

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F000000	<p>This visit was for the Investigation of Complaints IN00156570 and IN00154633.</p> <p>Complaint IN00156570-Substantiated, Federal deficiencies cited at F465, F312, and F353.</p> <p>Complaint IN00154633-Substantiated, Federal deficiencies cited at F226, F312, F323, and F353.</p> <p>Survey dates: September, 30, October 1, 2, 2014</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Survey Team: Sylvia Scales, RN TC Anne Marie Crays, RN (9/30, 10/2)</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 13 Medicaid: 48 Other: 5</p>	F000000	Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

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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F000226 SS=D	<p>Total: 66</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.-3.1</p> <p>Quality review completed on October 6, 2014 by Jodi Meyer, RN</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview, and record review, the facility failed to ensure potential employees were screened prior to and/or within 3 days of their date of hire and/or possessed a current certification for hired position, in that, employee records were lacking documentation that a criminal background check had been completed for 3 of 5 records reviewed and 1 of 5 employees lacked current certification for position currently working all reviewed for abuse prohibition. (CNA #1, CNA #4, HSK #1)</p> <p>Findings include:</p>	F000226	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F226D – Develop/Implement abuse/neglect, etc. policies</p>	10/15/2014			

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	<p>1. The employee file for CNA#4 was reviewed on 10/1/14 at 11:50 A.M., the date of hire was listed as 9/4/14. CNA #4's time card was reviewed it indicated CNA #4 had worked 13 shifts in the facility. The facility was unable to provide documentation that a criminal background check had been completed prior to CNA #4 beginning work.</p> <p>2. The employee file for housekeeper aide (HSK) #1 was reviewed on 10/1/14 at 12:00 P.M., the date of hire was listed as September 19, 2014. HSK #1's time card was reviewed it indicated HSK #1 had worked 5 shifts in the facility. The facility was unable to provide documentation that a criminal background check had been completed prior to HSK #1 beginning work.</p> <p>3. The employee file for CNA #1 was reviewed on 10/1/14 at 12:05 P.M., the date of hire for CNA #1 was listed as 9/18/14. CNA #1's certification was reviewed it listed an expiration date of 7/9/14, 84 days prior to the date of the review. CNA#1's time card was reviewed; it indicated CNA #1 had worked 9 shifts in the facility. The facility was unable to provide documentation that criminal background and certification for CNA #1 had been verified prior to CNA #1 beginning work.</p>		<p>It is the intent of this facility to ensure potential employees are screened prior to and/or 3 days of date of hire and/or possesses a current certificate for hired positions.</p> <p>1. Actions Taken:</p> <p>A) CNA#1, HSK#1 and CNA#4 had immediately had a background checks on October 1, 2014 and the checks were without findings. CNA #1 also had her certificate recertified on October 1, 2014.</p> <p>2. How other residents would have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>A) All interviewable residents were asked if they had ever had any one mistreat them in any way. No resident reported any misuse. Resident's whom were not interview able had a full body assessment to check for any redness, bruising or any evidence of abuse. No resident had any evidence of abuse.</p> <p>B) Prior to Orientation the ADON/Designee will assure all potential staff has a current certificate/license and a background check.</p>	

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	<p>On 10/1/14 at 1:20 P.M., the Administrator indicated the criminal background checks were supposed to be completed by the business office upon hire. She further indicated these had been overlooked because the facility did not have a business office manager at the time. She indicated she was not aware of the error until notified.</p> <p>On 10/1/14 at 1:25 P.M., the Director of Nursing (DON) indicated she was unaware that the certification for CNA #1 had expired. She further indicated normally she would check them prior to hire but had overlooked this one.</p> <p>On 10/1/14 at 2:18 P.M., the facility provided a policy titled "Criminal History Checks", dated 3/1/1999, it included, "...It is the responsibility of the Administrator to implement Criminal History Checks for all newly hired employees..." and "A. Facilities must process a Limited Criminal History Check <u>within three (3) business days</u> of employing a person (18 years of age or older) in the qualifying job classifications listed above.</p> <p>On 10/1/14 at 2:19 P.M., the facility provided a policy titled "</p>		<p>C) IDT was in serviced on background checks prior to hire and/or within 3 days of hiring and can certificate renewals.</p> <p>3. Measures Taken:</p> <p>A. Prior to Orientation the ADON/Designee will assure all potential staff has a current certificate/license and a ba</p> <p>A. Facility will utilize a new employee checklist for completion prior to working the floor after Orientation for accurate and complete information.</p> <p>B. IDT was in serviced on background checks prior to hire and/or within 3 days of hiring and can certificate renewals.</p> <p>1. How Monitored: A) Administrator will monitor and review all new hires prior to orientation for completed background checks B) DON/Designee will monitor and review all new hires for current certificate/licensure prior to orientation. C) Any inconsistent results will be immediately clarified and corrected appropriately. Results would be monitored and reviewed at the monthly and quarterly QA meetings.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 15, 2014</p>				

