. to 10:15 a.m., Resident #13 was observed sitting in her wheelchair in her room yelling, "Hey" or "Help." The resident was not provided objects or items to engage in a meaningful activity</p> <p>On 3/15/16 at 1:30 p.m. to 2:15 p.m., Resident #13 was observed in her room sitting in a wheelchair, yelling, "Hey" or "Help." The resident was not provided objects or items to engage in a meaningful activity</p> <p>On 3/16/16 at 9:04 a.m. to 10:15 a.m., Resident was observed sleeping in a recliner in her room.</p> <p>On 3/16/16 at 10:40 a.m., sitting in a wheelchair in the hallway outside of her room, yelling, "Hey" or "Help."</p> <p>On 3/16/16 at 1:34 p.m. to 4:15 p.m., Resident #13 was observed sleeping in a recliner in her room.</p>			

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	<p>On 3/11/16 at 2:28 p.m., the DON (Director of Nursing) indicated the IDT (Interdisciplinary Team) met for focus charting for Resident #13 for pain. The DON indicated the yelling was not a result of pain and was not a behavior. She indicated the resident's dementia was getting worse. The DON indicated Resident #13 was taken to activities with supervision. She indicated the resident was not aware she was screaming. She indicated when the resident was engaged in an activity or with someone, she did not yell out. She indicated the yelling was a soothing mechanism for the resident.</p> <p>On 3/16/16 at 3:20 p.m., RN #1 indicated today at 11:00 a.m., Resident #13 had been given Lorazepam 0.25 mg (milligrams), an antianxiety medication prescribed to the resident as needed for anxiety to "calm and quiet her down." Resident #13's record was reviewed on 3/15/16 at 10:07 a.m. Resident #13 had a diagnoses which included, but were not limited to, depression and dementia with behavioral disturbances. A Minimum Data Set (MDS) assessment, dated 9/28/15, indicated Resident #13 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 and required total dependence of staff for locomotion on</p>			

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	<p>unit. The assessment also indicated it was very important for Resident #13 to have books, newspapers, and magazines to read, to keep up with the news and to do her favorite activities.</p> <p>An activity care plan, dated 2/16/16, indicated Resident #13 preferred to stay in her room most of the day and may require 1:1 programming due to families' choice for resident to remain in her room and resident has impairments of: hollering and very disruptive. A goal indicated she would accept/participate in 1:1 visits at least 2 times per week through next review. Approaches indicated Activities will provide 1:1 visits 2-3 times per week for sensory and social stimulation. The Activity Director could not provide documentation Resident #13 had received any 1:1 visits.3. On 3/15/16 at 9:15 a.m., Resident # 3 was observed in the hallway next to nurses' station entrance door. Resident was not engaged in any activity nor were staff acknowledging her.</p> <p>On 3/16/16 at 1:19 p.m. until 1:44 p.m., Resident was observed sitting in her wheelchair in the hallway. Resident was not engaged in an activity nor were staff acknowledging her.</p> <p>On 3/16/16 at 1:44 p.m., A housekeeper was observed pushing Resident # 3 to a</p>			

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	<p>table in the dining room and provided no objects or items to engage her in a meaningful activity. Per activity calendar no activities were scheduled until 2:30 p.m.</p> <p>On 3/16/16 at 1:44 p.m. until 2:30 p.m., Resident # 3 remained in the dining room not engaged in any activity until BINGO started at 2:30 p.m.</p> <p>O 3/17/16 at 1:40 p.m. until 2:25 p.m., Resident # 3 was observed sitting in her wheelchair in the middle of the hallway outside of the nurses station. No interaction from staff or residents was observed during this time.</p> <p>During an interview on 3/17/16 at 9:45 a.m., the Administrator indicated dietary and activity staff are cross trained and perform duties in both departments.</p> <p>During an interview on 3/17/16 at 10:00 a.m., the Activity Director indicated she did not have documentation of her 1 on 1 visits with the residents. She further indication her scheduled time for 1-1 visits with the residents was limited to one hour daily due to other responsibilities.</p> <p>An activity progress note dated 12/9/15 was provided by the Director of Nursing</p>			

