

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2015
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NAME OF PROVIDER OR SUPPLIER  LOGOOTEHEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTEHE, IN 47553
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 14, 15, 16, 17, 2015</p> <p>Facility number: 000571 Provider number: 155374 AIM number: 100266920</p> <p>Census bed type: SNF: 2 SNF/NF: 33 Total: 35</p> <p>Census payor type: Medicare: 7 Medicaid: 21 Other: 7 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p>	F 000	By submitting the following material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of the any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective 5/15/2015 to the state findings of the recertification and state licensure survey. I am requesting paper compliance.	
F 225 SS=E Bldg. 00	<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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>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 observation, interview, and record review, the facility failed to ensure allegations of abuse were immediately reported, thoroughly investigated, and/or criminal background checks of new employees were completed timely, in</p>	F 225	It is the intent of this facility to ensure that the residents have the right to be free from verbal, physical, sexual, mental abuse, corporal punishment and involuntary seclusion. It is also the intent of the facility to immediately notify the State Department of	05/15/2015

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	<p>that, allegations of abuse were not immediately reported to the Indiana State Department of Health, an allegation of abuse reported was not thoroughly investigated, and/or criminal background checks were not completed within 3 days for 2 of 3 abuse allegations reviewed (Resident #60, Resident #24) and 3 of 10 employee files reviewed. (CNA #3, MS #1, RN #5)</p> <p>Findings include:</p> <p>1. During a confidential interview on 4/14/15 at 3:38 P.M. Resident #60 was observed lying in bed and indicated, at that time, [name of Resident #60] had witnessed staff throw another resident into a wheelchair. Resident #60 further indicated, at that time, the incident had not been reported to the facility.</p> <p>On 4/14/15 at 3:50 P.M., the Administrator was notified a resident who wished to remain anonymous had made an allegation of abuse. She indicated at that time the facility would investigate the allegations.</p> <p>The clinical record for Resident #60 was reviewed on 4/16/15 at 11:18 A.M., diagnoses include, but were not limited to, congestive heart failure and back pain.</p>		<p>Health of all allegations of abuse and to screen employees prior to placing them on the work schedule.1). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the allegation of abuse by the resident identified as Resident #60 which was reported to the Administrator by the State Surveyors was investigated. It was an oversight by the Administrator as far as reporting it to the office of ISDH since the allegation had been brought to the Administrator by the State Surveyor. During the investigation Resident #60 was interviewed however, Resident #60 did not report the allegation to Administration during the investigation. The allegation could not be substantiated at the time of the investigation due to the resident not reporting the information to Administration that Resident #60 provided to the State Surveyor.</i></p> <p>2). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the event that was reported by the resident identified as Resident #24 was identified during the investigation of an allegation of abuse by Resident #60. The event that the resident was making reference to was a discussion between the resident and the AIT (Administrator in Training) who was attempting to explain to the resident the resident's financial responsibility</i></p>	

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	<p>A Minimum Data Set assessment (MDS) dated 3/18/15 was reviewed, it included a Brief Interview for Mental Status score (BIMS) of 14 indicating Resident #60 was cognitively intact. The MDS also indicated Resident #60 experienced no behavioral or mood disorders.</p> <p>2. On 4/15/15 at 12:00 P.M., the facility investigations were reviewed. An untimed "Resident Interview &amp; Resident Observation" form dated 4/14/15 for Resident #24 included, but was not limited to, "[resident name] cussing ' yelling ' Beating on Bathroom door" and "Owners girlfriend upset me. Heckling [sic] me' about my medicaid [and] past bill."</p> <p>The clinical record for Resident #24 was reviewed on 4/15/15 at 2:00 P.M., diagnoses include, but were not limited to, congestive heart failure, coronary artery disease and hypertension.</p> <p>An MDS dated 1/22/15 was reviewed, it indicated Resident #24's BIMS score was 15 indicating she was cognitively intact. It further indicated Resident #24 experienced no behavioral concerns.</p> <p>On 4/16/15 at 11:00 A.M., during an interview with Administrator she indicated neither allegation had not been</p>		<p>in paying the bill at the nursing facility for her care. It has been re-explained to the resident that the conversation was only meant to explain to her the need to pay her liability to the facility. The resident has been assessed by Social Services. There has been no change in the resident's level of daily activities. Due to some bathroom issues the resident has elected to change rooms at the facility and appears very content with the care and services she is receiving. The resident was provided additional education on the importance of reporting any allegation of abuse immediately to the Administrator. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was conducted of all alert and oriented residents as well as all staff members related to abuse and no other allegations of abuse have been reported.</i></p> <p>3, 4, 5).<i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. The criminal background checks on CNA #3, MS #1, and RN #5 did come back with clean records.</i></p> <p>1&amp;2).<i>The measures that have been put into place to ensure that the</i></p>	

