

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN 46970
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 3, 4, 5, 6, and 7, 2012</p> <p>Facility number: 003130 Provider number: 155702 AIM number: 200386750</p> <p>Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 68 Total: 71</p> <p>Census payor type: Medicare: 10 Medicaid: 46 Other: 7 Total: 71</p> <p>Sample: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/13/12</p>	F0000		
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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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	Cathy Emswiller RN			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 2</p>	F0225	F225 The filing of this plan of correction does not constitute an admission that the alleged	07/03/2012			

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	<p>of 3 allegations of abuse reviewed which affected 2 residents in a sample of 15. (Residents #1 and 14) The facility further failed to report 1 of 3 allegations of abuse which affected 1 resident in a sample of 15 (Resident #1)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was reviewed on 06/04/12 at 9:05 A.M. Resident #1 was admitted to the facility on 05/11/12 with diagnoses, including but not limited to, dementia with behavioral disturbances, difficulty walking, anxiety, and depressive disorder.</p> <p>Review of nursing progress notes, dated 05/15/12 at 15:15 (3:15 P.M.) by the Social Service Director indicated resident had a behavior of "accusations." The note indicated the following: "Resident stated that staff member (staff's name) was 'sharp' with her. Resident stated that when getting dressed, (staff's name) took her arm to help her get dressed and it hurt her (resident). Resident stated that she said 'ouch, that hurt' and (staff's name) said 'I didn't meant to hurt you. I barely touched you.' Resident then stated that (staff's name) was putting things in there (sic) place and hit her bed and jolted her. Writer asked resident if she believes that staff hit the bed on purpose and resident</p>		<p>deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does complete a thorough investigation of allegations of abuse and does report allegations that meet the definition of abuse to the appropriate state agencies I. Immediate actions taken for those residents identified: Regarding resident number one the employee was reassigned and no longer takes care of resident per residents request as stated in the 2567. Residents care plan was update for her making false accusations. Regarding resident number 14 the facility did conduct a thorough investigation according to the staff member that reported the allegation there were no one else in the dinning room. The SSD did conduct interviews as stated in the 2567 of other residents regarding abuse. The documentation of the interviews had been provided to the surveyor and is mentioned in the 2567. Resident #14 is care planned for cursing and this is part of his normal conversation. The conclusion of the investigation was that that resident had in fact sworn at the staff member. This occurrence was reported</p>				

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	<p>stated, well no I don't think so, but she has acted this way to me since I was admitted here. Staff member (staff's name) was in admission when resident was here previously and did not complete one on one care with resident. Resident also stated, "everyone else hugs me when they see me and she doesn't. I don't know what her problem is."</p> <p>On 06/04/12 at 10:00 A.M., the Administrator was asked to provide the investigation into the alleged abuse Resident #1 had reported on 05/15/12.</p> <p>Interview with the Administrator on 06/04/12 at 11:00 A.M. and review of a "Grievance/concern Form presented on 06/05/12 at 9:30 A.M. indicated the Administrator had been informed by the social service director of the incident and he interviewed the nursing assistant involved and the Director of Nursing interviewed Resident #1. The Administrator indicated Resident #1 "recanted" her allegations and was more concerned that she wasn't "welcomed" back to the facility by the alleged perpetrator. He indicated since no abuse was substantiated on 06/15/12 there was no further action required and the alleged abuse was not reported to the state and other agencies as required. He also indicated the resident had a history on</p>		<p>to the state board of health.</p> <p>II. How the facility identified other residents: All residents were interviewed for abuse and any concerns obtained through the interview process will be thoroughly investigated per the facility policy and state requirements.</p> <p>III. Measures put into place/ System changes: An inservice was provided for the facility staff on 6-14-2012 regarding abuse. The SS consultant provided one on one training with the SSD in regards to abuse investigation, grievance, and behavior documentation and care planning. Staff will immediately report any allegations of abuse to the Administrator. An investigation will be initiated and the allegation will be reported as required by state guidelines.</p> <p>IV. How the corrective actions will be monitored: Random sample of residents will be interviewed regarding abuse 3 times a week for 3 months. The results of resident interviews/investigations will be discussed during the monthly quality assurance meetings. After the three months, the quality assurance team will determine the frequency of resident interviews, at a minimum residents are interviewed</p>		

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	<p>previous admissions of making "false allegations." The grievance/Concern form, completed on 05/15/12 indicated staff were to do care in pairs and the involved staff member was no to provide restorative care to Resident #1.</p> <p>There was a statement from the staff member involved but there was no statement from other staff working around Resident #1 nor were there any statements from other alert and oriented residents who might have received care from the involved staff member. The alleged staff perpetrator was not suspended from work either.</p> <p>2. A review of a reported incident involving Resident #14 on 4-1-2012 at 6 p.m. indicated CNA #4 reportedly called Resident #14 an inappropriate name while bringing him into the dining room according to the statement of Dietary Aide #5. There were other statements available to review.</p> <p>A review of Resident #14's cognitive status indicated he was alert, but confused.</p> <p>In an interview on 6-6-12 at 12:55 p.m. the SSD indicated interviews of residents were conducted, but there were no eye witness statements obtained, but a follow up questionnaire was completed. The</p>		<p>monthly as part of Abaqis program. Action plans are developed and implemented to address/resolve the issues identified in quality assurance meetings. The Administrator is responsible for the coordination of the monitoring.V. Date of compliance:7-3-2012</p>		

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	<p>questionnaire asked of residents have been treated roughly or yelled at, if the residents felt afraid, if the residents felt they were treated with respect and dignity, if there had been any missing items, if they had reported it an dif the property was still missing. The residents had not been asked about the incident in the dining area, if the incident had been witnessed, or what had happened.</p> <p>In an interview with the Director of Nursing on 6-6-12 at 1:05 p.m., she indicated no other staff had been in the dining area during the alleged incident and so, no one had been interviewed. She indicated no staff had been asked any question as to if they were in the area during the alleged incident. She further indicated there was no documentation in her possession regarding interviews.</p> <p>A current policy dated 1-12 titled Abuse, neglect and misappropriation of resident property indicated the facility will keep evidence that all alleged allegations have been thoroughly investigated.</p> <p>3.1-28(e)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their abuse policy and procedure for 2 of 3 allegations of abuse reviewed which affected 2 residents in a sample of 15. (Residents #1 and 14) The facility further failed to report 1 of 3 allegations of abuse which affected 1 resident in a sample of 15 (Resident #1)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was reviewed on 06/04/12 at 9:05 A.M. Resident #1 was admitted to the facility on 05/11/12 with diagnoses, including but not limited to, dementia with behavioral disturbances, difficulty walking, anxiety, and depressive disorder.</p> <p>Review of nursing progress notes, dated 05/15/12 at 15:15 (3:15 P.M.) by the Social Service Director indicated resident had a behavior of "accusations." The note indicated the following: "Resident stated that staff member (staff's name) was 'sharp' with her. Resident stated that</p>	F0226	<p>F 226 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does follow their policy and procedure for abuse, neglect, and misappropriation of property. The Facility did keep evidence of interviews regarding the alleged alligations and did conduct a thorough investigation. Evidence of those interviews is sited in the 2567 on page 8 of 49 paragraph 4. I. Immediate actions taken for those residents identified: Regarding resident number one the employee was reassigned and no longer takes care of resident per residents request as stated in the 2567. Residents care plan was update for her making false accusations. Regarding resident number 14 the facility did conduct a thorough investigation according to the staff member that reported the allegation there were no one else in the dinning room. The</p>	07/03/2012			

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	<p>when getting dressed, (staff's name) took her arm to help her get dressed and it hurt her (resident). Resident stated that she said 'ouch, that hurt' and (staff's name) said 'I didn't meant to hurt you. I barely touched you.' Resident then stated that (staff's name) was putting things in there (sic) place and hit her bed and jolted her. Writer asked resident if she believes that staff hit the bed on purpose and resident stated, well no I don't think so, but she has acted this way to me since I was admitted here. Staff member (staff's name) was in admission when resident was here previously and did not complete one on one care with resident. Resident also stated, "everyone else hugs me when they see me and she doesn't. I don't know what her problem is."</p> <p>On 06/04/12 at 10:00 A.M., the Administrator was asked to provide the investigation into the alleged abuse Resident #1 had reported on 05/15/12.</p> <p>Interview with the Administrator on 06/04/12 at 11:00 A.M. and review of a "Grievance/concern Form presented on 06/05/12 at 9:30 A.M. indicated the Administrator had been informed by the social service director of the incident and he interviewed the nursing assistant involved and the Director of Nursing interviewed Resident #1. The</p>		<p>SSD did conduct interviews as stated in the 2567 of other residents regarding abuse. The documentation of the interviews had been provided to the surveyor and is mentioned in the 2567. Resident #14 is care planned for cursing and this is part of his normal conversation. The conclusion of the investigation was that that resident had in fact swore at the staff member. This occurrence was reported to the state board of health. II. How the facility identified other residents: All residents were interviewed for abuse and any concerns obtained through the interview process will be thoroughly investigated per the facility policy and state requirements. III. Measures put into place/ System changes: An inservice was provided for the facility staff on 6-14-2012 regarding abuse. The SS consultant provided one on one training with the SSD in regards to abuse investigation, grievance, and behavior documentation and care planning. Staff will immediately report any allegations of abuse to the Administrator. An investigation will be initiated and the allegation will be reported as required by state guidelines. IV. How the</p>		