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	<p>(DON) on 3/16/16 at 2:42 p.m., indicated Resident # 3 was to be provided 1-1 visits three times a week for mental and sensory stimulation.</p> <p>A care plan initiated 3/14/13 was provided by the DON on 3/17/16 at 11:26 a.m., addressed the problem of "The resident is dependent on staff for activities, cognitive stimulation, social interaction related to her Downs and Cognitive deficits. " Interventions included but were not limited to...Assure that the activities she is attending are compatible with known interests and preferences...Provide her with materials for individual activities as desired...The resident needs 1 to 1 bedside/in room visits and activities if unable to attend out of room events. Such as coloring and watching cartoons...."</p> <p>Resident #3's clinical record was reviewed on 3/16/16 at 1:30 p.m. A Significant Change Minimum Data Set (MDS) assessment dated 12/9/15 indicated resident had severe cognitive impairment and was totally dependent with one person physical assist for locomotion off the unit.</p> <p>The resident's active medical diagnoses included but were not limited..."down syndrome, depression, mental retardation,</p>			

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	<p>and organic mental syndrome...."</p> <p>4. On 3/10/16 at 2:41 p.m., Resident #26 indicated she attended facility activities. She indicated there are no activities on the evenings or weekends.</p> <p>On 3/15/16 at 8:51 a.m., review of the facility activity calendar indicated weekend activities were scheduled at 10:30 a.m., 11:00 a.m., 2:30 p.m., 3:30 p.m., 4:00 p.m., and 6:30 p.m., each weekend day. The calendar indicated no activities were scheduled Monday through Friday after 4:40 p.m.</p> <p>A review of Resident #26's medical record on 3/15/16 at 8:54 a.m., indicated the resident's admission MDS (Minimum Data Set) assessment dated 5/19/15, indicated activity preferences which were very important to the resident included, but were not limited to, listening to music she liked, keeping up with the news, doing her favorite activities, and going outside in good weather. The assessment indicated the activities not important at all to the resident included, but were not limited to, doing things with groups of people.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 1/22/16, indicated the resident had no cognitive deficit.</p>			

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	<p>A care plan dated 6/9/15, indicated the resident preferred independent activities of choice, such as, visiting with family, word search and crossword puzzles. Interventions included, but were not limited to, invite to activities of her own choosing, provide monthly activity calendar, and provide leisure supplies as needed.</p> <p>A policy dated August 2006 and identified as current, titled, "Activity Programs," was provided by the Administrator on 3/17/16 at 1:35 p.m. The policy indicated, "Policy Statement: Activity programs are designed to meet the needs of each resident are available on a daily basis...Policy Interpretation and Implementation: 2. Activities are scheduled 7 (seven) days a week...3.e. At least one evening activity is offered per week...7. Individualized and group activities are provided that: a. Reflect the schedules, choices and rights of the residents; b. Are offered at hours convenient to the residents, including evenings, holidays and weekends...."</p> <p>3.1-33(a) 3.1-33(c)</p>			

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide services to address maladaptive behaviors for 1 of 1 resident reviewed for behavior management. (Resident #13)</p> <p>Finding includes:</p> <p>On 3/11/16 at 2:01 p.m., Resident #13 ambulated self to room with wheelchair and sat in room yelling "hey" or "help." When questioned, Resident #13 stopped yelling, denied any pain and indicated she was doing "alright." Resident continued to yell "hey" or "help" until 2:25 p.m., when staff assisted the resident to the dining room.</p> <p>On 3/14/16 at 1:35 p.m. to 2:20 p.m., Resident #13 was observed sitting in a wheelchair in her room yelling, "Hey" or "Help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/15/16 at 9:05 a.m. to 10:15 a.m.,</p>	F 0250	<p>It is the standard of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>I: The Interdisciplinary Team has reviewed resident #13's maladaptive behavior and care plan. R.#13 will be reviewed by psych services to reevaluate her case and discuss additional interventions. R. #13 was reassessed for their activity preferences and abilities. R. # 13 is being re assessed for pain management.</p> <p>II: The facility Interdisciplinary Team (IDT) will meet at the monthly Behavior Management meeting to review each resident for new, continued, and worsening maladaptive behavior and recommend interventions as needed.</p>	04/15/2016

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	<p>Resident #13 was observed sitting in her wheelchair in her room yelling, "Hey" or "Help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/15/16 at 1:30 p.m. to 2:15 p.m., Resident #13 was observed in her room sitting in a wheelchair, yelling, "Hey" or "Help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>On 3/16/16 at 10:40 a.m., sitting in a wheelchair in the hallway outside of her room, yelling, "Hey" or "Help." Staff were not observed to interact or redirect the resident from yelling.</p> <p>During an interview on 3/10/16 at 3:16 p.m., Resident #15's daughter indicated she often heard Resident #13 yelling.</p> <p>On 3/11/16 at 10:10 a.m., Resident #37 indicated he heard a woman next door yelling a lot, and indicated he had gotten used to hearing the noise. Resident #37's room was located next to Resident #13's room.</p> <p>On 3/11/16 at 2:28 p.m., the DON (Director of Nursing) indicated the Interdisciplinary Team (IDT) determined Resident #13's yelling was not a result of</p>		<p>III: All staff will be in serviced on recognizing, intervening, and documenting behaviors. The Social Service Director (SSD) shall review Social Service Alerts, and the 24 hr. report daily when on duty for new, continued, and worsening maladaptive behaviors and add new interventions as needed. SSD shall also monitor the efficacy of interventions used with residents exhibiting behaviors.</p> <p>The IDT will review maladaptive behaviors, care plans, and Social Service Alert forms at the monthly Behavior Management meeting and recommend interventions as needed.</p> <p>IV: Administrator will review behavior management documentation for maladaptive behaviors monthly for 3 months and quarterly thereafter until 100% compliance is achieved. Administrator shall bring results to the monthly Quality Assurance (QAPI) meeting</p>	