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	<p>reported to the State Department of Health. She further indicated she did not feel the concern voiced by Resident #24 was an allegation of abuse.</p> <p>An undated facility policy titled "ABUSE" was provided by the Administrator was reviewed on 4/16/15 at 1:00 P.M., it included, but was not limited to, "Resident abuse is defined as any action which may cause a resident to suffer from discomfort, fear, or embarrassment."</p> <p>An Indiana State Department of Health Incident Report Form provided by the Administrator on 4/17/15 at 12:03 P.M. indicated, Allegation #1 and Allegation #2 were reported 4/16/15 at 6:05 P.M. (2 days after the allegations were initially reported to the Administrator).</p> <p>The policy and procedure for abuse provided by the Administrator on 4/14/15 at 9:15 A.M. indicated, "...5.) Should the incident be deemed an 'unusual occurrence', the state survey and certification Agency shall be notified ...9.) Verified occurrence of abuse shall be reported to the applicable agency (i.e. state nurse aide registry, Health Professions Bureau, etc.). The policy lacked any documentation related to immediately reporting all allegations of</p>		<p><i>deficient practice does not recur is that</i>an in-service to all staff has been conducted on the facility's revised abuse policy. In addition the resident council has been educated on the revised abuse policy.3, 4, &amp; 5).<i>The measures that have been put into place to ensure that the deficient practice does not recur is that</i> on January 2015, the facility adopted the practice that criminal background checks are now being completed electronically. In turn, eliminating any potential of a new hire being placed on the work schedule until the criminal background check has been received by the facility and is clear of any offenses that prohibit the facility from hiring the applicant.</p> <p><i>The corrective action taken to monitor to ensure the deficient practice does not recur is that</i> a Quality Assurance tool has been developed and implemented to monitor for any allegations of abuse to ensure that the allegations of abuse are reported timely to the Indiana State Department of Health as well as all other appropriate agencies, and to ensure that all allegations are thoroughly investigated. This tool will be completed by the Director of Social Services and/or designee weekly for four(4) weeks, then monthly for three(3) months, and then quarterly for three(3) quarters. The outcome of this tool will be reviewed at the</p>	

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	<p>abuse and on screening of potential employees and/or prevention of abuse.</p> <p>3. The employee file of CNA #3 was reviewed on 4/16/15 at 10:15 A.M. The file indicated the hire date of CNA #3 was 10/14/14. A time card for the pay period ending 10/18/14 indicated CNA #3 began working around residents on 10/17/14. An Indiana State Police Criminal Background Report indicated, "...Date of Inquiry: 11/3/2014..." (CNA #3 worked with residents for 17 days without a completed criminal background check.)</p> <p>4. The employee file of MS #1 was reviewed on 4/16/15 at 10:20 A.M. The file indicated the hire date of MS (Maintenance Supervisor) #1 was 12/19/14. A time card for the pay period ending 12/27/14 indicated MS #1 began working around residents on 12/19/14. An Indiana State Police Criminal Background Report indicated, "...Date of Inquiry: 12/31/2014..." (MS #1 worked with residents for 12 days without a completed criminal background check.)</p> <p>5. The employee file of RN #5 was reviewed on 4/16/15 at 10:25 A.M. The file indicated the hire date of RN #5 was 12/16/14. A time card for the pay period ending 12/27/14 indicated RN #5 began working around residents on 12/16/14.</p>		<p>facility's Quality Assurance meetings to determine if any additional action is warranted. An additional Quality Assurance tool has been developed and implemented to audit new hires files to ensure that criminal background checks have been completed and are clear, prior to the new hire being placed on the work schedule. This tool will be completed by the Administrator and/or designee weekly for four(4) weeks, then monthly for three (3) months, and the quarterly for three(3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p>	

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F 226 SS=E Bldg. 00	<p>An Indiana State Police Criminal Background Report indicated, "...Date of Inquiry: 12/29/2014..." (RN #5 worked with residents for 13 days without a completed criminal background check.)</p> <p>During an interview on 4/16/15 at 2:30 P.M., the AA (Administrative Assistant) #1 indicated the criminal background checks were not timely because the requests had to be mailed.</p> <p>A Policy and Procedure for Criminal Background Checks provided by the HFA (Health Facilities Administrator) dated 4/17/15 at 2:00 P.M. indicated, "...Criminal background checks will be done on all prospective new employees prior to the person being hired..."</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F 226	It is the intent of this facility to have and implement written policies and procedures that prohibit mistreatment, neglect,	05/15/2015

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	<p>the facility's abuse policy indicated to immediately notify the state agency regarding any allegation of abuse and/or contained procedures for screening and/or prevention of abuse. (Resident #24, Resident #60)</p> <p>Findings include:</p> <p>1. During a confidential interview on 4/14/15 at 3:38 P.M. Resident #60 was observed lying in bed and indicated, at that time, [name of Resident #60] had witnessed staff throw another resident into a wheelchair. Resident #60 further indicated, at that time, the incident had not been reported to the facility.</p> <p>On 4/14/15 at 3:50 P.M., the Administrator was notified of the anonymous allegation of abuse. The Administrator, at that time, an investigate would be started.</p> <p>The clinical record for Resident #60 was reviewed on 4/16/15 at 11:18 A.M., diagnoses include, but were not limited to, congestive heart failure and back pain.</p> <p>A Minimum Data Set assessment (MDS) dated 3/18/15 was reviewed, it included a Brief Interview for Mental Status score (BIMS) of 14 indicating Resident #60 was cognitively intact. The MDS also</p>		<p>and abuse of residents and misappropriation of resident property. 1). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the allegation of abuse by the resident identified as Resident #60 which was reported to the Administrator by the State Surveyors was investigated. It was an oversight by the Administrator as far as reporting it to the office of ISDH since the allegation had been brought to the Administrator by the State Surveyor. During the investigation Resident #60 was interviewed however, Resident #60 did not report the allegation to Administration during the investigation. The allegation could not be substantiated at the time of the investigation due to the resident not reporting the information to Administration that Resident #60 provided to the State Surveyor. 2). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that he event that was reported by the resident identified as Resident #24 was identified during the investigation of an allegation of abuse by Resident #60. The event that the resident was making reference to was a discussion between the resident and the AIT (Administrator in Training) who was attempting to explain to the resident the</i></i></p>	