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	<p>Administrator indicated Resident #1 "recanted" her allegations and was more concerned that she wasn't "welcomed" back to the facility by the alleged perpetrator. He indicated since no abuse was substantiated on 06/15/12 there was no further action required and the alleged abuse was not reported to the state and other agencies as required. He also indicated the resident had a history on previous admissions of making "false allegations." The grievance/Concern form, completed on 05/15/12 indicated staff were to do care in pairs and the involved staff member was no to provide restorative care to Resident #1.</p> <p>There was a statement from the staff member involved but there was no statement from other staff working around Resident #1 nor were there any statements from other alert and oriented residents who might have received care from the involved staff member. The alleged staff perpetrator was not suspended from work either.</p> <p>2. A review of a reported incident involving Resident #14 on 4-1-2012 at 6 p.m. indicated CNA #4 reportedly called Resident #14 an inappropriate name while bringing him into the dining room according to the statement of Dietary Aide #5. There were other statements</p>		<p>corrective actions will be monitored: Random sample of residents will be interviewed regarding abuse 3 times a week for 3 months. The results of resident interviews/investigations will be discussed during the monthly quality assurance meetings. After the three months, the quality assurance team will determine the frequency of resident interviews, at a minimum residents are interviewed monthly as part of Abaqis program. Action plans are developed and implemented to address/resolve the issues identified in quality assurance meetings. The Administrator is responsible for the coordination of the monitoring.V. Date of compliance: 7-3-2012</p>				

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	<p>available to review.</p> <p>A review of Resident#14's cognitive status indicated he was alert, but confused.</p> <p>In an interview on 6-6-12 at 12:55 p.m. the SSD indicated interviews of residents were conducted, but there were no eye witness statements obtained, but a follow up questionnaire was completed. The questionnaire asked of residents have been treated roughly or yelled at, if the residents felt afraid, if the residents felt they were treated with respect and dignity, if there had been any missing items, if they had reported it an dif the property was still missing. The residents had not been asked about the incident in the dining area, if the incident had been witnessed, or what had happened.</p> <p>In an interview with the Director of Nursing on 6-6-12 at 1:05 p.m., she indicated no other staff had been in the dining area during the alleged incident and so, no one had been interviewed. She indicated no staff had been asked any question as to if they were in the area during the alleged incident. She further indicated there was no documentation in her possession regarding interviews.</p> <p>A current policy dated 1-12 titled Abuse,</p>				

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	neglect and misappropriation of resident property indicated the facility will keep evidence that all alleged allegations have been thoroughly investigated. 3.1-28(a)			

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F0244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review the facility failed to address resident council concerns regarding receiving bedtime snacks for 6 of the previous 12 monthly group meetings. (Resident #75, 76, 77, 78, 79, 80, 81, and 82)</p> <p>Findings include:</p> <p>Review of the resident council minutes for the past year indicated: 9/3/11: New business: "Residents state that they are not being offered bedtime snacks."; 10/5/11: New business: "Residents state that HS" (bedtime) "snacks are still not being passed."; Old business: "Residents state that they are not being offered bedtime snacks."; 11/2/11: New business: "HS snacks are not being passed out and not being stocked for CNA's to have access to."; Old business: "Residents stat that HS snacks are still not being passed." 3/7/12: The regional Ombudsman was in</p>	F0244	<p>F244 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does follow up on resident concerns that are addressed in the resident council meeting. I. Immediate actions taken for those residents identified: Regarding residents #75, #76, #77, #78, #79, #80, #81, and #82 the facility was not provided a roster to identify these residents. II. How the facility identified other residents: All residents were interviewed in regards to being offered HS snacks. III. Measures put into place/ System changes: An inservice was provided for the facility ,dietary and nursingstaff on 6-14-2012 regarding HS snacks. The SS consultant provided one on one training with the SSD in regards to resident council and policy and prodedure. Per the facility</p>	07/03/2012			

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	<p>attendance with the resident council and discussed resident rights including HS snacks. It was not and HS snacks-concern form filed at this time. Residents stat that they are not always receiving or being offered a variety of snacks nightly.";</p> <p>4/4/12: New business: "Residents stat that they are not being offered an HS snack every night.";</p> <p>Old business: "Residents stated that they are not always receiving or being offered a variety of snacks nightly.";</p> <p>5/4/12: New business: "Are not being offered their HS snacks every night and nursing is limiting their options, by not bringing all the options to them.";</p> <p>Old business: Complaint: "Residents stated that they are not being offered an HS snack every night.";</p> <p>Response: "DON spoke with all the nursing unit managers to remind their staff to pass HS snacks to all residents. If residents are refusing and/or asking for an alternate snack, they are to inform management to see what changes can be made."</p> <p>No response to resident complaints was noted until the resident council minutes of 5/4/12.</p> <p>On 6/5/12 at 10:45 A.M. a group interview was conducted at the facility with alert and oriented residents. During</p>		<p>policy the AD/designee will provide written resolution to the resident council president prior to the next meeting. A variety of HS snacks will be provided and included on the menu daily. This will be communicated to the resident council. IV. How the corrective actions will be monitored: Administrator will meet with the president of resident council prior to the next monthly meeting to monitor for resolution of concerns. Issues of concern not resolved will be discussed monthly with the quality assurance team, action plans to address the issue/concerns will be developed and implemented. This monitoring will continue for at least one year. The Adminsitrator/Designee will be responsilbe for the monitoring.V. Date of compliance: 7-3-2012</p>				

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	<p>the interview 8 of the 12 group members (Resident #75, Resident #76, Resident #77, Resident #78, Resident #79, Resident #80, Resident #81, and Resident #82) indicated the were not routinely offered bedtime snacks.</p> <p>Review of the undated facility policy "Resident Council" indicated #11. "The AD" (Activity Director) "and/or designee will provide the written resolution to the Resident Council president prior to the next meeting."</p> <p>3.1-31(l)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure health care plans regarding behaviors for 1 of 6 residents reviewed for behaviors in a sample of 15. (Resident #1) In addition the facility failed to ensure health care plans were initiated insomnia for 1 of 6 residents reviewed for psychoactive medications including hypnotics in a sample of 15. (Resident #73) Finally, the facility failed to ensure a health care plan had been initiated regarding pressure ulcers for 1 of 15 residents reviewed for health care plans in a sample of 15.</p>	F0279	<p>F279 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does review and revise the comprehensive care plans I. Immediate actions taken for those residents identified: Regarding resident #1 her behaviors were added to her care plan, there was no resident identified to be lacking a care plan for insomnia on the 2567. Regarding resident #73</p>	07/03/2012

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	<p>(Resident #30)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was reviewed on 06/04/12 at 9:03 A.M. Resident #1 was admitted to the facility for this admission on 05/11/12 with diagnoses, including but not limited to dementia with behavioral disturbances, anxiety, and depressive disorders.</p> <p>The physician's orders on admission to the facility, on 05/11/12 included the medication, Cymbalta (an antidepressant) 60 mg once a day, Lorazepam(an antianxiety medication) 1 mg Tid (three times a day), Mirtazapine (a hypnotic medication) 15 mg at bedtime, and Clonidine (an antianxiety medication) 1 mg twice a day.</p> <p>The initial Minimum Data Set (MDS) assessment for Resident #1 was completed on 05/21/12. The form indicated the resident had scored 15/15 on a cognitive exam and had displayed no behaviors or mood issues.</p> <p>Review of the health care plans for Resident #1, initiated on 05/25/12, indicated there was no plan to address the resident's routine use of a hypnotic medication, routine use and diagnosis of</p>		<p>resident did have a care plan for the potential for pressure sores. The residents reddened area was addressed on the care plan on 6-5-12 prior to the surveyor expressing the care plan concern. II. How the facility identified other residents: No residents were effected. III. Measures put into place: Inservice was provided for licensed nurses and care plan team regarding care plan development and revision. New orders will be reviewed during clinical meeting, acute care plans will be updated as needed during clinical meeting. Any behaviors will be discussed during this meeting and care plan will be updated to reflect any changes or revisions as determined by the interdisciplinary team. All residents on psychoactive meds/behaviors will have care plans updated and revised as needed. All residents with pressure sores will have care plans reviewed and updated as needed. IV. How the corrective actions will be monitored: Medical records will run a report weekly for residents that have behaviors, psychotropic meds, and pressure areas to ensure that they have been appropriately addressed on the care plan. This report will be provide to the DON to monitor</p>				

