

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 4, 5, 6, 7 and 10, 2014</p> <p>Facility number: 00290 Provider number: 155699 AIM number: 100379970</p> <p>Survey Team: Kim Davis, RN, TC Jason Mench, RN Angela Selleck, RN Ginger McNamee, RN (3/5/14 - 3/10/14)</p> <p>Census bed type: SNF/NF:45 Total: 45</p> <p>Census payor type: Medicare: 4 Medicaid: 38 Other: 3 Total: 45</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</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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F000248 SS=D	<p>Barth, RN.</p> <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 activities were provided for 1 of 1 resident reviewed for activities. (Resident # 53).</p> <p>Findings Include:</p> <p>Resident #53 was interviewed on 3/4/14 at 2:15 p.m. During the interview, Resident #53 indicated he did not participate in the facility activity program because the facility did not offer activities to meet his interests. Resident #53 indicated he was bored.</p> <p>RN #8 was interviewed on 3/5/14 at 9:00 a.m. During the interview, RN #8 indicated Resident #53 stayed in his room and ate meals in his room.</p> <p>Resident #53 was observed in his</p>	F000248	<p>1 Resident #53 is currently receiving activities of choice daily and is being provided one on one activities. 2 All other residents have the potential to be affected and have been reviewed, Residents are currently receiving activities of choice daily and one on ones if indicated 3. The facility's policy for One to One Programming has been reviewed and no changes are indicated at this time (See Attachment A) The Activities director and activities staff have been re-educated on Activities with special focus on providing One on One's with the resident if indicated. (See Attachment B) An Activity Survey form and 1:1 Activity Program Audit Sheet has been implemented (See Attachment C) 4. The Activities Director or designee will be responsible to complete the Activity Survey form and 1:1 Activity Program Audit Sheet to ensure activities of the residents</p>	03/27/2014			

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	<p>room with his door closed on 3/4/14 between 9:30 a.m. and 11:00 a.m. and 1:00 p.m. to 2:45 p.m.</p> <p>Resident #53 was observed in his room with the door closed on 3/5/14 between 9:15 a.m. and 11:00 a.m. and between 1:00 p.m., and 3:00 p.m.</p> <p>Resident #53 was observed in his room with the door closed 3/6/14 8:15 a.m. and 11:00 a.m., between 12:00 p.m. and 2:00 p.m. and between 2:15 p.m. and 3:00 p.m.</p> <p>The clinical record of Resident #53 was reviewed on 3/6/13 at 1:00 p.m. The record indicated the resident's diagnoses included, but were not limited to, vertebral fracture, depression, anxiety, and diabetes.</p> <p>The initial activity assessment, dated 1/31/14, indicated, Resident #53 enjoyed sports and exercise, spiritual activities, parties, television, talking and conversing, and spending time out of doors.</p> <p>The activity care plan, dated 1/31/14, indicated Resident #53 could make decisions regarding activity choices. The care plan interventions included, providing an</p>		<p>choices are being provided and one on ones are being completed if indicated. These interviews will be conducted with 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, then monthly thereafter Should concerns be found, immediate corrective action will occur These reviews will be discussed during the facilities quarterly QA meetings on an ongoing basis and the plan adjusted if indicated</p>		

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	<p>activity calendar, assisting to activities and reminders for activity events.</p> <p>The Activity Calendar indicated the following activities were offered from 3/4/14, 3/5/14, 3/6/14:</p> <p>3/4/14: 10:00 a.m.- News and Travel 1:15 p.m.- Smoking 2:00 p.m.- Songs 3:30 p.m. - Games</p> <p>3/5/14: 10:00 a.m.- News and Chit Chat 1:15 p.m.- Smoking 2:00 p.m. - Appealing Apparel 2:30 p.m.- Movie</p> <p>3/6/14: 10:00 a.m.- Bible Study 10:30 a.m.- Move It 1:15 p.m.- Smoking 2:00 p.m.- Bingo 3:00 p.m.- Pretty Nails</p> <p>The Activity Director (AD) was interviewed on 3/10/14 at 9:30 a.m. During the interview, the AD indicated she provided one to one time with Resident #53. The AD had no documentation of any one on one time spent with the resident. The AD provided documentation of group activities for March 2014. Resident #53 did not attend any of the group activities.</p>			