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	<p>indicated Resident #60 experienced no behavioral or mood disorders.</p> <p>2. On 4/15/15 at 12:00 P.M., the facility investigations were reviewed. An untimed "Resident Interview &amp; Resident Observation" form dated 4/14/15 for Resident #24 included, but was not limited to "[resident name] cussing 'yelling' Beating on Bathroom door" and "Owners girlfriend upset me. Heckling [sic] me' about my medicaid [and] past bill."</p> <p>The clinical record for Resident #24 was reviewed on 4/15/15 at 2:00 P.M., diagnoses include, but were not limited to, congestive heart failure, coronary artery disease and hypertension.</p> <p>An MDS dated 1/22/15 was reviewed, it indicated Resident #24's BIMS score was 15 indicating she was cognitively intact. It further indicated Resident #24 experienced no behavioral concerns.</p> <p>On 4/16/15 at 11:00 A.M., during an interview with Administrator she indicated neither allegation had not been reported to the State Department of Health. She further indicated she did not feel the concern voiced by Resident #24 was an allegation of abuse.</p>		<p>resident's financial responsibility in paying the bill at the nursing facility for her care. It has been re-explained to the resident that the conversation was only meant to explain to her the need to pay her liability to the facility. The resident has been assessed by Social Services. There has been no change in the resident's level of daily activities. Due to some bathroom issues the resident has elected to change rooms at the facility and appears very content with the care and services she is receiving. The resident was provided additional education on the importance of reporting any allegation of abuse immediately to the Administrator. 3). <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was conducted of all alert and oriented residents as well as all staff members related to abuse and no other allegations of abuse have been reported. All residents have the potential to be affected by this deficient practice. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has reviewed and revised the policy on abuse to include immediately reporting to the State Department of Health all allegations of abuse. The facility adopted the practice on</i></p>	

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	<p>An undated facility policy titled "ABUSE" was provided by the Administrator was reviewed on 4/16/15 at 1:00 P.M., it included, but was not limited to, "Resident abuse is defined as any action which may cause a resident to suffer from discomfort, fear, or embarrassment."</p> <p>An Indiana State Department of Health Incident Report Form provided by the Administrator on 4/17/15 at 12:03 P.M. indicated, Allegation #1 and Allegation #2 were reported 4/16/15 at 6:05 P.M. (2 days after the allegations were initially reported to the Administrator).</p> <p>3. The policy and procedure for abuse provided by the Administrator on 4/14/15 at 9:15 A.M. indicated, "...5.) Should the incident be deemed an 'unusual occurrence', the state survey and certification Agency shall be notified ...9.) Verified occurrence of abuse shall be reported to the applicable agency (i.e. state nurse aide registry, Health Professions Bureau, etc.).</p> <p>The policy lacked any documentation related to immediately reporting all allegations of abuse and on screening of potential employees and/or prevention of abuse.</p> <p>3.1-28(a)</p>		<p>electronically completing criminal background checks. In turn eliminating any potential of a new hire being placed on the work schedule until the criminal background check has been received and is clean. An in-service to all staff has been conducted on the facility's revised abuse policy. In addition the resident council has been educated on the revised abuse policy. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised the policy on abuse to include immediately reporting to the State Department of Health all allegations of abuse. The facility adopted the practice on electronically completing criminal background checks. In turn eliminating any potential of a new hire being placed on the work schedule until the criminal background check has been received and is clean. The measures that have been put into place to ensure that the deficient practice does not recur is that an in-service to all staff has been conducted on the facility's revised abuse policy. In addition the resident council has been educated on the revised abuse policy. The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor for any</i></p>	

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F 246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and		allegations of abuse to ensure that the allegations of abuse are reported timely to the Indiana State Department of Health as well as all other appropriate agencies, and to ensure that all allegations are thoroughly investigated. This tool will be completed by the Director of Social Services and/or designee weekly for four (4) weeks, then monthly for three (3) months, and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. An additional Quality Assurance tool has been developed and implemented to audit new hires files to ensure that criminal background checks have been completed and are clear, prior to the new hire being placed on the work schedule. This tool will be completed by the Administrator and/or designee weekly for four (4) weeks, then monthly for three (3) months, and the quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	<p>preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' call lights were within their reach for 3 of 7 residents reviewed during Stage 1. (Resident #27, Resident #19, Resident #37)</p> <p>Findings include:</p> <p>The clinical record of Resident #27 was reviewed on 4/16/15 at 10:30 A.M. The record indicated Resident #27 was admitted to the facility on 11/6/14. The diagnoses of Resident #27 included, but were not limited to, dementia, syncope (passing out), recurrent falls.</p> <p>A Fall Risk Evaluation dated 11/9/14 indicated Resident #27 was a high risk to experience a fall.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/5/15 indicated Resident #27 experienced moderate cognitive impairment, balance impairment, and/or required the assistance of one staff for transfers and walking.</p> <p>A Care Plan for Falls dated 11/12/14 included, but was not limited to, an</p>	F 246	<p>It is the intent of this facility for a resident to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as Resident #27 has been assessed and placement of service bell will be placed.</i> 2). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as Resident #19 has been assessed and placement of service bell will be placed.</i> 3). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as Resident #37 has been assessed and placement of service bell will be placed. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents MDS's were reviewed for their physical/cognitive ability to need modifications to call lights. Modifications were made based on the outcome of this audit. Facility is contacting vendors for</i></p>	05/15/2015

