

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2015
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00164866</p> <p>Complaint #IN00164866 - Unsubstantiated</p> <p>Survey dates: January 28, 29, 30, 2015 and February 2, 3, 4, 2015</p> <p>Facility Number: 000139 AIM Number: 100266410 Provider Number: 155234</p> <p>Survey Team: Vickie Nearhoof RN, TC Geoff Harris RN Laura Brashear RN Mary Weyls RN (February 2, 3, 4, 2015)</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census by Payor Source: Medicare: 3 Medicaid: 48 Private: 6 Total: 57</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged of correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending February 4, 2014. Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me. Respectfully, Tina Harden Administrator</p>	
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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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F000164 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 2/9/15 by Brenda Marshall, RN.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's</p>				

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	<p>records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record review, the facility failed to ensure privacy for 3 of 4 residents observed receiving blood sugar testing and/or a respiratory treatment. (Resident #'s 66, 21 and 60)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 2/3/15 at 11:10 a.m., Resident #66 was sitting on the side of the bed, facing the hallway. LPN #4 listened to Resident #66 's lung sounds and placed a meter on the resident's finger to check oxygen saturation. The nurse then placed medication into a nebulizer mask, and placed the mask on the resident to administer the medication. During the assessment and beginning of the administration of the medication the resident's door to the hallway was left wide open. On 2/3/14 at 11:20 a.m., LPN #4 used a meter to check Resident #21's blood sugar. During the procedure the resident's door to the hallway was left open. On 2/3/15 at 11:30 a.m., RN #9 used a lancet to prick Resident # 60's finger in 	F000164	<ol style="list-style-type: none"> Resident #66, 21 and 60 were affected. The staff involved were immediately re-educated on providing privacy for residents. All residents have the potential to be affected. All nursing staff will be in-serviced on providing privacy with care, HIPAA, and resident rights, (please see attachment A). As a measure for ongoing compliance the DON or designee will complete an audit to ensure privacy is maintained for residents, (please see attachment B). This audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly. Any findings will be addressed immediately. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted. 	02/20/2015

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F000241 SS=E	<p>order to check the resident's blood sugar. During the procedure the resident's door to the hallway was left wide open.</p> <p>During review of a facility policy and procedure, titled "STEPS, INITIAL AND FINAL- PROVISIONS OF CARE," provided by the nurse consultant on 2/4/15 at 11:05 a.m., indicated, "...To provide resident with care in a manner that ensures maintenance of Resident Rights and ensures maximum communication, privacy, safety, infection control and comfort...7. Close curtains, drapes and doors. Keep resident covered, expose only area of resident's body necessary to complete procedure...."</p> <p>3.1-3(o) 3.1-3(p)(2)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review, the facility failed to ensure a dignified dining experience for 1 of 2 dining rooms. (Residents #24, #52, #and #48)</p>	F000241	1.Resident #24, 52, and 48 were affected. The dining area where the residents are seated includes a large window and a television to provide a homelike environment.	02/20/2015

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	<p>Finding includes:</p> <p>On 1/28/15 at 12:20 p.m., the East wing lounge/dining/nurses' station area was observed during the noon meal. Four residents were positioned at a horse shoe shaped table being assisted by CNA #1. Residents #48 and #52 were seated in wheelchairs facing the wall. Resident #24 was positioned reclined in a geri chair facing the nurses' station. CNA #1 was seated in between Residents #24 and #48 and was feeding the two residents. The residents' meals were not removed from the delivery trays. Maintenance and Housekeeping staff went up and down the hallway by the dining area wheeling mop buckets and carts during the meal.</p> <p>The facility policy, titled "Feeding Resident," dated 10/2014, included but was not limited to, "Policy: Residents should be fed to ensure adequate nutritional intake when unable to independently feed self...6. Sit on unaffected side, eye level with resident, facing them...13. Make conversation with resident; atmosphere should be pleasant...."</p> <p>A facility policy, dated 1/2015 and titled, "Resident Rights," included but was not limited to, "Quality of Life (a) Dignity. A facility must care for its residents in a</p>		<p>Additionally, the said dining area is being updated to provide a more homelike environment.</p> <p>2.All residents in said dining area have the potential to be affected. Housekeeping staff will be in-serviced on proving a homelike environment during meal times, (please see attachment C). Nursing staff will be in-serviced on providing a homelike environment during meal times, (please see attachment A).</p> <p>3.As a measure of ongoing compliance the DON or designee will complete an audit to ensure dignity is provided during meal times, (please see attachment D). This audit will be completed weekly for 3 months, then monthly ongoing. Any findings will be addressed immediately.</p> <p>4.As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan of correction will be revised as warranted.</p> <p>Addendum: Please indicatethe changes that were made for the residents listed in the finding to providedignified dining (positioning to avoid facing a wall or the nurses' station,geri chair in an upright position instead of reclined, food removed from trays,etc.) To provide increased dignity with dining, the in-servicing completed for CNA's</p>		