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F000280 SS=D	<p>3.1-33(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure care plans were updated for 1 resident regarding antipsychotic medications with behavior interventions and regarding activities and 1 resident regarding falls in a sample of 18 residents' reviewed of care plans. (Resident # 53 and 49)</p> <p>Findings include:</p>	F000280	<p>1 Resident #53's care plan has been updated to reflect activities of preference and specific behaviors resident experiences and interventions which are successful for resident. Resident #43's care plan has been updated to reflect individualized goals including the fall care plan. 2 All other residents have the potential to be affected. Their careplans have been reviewed and individualized if indicated. 3 The facility's policy for Care Plan Development has been reviewed and no changes are indicated at</p>	03/27/2014			

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	<p>1. a. Resident # 53 was interviewed on 3/4/14 at 2:15 p.m. During the interview, Resident #53 indicated he did not participate in the facility activity program because the facility did not offer activities to meet his interests. Resident #53 indicated he was bored.</p> <p>The clinical record of Resident #53 was reviewed on 3/6/14 at 1:00 p.m. The record indicated the resident's diagnoses included, but were not limited to, vertebral fracture, depression, anxiety, and diabetes.</p> <p>The initial activity assessment, dated 1/31/14, indicated, Resident #53 enjoyed sports and exercise, spiritual activities, parties, television, talking and conversing, and spending time out of doors.</p> <p>The activity care plan, dated 1/31/14, indicated Resident #53 could make decisions regarding activity choices. The care plan interventions included, providing an activity calendar, assisting to activities and reminders for activity events. The plan of care had not been updated to reflect the activity preferences of Resident #53.</p> <p>The Activity Director (AD) was</p>		<p>this time (See Attachment D). The interdisciplinary team has been re-educated on care planning with special focus on resident preferences, individualized problems, goals, and interventions (See Attachment E). A Care Plan review form has been implemented (See Attachment F). 4 The Administrator or designee will be responsible for completing the care plan review form on scheduled work days reviewing 3 resident care plans as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>	

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	<p>interviewed on 3/10/14 at 9:30 a.m. During the interview, the AD indicated she provided one to one time with Resident #53. The AD had no documentation of any one on one time spent with the resident. The AD provided documentation of group activities for March 2014. Resident #53 did not attend any of the group activities.</p> <p>1.b. The clinical record of Resident #53 was reviewed on 3/6/14 at 1:00 p.m. The record indicated the resident's diagnoses included, but were not limited to, vertebral fracture, depression, anxiety, and diabetes.</p> <p>The physician orders, signed on 3/5/14, included orders for the antidepressant medication, Cymbalta, daily and Valium and trazadone given for anxiety as needed.</p> <p>The care plan, dated 2/3/14, of Resident #53 was reviewed. The care plan indicated Resident #53 displayed anxiety, had hallucinations, a depressed mood, and received psychotropic medications. The care plan interventions were not updated to reflect behaviors documented on the</p>						