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	<p>intervention of, "...KEEP CALL LIGHT IN PLACE AT ALL TIMES...Remind resident to use call light for assistance..."</p> <p>On 4/16/15 at 9:34 A.M., Resident #27 was observed at that time to not activate the call. The call light was observed to be attached to a tissue box on the bedside table. A quilt was observed on top of the connecting string.</p> <p>2. The clinical record of Resident #19 was reviewed on 4/16/15 at 3:26 P.M. The record indicated Resident #19 was admitted on 4/1/14. The diagnoses of Resident #19 included, but were not limited to, history of Cerebrovascular accident, chronic ataxia [ongoing abnormal or unsteady gait].</p> <p>A Fall Risk Evaluation dated 3/5/15, indicated Resident #19 was at risk to experience a fall.</p> <p>The Quarterly MDS [Minimum Data Set] assessment dated 2/5/15 indicated Resident #19 experienced moderate cognitive impairment and required the assistance of one staff for walking.</p> <p>A Care Plan for Falls dated 3/5/15 included, but was not limited to, an intervention of "...KEEP CALL LIGHT IN PLACE AT ALL TIMES..."</p>		<p>bids of upgrading the current call light system. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that a policy and procedure for assessing a residents' ability to use the call light system will be added to a call light assessment for all new admissions. The residents physical/cognitive abilities will be reviewed with each quarterly MDS, the annual MDS, and with any significant change MDS, and as needed by nursing. All new information will be forwarded to the D.O.N. and/or Designee. The D.O.N. will instruct maintenance on appropriate call light for each resident. An in-service has been conducted for all nursing employees on the new policy as well as a reminder that call lights and/or service bell are to be placed within resident's reach at all times. The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the type and placement of call lights. This tool will be completed by the D.O.N. and/or designee weekly for four (4) weeks, then monthly for three (3) months, and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</i></p>	

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	<p>On 4/16/15 at 9:34 A.M., Resident #19 was observed in her room sitting in her recliner chair. The call light was observed to be clipped to the privacy curtain on the other side of the room. During an interview, at that time, Resident #19 indicated in order to call for assistance she would need to get out of the recliner, get into her wheelchair, wheel over to the curtain, and pull the string. Resident #19 further indicated the pull string previously had an extension so it would reach the recliner, but she did not know what had happened to the extension. Resident #19 indicated a bell had also been provided, but it was observed to be sitting on the window sill and was located out of reach.</p> <p>3. The clinical record of Resident #37 was reviewed on 4/16/15 at 1:45 P.M. The record indicated Resident #37 was admitted on 6/6/14. The diagnoses of Resident #37 included, but were not limited to, dementia, history of a left fracture, history of falls.</p> <p>A Fall Risk Evaluation dated 2/5/15, indicated Resident #37 was a high risk to experience a fall.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/5/15 indicated</p>						

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	<p>Resident #37 experienced moderate cognitive impairment, balance impairment, and/or required the assistance of two staff for transfers and walking.</p> <p>A Care Plan for Falls dated 6/12/14 included, but was not limited to, an intervention of "...KEEP CALL LIGHT IN PLACE AT ALL TIMES..."</p> <p>On 4/16/15 at 9:34 A.M., Resident #37 was observed in her room sitting in her wheelchair. The bell provided by the facility and the pull string for the call light were not within reach of Resident #37.</p> <p>During an interview on 4/16/15 at 11:50 A.M., CNA #5 indicated Resident #37 and Resident #19 used their call lights and bells when they needed assistance. CNA #5 further indicated Resident #19's call light should have been within reach and would be repositioned. CNA also indicated that Resident #19 would be provided with an extension to ensure it would be within reach of Resident #19's reclining chair.</p> <p>During an interview on 4/16/15 at 11:54 A.M., LPN #10 indicated it was the policy of the facility to place call lights within reach of the residents. After</p>			

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F 250 SS=D Bldg. 00	<p>making LPN #10 aware that Resident #27's call light pull string was obstructed by the blanket located on the arm of the chair, LPN #10 indicated the blanket needed to be removed and the call light pull string shortened.</p> <p>A policy and Procedure for Call Lights dated 4/17/2015 was provided by the Heath Care Administrator on 4/17/15 at 1:51 P.M., and it read as follows: "...POLICY: It is the policy of the facility to provide every resident with a call light or alternate means of alerting staff of need for assistance..."</p> <p>During an interview on 4/17/15 at 10:45 A.M., the Heath Care Administrator indicated it was the policy of the facility to ensure residents have a functioning call light within reach.</p> <p>3.1-3(v)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure, social services were provided, in that, a resident who experienced</p>	F 250	It is the intent of this facility to provide medically-related social services to attain or maintain the	05/15/2015			

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	<p>behaviors was not provided social services for 1 of 1 residents who met the criteria for review of behaviors. (Resident #21)</p> <p>Findings include:</p> <p>On 04/15/2015 at 2:05 P.M., Resident #21 was observed asleep in a recliner, in no apparent distress.</p> <p>The clinical record for Resident #21 was reviewed on 4/16/15 at 9:22 A.M. The diagnoses, included, but were not limited to, psychosis, dementia, congestive heart failure and chronic obstructive pulmonary disorder.</p> <p>The care plans included, but were not limited to, potential for alteration in mood related to dementia with behavioral disturbances, aggressive symptoms initiated 2/26/2015. Interventions include, but were not limited to, approach resident with smile, speak slowly to resident, provide a quiet environment, and offer resident another restroom to use if hers is occupied, psychotropic medication use, monitor for changes in mood and behavior and notify physician of changes.</p> <p>The Minimum Data Set assessment (MDS) dated 2/26/15 indicated Resident</p>		<p>highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p><i>The corrective action taken for those residents found to have been affected by the deficient practice is that Resident #21 was allegedly affected needing social service intervention. Resident #21 nurse's notes stated resident had started to have anxiety over not being able to use the bathroom quick enough due to residents in other room occupying it frequently. Social Service had addressed the issue in the past with an effective care plan but was unaware of the problem arising again. Social Services presented to the residents adjoining Resident #21 that a room had become available that did not adjoin a room and they requested to transfer. Resident #21 and responsible party had declined the room. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected.</i></p> <p>All resident behavior plans and nurse's notes were reviewed for effectiveness of care plans and behavior plans. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that staff members were</i></p>	