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F000312 SS=D	<p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."</p> <p>3.1-3(t)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to thoroughly cleanse a dependent resident's skin after being incontinent of urine. (Resident #18)</p> <p>Finding includes:</p>	F000312	<p>addressed taking food items off of meal trays and sitting resident's in an upright position for meals. The in-servicing provided for housekeeping staff included keeping housekeeping carts out of hallways and dining areas during meal times. The seating arrangement for the involved residents was revised so that the residents were facing each other. The audits completed by the DON or designee will continue to monitor and ensure the residents are provided dignity with dining. Additionally, a restorative dining program is being implemented in the main dining room which includes resident #24, 52, and 48. These residents will begin eating their meals in the main dining room as part of the restorative dining program providing increased dignity with dining as well.</p> <p>1.Resident # 18 was affected. The CNA's involved were immediately re-educated on providing proper perineal care. 2.All residents requiring incontinence care have the potential to be affected. All nursing staff will be in-serviced on</p>	02/20/2015

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	<p>On 1/28/15 at 2:39 p.m., CNAs #2 and #3 provided incontinence care to Resident #18. The resident had been incontinent of urine and stool. The resident's gown and cloth underpad were saturated with urine and had brown drying rings. The resident was positioned on the left side, the bowel movement was cleansed, and a clean gown and underpad were placed. The staff did not cleanse the thighs, buttocks, and perineal area that had been in contact with the urine.</p> <p>The Director of Nursing (DON) was interviewed on 2/05/15 at 11:23 a.m. The DON indicated the facility may not have a policy on cleansing the skin. The DON indicated the skin that had been in contact with the urine should have been cleansed.</p> <p>Resident #18's clinical record was reviewed on 2/3/15 at 1030 a.m. A Minimum Data Set (MDS) assessment dated 12/13/14, coded the resident as always incontinent of bowel and bladder, required total assistance of staff for all activities of daily living.</p> <p>A plan of care dated 12/16/14, addressed the problem of "The resident is incontinent of bladder due to: need for total assist "...disease process...Provide</p>		<p>the facility's Peri care policy as well as cleansing all skin areas that may have been in contact with urine, (please see attachment A).</p> <p>3.As a measure ongoing compliance the DON or designee will complete an audit to ensure proper perineal care is provided, (please see attachment E). This audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Any findings will be addressed immediately.</p> <p>4.As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quality assurance meeting. The plan will be revised as warranted.</p>	

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F000315 SS=D	<p>peri care each shift and with each incontinent episode."</p> <p>3.1-38(a)(3)(A)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on observation, record review, and interview, the facility failed to ensure services were provided to prevent possible urinary tract infections for 1 of 1 resident reviewed with a urinary catheter. (Resident #48)</p> <p>Finding includes:</p> <p>On 2/2/15 at 9:25 a.m., Resident #48 was observed sitting in a wheelchair at the nurse's station. The drainage tube from the resident's indwelling urinary catheter was on the floor under her wheelchair.</p> <p>On 2/3/15 at 10:48 a.m., Resident #48 was observed sitting in a wheelchair in</p>	F000315	<p>1. Resident #48 was affected. The CNA's involved were immediately re-educated on proper placement of catheter tubing and providing catheter care.</p> <p>2. All residents utilizing a catheter have the potential to be affected. All nursing staff will be in-serviced on the facility's policy for catheter care as well as proper positioning of the catheter tubing, (please see attachment A).</p> <p>3. As a measure for ongoing compliance the DON or designee will complete an audit to ensure the catheter bag and tubing are positioned appropriately, (please see attachment F). This audit will be completed three times weekly for 30 days, then weekly for 30</p>	02/20/2015