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	<p>anxiety, or any other potential behavioral issues. On 05/15/12, Social Services documented a behavior issue with "accusations (false)" towards staff but there was also no plan initiated regarding that issue. The only plan addressing anything close to mood and behavior issues was a plan to address the adjustment issues the resident might potentially experience.</p> <p>Interview with the Social Service Director, on 06/04/12 at 10:00 A.M., confirmed there were no behavioral or mood care plans and she must have "missed" them.</p> <p>2. The closed clinical record for Resident #73 was reviewed on 06/06/12 at 9:00 A.M. Resident #73 was admitted to the facility on 01/13/12 with diagnoses, including but not limited to, weakness, cognitive decline, and anxiety.</p> <p>The physician's orders on admission, on 01/13/12 included the hypnotic type supplement, Melatonin 6 mg to be given at bedtime as needed for insomnia. Review of the April 2012 Medication Administration Record indicated the resident had received the medication 6 times during the month.</p> <p>The initial Minimum Data Set (MDS)</p>		<p>for compliance. The results of this monitoring will be discussed monthly in the quality assurance meeting. Once three consecutive months of 100% compliance has been reported in the meeting the weekly monitoring will be stopped. The DON/Designee is responsible for the coordination of the monitoring.V. Date of compliance: 7-3-2012</p>				

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	<p>assessment for Resident #73 completed on 01/17/12 and the quarterly MDS assessment review, completed on 04/10/12 indicated the resident had no mood and/or behavioral issues.</p> <p>Resident #73's discharge date was 5-6-2012.</p> <p>The health care plans for Resident #73 from her admission to her discharge, were provided and reviewed on 06/07/12 at 10:00 A.M. There were no plans to address the resident's insomnia. However, the current health care plans indicated the resident was admitted on 01/13/12 but the goal dates were 10/19/10.</p> <p>3. Resident #30's record was reviewed 6-5-12 at 10:30 a.m. Resident #30's diagnoses included but were not limited to seizure disorder, anemia, and hemiplegia.</p> <p>During an observation on 6-5-12 at 9:45 a.m., Resident #30 was observed to have a reddened area in the left buttocks fold. The area was protected with a duoderm dressing.</p> <p>During a review of Resident #30's care plans, no care plan was able to be located in regard to Resident #30's reddened area.</p>						

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	<p>In an interview on 6-5-12 at 2:11 p.m. LPN#1 indicated a care plan should have been initiated for Resident #30's reddened area.</p> <p>In an interview on 6-6-12 at 3:07 p.m., the QA nurse indicated the facility utilized the guidelines in the Resident Assessment Instrument (RAI) manual to determine when a care plan was needed and updated.</p> <p>3.1-35(a)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure the health care plans regarding toileting needs and ambulation needs were followed for 3 of 8 residents reviewed for incontinence in a sample of 15. (Resident #14, and 10) and 1 of 15 residents reviewed for care plans in a sample of 15. (Resident #10)</p> <p>Finding includes:</p> <p>1. On 06/05/12 at 8:30 A.M., Resident #14 was observed to be awake in his room, seated in his wheelchair, watching television. He remained in his room in his wheelchair until 10:00 A.M., when he was taken to a hallway to wait for an appointment with a podiatrist. The resident was propelled back into his room in his wheelchair from the doctor's appointment at 10:35 A.M. He remained in his room in his wheelchair until 11:20 when CNAs #15 and #16 utilized a stand up lift and changed the resident's incontinence brief. The resident's brief was noted to be heavily saturated with urine and stool. The resident's pants were wet with urine and a towel, which had</p>	F0282	<p>F 282 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide services by qualified persons in accordance with each residents written plan of care. I. Immediate actions taken for those residents identified: Regarding residents #14 and #10 this finding is based on an assumption that the residents had remained in their rooms/wheelchair without position changes. Surveyor did not continuously observe any one resident as she sites more than one resident at the same time on the same days. Important to note that resident #14 who is immobile, requires assist with transfers and repositioning, has no excoriation or pressure areas, residents care plan indicates that the resident will be "checked" and changed as needed for incontinence. There is no evidence to</p>	07/03/2012	

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	<p>been on the resident's wheelchair, underneath the resident, had a large yellow brown stain and the wheelchair seat was also wet with urine.</p> <p>On 06/06/12 at 8:15 A.M., Resident #14 was observed to be awake in his room in his wheelchair. The resident remained in his room in his wheelchair with no position change from 8:15 A.M. until 11:01 A.M. when he his brief was changed and he was propelled to the dining room for the noon meal.</p> <p>The clinical record for Resident #14 was reviewed on 06/05/12 at 9:10 A.M. Resident #14 was admitted to the facility on 08/09/07 with diagnoses, including but not limited to, Paralysis Agitians and Hyperplasia of the prostate.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident #14, completed on 05/24/12, indicated the resident was always incontinent of his bowels and bladder. The most recent health care plan related to incontinence for Resident #14, which had been revised on 05/28/12, indicated the resident was to be checked for incontinence every two hours and as required for incontinence.</p> <p>2. On 06/03/12 at 4:45 P.M., Resident #10 was observed in his room in his</p>		<p>substantiate that the resident was not checked and repositioned by the staff when the resident was not in continuous view of the surveyor. Regarding resident #10, the careplan and CNA tasks in the computer were updated to reflect the changes. Resident #10, restorative program has been reviewed and updated. II. How the facility identified other residents: All resident restorative programs have been reviewed, CNA tasks will be updated to reflect the changes. III. Measures put into place/ System changes: An inservice was provided for the nursing staff regarding toileting programs, restorative programs and updating CNA tasks. Upon completion of therapy the IDT will discuss during the careplan meeting restorative/maintenance programs needed. The MDS Coordinator will make the determination if the resident is in need of a nursing restorative program. The careplan will be developed and tasks will be assigned to the facility nursing staff. IV. How the corrective actions will be monitored: The MDS Coordinator will be responsible to monitor compliance of CNA tasks by coordinating quality assurance</p>		

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	<p>wheelchair. The resident's pants were noted to be wet in the crotch area. The resident was taken to the dining room by staff without changing his wet pants or toileting the resident.</p> <p>On 06/06/12 at 8:15 A.M., Resident #10 was observed to be in his room in his wheelchair watching television. He remained in his room in his wheelchair with no position change from 8:15 A.M. - 10:55 A.M. At 10:55 A.M., CNA #16 indicated she had just stood the resident at the bedside and changed his brief. She indicated the resident's brief was changed but he was not toileted in the bathroom.</p> <p>On 06/06/12 at 12:36 P.M., Resident #10 was observed propelling himself in his wheelchair from the dining room to his room. He remained in his room in his wheelchair from 12:45 P.M., when he got back from the dining room until 1:30 P.M.. No staff were noted to go into the resident's room.</p> <p>The clinical record for Resident #10 was reviewed on 06/05/12 at 1:30 P.M. The most recent quarterly Minimum Data Set (MDS) assessment for Resident #10, completed on 05/10/12, indicated the resident's bladder continence had declined and the resident was now always incontinent of his bladder. The MDS</p>		<p>rounds for those residents identified as needing toileting/repositioning program. MDS/designee will observe CNAs complete restorative programs on 3 residents daily 3 times a week. The results of these rounds/observation will be reported monthly in the quality assurance meeting. These quality assurance rounds will continue for one year. V. Date of compliance: 7-3-2012</p>				

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	<p>further indicated Resident #10 required maximum assistance of 1 for toileting.</p> <p>The most recent bladder incontinence assessment, completed on 04/09/12 indicated the resident had functional disability and urgency related to his bladder functioning. The resident was assessed to have a greater than 2 hours bladder elimination pattern and was placed on an elimination plan.</p> <p>The current health care plan for Resident #10, revised on 05/16/12, indicated the resident was to be taken and/or assisted to go to bathroom upon rising, after meals, and at bedtime.</p> <p>Interview with CNA #16, who was documenting toileting and/or incontinence for Resident #10 on 06/06/12 at 1:20 P.M. in the electronic system, indicated the times of 7:00 A.M., 9:00 A.M., 11:00 A.M., and 1:00 P.M., were highlighted on the screen for Resident #10. CNA #16 then was noted to input how much help the resident needed and if he was continent or incontinent at those times. When questioned regarding why she was putting information into the computer when the resident had only been checked for incontinence and changed around 11:00 A.M., she indicated there was no place for</p>						