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	<p>#21 had a brief interview for mental status (BIMS) score of 6 indicating resident #21 was severely cognitively impaired. It further indicated Resident #21 had experienced no delirium and/or behaviors during the assessment period.</p> <p>The nurses notes were reviewed and included, 4/1/15 8:00 A.M., "Res (Resident) yelling 'Hurry [sic] up.' et [and] banging on bathroom door. States 'I'm dying. I can't breathe.' Calmed res et assisted her to recliner in room... " and "...Fax sent to [name of medical doctor]."</p> <p>A nurse's note dated 4/4/15 at 5:00 A.M., included "Res [resident] restless, [sign for up] anxious [sic]. Banging on bathroom door 'Hurry Up! [sic]"</p> <p>The Social Service Progress Notes were reviewed and included an untimed note dated 4/15/15 included, "Resident hasn't had anymore [sic] behaviors present since being monitored...."</p> <p>During an interview with the Social Service Director on 4/16/15 at 2:20 P.M., she indicated she was unaware of Resident #21 experiencing any behaviors. She indicated staff would alert her using behavior monitoring alert forms as well as the behavior log at the hall 2 nurses station and no behaviors had been</p>		<p>in-serviced to educate on the new behavior policy and procedure.A new Policy and Procedure for the Behavior Management Program was put into place that includes the following:· Identification of a new or worsening behavior· Assessment of new behaviors as well as in-crease or decreased behaviors.· Monitoring to determine frequency and impact of challenging behaviors.· Initiation of Behavior Management intervention/plan· Behavior plan in effect· Education of staff membersObjective: Each resident of the facility identified as exhibiting problematic behavior will be reported on MARS to identify the causal factor, if possible, of the behavior as well as seek approaches/interventions appropriate for these said behaviors.</p> <p>All behaviors are reviewed and discussed daily during stand up meeting to ensure appropriate interventions are in place.<i>The corrective action taken to monitor to ensure the deficient practice does not recur is that</i> Social services will be responsible to monitor the MARS and meet with the IDT weekly to monitor and discuss any and all behaviors and interventions. QA audit tool will be completed by the Director of Social Services and/or designee weekly for four (4) weeks, then monthly for three (3) months, and then quarterly for three (3) quarters. The outcome of this tool</p>	

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	<p>logged.</p> <p>An undated policy titled "POLICY AND PROCEDURE FOR BEHAVIOR LOG" was provided by the Social Service Director on 4/16/15 at 3:16 P.M., it included, but was not limited to, "Policy : It is the policy of the facility to document all unusual behaviors in the nurse's notes and logged into the Behavior Log for tracking..." The policy lacked any documentation related to Social Service monitoring of behaviors if nursing staff was not utilizing the log.</p> <p>A document dated 7/2000 titled "SOCIAL SERVICE DIRECTOR JOB DESCRIPTION" included, but was not limited to, "DUTIES AND RESPONSIBILITIES: ...Provide medically related social services or referrals to assist residents in maintaining or improving their ability to manage their everyday physical, mental and psychosocial needs."</p> <p>During an interview with the Administrator on 4/17/15 at 11:20 A.M., she indicated no documentation could be provided that indicate social services had been provided to Resident #21 following the recent occurrence of behavioral issues.</p>		will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.		

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F 258 SS=D Bldg. 00	<p>3.1-34(a)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a quiet, homelike environment, in that, laundry barrels were noisy during early morning transport for 2 of 3 residents who met the criteria for review of comfortable sound levels. (Resident #25, Resident #24)</p> <p>Findings include:</p> <p>During an interview on 4/15/15 at 3:24 P.M., Resident #25 was observed sitting in a wheelchair with eyes closed. Resident #25 indicated, at that time, (name of Resident #25) had been awakened multiple times before 5:00 A.M. when staff transported laundry barrels in the hallway.</p> <p>During an interview on 4/15/15 at 3:30 P.M., Resident #24 was observed laying in bed with eyes closed. Resident #24 indicated, at that time, (name of Resident #24) had been awakened multiple times</p>	F 258	<p>It is the intent of this facility to provide for the maintenance of comfortable sound levels. <i>The corrective action taken for those residents found to have been affected by the deficient practice is that Resident #24 and Resident #25 were allegedly affected by noise created by laundry barrels pushed in the halls prior to 5 a.m. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected. During Resident Council, the laundry cart noisy level was discussed with alert and oriented residents with discussion of the revised facility policy. The facility policy was updated to include No barrels to be taken from the soiled utility room between the hours of 9pm and 5am. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility policy was updated to include No barrels to be taken from the soiled utility room between the hours of 9pm and 5am. Staff was in-serviced</i></p>	05/15/2015