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	<p>her room. The drainage tube from the resident's indwelling urinary catheter was lying on the floor under the wheelchair.</p> <p>On 2/3/15 at 2:09 p.m., Resident #48 was observed in a wheelchair at the nurses' station. The drainage tube from the resident's indwelling urinary catheter was lying on the floor under the wheelchair</p> <p>On 2/3/15 at 2:35 p.m., Resident #48 was observed sitting in a wheelchair at the nurses' station. The drainage tube from the resident's indwelling urinary catheter was lying on the floor under the wheelchair.</p> <p>On 2/3/15 at 2:37 p.m., a portion of Resident #48's urinary drainage tube dragged on the floor through the hallway as CNA #11 transferred the resident from the nurses' station to the resident's room.</p> <p>On 2/3/15 at 2:52 p.m., Certified Nursing Assistant (CNA) #11 and CNA #1 were observed providing incontinence care for Resident #48. CNA #11 applied a wet and soapy washcloth to the resident's bottom but neglected to wash her perineum area and did not perform Foley catheter care.</p> <p>On 2/4/15 at 10:15 a.m., Resident #48 was observed in wheelchair at the nurses'</p>		<p>days, then monthly ongoing. Additionally, the DON or designee will complete an audit to ensure proper perineal care and catheter is provided, (please see attachment E). This audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Any findings will be addressed immediately.</p> <p>4. As a measure for quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>		

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	<p>station. The drainage tube from Resident #48's indwelling urinary catheter was lying on the floor under her wheelchair.</p> <p>The clinical record for Resident #48 was reviewed on 1/30/15 at 11:09 a.m. Diagnosis included, but was not limited to, a history of urinary tract infections. The most recent Minimum Data Set (MDS) was completed on 12/16/14. The assessment identified the resident as severely impaired in cognitive decision making skills with a Brief Interview Mental Status Score of 1 out of 15.</p> <p>The care plan indicated a "Problem- The resident requires use of a Foley catheter due to: Neurogenic Bladder and is at risk for infection. Goal- The resident will be free from signs and symptoms of infection. Thru next review (sic)." Interventions included but were not limited to, provide catheter care every shift and as needed and position catheter tubing and drainage bag in such a way to avoid contact with the floor.</p> <p>During an interview on 02/04/2015 at 11:20 a.m., the Assistant Director of Nursing (ADON) indicated Urinary drainage tubing is supposed to be clipped to the wheelchair and not to touch the floor at any time.</p>						

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F000323 SS=E	<p>An undated policy, identified as a current, titled, "Catheter Care, Indwelling," provided by the Nurse Consultant on 2/4/15 at 10:50 a.m., included but not limited to, "...Indwelling catheter care will be provided at least every shift, during perineal care, and as indicated after each bowel movement...Check catheter for leakage, secretions, or irritation...Gently wipe four inches of catheter tubing with a washcloth (dampened with soap and water) from the meatus away from the body, stabilizing the catheter tubing with the non-dominant hand...."</p> <p>An undated policy, identified as a current, titled, "Perineal Care," provided by the Nurse Consultant on 2/4/15 at 10:50 a.m., included but not limited to, "...Perineal care will cleanse the perineum and prevent infection and odors....For females: Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs...."</p> <p>3.1-41(a)(2)</p>			
	483.25(h) FREE OF ACCIDENT			