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	<p>behavior logs.</p> <p>The Social Service Director (SSD) was interviewed on 3/7/14 at 9:50 a.m. The SSD indicated Mood and Behavior forms are available at the nurse stations. The SSD indicated staff completed the forms with behaviors and gave them to her. She in turn, kept a log of these behaviors. The SSD indicated she used the behavior logs for behavior meetings. She did not up date the care plan to reflect intervention changes made.</p> <p>2. Resident #49's clinical record was reviewed on 3/6/14 at 1:30 p.m. The resident's diagnoses included, but were not limited to, weakness, dementia with agitation, and degenerative arthritis.</p> <p>Resident #49 had a 12/28/13, annual Minimum Data Set assessment indicating the resident had severe cognitive impairment, required the assistance of one for ambulation and transfers and had a history of falls.</p> <p>Review of the "Fall Risk Assessment", dated 2/1/14, indicated the resident had a history of falls, used assistive devices, had confusion, an unsteady gait at times,</p>			
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	<p>used anti-psychotics and anti-hypertensives.</p> <p>Review of a Nurses Note, dated 2/1/14, 1:20 p.m., indicated the resident was found sitting on the floor. He stated he didn't know what happened, but he was okay. The note also indicated the resident was attempting to sit down after standing by himself with the brakes to the wheelchair not locked. The note indicated it appeared the resident fell on his buttocks and an abrasion was noted to the right middle back.</p> <p>The resident had a 1/10/14, care plan problem of multiple risk factors for falls, such as: decreased mobility, history of falls, impaired cognition, hearing, use of a wheelchair, impaired balance, unsteady gait, needs assist with activities of daily living, mental status fluctuates, and medication use. The goal for this problem was "The resident's risk factors will be reduced in an attempt to avoid significant injury related to falls. Thru next review."</p> <p>The fall care plan goal was reviewed with the Director of Nursing during an interview on 3/10/14 at 9:41 a.m. The Director of Nursing indicated "I</p>				

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	<p>don't know what risk factors can be reduced for his falls."</p> <p>During a 3/10/14, 10:21 a.m., interview with the Director of Nursing she stated "we use a standard care plan goal in all our facilities for falls." She indicated it was to reduce the risk factors for falls. She indicated the resident was on Aricept or Namenda for dementia and on the walk to dine program with restorative nursing. She indicated his dementia and ambulation could not be improved but were being maintained with the interventions. Review of the resident's physician's orders lacked an order for Aricept or Namenda.</p> <p>During an interview with the Restorative CNA #10 on 3/10/14 at 11:06 a.m., she indicated the resident received active range of motion to his upper and lower extremities and ambulated 400 feet six days a week with restorative nursing and ambulated to the dining room at lunch time Monday through Friday. She indicated he had always been able to do this and has had no improvement or decline.</p> <p>3.1-35(a)</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, interview and observation, the facility failed to ensure anti-roll back wheelchair locks were in proper working order to prevent falls for 1 of 3 residents reviewed for falls. (Resident #49)</p> <p>Findings include:</p> <p>Resident #49 was observed up in his wheelchair in his room on: 3/5/14 at 8:30 a.m., working with the restorative CNA. 3/6/14 at 1:10 p.m., sitting in his wheelchair facing the door. 3/7/14 at 8:30 a.m., sitting in his wheelchair. 3/10/14 at 8:30 a.m., sitting in his wheelchair propelling himself around the room.</p> <p>Resident #49's clinical record was reviewed on 3/6/14 at 1:30 p.m. The resident's diagnoses included, but were not limited to, weakness, dementia with agitation, and degenerative arthritis.</p>	F000323	<p>1 The antiroll back brakes on Resident#43's wheel chair were tightened on 2/1/14. They are currently being checked for functional use on a routine basis and are in good working order.</p> <p>2. All other residents utilizing antiroll back brakes on their wheelchairs have the potential to be affected. Their wheelchairs are currently being checked for functional use on a routine basis and are in good working order.</p> <p>3. The facility's policy for preventative maintenance has been reviewed and no changes are indicated at this time (See Attachment G). The maintenance director has been re-educated on preventative maintenance with a special focus on antiroll back brakes (See Attachment H). A Preventative Maintenance for All Wheelchairs Equipped with Anti-rollback or Anti-tippers form has been implemented (See Attachment I).</p> <p>4 The Maintenance Director or designee will be responsible to complete the preventative maintenance checklist to ensure antiroll back brakes are functioning properly on scheduled work days</p>	03/27/2014