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	<p>her to put if the toileting plan was not followed. She indicated the resident had informed her he did not have much voiding sensation and so the resident was not currently being toileted.</p> <p>Review of the electronic documentation for continence for Resident #10 from 05/31/12 - 06/06/12 indicated the resident was documented as having been incontinent and the day shift documented three episodes on 05/31/12, two episodes on 06/01/12, 06/03/12 - 06/06/12, and 1 episode on 06/02/12. Only the 05/31/12 day shift even indicated the resident had been checked for incontinence on the toileting plan schedule of upon rising, and after meals. There were no specific times on the continence form to indicate what specific time the resident was checked and changed. There was also a form to indicated how much staff assistance the resident required for toilet use. Review of the form, from 06/03/12 - 06/ 05/12 indicated activity did not occur on 06/03/12, the resident required total staff assistance for toileting needs on 06/04 and 06/05, and extensive staff assistance on 06/06/12. The form also indicated on 3 of the 4 days "activity did not occur" was documented on 2 of the 3 nursing shifts.</p> <p>The Certified Nursing Assistant (CNA)</p>						

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	<p>assignment sheet, given to surveyors on 06/03/12 indicated Resident #10 was a "check and change" regarding toileting needs.</p> <p>3. On 06/03/12 at 4:45 P.M., Resident #10 propelled himself to the dining room for the evening meal. On 06/06/12 at 12:36 P.M., Resident #10 propelled himself from the dining room back to his room.</p> <p>The clinical record for Resident #10, reviewed on 06/05/12 at 1:30 P.M., the most recent Minimum Data Set (MDS) assessment had been completed on 05/10/12. The assessment indicated Resident #10 required limited staff assistance for ambulation in his room and had only ambulated outside of his room one time in the assessment reference period. The previous full MDS assessment, completed on 12/29/11, indicated the resident had required only supervision for ambulation in his room and had only ambulated one time with staff during the assessment reference period.</p> <p>The current health care plans for Resident #10, revised on 05/16/12, indicated the resident had a potential for a decline in walking related to decreased mobility. The goal was for the resident to walk 60</p>				

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	<p>feet to the dining room. The intervention indicated the resident was to "walk to and from dining room using RW (rolling walker) with assist of 1/2. (1 or 2 staff)"</p> <p>Interview with the Restorative Nursing Assistant, CNA #17, on 06/06/12 at 12:53 P.M. indicated Resident #10 was not currently on the ambulation program because he had been receiving physical therapy as he was experiencing issues with abdominal pain and bloating and had not been walking.</p> <p>Interview with the Occupation Therapy Assistant, employee #18, on 06/06/12 at 2:00 P.M. and review of a "therapy communication to nursing" indicated on 05/04/12 the resident was discharged from physical therapy and was supposed to be ambulated with a rolling walker on a "walk to dine" program 60 feet wearing a right lower extremity brace. Employee #18 indicated the communication form was given to the facility admissions coordinator but she was unclear on the process after that to ensure the Restorative Aides were informed of the need to start ambulating residents.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview the facility failed to ensure 2 residents (#37, 40) of 4 residents reviewed for pain, were treated and consistently assessed for pain, resulting in unrelieved pain. The facility further failed to ensure a treatment was provided as ordered for 1 of 15 residents reviewed for physician orders in a sample of 15. (Resident #1) Finally, the facility failed to ensure 1 of 8 nursing staff observed administering medications followed manufacturer's instructions while administering medications to 1 of 2 residents observed receiving insulin injections. (Resident #9)</p> <p>Findings include:</p> <p>1. On 6/6/12 at 8:35 A.M. an observation of resident #37 indicated she was sitting in a wheelchair in the common room and the back of her left hand was red and swollen. The resident showed no obvious signs of pain.</p>	F0309	<p>F309 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well being. I. Immediate actions taken for those residents identified: Regarding resident #37 and #40 a pain assessment was completed. Regarding resident #1 according to the 2567 the resident indicated that her legs and arms were much better and the surveyor observed healed spots. These findings are based on an assumption from the surveyor that the lotion had not been applied because in her opinion more should have been missing from the bottle. The nurses were documenting the application of the treatment. Regarding</p>	07/03/2012			

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	<p>Resident #37's clinical record was reviewed on 6/5/12 at 1:40 P.M.. The progress notes indicated on 6/1/12 at 10:20 A.M. the resident was noted to have localized edema to left hand and resident complains of pain to hand when touched or moved. The progress note did not indicate the resident was offered any treatment for pain.</p> <p>On 6/1/12, the progress note from 10:20 A.M. indicated a physician's order was received for a left hand x-ray. The x-ray was completed on 6/1/12 and the results were documented in the progress notes at 11:36 P.M. to have arthritic changes at the PIP and DIP joints and the base of the thumb of the left hand</p> <p>Review of the progress notes indicated on 6/2/12 at 6:31 A.M. the resident denied any pain. The progress note did not indicate any assessment of the left hand.</p> <p>The next progress note indicating any assessment of pain was on 6/4/12 at 2:20 P.M. which indicated resident's left hand continues with swelling and pain. The progress note does not indicate the resident was offered any treatment for pain.</p> <p>The next progress note indicating any assessment of pain was on 6/5/12 at 9:33</p>		<p>resident #9, it is important to note that this was an isolated occurrence due to the fact of the meal trays being served slightly late, the blood sugar was 319 as indicated in the 2567 when the insulin was administered. Residents blood sugar the following day at 7am was 256, at 11am 293, and at 4pm 231. Insulin administration times have been changed to after meals. II. How the facility identified other residents: An audit was completed on all other residents in that dining room who received fast acting insulin and no other residents received fast acting insulin. III. Measures put into place/ System changes: All administration times for fast acting insulin will be moved to after meals. We reviewed all resident treatments and discontinued any items that were healed/resolved and disposed of medication as per policy. An inservice was provided on fast acting insulin, treatments, and pain assessments. Pain assessments will be completed on each resident at least quarterly any issues identified will be addressed. IV. How the corrective actions will be monitored: DON/designee will monitor for compliance by</p>		

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	<p>A.M. which indicated "resident noted this morning with continued swelling to left hand, warm to the touch, and resident is guarding left hand and arm. Resident states that is painful." The progress note does not indicate the resident was offered any treatment for pain.</p> <p>The next progress note indicating any assessment of pain was on 6/5/12 at 9:40 A.M. which indicated "resident's left hand continues with swelling, warmth and pain. The progress note does not indicate the resident was offered any treatment for pain. The progress note did indicate the physician was notified and an order was received for left upper extremity ultrasound. The ultrasound was noted in the progress notes at 3:32 P.M. to have been completed. The progress note of 6/6/12 at 10:45 A.M. indicated the results of the left upper extremity ultrasound were received and the was no evidence of thrombosis within the left upper extremity.</p> <p>The next progress note indicating any assessment of pain was on 6/6/12 at 1:04 A.M. which indicated the resident "denies pain or discomfort at this time."</p> <p>The next progress note indicating any assessment of pain was on 6/6/12 at 10:13 A.M., which indicated "Resident</p>		<p>completing skills validations on insulin administration and treatments, this skills validation form will be used to monitor for compliance with insulin administration and treatments administration on random residents 3 times a week for 3 months then monthly for 6 months. Issues identified during these skills validations will be addressed by additional training and/ or disciplinary action as appropriate with the employee. Review of the 24 hour report documentation will be completed during clinical meeting, any issues identified with lack of assessment/treatment of pain will be addressed as appropriate. Evidence of this review will be by auditors signature on the report. Compliance will be discussed during quality assurance meeting monthly x 3 months, then quarterly for one year. V. Date of compliance: 7-3-2012</p>				

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	<p>continues to have swelling to left hand. Resident complains of pain to left hand if touched or moved a lot. Resident favors left hand not using it much."</p> <p>Review of the resident's medication administration record (MAR) from 6/1/12 through 6/6/12, 11:00 A.M. indicated the resident had a physician's order for Acetaminophen 650 milligrams every 4 hours as needed for mild pain. The MAR indicated the resident had not received Acetaminophen 650 mg during the time period indicated.</p> <p>An interview with the Director of Nursing (DN) on 6/7/12 at 10:30 A.M. did not indicate any further information on treatment of pain assessments.</p> <p>2. Resident #40's clinical record was reviewed on 6/5/12 at 1:25 P.M.. The progress notes indicated on 4/29/12 at 5:37 A.M. the resident's "right middle finger is red and edematous. CNA reported there was thick, green pus from the cuticle. Area cleaned and Band-Aid applied." The progress note did not indicate any pain assessment related to the right middle finger.</p> <p>A progress note of 4/29/12 at 8:29 A.M. indicated "right hand middle finger/cuticle red and edematous, MD</p>			