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F000312 SS=D	<p>Abuse-Employee/Volunteer Screening" dated 7/1/11. The policy included, "It is the intend of the facility to not hire applicants or allow volunteers to be in the facility who may pose a risk to resident safety....When a potential new employee is considered for hire, each of the following steps should be taken to assure that the applicant is suitable for the position before an offer of employment is extended: ... 1. Candidates are required to authorize the facility to conduct a background check for conviction of crimes.... 3. Verification of licensure/certification and identification of previous disciplinary actions or restrictions on licensure/certification will be obtained for all applicable positions.</p> <p>This Federal tag relates to Complaint IN00154633.</p> <p>3.1-14(a) 3.1-14(e) 3.1-28(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral</p>			

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	<p>hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a dependent resident received ADL (Activities of Daily Living) care, including repositioning, toileting, and dressing, for 1 of 3 residents reviewed for ADL care, in a sample of 8. Resident C</p> <p>Findings include:</p> <p>1. On 9/30/14 at 9:00 A.M., during the initial tour, Resident C was observed lying in bed, on her back, wearing a hospital gown.</p> <p>The clinical record of Resident C was reviewed on 9/30/14 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's dementia and fracture of left leg.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 8/18/14, indicated the resident scored a 4 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two + staff for bed mobility, transfer, and toilet use, and extensive assistance of one staff for dressing and hygiene/dressing. The MDS assessment indicated the resident was always incontinent of bowel and bladder.</p>	F000312	<p>F312D –ADL care provided for dependent residents</p> <p>It is the intent of this facility to ensure a dependent resident, received ADL care, including repositioning, toileting, and dressing.</p> <p>1. Actions Taken:</p> <p>A. Resident C was assessed upon notification from surveyor with no breakdown noted. Resident was provided ADL care.</p> <p>2. How other residents would have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>A. IDT team completed a round on all residents at the time of identification and no one else was affected.</p> <p>3. Measures Taken:</p> <p>A) In-service completed for nursing staff related to Dependent ADL care for residents, Turn and Reposition, Incontinent Care.</p>	10/15/2014

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	<p>A resident care plan, initially dated 6/5/14, indicated, "Resident requires assistance with ADL's." The Interventions included: "Assist as needed so resident is clean and dry...T Time [turn and toilet] as indicated."</p> <p>An additional resident care plan, initially dated 5/29/14, indicated, "At risk for skin breakdown due to diagnosis." The Interventions included: "Ensure T time at least every 2 hours. Keep clean and dry."</p> <p>A Nurse's Note, dated 9/28/14 at 6:27 P.M., indicated, "...Depends upon staff for all ADL care. All transfers by staff assist. Up in w/c [wheelchair] daily, propelled by staff..."</p> <p>Resident C was observed on 9/30/14 at 10:25 A.M. and 11:40 A.M. lying in bed on her back with her hospital gown on. Her hair was uncombed. At 1:15 P.M., Resident C was observed sitting in bed, with her hospital gown on, and her uneaten food tray in front of her. Resident C indicated at that time that she was "not hungry."</p> <p>On 9/30/14 at 1:25 P.M., CNA # 1 was interviewed, and indicated she was the staff member taking care of Resident C. A skin assessment on Resident C was</p>		<p>B) C.N.A #1 was re-educated on proper ADL care and is being retrained.</p> <p>C) T Time log (Turn and reposition) to be completed on all appropriate residents every 2 hours.</p> <p>4. How Monitored:</p> <p>A. IDT team will observe all residents during daily rounds for completion of ADL care, Toileting needs and Turn and repositioning.</p> <p>B. DON/Designee will observe 3 residents a week for 4 weeks, 2 residents a week for 4 weeks and 1 resident a week ongoing for completed ADL care, Incontinent care, Turning and repositioning and completion of the t-time log</p> <p>C. Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for determination of ongoing monitoring and/or changes.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 15, 2014.</p>	