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	<p>Resident #49 had a 12/28/13, annual Minimum Data Set assessment indicating the resident had severe cognitive impairment, required the assistance of one for ambulation and transfers and had a history of falls.</p> <p>Review of the "Fall Risk Assessment", dated 2/1/14, indicated the resident had a history of falls, used assistive devices, had confusion, unsteady gait at times, used anti-psychotics and anti-hypertensives.</p> <p>Review of a Nurses Note, dated 2/1/14, 1:20 p.m., indicated the resident was found sitting on the floor. He indicated he didn't know what happened, but he was okay. The note also indicated the resident was attempting to sit down after standing by himself with the brakes to wheelchair not locked. The note indicated it appeared the resident fell on his buttocks and an abrasion was noted to the right middle back.</p> <p>Review of the 2/1/14, "Post Fall Investigation Worksheet" indicated the anti-roll backs on the wheelchair were in place but not working properly or effective.</p>		asfollows: weekly for 4 weeks then monthly thereafter. If concerns are found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.	

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F000325 SS=D	<p>During an interview with the Director of Nursing on 3/10/14 at 8:05 a.m., she indicated the anti-roll backs on the wheelchair were loose and did not stop the wheelchair from rolling backwards when the resident transferred himself from the bed to wheelchair. She indicated the resident fell because the wheelchair rolled backwards. She indicated the anti-roll backs had not been checked for functional use on a routine basis since applied on 12/21/13.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to assess for, and implement dietary interventions to prevent a documented 16% weight loss for 1 of 3 residents reviewed for weight loss.(Resident #21)</p>	F000325	<p>1. Prior to Resident #21's hospital stay in December, 2013 the previous 6 months of weights ranged from 125 to 131. While at the hospital the resident was being surgically treated for a fracture, during that time, fluid overload developed and the resident was admitted to</p>	03/27/2014

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	<p>Findings include:</p> <p>The clinical record of Resident #21 was reviewed on 3/7/14 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, Gastroesophageal Reflux Disease (GERD), anemia, and dementia.</p> <p>The admission nursing assessment, dated 1/19/14, indicated Resident #21 weighed 150 pounds on admission to the facility.</p> <p>The initial nutritional assessment, dated 12/23/13, indicated Resident #21's weight log admission weight was 150 and 143.8 pounds on 12/23/13. The assessment indicated the resident ate 25-100% of meals in the room. The assessment indicated the resident would be followed by the facility weight committee (SWAT) for four weeks.</p> <p>The food preference record, dated 12/23/13, documented only drink preferences. The food portion of the record had not been completed with the resident's food likes and dislikes.</p> <p>A Dietician note, dated 12/31/13, indicated, "assessment complete."</p>		<p>Bridgewater with a weight of 150. The resident was initially placed on SWAT (skin/weight team) at the time of admission as this was done with all new admissions and weights are tracked weekly. The resident continued to lose weight each week as this was expected due to the fluid overload. During this time, the resident was placed on mighty shakes as a precautionary step which was discontinued due to resident's refusals. The resident was placed on ice cream, super-cereal, and cottage cheese as this is what the resident requested. These were being served with meals and consumption was documented with meal intake on the food and fluid acceptance records. The resident's current weight is 121.5. Resident #23 has been nutritionally assessed, supplements are being individually documented with amount consumed, and the nutritional care plan has been updated to reflect current status.</p> <p>2. All residents experiencing weight loss have the potential to be affected. Their clinical records have been reviewed and updated if indicated.</p> <p>3. The facility's policy for Nutrition and Weight Loss Management Program has been reviewed and no changes are indicated at this time (See Attachment J). The interdisciplinary team and nurses have been re-educated on the policy (See Attachment E). A</p>	