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	<p>notified and received new order for Keflex 500 mg po" (by mouth) "bid" (twice daily) "x 7 days". The progress note did not indicate any pain assessment related to the right middle finger.</p> <p>A progress note of 4/29/12 at 9:05 A.M. indicated "right hand middle finger/cuticle red and edematous, resident removed Band-Aid." The progress note did not indicate any pain assessment related to the right middle finger.</p> <p>A progress note of 4/29/12 at 1:41 P.M. indicated ""right hand middle finger/cuticle, redness and edema continues." The progress note did not indicate any pain assessment related to the right middle finger.</p> <p>A progress note of 4/30/12 at 12:48 A.M. indicated "Antibiotic continues for infection of right middle finger. Area remains red and edematous." The progress note did not indicate any pain assessment related to the right middle finger.</p> <p>A progress note on 4/30/12 at 10:24 A.M. indicated "resident's middle finger to right hand is red and edematous but resident denies any pain.</p> <p>Further progress notes after 4/30/12 at</p>				

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	<p>10:24 A.M. though completion of antibiotic treatment on 5/6/12 indicated at least daily assessment of pain for the infection to the middle finger of the right hand. The resident denied pain on all assessments.</p> <p>3. The clinical record for Resident #1 was reviewed on 06/04/12 at 9:03 A.M. Resident #1 was admitted to the facility from an assisted living facility on 05/11/12. The current physician's orders for June 2011 included an order, initiated on 05/16/12 for Ammonium Lactate 12 % to be administered to entire body except to skin folds of web spaces.</p> <p>A skin assessment was completed by LPN #21 on 06/05/12 at 10:35 A.M. The resident was noted to have her blouse on and an incontinence brief. The top of the brief was pulled down a little to view the resident's abdomen and lower back. Several healed spots were noted on the resident's arms and legs. The resident indicated her arms and legs were "much" better. When asked if she thought the lotion the nurses were putting on her body was helping the resident replied, "They (nurses) are not good about that kind of thing. I get lotion from them (nurses) maybe once every two weeks but I use the lotion I brought with me from the other place myself the best I can." The resident</p>			

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	<p>pointed to a pump type bottle of "Sarna" lotion in a basin on her nightstand.</p> <p>Observation of the treatment cart, with RN #22, indicated an almost completely full bottle of Ammonium Lactate 12% in the treatment cart. The bottle indicated it had been delivered by pharmacy on 05/16/12. RN #22 indicated the second shift nurses had been documenting the treatment since 05/16/12 on a nightly basis and she thought perhaps the pharmacy had delivered more than one bottle of the lotion.</p> <p>On 06/06/12 at 10:15 A.M., Resident #1 indicated she had received the lotion treatment the previous evening. She indicated the lotion from the nurses was "greasier" feeling than the Sarna lotion she had been using.</p> <p>Observation of the bottle of Ammonium Lactate 12%, with LPN #23, on 06/06/12 at 8:50 A.M. indicated the bottle was now 2/3 - 3/4 full after the 06/05/12 treatment. The label on the bottle contained 225 grams of lotion. The pharmacy requisition indicated on 05/16/12 the pharmacy had delivered 225 grams of the lotion, which was equivalent to 1 bottle.</p> <p>4. On 06/03/12 at 4:52 P.M., LPN #19 was observed administering 8 units of</p>				

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	<p>Novolog insulin subcutaneous to Resident #9. The resident's blood sugar, obtain just prior to the administration of the insulin was noted to be 319. The resident was then noted to go to the dining room. The resident received a glass of lemonade and ice water at 5:22 P.M. He did not take a drink of the lemonade. The resident's meal tray was delivered at 5:42 P.M. The resident was not noted to experience any adverse reaction related to the injection of the Novolog insulin.</p> <p>Interview with Resident #9's spouse, on 06/06/12 at 11:01 A.M., indicated the resident had not been feeling very well and his blood sugar had been really low on 06/05/12 and high at other times.</p> <p>Review of the Manufacturer's instructions for the administration of Novolog insulin, provided by the Administrator on 06/07/12 at 9:30 A.M. indicated the following instructions: "Administer within 15 minutes before a meal or immediately after a meal." The instructions indicated depending on the individual, Humalog insulin could peak as early as 30 minutes after administration.</p> <p>3.1-35(g)(1) 3.1-37(a)</p>						

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review, and interview the facility failed to ensure restorative ambulation services were provided as care planned to ensure 1 of 15 residents reviewed for ADLs in a sample of 15 did not decline. (Resident #10) In addition, the facility failed to ensure restorative range of motion services were provided as care planned for 1 of 15 residents reviewed for ADL's in a sample of 15. (Resident #14)</p> <p>Findings include:</p> <p>1. On 06/03/12 at 4:45 P.M., Resident #10 propelled himself to the dining room for the evening meal. On 06/06/12 at 12:36 P.M., Resident #10 propelled himself from the dining room back to his room.</p> <p>The clinical record for Resident #10, reviewed on 06/05/12 at 1:30 P.M., the most recent Minimum Data Set (MDS) assessment had been completed on 05/10/12. The assessment indicated Resident #10 required limited staff assistance for ambulation in his room and</p>	F0311	<p>F 311 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide appropriate treatment and services to maintain his/her abilities. I. Immediate actions taken for those residents identified: Regarding resident #14 this finding is based on the assumption that only restorative aides provide ROM/AROM in the facility which is incorrect. II. How the facility identified other residents: All resident restorative programs have been reviewed, CNA tasks will be updated to reflect the changes. III. Measures put into place/ System changes: An inservice was provided for the nursing staff regarding toileting programs, restorative programs and updating CNA tasks. Upon completion of therapy the IDT will discuss during the careplan meeting restorative/maintenance</p>	07/03/2012

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	<p>had only ambulated outside of his room one time in the assessment reference period. The previous full MDS assessment, completed on 12/29/11, indicated the resident had required only supervision for ambulation in his room and had only ambulated one time with staff during the assessment reference period.</p> <p>The current health care plans for Resident #10, revised on 05/16/12, indicated the resident had a potential for a decline in walking related to decreased mobility. The goal was for the resident to walk 60 feet to the dining room. The intervention indicated the resident was to "walk to and from dining room using RW (rolling walker) with assist of 1/2. (1 or 2 staff)"</p> <p>Interview with the Restorative Nursing Assistant, CNA #17, on 06/06/12 at 12:53 P.M. indicated Resident #10 was not currently on the ambulation program because he had been receiving physical therapy as he was experiencing issues with abdominal pain and bloating and had not been walking. She indicated she had not received instructions from therapy to indicate if the resident needed to be placed back onto the restorative ambulation programs</p> <p>Review of the restorative documentation</p>		<p>programs needed. The MDS Coordinator will make the determination if the resident is in need of a nursing restorative program. The careplan will be developed and tasks will be assigned to the facility nursing staff. IV. How the corrective actions will be monitored: The MDS Coordinator will be responsible to monitor compliance of CNA tasks by coordinating quality assurance rounds for those residents identified as needing toileting/repositioning program. MDS/designee will observe CNAs complete restorative programs on 3 residents , 3 times a week for 3 months, then 3 residents monthly for 6 months.The results of these rounds/observation will be reported monthly in the quality assurance meeting. These quality assurance rounds will continue for one year. V. Date of compliance: 7-3-2012</p>				

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	<p>for April 2012 indicated the direct care staff and "nursing rehab" were to perform "walk to dine program" for Resident #10. The documentation indicated "not applicable" was documented for 18 of the 25 days with documentation in April. The response documented was unclear as to whether number feet or minutes spent ambulating were documented. The highest number documented for "response" was "20." In addition, it was unclear why there was any documentation while the resident was receiving physical therapy from 04/23/12 - 05/17/12.</p> <p>Interview with the Occupation Therapy Assistant, employee #18, on 06/06/12 at 2:00 P.M. and review of a "therapy communication to nursing" indicated on 05/04/12 the resident was discharged from physical therapy and was supposed to be ambulated with a rolling walker on a "walk to dine" program 60 feet wearing a right lower extremity brace. Employee #18 indicated the communication form was given to the facility admissions coordinator but she was unclear on the process after that to ensure the Restorative Aides were informed of the need to start ambulating residents.</p> <p>2. On 06/05/12 at 8:30 A.M., Resident #14 was observed to be awake in his room, seated in his wheelchair, watching</p>				

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	<p>television. He remained in his room in his wheelchair until 10:00 A.M., when he was taken to a hallway to wait for an appointment with a podiatrist. The resident was propelled back into his room in his wheelchair from the doctor's appointment at 10:35 A.M. He remained in his room in his wheelchair until 11:20 when CNAs #15 and #16 utilized a stand up lift and changed the resident's incontinence brief. The resident's brief was noted to be heavily saturated with urine and stool. The resident's pants were wet with urine and a towel, which had been on the resident's wheelchair, underneath the resident, had a large yellow brown stain and the wheelchair seat was also wet with urine.</p> <p>On 06/06/12 at 8:15 A.M., Resident #14 was observed to be awake in his room in his wheelchair. The resident remained in his room in his wheelchair with no position change from 8:15 A.M. until 11:01 A.M. when he his brief was changed and he was propelled to the dining room for the noon meal.</p> <p>The clinical record for Resident #14 was reviewed on 06/05/12 at 9:10 A.M. Resident #14 was admitted to the facility on 08/09/07 with diagnoses, including but not limited to, Paralysis Agitans and Hyperplasia of the prostate.</p>						