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	<p>requested at that time. CNA # 1 indicated she gave Resident C a bed bath earlier that morning, and had to clean her up again "around breakfast [6:30 A.M.], because she kept pooping." CNA # 1 indicated she had been unable to get to the resident since then, but was planning on checking her before her shift ended at 2:00 P.M. The resident's brief was observed to be wet with urine, and dried BM was observed on the resident's buttocks. The resident's skin was creased and reddened. CNA # 1 indicated she did not usually get the resident up and out of bed, unless she had another staff member to help her. She indicated she could pull another CNA off of an adjoining hall if she needed to.</p> <p>The resident had not been toileted or turned from approximately 6:30 A.M. until 1:25 P.M.</p> <p>2. On 10/2/14 at 2:15 P.M., the Director of Nursing provided the current facility "Job Description, Position: Certified Nursing Assistant," dated June 1, 2012. The document indicated: "Resident Care Responsibilities:...Completes or assists resident with bathing, dressing, hygiene, and grooming, in accordance with established Care Plan...Moves or assists residents in moving to and from bed as necessary...Turns, positions and toilets</p>			

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F000323 SS=G	<p>residents as per Care Plan...."</p> <p>This Federal tag relates to Complaint IN00156570 and IN00154633.</p> <p>3.1-38(a)(2) 3.1-38(a)(3)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to develop appropriate individualized interventions to prevent falls in a resident at high risk for falls, resulting in a fall with a right leg fracture, for 1 of 3 residents sampled with falls, in a sample of 8. Resident C</p> <p>Findings include:</p> <p>1. On 9/30/14 at 9:00 A.M., during the initial tour, Resident C was observed lying in bed, on her back, wearing a hospital gown.</p> <p>The clinical record of Resident C was reviewed on 9/30/14 at 11:45 A.M.</p>	F000323	<p>We request a face to face IDR on this tag to decrease the severity of tag. As we believe The spiral fracture of resident C caused the fall. The fall did not cause the fracture. F323G Free of Accident Hazards/Supervision/Devices It is the intent of this facility to develop appropriate individualized interventions to prevent falls in a resident at high risk for falls. 1. Actions Taken: A. Resident C upon readmission on 6-22 was in a WC, receiving PT/OT and the intervention placed of a speaking alarm (male voice) reminding resident to sit down. This intervention has been successful as resident has had no other falls. 2. How other residents would have the potential to be affected by the same deficient practice will be identified and what corrective</p>	10/15/2014			

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	<p>Diagnoses included, but were not limited to, Alzheimer's dementia and fracture of right leg.</p> <p>Progress notes included the following notations:</p> <p>5/29/14 at 4:15 P.M.: "New admit...Entered facility by w/c [wheelchair]. Son says she is a little weak to walk...."</p> <p>A Fall Risk Assessment, dated 5/29/14, indicated, "Intermittent Confusion, Ambulatory/Continent, 1-2 falls in past 3 months, Balance problem while standing, Balance problem while walking, Requires use of assistive devices..." A total number of the risk factors was not documented.</p> <p>A Physical Therapy Evaluation & Plan of Treatment, dated 5/30/14, included: "Reason for Referral:...falling twice at home same day and several falls at home in the past...The EMS [emergency medical system] staff came to her home x 2 day of admission assting [sic] her off the floor after a fall...Impressions:...poor plus static and dynamic standing balance with recent history of several falls, inability to get up off the floor after falling...Risk factors:...high fall risk, osteoporosis...Hx [history]...CVA with</p>		<p>action(s) will be taken: A. A 100% audit completed on all residents with review of proper interventions was completed. Care plans updated as indicated. NO other residents were found to be affected. 2. Measures Taken: A. In-service completed for nursing staff related to falls, incidents, interventions and plan of care for residents. B. 100% audit completed on current residents for appropriate care plan interventions for falls. 3. How Monitored: A. All residents records upon admission will be reviewed for fall risk needs and place a plan of care on record as indicated. B. All residents with falls will be reviewed daily by the IDT team for appropriate intervention and completion of incident review and this is ongoing. C. A weekly fall meeting will occur to track and trend all falls. D. IDT team will complete Quarterly care plan reviews for all residents and review fall risk and current and applicable fall interventions. E. Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for determination of ongoing monitoring and/or changes. 4. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our</p>		