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	<p>HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review the facility failed to ensure safe transfers for 2 of 2 mechanical transfers observed (Residents #18 and #48) and failed to ensure the environment was free of hazards for 1 of 3 units (200 hallway) observed for environmental hazards.</p> <p>Findings include:</p> <p>1. During observation on 2/3/15 at 2:20 p.m., CNAs #1 and #11 transferred Resident #18 from the geri-chair to the bed with a Medline mechanical lift. The base of the lift was positioned from the side of the chair. The base was not fully engaged (fully opened) before attaching the sling and raising the resident over the arm of the chair. With the resident waist high to the CNA and perpendicular to the mast, the chair was moved out of the way and the resident was transported to the bed. With the base still in the closed position the CNAs lowered the resident into the bed.</p> <p>The Minimum Data Set (MDS) assessment dated 12/13/14 assessed the</p>	F000323	<p>1. Resident #18 and 48 were affected. The CNA's involved were immediately re-educated on the facility policy for Mechanical Lift. The tiles next to the east exit doors will be repaired. The metal exposed next to the sink in the south wing employee restroom has been repaired.</p> <p>2. All residents that exit through the east wing doors, utilize the employee bathroom, and/or are transferred via a mechanical lift have the potential to be affected. All nursing staff will be in-serviced on utilizing the mechanical lift per policy and manufacturer's instructions, (please see attachment A). All areas in the facility were checked by the Maintenance Director to ensure there were no further potential trip or sharp edge hazards.</p> <p>3. As a measure for ongoing compliance the DON or designee will complete an audit to ensure the mechanical lift is utilized per policy during varied times with varied staff, (please see attachment G). The audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Any findings will be addressed immediately. Additionally the Maintenance Director or designee</p>	02/20/2015

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	<p>resident as non ambulatory required extensive assistance of two for bed mobility and transfers.</p> <p>The CNA assignment sheet, provided by the Director of Nursing on 2/3/15 at 10:31 a.m., information included that the resident was non-ambulatory and was transferred with a mechanical lift. 2. On 2/3/15 at 2:52 p.m., CNA #11 and CNA #1 transferred Resident #48 from the geri-chair to the bed with the Medline mechanical lift. The base of the lift was positioned from the side of the chair. The base was not fully engaged before attaching the sling and raising the resident over the arm of the chair. With the resident waist high to the CNA and perpendicular to the mast, the chair was moved out of the way and the resident was transported to the bed. With the base still in the closed position the CNAs lowered the resident into the bed.</p> <p>The clinical record for Resident #48 was reviewed on 1/30/15 at 11:09 a.m. Diagnoses included, but were not limited to, Cerebrovascular accident, Chronic respiratory failure, and Altered mental status. The most recent Minimum Data Set (MDS) was completed on 12/16/14. The assessment identified the resident as severely impaired in cognitive decision making skills with a Brief Interview</p>		<p>will complete facility round audits, (pleasesee attachment H) to monitor for potential hazards and immediately correct any potential problems. This audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly ongoing.</p> <p>4.As a measure of quality assurance the DON or designee and Maintenance Director or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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	<p>Mental Status Score of 1 out of 15.</p> <p>The CNA assignment sheet was provided by the Director of Nursing on 2/3/15 at 10:31 a.m. The information included on the sheet the resident was non-ambulatory and was transferred with a mechanical lift.</p> <p>The manufacturer's directions for the mechanical lift, dated 4/16/13, included but was not limited to, "...ALWAYS CHECK THE FOLLOWING BEFORE LIFT OPERATION: The base legs are fully engaged from the stowed position...During lifting or lowering, whenever possible, always keep the base of the lift in the widest position with the casters unlocked...While being lifted in a sling, always keep the resident centered over the base and facing the caregiver operating the lifter."</p> <p>3. During the environmental tour with the Maintenance Supervisor on 2/4/15 at 9:55 a.m., cracked and broken floor tiles were observed at the exit door leading to the resident's smoking area. The affected area was measured by the Maintenance Supervisor and measured 36 inches in length and 2.25 inches in width. The broken tiles made an uneven surface and was a potential fall hazard.</p> <p>During an interview with the Activity</p>						

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F000441 SS=D	<p>Director on 2/4/15 at 2:15 p.m., she indicated there were between 6 and 10 residents who go outside to smoke during the facility smoking times.</p> <p>4. On 2/4/15 at 9:55 a.m. with the Maintenance Supervisor, a sharp piece of exposed metal was observed on the right side of the sink base below sink counter in the bathroom at the end of the north hall. The Activity Director indicated the bathroom is suppose to be for staff and visitors, but the residents do use the bathroom from time to time.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <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>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure procedures for sanitary handling for 2 of 3 accucheck meters. (Resident #21 and #10)</p> <p>Findings include:</p> <p>1. On 2/3/14 at 11:20 a.m. LPN #4 used a meter to check Resident #21's blood sugar. The LPN placed a black case, which housed a blood sugar meter, on a paper towel on the resident's over bed table. The nurse removed the meter, and while wearing gloves, stuck the resident's finger to place blood on a strip. During the procedure the nurse's right gloved pointer finger was observed to be</p>	F000441	<p>1. Resident #21 and 10 were affected. The nurses involved were immediately re-educated on proper infection control practices. All blood glucose machines, storage pouches and storage areas were immediately cleaned and disinfected.</p> <p>2. All residents that require blood sugar monitoring have the potential to be affected. All nurses will be in-serviced on the facility's policies on Blood Glucose Measurement, Handwashing, and Glove Use, (Please see attachment A).</p> <p>3. As a measure for ongoing compliance the DON or designee will complete an audit tool three times weekly for 30 days, then weekly for 30 days, then monthly to ensure proper infection control</p>	02/20/2015