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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348			
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	<p>The care plan, dated 12/26/13, indicated Resident #21 had GERD, anemia, dementia, and missing teeth. The care plan goal indicated the resident's weight would be maintained. The care plan interventions included, regular diet with regular texture, house shakes three times a day, encourage resident to eat 75% of meals, offer substitutes, nightly snack, vitamins, and laboratory tests as needed.</p> <p>The resident's weights were recorded in the clinical record. The weight record indicated Resident #21 weighed 150 pounds on admission. On 1/4/14, a 19 pound weight loss or 12.7% at 130 pounds was documented. On 2/11/14, the resident weighed 126 pounds, which was a 16% weight loss. On 3/6/14 the resident's weight was 118 pounds.</p> <p>The physician orders indicated Mighty Shakes, a high calorie nutritional supplement was ordered by the physician on 1/10/14, 22 days after admission. The shake supplement was discontinued due to the resident refusal of the shakes on 3/5/14.</p>		<p>Nutritional Monitoring form has been implemented (See Attachment K). 4. The DON or designee will be responsible for completing the Nutritional Monitoring form to ensure residents with weight loss have been assessed, any supplements are being individually documented with amount consumed, and nutritional care plans reflect current status on scheduled work days as follows: daily for 2 weeks, then weekly thereafter. If a concern is noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>				

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	<p>The Resident's diet card was presented by the Dietary Manager (DM) on 3/7/14 at 9:00 a.m. The card indicated the resident was to be served ice cream, supercereal, and yogurt in addition to the regular meal.</p> <p>The DM was interviewed on 3/7/14 at 9:40 a.m. The DM indicated there was no documentation of how much of the supplements the resident actually ate.</p> <p>RN #8 was interviewed 3/7/14 at 9:45 a.m. The nurse indicated all intakes of house supplements were documented on the Medication Administration Record (MAR).</p> <p>The MAR was reviewed with RN #8 on 3/7/14 at 9:45 a.m. RN #8 indicated the ice cream, yogurt, and supercereal had not been added to the MAR so there was no documentation of consumption of the supplements.</p> <p>The Director of Nursing (DoN) and Assistant Director of Nursing (ADoN) were interviewed on 3/10/14 at 9:00 a.m. During the interview, the DoN indicated she had reviewed Resident #21's record on 3/7/14. She indicated the resident's</p>			

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F000371 SS=F	<p>admission weight was due to fluid overload related to surgery and heart disease. The DoN indicated she did not investigate the resident's weight loss. She indicated the resident was followed by the facility weight committee. The DoN indicated the facility had not done daily weights for Resident #21, and had not documented intakes of supplements, and had not updated care plan interventions.</p> <p>3.1-46(a)(1)</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, record review and interview, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. This deficient practice had the potential to impact 44 of 45 residents who were served from the facility's kitchen.</p> <p>Findings include:</p> <p>1. Kitchen sanitation tour</p>	F000371	<p>1. The facility is currently storing, preparing, distributing and serving food under sanitary conditions. The following has been corrected: a. The outside of the peanut butter container was immediately cleaned b. The old milk cooler was immediately removed from the facility and a new milk cooler is now in place. The milk gallons, prune juice containers, and the containers of thick and easy were immediately cleaned. c. The Teflon frying pan was</p>	03/27/2014