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F 323 SS=D Bldg. 00	<p>before 5:00 A.M. when staff transported laundry barrels in the hallway.</p> <p>During an interview on 4/15/16 at 8:15 A.M., Housekeeper #1 indicated the laundry barrels were returned by staff to the laundry near the end of each shift, the wheels were noisy, and she always worried about waking residents. The laundry barrel wheels were observed, at that time, to be in motion and loud.</p> <p>A Policy and Procedure for Noise provided by the HFA (Health Facilities Administrator) on 4/17/15 at 2:00 P.M. indicated, "...It is the policy of the facility to keep noise down to a comfortable level not to interfere with the resident hearing and enhance privacy. Procedure: 1. Laundry barrels will not be taken from the Soiled Utility rooms between the hours of 9 pm [9:00 P.M.] and 5 am [5:00 A.M.]..."</p> <p>3.1-32(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>		<p>on this updated policy. New bases for the barrels were purchased and installed called "Quiet" Dolly. During Resident Council, the laundry cart noisy level was discussed with alert and oriented residents with discussion of the revised facility policy along with the new bases that were installed on the laundry carts. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that monitoring of above will be the responsibility of the Charge Nurse 5xweekly x1week, 4xweekly x 1week, 3xweekly x 1week, then 2xweekly x 1week. Results of the monitoring will be taken to QA to determine if further monitoring is necessary.</i></p>	

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	<p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided, and/or effective interventions were implemented, in that, dependent residents, identified as high risk to experience a fall, were not provided adequate supervision for 2 of 3 residents and effective interventions were not implemented for 1 of 3 residents who met the criteria for review of accidents. (Resident #27, Resident #40, Resident #55)</p> <p>Findings include:</p> <p>1. On 4/14/15 at 12:00 P.M., Resident #55 was observed sitting in a reclined Broda (a reclining positioning chair) chair with Activity Staff #1 propelling her in her chair in the hall.</p> <p>Resident #55's clinical record was reviewed on 4/14/15 at 4:35 P.M. Her diagnoses included, but were not limited to, dementia, vascular disease, depression, and pelvic fracture. Her current Minimum Data Set assessment (admission assessment) dated 1/5/15 indicated a short and long term memory impairment and a severe impairment in decision making. Extensive assistance of 2 staff needed for bed mobility, transfers,</p>	F 323	<p>It is the policy of this facility to 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.1).<i>The corrective action taken for those residents found to have been affected by the deficient practice is that a review of Resident #55 has been completed on care plan for appropriateness and completeness. Resident #55 is receiving Hospice services and facility collaborates with Hospice with residents care. Resident #55 is alert but confused. Current interventions include low bed, landing mat next to bed, tabs alarm and sensor alarm to bed and are secured to bed frame, padding on footboard of the bed, tabs alarm secured to the broda chair. Additional interventions have been put into place, laser alarm while abed, concave mattress, medication review and consult with psychiatrist for possible medication recommendations and 1:1 supervision by staff or family if interventions unsuccessful. Resident #55 was assessed by psychiatrist on 4/30/15, the psychiatrist recommended inpatient therapy for medication adjustment. Resident was transferred to Transitions Behavioral unit on 05/01/15, with family consent.</i></p>	05/15/2015

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	<p>and ambulation. A Fall Risk Evaluation dated 12/30/14 and 1/8/15 indicated a total score of 18 (10 or above represents a high risk for falls). A Fall Risk Evaluation dated 3/2/15 and 3/23/15 indicated a total score of 20.</p> <p>On 4/16/15 at 1:50 P.M., the Director of Nursing (DON) was interviewed regarding Resident #55's falls since admission to the facility on 12/30/14. During the interview the resident's care plan and nursing progress notes were reviewed. The care plan problem of potential for falls had been initiated on 1/5/15. The goal was "WILL HAVE NO FALL RELATED INJURY THROUGH NEXT REVIEW." Interventions included but were not limited to, recording of all falls, alarms as ordered, call light in reach... The DON indicated in interview at that time on admission to the facility Resident #55 had pressure alarms for the chair and bed and a low bed that had been provided by Hospice. She also indicated 2 landing mats were utilized and bilateral 1/2 side rails. The DON indicated Resident #55 could use side rails to turn.</p> <p>The following nursing notes were reviewed:</p> <p>Nursing progress notes dated 1/8/15 at</p>		<p>2).The corrective action taken for those residents found to have been affected by the deficient practice is that a review of Resident #27 has been completed on care plan for appropriateness and completeness. Resident #27 is alert with periods of confusion. Call light to be in easy reach and in open sight. Resident will have call light assessment completed to determine if call light modifications will need to be made to ensure that resident is able to use call light for assist.</p> <p>3).The corrective action taken for those residents found to have been affected by the deficient practice is that a review of Resident #40 has been completed with Occupational Therapy doing evaluation for positioning and safety in wheelchair. Resident now has reclining wheelchair with drop seat and wedge cushion. Occupational therapy monitored for effectiveness. Staff has been instructed to transfer to personal recliner if resident is noted to be leaning forward. Care plan was reviewed for appropriateness and completeness. The corrective action taken for the other residents having the potential to be affected by the same deficient is that continuation of use of alarm sheets to check for placement and function of alarms at the change of every shift. A</p>	