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	<p>The health care plans for Resident #14, current through 08/26/12, indicated the resident had a potential for a decline in ROM (Range of motion) related to decreased mobility and decreased endurance. The goal was for the resident to perform 7 reps of 2 sets of AROM (active range of motion) exercises to upper and lower extremities daily 6 times a week.</p> <p>Review of the restorative aids list of residents for whom they provided services and interview with Restorative Aide, CNA #17, on 06/06/12 at 12:53 P.M., indicated Resident #14 received his daily AROM exercises in a small group around 8:30 A.M. She indicated he did not receive his AROM exercises on 06/05/12 or 06/06/12. She indicated she and the other Restorative Aide were pulled to work as CNAs on the nursing floors routinely about 2 times per week. #17, on 06/06/12 at 3:20 P.M. indicated she had done the exercises with Resident #14 on 06/05/12 but not on 06/04/12 because she had been pulled to work the west nursing unit. Review of the past 7 days, from 05/31/12 - 06/06/12 on 06/06/12 at 3:00 P.M. indicated Resident #14 had only received AROM exercises 2 of the 7 days.</p>						

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	3.1-32(a)(2)(B)				

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F0312 SS=D	<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 hygiene.</p> <p>Based on observation, interview and record review the facility failed to keep a physician's appointment, and provide oral hygiene to prevent plaque buildup for 1 of 6 residents reviewed for adequate oral care(Resident #30) in a sample of 15.</p> <p>Findings include:</p> <p>Resident #30's record was reviewed 6-5-12 at 10:30 a.m. Resident #30's diagnoses included but were not limited to seizure disorder, anemia, and hemiplegia.</p> <p>During an observation on 6-5-12 at 9:30 a.m., Resident #30 was observed sitting up in a BRODA chair in his room. He was observed to have whitish film on his teeth and whitish substance around the base of the teeth and gums. Resident #30's gums were noted to be reddened in color.</p> <p>In an observation on 6-6-12 at 9:10 a.m., Resident #30 was observed in bed laying on his right side. He was observed to have whitish film on his teeth and a whitish</p>	F0312	<p>F312 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide activities of daily living necessary to those who are dependent residents. I. Immediate actions taken for those residents identified: Regarding resident #30 an oral assessment was completed on the resident and he was seen by the dentist. II. How the facility identified other residents: An oral assessment was completed on all residents and care plan and cna tasks were updated. An audit was completed on all residents to identify any residents that has not had a dental exam in the last year. III. Measures put into place/ System changes: CNA's were inserviced regarding oral care, cna tasks and completion. Oral care will be provided to each resident atleast daily. IV. How the corrective actions will be monitored: CNA's skills</p>	07/03/2012	

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	<p>buildup around the base of his teeth. Resident #30's gums were noted to be reddened in color.</p> <p>In an interview on 6-6-12 at 1:24 p.m. CNA #1 indicated there was no direction for the staff to brush Resident #30's teeth, so his teeth were not brushed.</p> <p>In an interview on 6-6-12 at 1:30 p.m. CNA #3 indicated there was no note to brush Resident 330's teeth, so his teeth had not been brushed.</p> <p>A review of Resident #30's care plan dated 12-21-10 titled requires extensive total assist indicated oral care was to be given in the a.m. and p.m. and to encourage resident to assist</p> <p>A review of a dentist consult dated 1-5-12 indicated Resident #30 had a buildup of calcium and plaque on his teeth and his next scheduled visit was to be 4-15.2012. There was no documentation of a visit on 4-15-2012.</p> <p>In an interview with the Medical Records LPN on 6-1-12 at 2:00 p.m. she indicated Resident #30 was scheduled to see the dentist on 6-19-12. She was unsure why he had not been seen on 4-15-12 as there was no documentation to indicated why the appointment had not been kept.</p>		<p>validations will be completed on at least 3 residents daily 3 x a week for 7 months. The results of these audits will be reviewed in quality assurance meetings monthly. The DON will be responsible for the coordination of monitoring. All residents who are scheduled for appointments are discussed in morning meeting and the results of the appointments are reviewed the following business day. V. Date of compliance: 7-3-2012</p>		

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	<p>A current policy dated 3/2012 titled Personal Hygiene indicated personal hygiene was to be performed 2 times daily in the morning and before bed.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the toileting and incontinence management programs were followed for 3 of 8 residents reviewed for incontinence in a sample of 15. (Residents #14, 10, and 37)</p> <p>Findings include:</p> <p>1. On 06/05/12 at 8:30 A.M., Resident #14 was observed to be awake in his room, seated in his wheelchair, watching television. He remained in his room in his wheelchair until 10:00 A.M., when he was taken to a hallway to wait for an appointment with a podiatrist. The resident was propelled back into his room in his wheelchair from the doctor's appointment at 10:35 A.M. He remained in his room in his wheelchair until 11:20 when CNAs #15 and #16 utilized a stand up lift and changed the resident's</p>	F0315	<p>F315 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide toileting and incontinence programs. I. Immediate actions taken for those residents identified: Regarding residents #14 and #10 this finding is based on an assumption that the residents had remained in their rooms/wheelchair without position changes. Surveyor did not continuously observe any one resident as she sites more than one resident at the same time on the same days. Important to note that resident #14 who is immobile, requires assist with transfers and repositioning, has no excoriation or pressure areas,</p>	07/03/2012			

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	<p>incontinence brief. The resident's brief was noted to be heavily saturated with urine and stool. The resident's pants were wet with urine and a towel, which had been on the resident's wheelchair, underneath the resident, had a large yellow brown stain and the wheelchair seat was also wet with urine.</p> <p>On 06/06/12 at 8:15 A.M., Resident #14 was observed to be awake in his room in his wheelchair. The resident remained in his room in his wheelchair with no position change from 8:15 A.M. until 11:01 A.M. when he his brief was changed and he was propelled to the dining room for the noon meal.</p> <p>The clinical record for Resident #14 was reviewed on 06/05/12 at 9:10 A.M. Resident #14 was admitted to the facility on 08/09/07 with diagnoses, including but not limited to, Paralysis Agitans and Hyperplasia of the prostate.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident #14, completed on 05/24/12, indicated the resident was always incontinent of his bowels and bladder. The most recent health care plan related to incontinence for Resident #14, which had been revised on 05/28/12, indicated the resident was to be checked for incontinence every two</p>		<p>residents care plan indicates that the resident will be "checked" and changed as needed for incontinence. There is no evidence to substantiate that the resident was not checked and repositioned by the staff when the resident was not in continuous view of the surveyor. Regarding resident #10, the careplan and CNA tasks in the computer were updated to reflect the changes. Resident #10, restorative program has been reviewed and updated. Regarding resident #37 a voiding diary was completed and care plan cna tasks were updated II. How the facility identified other residents: : All resident restorative programs have been reviewed, CNA tasks will be updated to reflect the changes. III. Measures put into place/ System changes: : An inservice was provided for the nursing staff regarding toileting programs, restorative programs and updating CNA tasks. Upon completion of therapy the IDT will discuss during the careplan meeting restorative/maintenance programs needed. The MDS Coordinator will make the determination if the resident is in need of a nursing restorative program. The careplan will be</p>		

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	<p>hours and as required for incontinence.</p> <p>2. On 06/03/12 at 4:45 P.M., Resident #10 was observed in his room in his wheelchair. The resident's pants were noted to be wet in the crotch area. The resident was taken to the dining room by staff without changing his wet pants or toileting the resident.</p> <p>On 06/06/12 at 8:15 A.M., Resident #10 was observed to be in his room in his wheelchair watching television. He remained in his room in his wheelchair with no position change from 8:15 A.M. - 10:55 A.M. At 10:55 A.M., CNA #16 indicated she had just stood the resident at the bedside and changed his brief. She indicated the resident's brief was changed but he was not toileted in the bathroom.</p> <p>On 06/06/12 at 12:36 P.M., Resident #10 was observed propelling himself in his wheelchair from the dining room to his room. He remained in his room in his wheelchair from 12:45 P.M., when he got back from the dining room until 1:30 P.M.. No staff were noted to go into the resident's room.</p> <p>The clinical record for Resident #10 was reviewed on 06/05/12 at 1:30 P.M. The most recent quarterly Minimum Data Set (MDS) assessment for Resident #10,</p>		<p>developed and tasks will be assigned to the facility nursing staff. Bowel and bladder assessments will be completed quarterly. Care plans will be updated as needed at that time.</p> <p>IV. How the corrective actions will be monitored: The MDS Coordinator will be responsible to monitor compliance of CNA tasks by coordinating quality assurance rounds for those residents identified as needing toileting/repositioning program. MDS/designee will observe CNAs complete restorative programs on 3 residents , 3 times a week for 3 months, then 3 residents monthly for 6 months.The results of these rounds/observation will be reported monthly in the quality assurance meeting. These quality assurance rounds will continue for one year. V. Date of compliance: 7-3-2012</p>				