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	<p>accompanied by the Dietary Manager on 3/4/14 at 9:30 a.m. indicated the following concerns:</p> <p>a. Peanut butter, which was stored on the top rack beside the hand washing sink, had peanut butter on the outer edges of the five pound white container.</p> <p>b. The milk cooler had an off white watery substance and rust on the bottom of the cooler, which had a foul odor. The grey gaskets around the two milk cooler lids were loose and unattached in sections.</p> <p>One gallon of skim milk, one half gallon of skim milk, five plastic 48 fluid ounce containers of Thick n Easy, and two containers of 46 fluid ounce prune juice all had a pink dried substance splattered down the sides of the containers, which were stored in the milk cooler.</p> <p>c. One small eight inch Teflon frying pan had the black Teflon scratched down to the metal inside of the pan.</p> <p>d. Approximately one pound of turkey was stored in an unsealed clear plastic gallon zip lock bag on the bottom shelf of a three door stainless steel refrigerator with a</p>		<p>immediately disposed of. d. The one pound turkey was immediately disposed of e. The two vents and sprinker head in the dishwashing room were immediately cleaned f. The walls throughout the kitchen and dishwashing room were immediately cleaned. g. The corner edging of the wood paneling behind the hand sink has been fixed and the paneling is now attached to the wall. h. The brick tiles have been replaced 2. See Above 3. A facility policy for Kitchen Sanitation been implemented (See Attachment L). The cleaning schedule has been revised to include walls, sprinkler heads, vents, and the milk cooler (See Attachment M). The dietary and maintenance staff have been re-educated on the cleaning policy and revised cleaning schedule (See Attachment N). A Sanitation Checklist has been implemented (See Attachment O). 4 The dietary manager or designee will complete the Sanitation Checklist on scheduled work days to ensure a sanitary environment as follows: daily on an ongoing basis If concerns are found, immediate corrective action will occur Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated</p>	

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	<p>date of 2/27/14.</p> <p>e. One of two vents and a water sprinkler in the dishwasher room had grey dust hanging down. These were positioned over ready to use silverware and a rack of clean plastic glasses.</p> <p>f. The walls throughout the kitchen area had dried food debris and grime splattered on them.</p> <p>The wall beside the dishwasher had four dried paper towel balls stuck to the wall.</p> <p>g. The wall paneling behind the hand washing sink had corner edging that was broken, which resulted in approximately 3 inches of the wall paneling being unattached to the wall.</p> <p>h. Two sections of corner brick colored tiles in the food preparation area were broken and missing. One section of broken corner tile missing was located next to the food preparation table with a green paper covering and cement board visible. The second section of broken corner tile missing was located next to the gas stove and had dried white silicone visible.</p>				

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	<p>2) During a kitchen sanitation tour accompanied by the Dietary Manager and the Registered Dietician on 3/4/14 at 11:00 a.m., the Registered Dietician was made aware of all the concerns related to the kitchen.</p> <p>3) During a kitchen sanitation tour accompanied by the Administrator and Dietary Manager on 3/7/14 at 1:45 p.m., the Administrator measured the two sections of corner brick colored tiles that were broken, missing and five inches from the floor in the kitchen. The first broken and missing section of tile, next to the preparation table was 3.5 inches long by 2 inches wide. The second broken tile and missing section of tile, next to the gas stove, was 4 inches long by 1 3/4 inches wide.</p> <p>The Administrator indicated he had no clue how long the pieces had been chipped.</p> <p>4) During an interview with the Dietary Manager on 3/10/14 at 1:45 p.m., she stated "I did not notice the dried paper towels on the wall in the dishwasher room...</p> <p>I did not notice the peanut butter tub</p>			
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	<p>or even know when it was last used...</p> <p>All food in the refrigerator needs to be stored in a storage container with a use by date, sealed, and have a label of what the item is. I am unable to tell you if the date of 2/27/14 was the use by date or the date the turkey was placed in the refrigerator...</p> <p>Maintenance cleans the vents and water sprinklers...</p> <p>Every day the walls should be cleaned or any items that are dirty should be wiped off."</p> <p>The Dietary Manager indicated no repair order was placed to maintenance for repair of broken and missing tile or for replacement of the gaskets for the milk cooler both located in the kitchen.</p> <p>The Dietary Manager indicated she completed a sanitation observation once a week every two weeks.</p> <p>There was no cleaning schedule for the walls in the kitchen or checks of the vents in the kitchen.</p> <p>5) During an interview with the Maintenance Supervisor on 3/10/14 at 2:45 p.m., he indicated he had no</p>			