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	<p>contaminated with blood. Prior to removing the soiled gloves, the nurse placed the meter into the black case, zipped the case, walked out to the hallway to place the black case into a container on top of the medication cart. The container held several other black cases.</p> <p>2. On 2/3/14 at 11:40 a.m., On 2/3/14 at 11:20 a.m. LPN #10 used a meter to check Resident #12's blood sugar. The LPN placed a black case, which housed a blood sugar meter, on a paper towel, on the resident's over bed table. The nurse removed the meter, and while wearing gloves, stuck the resident's finger to place blood on a strip. Prior to removing gloves the nurse place the meter in the black case, zipped the case, walked out to the hallway to place the black case into a container on top of the medication cart. The container held several other black cases.</p> <p>During an interview on 2/4/15 at 11:10 a.m., with the DON (director of nursing) and consultant nurse, the DON indicated, the nurses should have removed their gloves after checking the blood sugars and prior to touching other surfaces.</p> <p>A policy and procedure, titled, "BLOOD GLUCOSE MEASUREMENT,</p>		<p>practices are followed when conducting blood sugar checks at varied times with varied staff, (please see attachment I). Any findings will be addressed immediately.</p> <p>4.As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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F000465 SS=E	<p>EVENCARE G2" was received from the nurse consultant on 2/4/14 at 10:50 a.m. The procedure indicated, "...2. Perform necessary initial steps. (See STEPS, INITIAL AND FINAL-PROVISIONS OF CARE for a complete list of steps.)..."</p> <p>On 2/14/15 at 11:05 a.m. a policy was received from the nurse consultant titled, "STEPS, INITIAL AND FINAL-PROVISIONS OF CARE." The policy indicated, "...Initial Steps: ...9. Wear gloves as indicated by Standard Precautions...FINAL STEPS 1. Remove gloves, if applicable, and wash hands...."</p> <p>3.1-18(I)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a comfortable living environment for 2 of 3 nursing units (100 and 200 hallways) and failed to ensure comfortable water temperatures for 14 of 17 resident bathrooms and/or shower rooms reviewed for water temperatures.</p> <p>Findings include:</p>	F000465	<p>1.Residents on 100 and 200 halls were affected. The mixing valve was immediately adjusted and water temperatures were rechecked and noted to be within range of 102-105 degrees. The mechanical lift was immediately cleaned and disinfected. The soiled laundry, causing the odors, were immediately taken to the laundry area to be washed. The resident in room215 was attended to. Nail holes were filled and the</p>	02/20/2015

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	<p>1. During an environmental tour with the Maintenance Supervisor on 2/4/15 at 9:55 a.m., the following were observed:</p> <p>The hoier lift on the east hall was observed to have blackish substance on the base of the unit. The hoier was also observed to have random brownish dried stains on the base of the unit.</p> <p>A strong ammonia smell was noticed on the east hall in the area of the shower rooms. A very strong ammonia smell was noticed in the middle portion of the east hall around rooms 211 to 217 and a very strong smell of feces was noticed in room 215.</p> <p>Nail and screw holes were observed on the east wall of the East lounge/dining area. The paint on the wall was marred and a patch of paint missing.</p> <p>The ceiling in the East Nurses's station area was observed to be partially freshly painted.</p> <p>Dried red/brown spots were observed on the floor at the foot of the bed against the north wall in room 122.</p> <p>The baseboard molding behind the toilet in the bathroom of rooms 107/109 was</p>		<p>walls will be painted. The ceiling painting is being completed. The floor in room 122 was cleaned. The baseboard molding in the bathroom between rooms 107/109 was repaired.</p> <p>2.All residents have the potential to be affected. Water temperatures throughout the facility were checked and were noted to be within a range of 102-110 degrees after the mixing valve was adjusted. Rounds were completed throughout the facility and a list was completed for needed repairs. Items on the list were categorized by priority. The repairs will be strategically completed with high priority items being completed first. All staff will be in-serviced on completing Maintenance Request forms when a repair is needed, (please see attachment J).</p> <p>3.As a measure for ongoing compliance the Maintenance Director or designee will complete water temperature checks throughout the facility in varied areas daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly ongoing to ensure water temperatures are appropriate, (please see attachment K). Any problems noted with water temperatures will be addressed immediately. Additionally, the Maintenance Director or designee will complete a facility round audit to monitor for needed repairs, (please see</p>	