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	<p>completed on 05/10/12, indicated the resident's bladder continence had declined and the resident was now always incontinent of his bladder.</p> <p>The most recent bladder incontinence assessment, completed on 04/09/12 indicated the resident had functional disability and urgency related to his bladder functioning. The resident was assessed to have a greater than 2 hours bladder elimination pattern and was placed on an elimination plan.</p> <p>The current health care plan for Resident #10, revised on 05/16/12, indicated the resident was to be taken and/or assisted to go to bathroom upon rising, after meals, and at bedtime.</p> <p>Interview with CNA #16, who was documenting toileting and/or incontinence for Resident #10 on 06/06/12 at 1:20 P.M. in the electronic system, indicated the times of 7:00 A. M., 9:00 A.M., 11:00 A.M., and 1:00 P.M., were highlighted on the screen for Resident #10. CNA #16 then was noted to input how much help the resident needed and if he was continent or incontinent at those times. When questioned regarding why she was putting information into the computer when the resident had only been checked for</p>						

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	<p>incontinence and changed around 11:00 A.M., she indicated there was no place for her to put if the toileting plan was not followed. She indicated the resident had informed her he did not have much voiding sensation and so the resident was not currently being toileted.</p> <p>Review of the electronic documentation for continence for Resident #10 from 05/31/12 - 06/06/12 indicated the resident was documented as having been incontinent and the day shift documented three episodes on 05/31/12, two episodes on 06/01/12, 06/03/12 - 06/06/12, and 1 episode on 06/02/12. Only the 05/31/12 day shift even indicated the resident had been checked for incontinence on the toileting plan schedule of upon rising, and after meals. There were no specific times on the continence form to indicate what specific time the resident was checked and changed. There was also a form to indicated how much staff assistance the resident required for toilet use. Review of the form, from 06/03/12 - 06/ 05/12 indicated activity did not occur on 06/03/12, the resident required total staff assistance for toileting needs on 06/04 and 06/05, and extensive staff assistance on 06/06/12. The form also indicated on 3 of the 4 days "activity did not occur" was documented on 2 of the 3 nursing shifts.</p>						

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	<p>The Certified Nursing Assistant (CNA) assignment sheet, given to surveyors on 06/03/12 indicated Resident #10 was a "check and change" regarding toileting needs.</p> <p>2. Resident #37's clinical record was reviewed on 6/5/12 at 1:40 P.M.. The record indicated the resident had a health care plan, last revised on 8/10/11, for being incontinent of bladder without a pattern of incontinence related to cognitively impaired, functionally disabled. The goal was will void in toilet when toileted. The interventions included, but were not limited to, "tale resident to bathroom upon rising, after meals, and at bedtime."</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment for Resident #37, completed on 03/15/12, indicated the resident's bladder continence was incontinent more than once a day.</p> <p>On 6/6/12 a constant observation was made of the resident from 8:35 A.M. until 11:40 A.M. when the resident was taken to lunch. The resident was not taken to the toilet during that time. A constant observation was made from 12:10 P.M. until 1:55 P.M. and the resident was not toileted during that time. At 12:10 P.M. the resident was still in the lunchroom</p>			

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	<p>finishing her meal. She remained in the lunchroom until 12:55 P.M. and was taken to her room and assisted to bed. The resident was still in bed at 1:55 P.M. and had not been taken to the toilet after lunch.</p> <p>An interview with CNA #12 on 6/6/12 at 2:00 P.M. indicated the resident was to be taken to the bathroom she requested it and the resident had not requested to be taken to the bathroom before or after lunch.</p> <p>3.1-41(a)(1)</p>				

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F0334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>			

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview the facility failed to administer influenza vaccine as required for 3 of 15 residents (#41, 25, 14) reviewed for influenza vaccine in a sample of 15.</p> <p>Findings include:</p> <p>1. Resident #41's clinical record was reviewed on 6/4/12 at 2:30 P.M.. The record indicated on 2/17/12, a Immunization consent was signed by resident #41's power of attorney giving the facility permission to administer an influenza vaccine annually.</p>	F0334	<p>F 334 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide flu and pneumococcal vaccinations. I. Immediate actions taken for those residents identified: Regarding residents # 41 #25, and #14 residents were added to list for influenza vaccine for the upcoming immunization season. The physicians/families were notified that the residents did</p>	07/03/2012			

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	<p>There was no physician's order or record of administration of the influenza vaccine for resident #41.</p> <p>An interview with the administrator on 6/6/12 at 3:00 P.M. indicated the resident had not received the influenza vaccine.</p> <p>2. Resident #25's record was reviewed 6-4-12 at 9:00 a.m. Resident #25's</p>		<p>not receive their vaccine. II. How the facility identified other residents: An audit was completed on all residents in the facility for flu vaccine consents for year of 2011/2012. Any issues identified physicians and families were notified. III. Measures put into place/ System changes: Completed an inservice on immunizations and mantoux. Immunizations will be discussed with resident and families upon admission and given to those consenting. A copy of all signed flu vaccines will be given to DON. Those residents will be added to the list to be vaccinated during appropriate season. IV. How the corrective actions will be monitored: Medical records will complete an audit of flu immunizations following administration in the fall. All new admissions will be audited the following business day to include an audit of immunizations and consents. The results of these audits will be discussed in the monthly quality assurance meeting. This monitoring of new admission will continue for one year.V. Date of compliance: 7-3-12</p>		

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	<p>diagnoses included but were not limited to high blood pressure, dementia, and diabetes.</p> <p>A consent dated 12-2-2011 indicated permission had been given to administer the influenza vaccine.</p> <p>A physician's order dated 12-2-2011 indicated an annual flu vaccine was to be given to Resident #25.</p> <p>A review of Resident #25's immunization record indicated the last flu vaccine had been given 9-22-2010. There was no documentation a flu vaccine had been given for the 2011-2012 flu season.</p> <p>In an interview on 6-5-2012 at 8:46 a.m., the Administrator indicated the flu vaccine had not been given.</p> <p>3. The clinical record for Resident #14 was reviewed on 06/05/12 at 9:10 A.M. Resident #14 was admitted to the facility on 08/09/07. The immunization documentation regarding the flu vaccine for Resident #14 indicated a consent for the vaccine had been obtained on 03/12/11 and the resident had received the vaccination for Influenza on 03/12/11. There was no documentation the resident had received a flu vaccination for the most recent flu season from October 2011 - March 2012.</p>						

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	<p>Interview with the Admission Nurse, RN #20, on 06/07/12 at 10:45 A.M. indicated the previous Director of Nursing had tried to be responsible for all of the facility's nursing programs by herself and had not been able to ensure all of them functioned as they should. There was no other reason given for the untimely vaccination for Resident #14.</p> <p>A current undated policy titled influenza vaccine of residents provided by the Administrator on 6-7-12 at 10:34 a.m. indicated the time for immunization will follow the recommendations of the CDC and the state department of health.</p> <p>3.1-18(b)(5)</p>				

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F0371 SS=C	<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</p> <p>Based on observation and interview the facility failed to properly store food items in the walk in cooler in the kitchen, the west nutritional pantry and the dementia unit nutritional pantry this deficient practice had the potential to affect 71 of 71 residents in the facility.</p> <p>Findings include:</p> <p>1. During the tour of the kitchen on 6/3/12 at 3:30 P.M., in the walk in cooler, a box of steaks (between 7 and 10) was noted to be thawing and undated.</p> <p>An interview with the Dietary Manager on 6/3/12 at 3:30 P.M. indicated she believed the steaks were put in the cooler to thaw on 6/1/12 but since they were undated and she didn't work on 6/1/12 she could not verify how long they had been thawing. The Dietary Manager disposed of the thawing steaks.</p>	F0371	<p>F 371 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does properly store food items. I. Immediate actions taken for those residents identified: Dietary manager disposed of the thawing steaks, cream pie in Styrofoam container, bowl of oranges, bowl of lettuce salad, and a sandwich. II. How the facility identified other residents: no residents were affected. III. Measures put into place/ System changes: Inserviced staff regarding dating food items. Pantries are checked by housekeeping daily and any items found undated will be discarded. Dietary staff will date items as appropriate. IV. How the corrective actions will be monitored: Rounds of the pantry and kitchen will be completed 5 times a week for dated items for 3 months the</p>	07/03/2012			