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	<p>pain or a behavior and indicated her dementia was getting worse. She indicated the resident's yelling was a soothing mechanism for the resident.</p> <p>Resident #13's record was reviewed on 3/15/16 at 10:07 a.m. Resident #13 had a diagnoses which included, but were not limited to, depression and dementia with behavioral disturbances. A Minimum Data Set (MDS) assessment, dated 9/28/15, indicated Resident #13 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 and required total dependence of staff for locomotion on unit. The assessment coded the resident with verbal behaviors.</p> <p>An Interdisciplinary Team Progress Note, dated 2/9/16, addressed the behavior of yelling. The note indicated staff were to address the resident's needs, and offer foods, fluids, and toileting as needed.</p> <p>A facility policy, titled "Behavior Management," dated December, 2015, included but was not limited to, "...Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents. Sometimes, a resident becomes dangerous to himself or</p>			

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F 0278 SS=D Bldg. 00	<p>abusive to others and may keep others from enjoying a quiet and peaceful place. The staff should assess the behaviors and document in a quantitative manner, to assist in determining whether the behaviors can be addressed in the facility or whether outside assistance may be needed...."</p> <p>3.1-34(a)(1) 3.1-34(a)(2)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully</p>			

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	<p>and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure a 90 day Minimum Data Set (MDS) assessment was accurately coded 1 of 1 resident reviewed for MDS coding for urinary continence. (Resident #7)</p> <p>Finding includes:</p> <p>On 3/14/16 at 12:04 p.m., a review of Resident #7's 90 day Minimum Data Set (MDS) assessment, dated 1/20/16, Section H (H0300) titled "Urinary Continence," indicated a code 0- for always continent.</p> <p>Bowel and Bladder Continence sheet was provided by Director of Nursing (DON) on 3/15/16 at 10:49 a.m. The sheet indicated Resident # 7 was incontinent of urine on 1/15/15 a total of 7 times, 1/16/16 a total of 6 times, 1/17/16 a total of 10 times, 1/18/16 a total of 7 times, 1/19/16 a total of 6 times, and 1/20/16 a total of 5 times.</p> <p>During an interview on 3/14/16 at 2:30</p>	F 0278	<p>It is the standard of this facility to complete assessments that accurately reflect the resident's status. No other resident was affected by this alleged deficient practice. I: Immediately after the survey team identifying the concern about R. #7's MDS assessment was corrected. II: All resident's MDS assessments will be audited to ensure correct coding of continence. III: MDS Coordinator will be in serviced on correct coding of continence. IV: Director of Nursing will audit continence coding on MDS with a random sample of 5 residents monthly for 3 months and quarterly thereafter until 100% compliance is achieved. The audit results will be reported to the facility Quality Assurance (QAPI) committee.</p>	04/15/2016

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	<p>p.m., MDS Coordinator indicated Resident # 7's urinary continence had not been coded correctly on her 90 day MDS assessment completed on 1/20/16.</p> <p>During an interview with the DON on 3/15/16 at 10:08 a.m., DON indicated Resident # 7's urinary continence had not been coded correctly on her 90 day MDS assessment completed on 1/20/16. She further indicated a modification should have been done.</p> <p>The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, H0300: "Urinary Continence," Coding Instructions for H0300, indicated "Code 0, always continent if throughout the 7 day look back period the resident has been continent of urine, without any episodes of incontinence." Code 1, occasionally incontinent if during the 7 day look back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime." Code 2, frequently incontinent if during the 7 day look back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of</p>			