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	<p>recovery...."</p> <p>Progress notes continued:</p> <p>6/3/14 at 6:31 P.M.: "...All transfers by staff assist...."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 6/6/14, indicated the resident scored a 8 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of one staff for transfer, walking, dressing, and personal hygiene. The MDS assessment indicated the resident was "Not steady, only able to stabilize with staff assistance" during a test for balance during transitions and walking. The resident had fallen in the month prior to admission to the facility, and had fallen since admission.</p> <p>Progress notes continued:</p> <p>6/6/14 at 7:00 A.M.: "Called to res [resident] room by cna. Res lying on back in floor between closet and bed. Chair sitting next to res. Posterior head bleeding with large hematoma. Laceration 0.4 cm long. No sutures needed. Res states she was getting in closet and tripped over chair...."</p> <p>6/9/14 at 6:11 A.M.: "Res removing pull</p>		date of compliance is October 15, 2014.				

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	<p>alarm x 2 since 5 am taking self to bathroom enc [encourage] res to ring call light for assistance...."</p> <p>6/9/14 at 1:54 P.M.: "Res alarm and working. Res has attempted to transfer unassisted sev [several] times this shift. Provided cues for safety...."</p> <p>6/10/14 at 1:55 P.M.: "Res got up unassisted and lost balance falling onto left knee. 2 cm laceration noted. Small amount of bleeding. Skin approximated. Bleeding stopped. Steri strips applied...."</p> <p>6/11/14 at 9:35 P.M.: "Summoned to residents [sic] room by residents roommate. Entered room to find resident lying on back by BR [bathroom] door, legs crossed, with Rt [right] leg over Lt [left] leg. Resident able to move Rt leg upon command, but thought her Lt leg was straight. This nurse had felt Lt knee and resident c/o [complained of] terrible pain to knee...."</p> <p>The resident was transferred to the hospital by ambulance on 6/11/14 at 10:14 P.M.</p> <p>A physician note, dated 6/26/14, indicated, "...Initially admitted...for weakness...for rehab. However, very shortly [after] she came, she tried to get</p>			

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	<p>up herself [and] fell suffering a spiral fx [fracture] of Rt [right] tibia [leg]...."</p> <p>A resident care plan, dated 7/3/14, indicated, "Resident is at risk for falls D/T [due to] history of recent fall...Interventions, Keep call light in reach, Therapy screen...."</p> <p>A resident care plan regarding the resident's fall risk prior to 7/3/14 was not located at that time.</p> <p>On 10/2/14 at 10:00 A.M., the Director of Nursing (DON) provided a care plan, dated 5/29/14 and revised 6/6/14, which indicated, "Potential for falls R/T [related to] new surroundings and weakness. Interventions, Call light in reach. Encourage to ask for assist with transfer or ambulation prn [as needed]. Keep paths free of clutter. Therapy screen quarterly and prn. 6-6-14 note in view to ask for assist use call light on bright paper."</p> <p>The DON indicated at that time that the care plan may have been under the therapy section, instead of the nursing section, regarding care plans. The DON indicated that after the resident first fell on 6/6/14, she added the bright reminder note. She indicated the resident also had alarms placed, but did not know why they</p>			

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F000353 SS=E	<p>were not documented on the care plan. She indicated the resident did not really fall on 6/10/14, but that she lost her balance and fell onto her wheelchair, causing the laceration.</p> <p>2. On 10/2/14 at 2:15 P.M., the Director of Nursing provided the current facility policy on a "Fall Risk Assessment," undated. The policy included: "It is the intent of the facility that all resident [sic] will have a Risk Assessment for Falls performed on admission/readmission...For residents who score a 10 or above, develop a preventative care plan for falls..." The DON indicated she was unable to locate a facility Fall Prevention Policy.</p> <p>This Federal tag relates to Complaint IN00154633.</p> <p>3.1-45(a)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by</p>						