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	<p>2. During environmental tour on 6-4-12 at 1:15 p.m. in the West nutrition pantry refrigerator, a cream pie was observed to be in a Styrofoam container. the container was not dated.</p> <p>During environmental tour on 6-4-2012 at 2:10 p.m. in the Touchstone pantry refrigerator, a bowl of uncovered, undated orange slices; a bowl of uncovered, undated lettuce salad; and an undated sandwich was observed.</p> <p>In an interview on 6-4-12 at 2:15 p.m., the Administrator indicated the items should have been covered and dated.</p> <p>A current policy dated 6-11 titled leftovers indicated all foods shall be stored labeled, and dated.</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p>		<p>results of these audits will be discussed in quality assurance meeting monthly. Dietary manager will be responsible for coordination and monitoring.</p> <p>V. Date of compliance: 7-3-2012</p>		

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and</p>	F0441	F 441 The filing of this plan of correction does not constitute an	07/03/2012			

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	<p>record review the facility failed to give a vaccine for 2 of 7 residents reviewed. (Resident #25, and Resident #41). The facility further failed to observe infection control precautions during a dressing change for 1 of 2 residents reviewed with dressing changes. (Resident #25). The facility additionally failed to perform a mantoux test for 1 of 15 residents reviewed for mantoux testing (Resident #73) in a sample of 15.</p> <p>Findings include:</p> <p>1. a. Resident #25's record was reviewed 6-4-12 at 9:00 a.m. Resident #25's diagnoses included but were not limited to high blood pressure, dementia, and diabetes.</p> <p>A consent dated 12-2-2011 indicated permission had been given to administer the influenza vaccine.</p> <p>A physician's order dated 12-2-2011 indicated an annual flu vaccine was to be given to Resident #25.</p> <p>A review of Resident #25's immunization record indicated the last flu vaccine had been given 9-22-2010. There was no documentation a flu vaccine had been given for the 2011-2012 flu season.</p>		<p>admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care The facility does have an infection control program to provide a safe, sanitary, and comfortable environment. I. Immediate actions taken for those residents identified: Regarding residents # 41 #25, and #14 residents were added to list for influenza vaccine for the upcoming immunization season. The physicians/families were notified that the residents did not receive their vaccine. Regarding resident #25 the residents wound was assessed and there were no signs and symptoms of infection. Regarding resident #73 has been discharged from the facility. II. How the facility identified other residents: : An audit was completed on all residents in the facility for flu vaccine consents for year of 2011/2012. Any issues identified physicians and families were notified. An audit was completed on mantoux's and any issues identified were addressed. III. Measures put into place/ System changes: Completed an inservice on immunizations, handwashing, dressing changes, and</p>				

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	<p>In an interview on 6-5-2012 at 8:46 a.m., the Administrator indicated the flu vaccine had not been given.</p> <p>A current undated policy titled Influenza Vaccine of Residents provided by the Administrator on 6-7-12 at 10:34 a.m. indicated the time for immunization will follow the recommendations of the CDC and the state department of health.</p> <p>1.b. Resident #41's clinical record was reviewed on 6/4/12 at 2:30 P.M.. The record indicated on 2/17/12, a Immunization consent was signed by resident #41's power of attorney giving the facility permission to administer an influenza vaccine annually.</p> <p>There was no physician's order or record of administration of the influenza vaccine for resident #41.</p> <p>An interview with the administrator on 6/6/12 at 3:00 P.M. indicated the resident had not received the influenza vaccine.</p> <p>2. During a dressing change observation on 6-4-12 at 9:50 a.m. LPN #6 prepared the supplies, entered Resident #25's room, explained the procedure, shut the room door, pulled the privacy curtain, set up the supplies, washed her hands, put on gloves, removed Resident #25's sock on</p>		<p>mantoux. Immunizations will be discussed with resident and families upon admission and given to those consenting. A copy of all signed flu vaccines will be given to DON. Those residents will be added to the list to be vaccinated during appropriate season. Medical records will provide a list of all mantoux's needing to be given monthly to the unit managers or administration. IV. How the corrective actions will be monitored: : Medical records will complete an audit of flu immunizations following administration in the fall. All new admissions will be audited the following business day to include an audit of mantoux's and immunizations and consents. An audit will be completed by medical records at the end of each month for annual mantoux's. Medical records will be responsible for compliance. Results of this audit will be discussed in the monthly quality assurance meeting x 12 months. Dressing change proficiencies will be completed on random nurses at least 3 x a week for 3 months, then monthly for 9 months. This will be reported monthly in quality assurance x 12 months. V. Date of compliance: 7-3-2012</p>				

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	<p>his left foot, and removed the old, dated (6-4-12) dressing. The dressing had a small amount of clear drainage. The area observed was approximately the size of a quarter and had loosely adherent, wet, whitish, yellow slough in the base. The depth was superficial and the skin around the wound was pink with no redness or swelling. LPN #6 then cleansed the wound without changing her gloves or performing hand hygiene. LPN #6 then covered the base of the wound with santyl on a cotton tipped swab, then applied bactroban in the same manner. LPN #6 then applied border gauze. LPN #6 was not observed to change her gloves or perform hand hygiene during the treatment.</p> <p>In an interview on 6-5-12 at 1:00 p.m. LPN #1 indicated gloves should have been changed during dressing change procedure.</p> <p>A current policy dated 10-10 titled Clean dressing change indicated remove soiled dressing, then cleanse hands and put on clean gloves. After cleansing the wound, the policy indicated gloves were to be changed again.</p> <p>3. The closed clinical record for Resident #73 was reviewed on 06/06/12 at 9:00 A.M. The resident was admitted to the facility on 01/13/12. The Mantoux</p>				

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	<p>documentation was requested.</p> <p>Documentation provided by the Administrator on 06/07/12 at 9:30 A.M. indicated the resident received a 1st step Mantoux test on 01/30/12. The electronic form indicated the results were "negative" but there was no date the skin test was read, no induration in mm (millimeters) documented, and by whom the test was read. A nursing progress note, dated 01/31/12 at 8:52 A.M. indicated the resident's Mantoux test on the left forarm was read. However, the test had been given less than 4 hours prior. There was no information provided as to why the resident did not receive the Mantoux skin test until 01/30/12, 17 days after admission.</p> <p>A second step Mantoux skin test was documented as having been administered to Resident #73 on 02/06/12 but although the form indicated the results were negative, there was no date the test was read, by whom the test was read and the induration in mm was not documented.</p> <p>Interview with the corporative admission nurse, #20 , on 06/07/12 at 10:30 A.M. indicated the nurses sometimes documented the test results on the Medication Administration Record, but she confirmed the results were not located</p>			

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	on any of the records for Resident #73. 3.1-18(b)(5) 3.1-18(j)				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to assure Mantoux documentation was complete for 2 of 15 residents reviewed for Mantoux documentation in a sample of 15. (Resident #74, Resident #5)</p> <p>Findings include:</p> <p>Resident #74's record was reviewed 6-6-12 at 10:28 a.m. Resident #74's diagnoses included but were not limited to blood clot in the Aorta, fatigue, and weakness.</p> <p>A review of Resident #74's immunization record revealed tuberculin testing had been administered on 5-24-2012. There was documentation the Mantoux results were negative, but the record did not indicate when the test had been read or if</p>	F0514	<p>F 514 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide complete and accurate and accessible clinical records. I. Immediate actions taken for those residents identified: Regarding resident #74 the nurse was contacted and the results were documented. Regarding resident #5 a mantoux was readministered.</p> <p>II. How the facility identified other residents: . An audit was completed on mantoux's and any issues identified were addressed. III. Measures put into place/ System changes: Completed an inservice on</p>	07/03/2012	

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NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN 46970		
(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>there was any reaction to the Mantoux serum.</p> <p>In an interview on 6-6-12 at 1:57 p.m. the Director of Nursing indicated the nurse reading the test had been contacted and she indicated the test had been read on 5-26-2012 with a result of 0 millimeters induration. The Director of Nursing indicated the nurse should have documented the results better.</p> <p>4. The clinical record for Resident #5 was reviewed on 06/04/12 at 8:50 A.M. Resident #5 was admitted to the facility on 02/29/12. The resident received a Mantoux skin test on 03/01/12 but although the results were documented as "negative" there was no documentation of who read the test, the date the test was read, and the induration in millimeters of the results.</p> <p>A current policy dated 10-2005 titled Tuberculosis testing did not indicated what documentation was required.</p> <p>3.1-50(a)(1)</p>		<p>immunizations, handwashing, dressing changes, and mantoux's. Medical records will provide a list of all montoux's needing to be given monthly to the unit managers or administration. IV. How the corrective actions will be monitored: : Medical records will complete an audit of flu immunizations following administration in the fall. All new admissions will be audited the following business day to include an audit of mantoux's and immunizations and consents. An audit will be completed by medical records at the end of each month for annual mantoux's. Medical records will be responsible for compliance. Results of this audit will be discussed in the monthly quality assurance meeting x 12 months. V. Date of compliance: 7-3-2012</p>		