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F 0314 SS=D Bldg. 00	<p>urine, daytime, and nighttime. " Code 3, always incontinent if during the 7 day look back period, the resident had no continent voids...."</p> <p>3.1-31(d)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective pressure reducing interventions to prevent a resident admitted without pressure ulcers from developing 2 unstageable (deep tissue or suspected deep tissue injury where wound bed is not visible) for 1 of 1 resident reviewed for pressure ulcers (Resident #20).</p> <p>Finding includes: On 3/11/16 at 1:37 p.m., Resident #20</p>	F 0314	<p>It is the standard of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable.</p> <p>No other resident was affected by this alleged deficient practice.</p> <p>I: Resident #20 is receiving care according to care plan and wound is showing signs of healing.</p>	04/15/2016

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	<p>was observed in the dining room, sitting in a wheelchair, with her feet elevated. The resident wore bilateral, protective footwear (waffle boots).</p> <p>On 3/11/16 at 2:15 p.m., Resident #20 was sitting in a wheelchair by the nurses' station with both feet elevated. The resident was bare foot and did not have protective footwear in place. The resident's left heel was visible and had a pressure ulcer. The wound had a dried, black cap that covered the distal portion of the heel. Towards the middle of the heel was a red raised, fluid filled blister.</p> <p>On 3/14/16 at 3:48 p.m., Licensed Practical Nurse (LPN) #5, applied Skin Prep (wound treatment) to Resident #20's bilateral heels. The LPN indicated the resident's right heel was "brownish in nature." and had a scab where the blister had been. He indicated the left heel had healthy tissue in the center, next to a "small red welt with some fluid retention." He indicated the area at the back of the left heel was hardened, black, and necrotic (dead tissue).</p> <p>During an observation of wound care on 3/16/16 at 9:21 a.m., Licensed Practical Nurse (LPN) #10 did not wash her hands prior to entering Resident #20's room. She used hand sanitizer after she entered</p>		<p>II: A skin sweep will be conducted to identify all current areas of skin breakdown. Braden risk assessments will be reviewed for all residents to identify those at high risk. Preventive measures will be updated on R. care plans and CNA assignment sheets as needed.</p> <p>III: Braden risk assessments will be completed upon admission, quarterly, and with significant change. Preventive measures will be updated on R. care plans and CNA assignment sheets as needed. Skin assessments will be completed weekly and treatment and interventions put into place as needed.</p> <p>An in-service will be provided on 4/8/16 that will include education for all nursing staff regarding the following of facility policies and procedures regarding following care plans for pressure relief.</p> <p>IV: The Director of Nursing will audit the placement of pressure relieving interventions, and ensure Skin and Braden Risk assessments are completed per policy daily while on duty for 4 weeks, weekly for 4 weeks, monthly for 2 months and then monthly until 100% compliance is achieved. The Director of Nursing will report findings to the facility Quality Assurance (QAPI) committee.</p>	

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	<p>Resident #20's room and donned gloves. LPN #10 removed the resident's right Ankle Contracture Boot and applied Skin Prep treatment to the pressure ulcer. LPN #10 immediately placed the freshly treated heel directly onto the bed sheet and went into the hallway, opened the medication cart while wearing the same glove worn when cleaning Resident #20's wound. The LPN retrieved wash cloths from the linen cart with the same gloved hand, and reentered the resident's room and placed a washcloth under the resident's right foot. The Skin Prep treated foot had adhered to the bed sheet. LPN #10 then removed her soiled gloves and placed the gloves and the used Skin Prep items directly onto the resident's bedside table without a protective barrier. At 9:29 a.m., LPN #10 donned new gloves, but did not wash her hands nor use hand sanitizer. LPN #10 removed the resident's Ankle Contracture Boot from the left foot, then proceeded out to the hallway, opened the medication cart with the soiled, gloved hand and retrieved a measuring tape. LPN #10 reentered the room, measured the wound on the left foot, applied Skin Prep treatment to the pressure ulcer wound, and placed a washcloth under the resident's left foot. LPN #10 placed the soiled gloves and the used Skin Prep items directly onto the resident's bedside table, without using a</p>			

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	<p>barrier. After applying the Skin Prep, LPN #10 placed the waffle boots on both feet, but did not float the resident's heels off of the bed. The LPN indicated the wound on the right heel measured 3 cm (centimeters) x 3 cm and the left heel measurements were 7 cm x 8 cm. In an interview immediately following wound care, at 9:36 a.m., LPN #10 indicated she should have washed her hands prior entering the resident's room and should not have accessed the medication cart twice while wearing soiled gloves. The LPN indicated she should have sanitized her hands before and after she left the resident's bedside. She further indicated she should have had supplies in the room prior to starting a wound care treatment.</p> <p>On 3/10/16 at 11:15 a.m., during a stage 1 staff interview, RN #1 indicated Resident #20 had unstageable pressure ulcers on her bilateral heels that were acquired in the facility on 2/23/16.</p> <p>On 3/11/16 at 2:10 p.m., the Director of Nursing (DON) indicated staff identified bilateral heel pressure ulcers on 2/23/16. She indicated the resident's care plan was reviewed and updated to address the pressure ulcers.</p> <p>On 3/14/16 at 12:15 p.m., the DON indicated Resident #20's care plan did not include interventions to prevent pressure</p>			