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	<p>cleaning schedule for vents or water sprinklers in the kitchen. There was no documentation of when vents or water sprinklers were last cleaned. The Maintenance Supervisor indicated he cleaned the vent and water sprinkler in the dishwasher room after it was brought to his attention on either 3/4/14 or 3/5/14.</p> <p>6) A review of "Sanitation Observation" was provided by the Dietary Manager on 3/10/14 at 1:45 p.m. It indicated the last sanitation observation was completed on 2/24/14.</p> <p>A review of " Magnolia Corporate Dietitian Consultant Report" was provided by the Dietary Manager on 3/10/14 at 1:45 p.m., it indicated the last dietician consult report was on 2/27/14.</p> <p>7) A current facility policy, dated 10/2/2008, titled "Cleaning Schedule" was provided by the Dietary Manager on 3/4/14 at 11:30 a.m., and indicated the following: "Policy: It is necessary to ensure that equipment is cleaned and sanitized on a timely basis. ...5. If another department does cleaning, dietary coordinates the cleaning.</p>						

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F000456 SS=E	<p>...6. All equipment is cleaned as it is used."</p> <p>8) A current facility policy, dated 10/2/2008, titled "Cleaning the Reach-In Refrigerator and Freezer" was provided by the Dietary Manager on 3/4/14 at 11:30 a.m., and indicated the following: "Policy: It is necessary to ensure that reach-in units are kept clean and organized. ...1. Wipe up spills...as they occur. ...5. ...check for outdated leftovers that need to be discarded and ensure that all items are covered and dated."</p> <p>3.1-21(i)(3) 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview, the facility failed to ensure 4 of 7 fire exit doors were free of snow to ensure Resident safety for evacuation and the facility failed to ensure 5 chairs and 2 loveseats were free of urine odors in 4 resident rooms and 1 of 2 television lounges.</p> <p>Findings Include:</p>	F000456	1 The fire exit doors were immediately shoveled to remove the snow and are being kept free from snow to allow egress from the facility by personnel and residents. The recliner in room 108, the two loveseats and two chairs in the lounge across from the nurses station, the recliner in room 103, the recliner in room 216, and the bariatric type chair in room 211 have all been deep cleaned and are currently free	03/27/2014			

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	<p>1. During the initial tour on 3/4/14 at 10:00 a.m., snow was observed at 4 fire exit doors. At each door, there was a three foot ramp leading out the door to piles of snow approximately two feet deep.</p> <p>The Administrator was interviewed on 3/4/14 at 11:50 a.m. The administrator indicated the Maintenance Director had just gotten to the facility and the snow had not been removed.</p> <p>The Maintenance Director was interviewed on 3/4/14 at 1:45 p.m. The Director indicated he did not shovel snow on 3/3/14. The last day he shoveled was after snow had fallen on 3/2/14.</p> <p>The facility policy, entitled Snow Emergency Preparedness, dated 2/09, was presented by the Administrator on 3/4/14 at 11:00 a.m. The policy indicated, "...All doorways will be kept free of snow to allow egress from the facility by personnel or residents...."</p> <p>2. Upon entrance to the facility on 3/4/14 at 9:30 a.m., a strong smell of urine was noticed at the front entrance and down one of two halls</p>		<p>from odors. 2 All resident areas have the potential to be affected. The areas have been observed and deep cleaned if indicated. 3 A facility Room Cleaning policy (See Attachment P) a Resident Room Cleaning, Daily policy (See Attachment Q), and a Deep Cleaning Calendar (See Attachment T) has been implemented. The housekeeping staff have been educated on the policies and calendar (See Attachment R). A facility Rounds Observation form (See Attachment S) has been implemented. 4 The Housekeeping Supervisor or designee will be responsible for completing the Rounds Observation form on scheduled work days as follows: daily for two weeks, then weekly thereafter. If concerns are noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>				