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	<p>observed leaning up against the wall and not attached to the wall.</p> <p>2. During a Stage 1 observation of Resident #40's room on 1/29/15 at 10:37 a.m., water from the bathroom faucet felt cool to touch after it flowed for 60 seconds.</p> <p>During an environmental tour on 2/4/15 at 9:55 a.m., the Maintenance Supervisor measured water temperatures by using a digital scanning thermometer he indicated was used to perform weekly random hot water checks in the facility. Results of the hot water temperatures were:</p> <p>North hall: Rooms 120/122 shared bathroom sink. The water ran for 5 minutes. The highest temperature was 85 degrees. Rooms 119/121 shared bathroom sink. The water ran for 3 minutes. The highest temperature was 87 degrees. Rooms 116/118 shared bathroom sink. The water ran for 3 minutes. The highest temperature was 87 degrees.</p> <p>South Hall: Rooms 315/317 shared bathroom sink. The water ran for 3 minutes. The highest temperature was 90 degrees. Rooms 311/313 shared bathroom sink.</p>		<p>attachment H). This audit will be completed three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Any findings will be addressed immediately.</p> <p>4.As a measure of quality assurance the Maintenance Director or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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	<p>The water ran for 3 minutes. The highest temperature was 90 degrees. Rooms 303/305 shared bathroom sink. The water ran for 3 minutes. The highest temperature was 99 degrees. 300 hall common shower room: The shower ran for 3 minutes. Highest temperature was 90 degrees.</p> <p>East Hall: East hall men's common shower room. The water ran for 3 minutes and 30 seconds. The highest temperature was 85 degrees.</p> <p>At the same time during an interview, the Maintenance Supervisor indicated the facility had some issues with the hot water not getting hot a couple of months ago. He indicated it was determined to be a mixing valve. He indicated the valve was replaced and he performs weekly random room checks and will adjust the water temps as necessary based on those findings.</p> <p>On 2/4/15 at 11:06 a.m., during an interview with Resident #13, the resident indicated he was not able to get his own wash water. He indicated the staff would prepare it for him. The resident indicated the staff had complained about the water being too cold at times as they prepared it to wash him.</p>						

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	<p>On 2/4/15 at 11:12 a.m., during an interview with Resident #29, the resident indicated his hot water was cold almost every day. He indicated he had reported it to the facility. During the interview the resident stated, "Are you going to get me some hot water?"</p> <p>On 2/4/15 at 11:30 a.m., during an interview with CNA #7 she indicated there was one or two times when they had an issue with the hot water being too cold. She indicated the maintenance staff fixed the issue. The CNA indicated when it happens, the staff can get hot water from therapy to use.</p> <p>On 2/4/15 at 11:37 a.m., during an interview with CNA #8 she indicated a few months ago they had an issue with the hot water not getting very hot. The CNA indicated someone from a sister facility came and assisted the facility to fix the issue. She indicated the hot water was a little cold today.</p> <p>During the initial tour with the Maintenance Supervisor on 2/4/15 at 9:55 a.m., the Maintenance Supervisor indicated the policy was to perform random room checks of hot water temperatures and he would maintain a log of the temperatures. The logs were</p>			

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	reviewed and the temperatures were within acceptable ranges. 3.1-19(f)(5) 3.1-19(r)(1) 3.1-19(r)(2)				