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	<p>ulcers on the heels prior to the resident developing the pressure ulcers on 2/23/16.</p> <p>On 3/14/16 at 2:35 p.m., the DON indicated Resident #20 was admitted to the hospital in January 2016 and returned to the facility on 2/4/16. She indicated the resident was weak and her cognition had declined. She indicated on 2/23/16 at 4:30 p.m., RN #1 assisted the resident to bed and found pressure ulcers on both heels. The DON indicated she believed the resident got the pressure ulcers because she previously had a regular wheelchair and drug her heels and slid down in the chair. She indicated foot pedals were placed on the chair and that was when the resident got the pressure ulcers.</p> <p>On 3/14/16 at 3:12 p.m., Certified Nursing Assistant (CNA) #6 indicated Resident #20 was supposed to wear waffle boots and have heels elevated when she was in the wheelchair.</p> <p>On 3/15/16 at 9:39 a.m., the Administrator (ADM) indicated staff implemented the waffle boots as an intervention as soon as the pressure ulcers were discovered.</p> <p>On 3/15/16 at 9:44 a.m., the Certified</p>			

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	<p>Occupational Therapy Assistant/Director of Rehabilitation (COTA/DOR) indicated, Ankle Contracture Boots were implemented for Resident #20's pressure ulcers. The therapist indicated the boots were applied while the resident was in the therapy room to get the resident used to the new boots and to ensure the boots were not too tight and did not cause additional pressure or red areas on the skin. The COTA indicated the resident should have her heels floated when she was in bed if she wore the waffle boots, but the heels did not have to be floated when the Ankle Contracture boots were worn.</p> <p>On 3/16/16 10:30 a.m., the Director of Nursing (DON) indicated staff should wash their hands prior to entering a resident's room for wound care treatment and use hand sanitizer before and after donning gloves for resident care. The DON further indicated LPN #10 should have allowed the Skin Prep treatment to dry thoroughly before placing the foot onto a surface.</p> <p>Resident #20's record was reviewed on 3/14/16 at 9:27 a.m. Resident #20 had diagnoses which included, but were not limited to, Huntington's disease and dementia.</p> <p>An admission Minimum Data Set (MDS)</p>			

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	<p>assessment, dated 9/14/15, indicated #20 required assistance of one person for mobility, did not have pressure ulcers on admission, and was not identified at risk of developing pressure ulcers.</p> <p>A MDS assessment, dated, 12/14/15, indicated the resident required assistance of one person for mobility, was at risk of developing pressure ulcers, and did not have pressure ulcers.</p> <p>A MDS assessment, dated 2/23/16, indicated resident had 2 unstageable pressure ulcers.</p> <p>An interim care plan, dated 2/24/16 indicated heels were to be floated at all times.</p> <p>A care plan for pressure ulcers, initiated 2/25/16, included interventions of floating heels in bed and wound monitoring weekly. A revision to the care plan on 3/1/16, indicated Skin Prep to bilateral heels twice daily and non-pressure heel boots. The care plan did not include guidelines for when the non-pressure boots were to be worn.</p> <p>A physician's order, dated 2/25/16, indicated apply skin prep twice a day on bilateral heels and leave open to air. The order indicated staff were to float heels while in bed and apply waffle boots when the resident was in the wheelchair.</p> <p>The record indicated Ankle Contracture</p>			

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	<p>boots were implemented for the reduction of heel pressure ulcers.</p> <p>The DON provided Skin Prep manufacturer's documentation on 3/16/16 at 11:25 a.m. The Skin Prep directions indicate, "...DIRECTIONS: Apply Skin Prep wipe and allow to dry thoroughly. Film coating forms and bonds to skin..."</p> <p>On 3/17/16 at 9:20 a.m., the DON provided an undated, but identified as current, facility policy, titled " Handwashing. " The policy included but was not limited to, "...Hand washing should be performed: As promptly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them, whether or not gloves are worn...After gloves are removed...."</p> <p>A facility policy, titled "Using Gloves", dated 2009, included but was not limited to, "...Used gloves should be discarded into the waste receptacle inside the room...Perform hand hygiene after removing gloves...."</p> <p>A facility policy, titled, "Skin Management, " dated November 2014, and identified as current, included but was not limited to, "...Residents who are at risk or with wounds and/or pressure</p>			