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	<p>sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staffing was sufficient to perform ADL (Activities of Daily Living) care promptly for residents, answer call lights timely, toilet residents, and receive ice water when requested, for 4 of 5 residents reviewed for staffing concerns in a sample of 8 residents. Resident C, F, G, and H</p> <p>Findings include:</p> <p>1. On 9/30/14 at 9:00 A.M., during the initial tour, Resident C was observed lying in bed, on her back, wearing a hospital gown.</p> <p>The clinical record of Resident C was reviewed on 9/30/14 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's dementia and fracture of left leg.</p>	F000353	<p>F353E- Sufficient 24 hour nursing staff It is the intent of this facility to ensure staffing is sufficient to perform ADL care promptly for residents, answer call lights timely, toilet residents, and receive ice water when requested. 1. Actions Taken: A. Resident C was assessed upon notification from surveyor with no breakdown noted. Resident was provided ADL care as she indicated. 2. How other residents would have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: IDT team completed a round on all residents at the time of identification and no one else was affected. 3. Measures Taken: A. In-service completed for nursing staff related to Dependent ADL care for residents, Turn and Reposition, Incontinent Care. B. CNA#1 was reeducated on importance of answering call lights timely /ADL care and is being retrained. C.</p>	10/15/2014

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	<p>The most recent Minimum Data Set (MDS) assessment, dated 8/18/14, indicated the resident scored a 4 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two + staff for bed mobility, transfer, and toilet use, and extensive assistance of one staff for dressing and hygiene/dressing. The MDS assessment indicated the resident was always incontinent of bowel and bladder.</p> <p>A resident care plan, initially dated 6/5/14, indicated, "Resident requires assistance with ADL's." The Interventions included: "Assist as needed so resident is clean and dry...T Time [turn and toilet] as indicated."</p> <p>An additional resident care plan, initially dated 5/29/14, indicated, "At risk for skin breakdown due to diagnosis." The Interventions included: "Ensure T time at least every 2 hours. Keep clean and dry."</p> <p>A Nurse's Note, dated 9/28/14 at 6:27 P.M., indicated, "...Depends upon staff for all ADL care. All transfers by staff assist. Up in w/c [wheelchair] daily, propelled by staff...."</p> <p>Resident C was observed on 9/30/14 at</p>		<p>T Time log (Turn and reposition) to be completed on all appropriate residents every 2 hours. 4. How Monitored: A. IDT team will observe all resident's during daily rounds for completion of ADL care, Toileting needs and Turn and repositioning. B. DON/Designee will observe 3 resident's a week for 4 weeks, 2 resident's a week for 4 weeks and 1 resident a week ongoing for completed ADL care, Incontinent care, Turning and repositioning and completion of the t-time log C. Administrator will review the daily staffing hours for appropriate staffing levels to meet the needs of the residents. D. Resident Council will be offered q week for 4 weeks to review care and staffing concerns. E. Guardian Angel Rounds will continue and include care and staffing questions. Results will be discussed in CQI and remedied. F. Any inconsistent results will be immediately clarified and corrected appropriately and care plans updated if needed. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for determination of ongoing monitoring and/or changes. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 15th, 2014</p>				

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	<p>10:25 A.M. and 11:40 A.M. lying in bed on her back with her hospital gown on. Her hair was uncombed. At 1:15 P.M., Resident C was observed sitting in bed, with her hospital gown on, and her uneaten food tray in front of her.</p> <p>On 9/30/14 at 1:25 P.M., CNA # 1 was interviewed, and indicated she was the staff member taking care of Resident C. She indicated she was the only CNA on that hall, and 2 CNAs worked the adjoining hall. A skin assessment on Resident C was requested at that time. CNA # 1 indicated she gave Resident C a bed bath earlier that morning, and had to clean her up again "around breakfast [6:30 A.M.], because she kept pooping." CNA # 1 indicated she had been unable to get to the resident since then, but was planning on checking her before her shift ended at 2:00 P.M. The resident's brief was observed to be wet with urine, and dried BM was observed on the resident's buttocks. The resident's skin was creased and reddened. CNA # 1 indicated she did not usually get the resident up and out of bed, unless she had another staff member to help her. She indicated she could pull another CNA off of an adjoining hall if she needed to.</p> <p>The resident had not been toileted or turned from approximately 6:30 A.M.</p>			