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	<p>9:45 A.M., indicated, "CNA's heard alarm sounding res [resident] lying on floor next to Broda chair. Res has a purple knot to (L) [left] side of head above the temple into the hairline. ROM [Range of Motion] WNL [Within Normal Limits] to all ext. [extremities]. Placed back in Broda chair. Neuro [checkmark symbol] initiated... During interview at that time the DON indicated the 1/8/15 fall had occurred in the hallway. She indicated the intervention had been to add dycem to the resident's chair on top and below the pressure alarm pad.</p> <p>Nursing progress notes dated 3/2/15 dated 7:00 A.M., indicated, "Res. [resident] alarms going off at 5:30 A [A.M.] in room was sitting in middle of floor (Indian Style) got resident up into chair. Resident was in hallway fell out of chair and chair came down on top of her." During interview with the DON on 4/16/15 at 1:50 P.M., she indicated that 2 falls had occurred on 3/2/15. One fall had occurred at 5:30 A.M., when Resident #55 was found on floor in her room. The DON indicated Resident #55 was placed in her Broda chair and taken out of her room into the hall area. The DON indicated the resident then had flipped her Broda chair trying to get out of her Broda chair at 6:00 A.M. She indicated the facility had obtained a</p>		<p>complete audit of all residents fall assessments to determine which residents are at high risk for falls. High fall risk residents will be identified by a red "*" placed on the lower right corner of the resident status sheet to ensure that staff is aware of high fall risk status. Call light assessments will be completed on all residents to determine if call light modifications appropriate. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that</i> continuation of use of alarm sheets to check for placement and function of alarms at the change of every shift. High fall risk residents will be identified by a red "*" placed on the lower right corner of the resident status sheet to ensure that staff is aware of high fall risk status. Staff will be in serviced on fall risks and prevention interventions. Investigation of all falls and taken to IDT meeting weekly. Call light assessments will be completed on all residents to determine if call light modifications appropriate. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that</i> DON or designee will monitor using current alarm sheets to check function and placement of all alarms daily x one week, then 3x/week x one week then weekly x 6 weeks with results taken to QA for further interventions if warranted. Monitoring will occur on both shifts and on both</p>	

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	<p>physician's order for a geri chair. The DON indicated the geri chair was a heavier weight than the Broda chair and indicated maybe the resident would not be able to flip the geri chair over.</p> <p>Nursing progress notes dated 3/19/15 at 11:00 A.M., indicated, "Res [resident] has been 1:1 c [with] staff all am. PRN [when needed] Ativan [antianxiety medication] given s [without] effectiveness. Res was toileted, ambulated, given snacks et activities prior to med [medication]. S.S. [Social Service staff] et Hospice aware of continued restlessness. Will cont [continue] to monitor."</p> <p>Nursing progress note dated 3/19/15 at 2:00 P.M., indicated, "Resident continues to be 1:1 c [with] staff. Very restless even p [after] ambulating, toileting et [and] activities. [Number zero] combativeness c [with] noted..."</p> <p>Nursing progress notes dated 3/21/15 at 5:15 A.M., indicated, "...@ 4 am Resident's bed alarm sounded, went immediately to room, resident had fallen from bed or tried to get out of bed &amp; fell. Landing mat in place..." "...Bruise to (R) [right] forehead, S/T [skin tear] to (R) [right] shin..."</p>		<p>weekdays and weekends. A QA tool has been developed to check placement of call lights, ensuring call lights are in easy reach, will be completed by DON or designee daily x one week, then 3x/week x 2 weeks, then weekly x 6 weeks. Results will be taken to QA to determine if further inventions are warranted.</p>				

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	<p>The DON during interview on 4/16/15 at 1:50 P.M., indicated, Resident # 55 had fallen on 3/21/15 at 4:00 A.M. The DON explained the alarm had sounded. She indicated the resident was found lying on her right side at the end of the bed partially on the landing mat. "... [Family member's name here] came to facility &amp; sat c [with] [resident's name]..." The DON indicated Resident # 55 had been restless and agitated the next several days. The DON was made aware the documentation lacked evidence Resident #55 had received adequate supervision to prevent falls.</p> <p>On 4/16/15 at 2:30 P.M., during interview with the DON, the DON indicated Resident #55 had a pelvis fracture before she had been admitted to the facility on 12/30/15.</p> <p>On 4/16/15 at 3:05 P.M., the DON provided documentation of an x-ray report of the right shoulder dated 3/24/15, which indicated "...no fracture or bone lesion..." The DON also provided documentation of a pelvis x-ray report dated 3/24/15 which indicated, "... Irregularity of the right hemipelvis at the superior ramus and pubic symphysis consistent with fracture. There are no prior studies to assist in determining if this represents acute versus chronic</p>			

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	<p>finding..." A right hip x-ray report dated 11/17/14, was also provided by the DON at that time and indicated "... Right superior pubic ramus fracture..."</p> <p>2. On 4/16/15 at 9:34 A.M., Resident #27 was observed at that time to not activate the call. The call light was observed to be attached to a tissue box on the bedside table. A quilt was observed on top of the connecting string.</p> <p>The clinical record of Resident #27 was reviewed on 4/16/15 at 10:30 A.M. The record indicated Resident #27 was admitted on 11/6/14. The diagnoses of Resident #27 included, but were not limited to, dementia, syncope (passing out), recurrent falls.</p> <p>A Fall Risk Evaluation dated 11/9/14, indicated Resident #27 was a high risk to experience a fall.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/5/15 indicated Resident #27 experienced moderate cognitive impairment, balance impairment, and/or required the assistance of one staff for transfers and walking.</p> <p>A Care Plan for Falls dated 11/12/14 included, but was not limited to, an intervention of "...KEEP CALL LIGHT</p>			

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	<p>IN PLACE AT ALL TIMES...Remind resident to use call light for assistance..."</p> <p>Fall #1.</p> <p>A Nurse's note, dated 4/5/15 at 7:30 P.M., read as follows: "...Rec'd [received] a call to facility from residents dtr [daughter] stating she was on the phone with resident when res [resident] stated she slid out of chair onto floor. This nurse immediately went to res room - Res sitting on floor up against recliner. Res was on phone with dtr when entering room. 0 [No] injury noted. Res had tab alarm disconnected from clothing - socks and shoes off. Res states she was getting up to sit in wheelchair. Educated res to use call light for assistance. Call light within reach hooked to right arm of recliner..."</p> <p>Fall #2.</p> <p>A Nurse's note, dated 2/15/15 at 9:00 P.M., read as follows: "...Alarm sounding. CNA answered immediately. Res standing up beside bed, barefoot. Feet slipping, CNA eased to floor on buttocks...Res stated 'I was going to shut my door.' Call light was with in reach...Res reminded to use call light for assist et [and] not to get up per self..."</p>			