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F 0356 SS=D Bldg. 00	<p>ulcers and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes ...Unavoidable Pressure Ulcers...Per CMS guidelines, 'unavoidable' means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. All of this must be clearly documented in the resident's clinical record...."</p> <p>3.1-40(a)(1) 3.1-40 (a) (2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p>			

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	<p>o Facility name.</p> <p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nurse staffing data was posted daily for 6 of 6 observations of staff postings.</p> <p>Finding includes:</p> <p>On 3/10/16 at 9:23 a.m., observation of the staffing information posted at the nurses' station was dated 3/1/16.</p>	F 0356	It is the standard of this facility to post the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. No resident was affected by this alleged deficient practice. I: Daily Nurse Staffing poster was revised to include daily census, total hours and actual hours worked for RN, LPN and C.N.A. This form is posted	04/15/2016

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	<p>On 3/11/16 at 11:34 a.m., observation of the staffing information posted at the nurses' station was dated 3/1/16.</p> <p>On 3/14/16 at 9:24 a.m., observation of the staffing information posted at the nurses' station was dated 3/1/16.</p> <p>On 3/15/16 at 7:18 a.m., observation of the staffing information posted at the nurses' station was dated 3/1/16.</p> <p>On 3/16/16 at 8:51 a.m., observation of the staffing information posted at the nurses' station was dated 3/1/16.</p> <p>On 3/17/16 at 8:38 a.m., no staffing information posting was observed posted in the facility.</p> <p>On 3/17/16 at 10:05 a.m., the DON (Director of Nursing) indicated the facility policy was for the day shift nurses to complete and post the daily staffing information in an area where it was visible to anyone who was in the facility.</p> <p>A undated policy, identified as current, titled, "Nurse Duties," provided by the DON on 3/17/16 at 10:35 a.m., indicated, "Nurse Duties: 6a-2p: Complete daily staffing sheet...Will be posted in a visible area...."</p>		<p>daily at the beginning of day shift.</p> <p>II: All have the potential to be affected. III: Nurses were educated on the completion and posting of the daily staffing poster. This will be reviewed at the April 8th in-service. IV: Administrator will monitor the completion and posting of the daily staffing poster daily during walking rounds. This will continue daily for 4 weeks, weekly for 2 months, and weekly until 100% compliance is achieved. Results will be presented to the Quality Assurance (QAPI) committee monthly.</p>	

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F 0371 SS=F Bldg. 00	<p>An untitled document, identified as current, provided by the Administrator on 3/17/16 at 1:24 p.m., indicated, "(e) Nurse staffing information-(2) Posting requirements. (i) The facility must post the nurse staffing data...on a daily basis at the beginning of each shift...(B) In a prominent place readily accessible to residents and visitors...."</p> <p>3.1-13(i)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to ensure the cleanliness and sanitation of the kitchen and food preparation areas for 5 of 5 kitchen observations. This deficient practice had the potential to affect 25 out of 26 residents who received food prepared in the kitchen.</p> <p>Finding includes:</p>	F 0371	<p>7F371</p> <p>It is the standard of this facility to store, prepare, distribute, and serve food under sanitary conditions.</p> <p>No resident was affected by this alleged deficient practice.</p> <p>I: Kitchen was cleaned and concern areas addressed in the kitchen.</p>	04/15/2016

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	<p>1. During an initial kitchen tour on 3/10/16 at 9:30 a.m., dried food particles and fresh food items were on the floor, including the area in front of the food preparation table. A plastic cup lid was seen on the floor behind the ice chest. Yellow-brown greasy build-up was present on the front and down the side of the stove. A pile of boxes was on the floor by the refrigerator. Stained cloths were on the top of boxes.</p> <p>2. On 3/11/16 at 11:30 a.m., there were multiple areas with dried food on the floor. A plastic cup lid remained on the floor behind the ice chest. The build-up on the stove front and side had not been removed. The pile of boxes were still present by the refrigerator.</p> <p>3. On 3/14/16 at 11:00 a.m., the floor was still covered with dried food, the plastic cup lid remained on the floor behind the ice chest, the pile of boxes had not been moved from the floor by the refrigerator, a hot chocolate mix wrapper was on the floor next to trash can, salt and pepper wrappers, a small paperclip, and a bread tie were on the floor by the stove. The walls and the outer side of closed unused door had dried splattered substances on them.</p>		<p>II: All residents except one resident who is NPO have the potential to be affected.</p> <p>III: All dietary staff will be in serviced on preparation, distribution and serving food under sanitary conditions. This training will include instruction on cleanliness of the floor, stove, and walls as well as The Daily Sanitation Checklist.</p> <p>The kitchen will be maintained in a clean condition daily by the cook. The Daily Sanitation checklist will be completed each shift by the cook. The Dietary Manager or Designee will review kitchen cleanliness and The Daily Sanitation Checklist daily.</p> <p>IV: A performance improvement tool has been initiated that reviews kitchen observations. The Administrator will complete this tool weekly for 8 weeks, monthly for 2 months and monthly thereafter until 100% compliance is achieved. Any identified issues will be immediately addressed. This performance tool will be reviewed at the Quality Assurance (QAPI) Committee monthly</p>	