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	<p>until 1:25 P.M.</p> <p>2. During a confidential interview Resident F indicated they often had to wait forty five minutes or more for someone to answer the call light and this resulted in incontinent episodes. Resident F further indicated they ate in bed because there was not enough staff to get them up in the morning.</p> <p>3. During a confidential interview Resident G indicated the facility did not have enough help. Resident G indicated two staff members were supposed to assist them with activity of daily living care (ADL's) The resident further indicate that often only one would come and they acted rushed and in a hurry. Resident G further indicated they had requested fresh ice water that morning and it took an hour for staff to bring it.</p> <p>4. During a confidential interview Resident H indicated they had to wait for an hour or more for their call light to be answered. Resident G indicated the night prior after waiting for 1 and 1/2 hours the staff informed them they did not have enough help to assist them onto the bedside commode and they would have to use the bedpan. Resident G further indicated they could not go on the bedpan and it caused them pain to sit on it for too long.</p>			

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F000465 SS=E	<p>5. The resident council minutes dated 7/8/14 were reviewed on 10/1/14 at 2:30 P.M., 9 residents were in attendance. Under "old business" concerns were voiced in regards to timeliness of staff answering call lights, making beds and also with assistance with meals. Under "new business" residents still voiced concerns regarding assistance with meals, call light, beds being made timely. This Federal tag relates to Complaint IN00156570 and IN00154633. 3.1-17(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure the floors in resident areas were maintained in a sanitary manner, in that, debris was observed around perimeter of the hallways in 1 of 3 units and in resident rooms, during 3 of 3 observations. (East Unit Room # 213, 222, 102)</p> <p>Findings include:</p> <p>1. During observations on 9/30/14 at 9:25</p>	F000465	<p>465E– Safe comfortable sanitary environment It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Actions Taken: A) The Housekeeping Director and her staff deep cleaned 213, 222, and 102 the floor tech stripped and waxed the rooms. The East hallway base boards and bathrooms were cleaned. 2. How other residents would have the potential to be affected by the same deficient practice will be</p>	10/15/2014

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	<p>A.M., 10/1/14 at 10:15 A.M. and 10/2/14 at 11:40 A.M. the floors in the East unit corridors were observed to have a layer of dark, gritty, debris present in the perimeter of the halls.</p> <p>2. During observations on 9/30/14 at 9:30 A.M., 10/1/14 at 10:15 A.M. and 10/2/14 at 11:45 A.M. the floor in room #213 was observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door. The bathroom was observed to have debris present at base of toilet that came up when wiped with wet tissue.</p> <p>3. During observations on 9/30/14 at 9:45 A.M., 10/1/14 at 1:00 P.M. and 10/2/14 at 11:50 A.M. the floor in room #222 was observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door. The bathroom was observed to have a brown substance and debris present around the base of the toilet.</p> <p>4. During observations on 10/1/14 at 1:00 P.M., 10/2/14 at 11:59 A.M. the floor in room #102 was observed to have a layer of dark, gritty, debris present in the perimeter of the room and behind the door. The bathroom was observed to have debris present on the floor, especially around the base of the toilet</p>		<p>identified and what corrective action(s) will be taken: A) IDT team performed rounds and asked each resident if they had any concerns regarding cleanliness. Areas identified were cleaned immediately. No residents had any concerns. 3. Measures Taken: A) 100% audit of all resident rooms/facility were completed to identify and rectify any issues. B. 3 New housekeepers were recently hired for the facility. 4. How Monitored: A) Daily rounds to be completed by the Housekeeping Director for cleanliness of resident rooms and hallways. B) Resident rooms, bathrooms and common area floors was placed on all housekeepers daily check-off sheets. C. IDT team to observe environment for issues on daily rounds. D.) Administrator/Designee will complete audits three times a week on all shifts for four weeks, 2 times a week for 4 weeks, then weekly ongoing. E.) Any inconsistent results will be immediately clarified and corrected appropriately. Results would be monitored and reviewed at the monthly and quarterly QA Meetings for ongoing monitoring and/or changes. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 15th, 2014.</p>		

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	<p>that came up when wiped with a paper towel.</p> <p>The Administrator was made aware of the concerns on 10/2/14 at 11:40 A.M., she indicated the facility housekeeping department was down in staff due to some illnesses. She indicated she understood the concerns and would have staff begin working on it right away.</p> <p>This Federal tag relates to Complaint IN00156570. 3.1-19(f)</p>				