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	<p>where residents resided.</p> <p>On 3/6/14, a recliner chair in room 108 smelled of urine.</p> <p>On 3/6/14 at 10:30 a.m., the two loveseats and the two chairs in the resident TV lounge across from the administrative offices, close to the main entrance smelled of urine.</p> <p>On 3/7/14 at 9:00 a.m., the recliner chair in room 103 smelled of urine.</p> <p>On 3/10/14 at 9:00 a.m., the recliner chair in room 216 and a vinyl bariatric type chair in room 211 smelled of urine.</p> <p>Housekeeper #7 was interviewed on 3/6/14 at 10:00 am. The housekeeper indicated chairs were cleaned during a room deep clean. The deep clean schedule for the 100 hall was located in a binder at the nurse station.</p> <p>The 100 hall deep clean schedule was reviewed. The binder contained schedules for January and February 2014. There was no schedule for March 2014 in the binder.</p> <p>Housekeeper #7, was interviewed on 3/10/14 at 10:30 a.m. The</p>			

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	<p>housekeeper indicated he was working on both the 100 hall and 200 hall. The housekeeper indicated he did not know where to find the cleaning binder for the 200 hall. The housekeeper indicated the Maintenance Director was the current Housekeeping Supervisor.</p> <p>The Maintenance Director was interviewed on 3/10/14 at 10:45 a.m. The director indicated the Administrator kept the deep cleaning schedules.</p> <p>The Administrator was interviewed on 3/10/14 at 10:55 a.m. He indicated the Housekeeping Supervisor had left facility employment on 3/1/14. The administration indicated he did not keep cleaning schedules in his office. A deep cleaning policy was requested.</p> <p>The Administrator was interviewed on 3/10/14 at 11:05 a.m. The Administrator indicated he could not locate deep cleaning schedules. The Administrator did not present a cleaning schedule policy.</p> <p>3.1-19(b)</p>			

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F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility Quality Assessment and Assurance Committee (QAA) failed to identify a deficient practice regarding food being stored, prepared, distributed and served under unsanitary conditions for 44 of 44 residents out of 45 total residents and for failing to assess and implement dietary interventions to prevent a documented weight loss for 1 of 3</p>	F000520	<p>1. Corrective actions as described in the Plan of Correction were taken for kitchensanitation and for Resident #21 relative to weight loss. 2. As all residents could be affected, the following corrective action(s) havebeen taken. 3. Administrative staff have reviewed the current Quality Assurance Committee procedures, adding monthly meetings (exceeding the quarterly requirement) to include audits of the kitchen area and specific care</p>	03/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2014	
NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348			
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	<p>residents reviewed for weight loss (#21).</p> <p>Findings include:</p> <p>1. During kitchen observations, unsanitary conditions were observed concerning the storage, preparation, distribution and service of food to 44 of 44 residents out of 45 total residents.</p> <p>2. During the review of Resident #21's chart for weight loss, it was found the facility failed to implement dietary interventions to prevent a documented weight loss of 16% for 1 of 3 residents reviewed for weight loss.</p> <p>3. During an interview with the Administrator on 3/10/14 at 1:00 p.m., the Administrator indicated the Facility had on going action plans in place addressing dietary sanitation by a sanitation check every month by the Dietary Manager, a meal observation check list, a room tray check list and the Registered Dietician visiting and checking their procedures twice a month. The Administrator indicated an action plan was in place since 2/23/14, for one staff member to obtain resident weights to ensure accurate resident</p>		<p>areas including, but not limited to, weight loss. Dietary Manager or designee and DON or designee shall be responsible to conduct and/or delegate audits in an effort to identify areas of concern and address with the QA committee in an effort to formulate an action plan should deficient practice be identified. 4. As a means of quality assurance, the Dietary Manager and DON shall report findings of aforementioned audits and immediate corrective actions taken to the QA committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality.</p>				

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	weights were obtained. 3.1-52(b)(2)			