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	<p>4. On 3/15/16 at 1:20 p.m., dried food like materials were on the kitchen floor, plastic cup lid remained behind the ice chest, the build-up had not been cleaned from the stove, walls and outer side of a closed unused door had dried splattered substances on them. Three used paper towels were seen on the floor next to the trash can by the sink, and 2 cloth napkins were on the floor by the refrigerator.</p> <p>5. On 3/16/16 at 10:00 a.m., dried food like materials were on the kitchen floor, the plastic cup lid remained behind the ice chest, the build-up had not been cleaned from the stove, walls and the outer side of a closed unused door and dried splattered substances on them.</p> <p>During an interview with Dietary Manager on 3/16/16 at 1:00 p.m., she indicated a daily cleaning schedule had been developed for the dietary staff.</p> <p>During an interview with Dietary Aide # 9 on 3/17/16 at 9:12 a.m., she indicated the floor is swept and mopped twice daily. Each shift will initial when tasks are completed. She further indicated deep cleaning of equipment is done daily on a rotating schedule.</p> <p>A March 2016 cleaning schedule grid was provided by the Dietary Manager on</p>			

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F 0441 SS=D Bldg. 00	<p>3/16/16 at 1:06 p.m., the grid had initials on it indicating both day and evening dietary staff had cleaned the kitchen and food preparation areas daily.</p> <p>A policy, identified as current, titled, "Cleaning and Sanitizing of Food and Non-Food Contact Surfaces," dated 12/06, was provided by the Administrator on 3/17/16 at 2:38 p.m. The policy indicated, "Standard: ...Non-food contact surfaces are cleaned per individual facility cleaning schedule to maintain optimal cleanliness...Guidelines:...5. Non-food contact surfaces are washed with soapy water per frequency identified on the facility cleaning schedule-or as visually necessary...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>			

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures and hand hygiene were maintained for 1 of 1 resident observed for wound care (Resident #20.)</p> <p>Finding includes:</p>	F 0441	It is the standard of this facility to 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. One resident was affected by this alleged deficient practice. I: R # 20 was monitored for signs and	04/15/2016
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	<p>During an observation of wound care on 3/16/16 at 9:21 a.m., Licensed Practical Nurse (LPN) #10 did not wash her hands prior to entering Resident #20's room. She used hand sanitizer after she entered Resident #20's room and donned gloves. LPN #10 removed the resident's right Ankle Contracture Boot and applied Skin Prep treatment to the pressure ulcer. LPN #10 immediately placed the freshly treated heel directly onto the bed sheet and went into the hallway, opened the medication cart while wearing the same glove worn when cleaning Resident #20's wound. The LPN retrieved wash cloths from the linen cart with the same gloved hand, and reentered the resident's room and placed a washcloth under the resident's right foot. The Skin Prep treated foot had adhered to the bed sheet. LPN #10 then removed her soiled gloves and placed the gloves and the used Skin Prep items directly onto the resident's bedside table without a protective barrier. At 9:29 a.m., LPN #10 donned new gloves, but did not wash her hands nor use hand sanitizer. LPN #10 removed the resident's Ankle Contracture Boot from the left foot, then proceeded out to the hallway, opened the medication cart with the soiled, gloved hand and retrieved a measuring tape. LPN #10 reentered the room, measured the wound on the left foot, applied Skin Prep treatment to the</p>		<p>symptomsof infection at the wound site with no infection noted. LPN #10 was provided corrective action, including 1:1 education regarding hand washing, glove donning, and the use of skin prep. Resident #20 is receiving care according to care plan and wound is showing signs of healing. II: All Residents with treatments were identified and will be considered to be at risk. III: An in-service will be provided on 4/8/16 that will include education for all nursing staff regarding the following of facility policies and procedures regarding handwashing, glove donning, and the use of skin prep and other treatments. IV: The Director of Nursing will randomly observe treatments including handwashing and changing of gloves weekly for 4 weeks, monthly for 2 months and monthly thereafter until 100% compliance is achieved. The Director of Nursing will report findings to Quality Assurance (QAPI) monthly.</p>	

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	<p>pressure ulcer wound, and placed a washcloth under the resident's left foot. LPN #10 placed the soiled gloves and the used Skin Prep items directly onto the resident's bedside table, without using a barrier. After applying the Skin Prep, LPN #10 placed the waffle boots on both feet, but did not float the resident's heels off of the bed. The LPN indicated the wound on the right heel measured 3 cm (centimeters) x 3 cm and the left heel measurements were 7 cm x 8 cm. In an interview immediately following wound care, at 9:36 a.m., LPN #10 indicated she should have washed her hands prior entering the resident's room and should not have accessed the medication cart twice while wearing soiled gloves. The LPN indicated she should have sanitized her hands before and after she left the resident's bedside. She further indicated she should have had supplies in the room prior to starting a wound care treatment.</p> <p>On 3/16/16 10:30 a.m., the Director of Nursing (DON) indicated staff should wash their hands prior to entering a resident's room for wound care treatment and use hand sanitizer before and after donning gloves for resident care. The DON further indicated LPN #10 should have allowed the Skin Prep treatment to dry thoroughly before placing the foot onto a surface.</p>			

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F 9999  Bldg. 00	<p>The DON provided Skin Prep manufacturer's documentation on 3/16/16 at 11:25 a.m. The Skin Prep directions indicate, "...DIRECTIONS: Apply Skin Prep wipe and allow to dry thoroughly. Film coating forms and bonds to skin...."</p> <p>On 3/17/16 at 9:20 a.m., the DON provided an undated, but identified as current, facility policy, titled " Handwashing. " The policy included but was not limited to, "...Hand washing should be performed: As promptly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them, whether or not gloves are worn...After gloves are removed...."</p> <p>A facility policy, titled "Using Gloves", dated 2009, included but was not limited to, "...Used gloves should be discarded into the waste receptacle inside the room...Perform hand hygiene after removing gloves...."</p> <p>3.1-18(a)</p> <p>3.1-20 DIETARY SERVICES</p>	F 9999	F9999	04/15/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/16/2016
NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(e) The food service director must be one (1) of the following:</p> <p>(2) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year experience in some aspect of institutional food service management.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview, and record review, the facility failed to ensure the Dietary Manager had completed the certification qualifications to be a Certified Dietary Manager (CDM) in a timely manner.</p> <p>Finding includes:</p> <p>On 3/11/16 at 9:20 a.m., the Dietary Manager provided a copy of a document titled, "ServSafe Certification," dated 9/23/11. The document indicated the Dietary Manager had completed the safe food handling course.</p> <p>On 3/11/16 t 9:20 a.m., the Dietary Manager provided documents from the University of Florida, dated July 2011, titled, "Dietary Manager Training</p>		<p>Itis the standard of this facility to employ a food service director who haswithin one year completed division approved instruction in food servicesupervision, or has a minimum of one year experience in food servicemanagement.</p> <p>Noresident was affected by this alleged deficient practice.</p> <p>I: Facility is currently recruiting for a foodservice director who has within one year completed division approvedinstruction in food service supervision, or has a minimum of one yearexperience in food service management.</p> <p>II: All employee fills shall be reviewed toensure they have the appropriate credentials for their specific positions.</p> <p>III: Business Office Manager shall ensureemployees have the appropriate credentials for their specific position uponhire.</p> <p>IV: Administrator will audit a random sample of 5employee files monthly for 3 months and then quarterly until 100% compliance iscompleted. Administrator shall bring theresults of these audits to the Quality Assurance (QAPI) committee monthly.</p>		

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	<p>Enrollment Form," The document included a receipt page that indicated the Dietary Manager had been registered for the course.</p> <p>On 3/11/16 at 9:20 a.m., the Dietary Manager provided a letter from the University of North Dakota, dated October 30, 2015, that indicated her re-enrollment into the Dietary Mangers online course. The letter indicated she had one year from the date of the re-enrollment to complete the course. The letter indicated no further extensions would be granted.</p> <p>During an interview on 3/11/16 at 11:00 a.m., the Dietary Manager indicated she had not yet completed the certification (CDM) course. She indicated she had enrolled in the online course in 2011 when she began the position of Dietary Manager, but was unable to complete the course at that time. She indicated she requested and was granted an extension for the course completion. She indicated she re-enrolled for the online course and was approved on 10/30/15.</p> <p>During an interview on 3/11/16 at 4:05 p.m., the Administrator indicated the Dietary Manager had started her position in July 2011 right after she had completed the ServSafe (safe food</p>			

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	handing) Certification. She indicated the Dietary Manager should have the completed the CDM course.				