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	<p>Fall #3.</p> <p>A Nurse's note, dated 1/29/15 at 8:30 A.M., read as follows: "...This nurse called to res's [resident's] room. Upon entering noted Res sitting on floor in front of w/c [wheelchair]. Res states she was moving from the w/c to recliner when she slid out of w/c..."</p> <p>During an interview on 4/16/15 at 11:54 A.M., LPN #10 indicated it was the policy of the facility to place call lights within reach of the residents. After making LPN #10 aware that Resident #27's call light pull string was obstructed by the blanket located on the arm of the chair, she indicated the blanket needed to be removed and the string shortened.</p> <p>During an interview on 4/16/15 at 2:11 P.M., PT#1 indicated Resident #27 could use the call light pull string, but sometimes forgot to call for help. Resident #27 had a decrease in safety awareness.</p> <p>3. On 4/16/15 at 10:17 A.M., Resident #40 was observed sitting at the Nurses' Station in a wheelchair with eyes closed and the back of the chair slightly reclined.</p> <p>The clinical record of Resident #40 was</p>			

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	<p>reviewed on 4/16/15 at 2:30 P.M. The record indicated Resident #40 was admitted on 8/21/13. The diagnoses of Resident #40 included, but were not limited to, severe dementia, recurrent falls.</p> <p>A Fall Risk Evaluation dated 10/23/14, indicated Resident #40 was a high risk to experience a fall.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/5/15 indicated Resident #27 experienced moderate cognitive impairment, balance impairment, and/or required the assistance of one staff for transfers and walking.</p> <p>A undated Care Plan for falls lacked any intervention related to ensuring the safety of Resident #40 when asleep in the wheelchair.</p> <p>A Nurse's note, dated 12/12/14 at 3:30 P.M., read as follows: "...Resident appears tired, at times bends over in W/C [wheelchair] as though she's sleeping..."</p> <p>Fall 1. A Nurses note, dated 3/4/15 at 6:20 A.M., read as follows: "...Alarm sounding, this nurse immediately responded...Noted resident lying across bed on stomach with knees touching</p>			

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F 371 SS=F Bldg. 00	<p>floor..."</p> <p>Fall 2. A Nurses note, dated 3/9/15 at 7:30 P.M., read as follows: "...Res [resident] sitting in hallway by lounge area, in w/c [wheelchair] leaning forward CNA walking toward res to take her to bed when res fell forward out of w/c hitting Lt [left] forehead on floor causing a bump et [and] redness measures approx [approximately] 3.2 cm [centimeters] X [by] 2.4 cm ..."</p> <p>During an interview on 4/16/15 at 2:11 P.M., OT (Occupational Therapy) #2 indicated Resident #40 would lean forward in her wheelchair and fall asleep. So when Resident #40 experienced the fall on 3/9/15, she was referred to Occupational Therapy for an evaluation and OT ordered her a new wheelchair that reclined.</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>						

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	<p>Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under sanitary conditions, in that, a cook was chewing gum and blowing bubbles while serving food on the serving line. This had the potential to affect 35 of 35 residents in the facility.</p> <p>Findings include:</p> <p>During an observation of the serving line through the dining room window on 4/14/15 at 12:05 P.M., Cook #1 was observed to be serving food from the steam table while chewing gum and blowing bubbles.</p> <p>During an observation of the serving line through the dining room window on 4/14/15 at 12:15 P.M., Cook #1 was observed to be serving food from the steam table while chewing gum and blowing bubbles.</p> <p>During an observation of the serving line through the dining room window on 4/14/15 at 12:17 P.M., Cook #1 was observed to be serving food from the steam table while chewing gum and blowing bubbles.</p> <p>The Policy and Procedure for</p>	F 371	<p>It is the intent of the facility to ensure that food is stored, prepared, and distributed (served) under sanitary conditions. <i>The corrective action taken for those residents found to have been affected by the deficient practice is that all residents allegedly had the potential to be affected by cook #1 chewing and blowing gum in the food serving area.1). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents allegedly had the potential to be affected by cook #1 chewing and blowing gum in the food serving area.1). The measures that have been put into place to ensure that the deficient practice does not recur is that Cook #1 was counseled and in-serviced on the policy and procedure for sanitation. All dietary personnel were in-serviced on the policy and procedure pertaining to no chewing gum in dietary area. New employee orientation for dietary department will be instructed that chewing gum in the dietary area is not allowed. The corrective action taken to monitor to ensure the deficient practice does not recur is that the dietary manager or designee will monitor for compliance 5xweekx1week, 4xweek x1week, 3xweekx1week, 2xweekx1week and then taken to Q.A. to determine whether further monitoring is necessary.</i></p>	05/15/2015

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F 441 SS=D Bldg. 00	<p>Environmental Sanitation/Infection Control was provided on 4/14/15 at 2:50 P.M., and it read as follows: "Smoking, eating, chewing gum...in food preparation or service area is not allowed."</p> <p>During an interview on 4/14/15 at 2:00 P.M., the Dietary Manager indicated chewing gum was not allowed in the food prep area or the serving area.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <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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NAME OF PROVIDER OR SUPPLIER  LOOGOOTEE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553		
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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 an alert notification was displayed and/or an effective disinfectant had been utilized to clean an isolation room which had a resident who resided with the diagnosis of C.diff (clostridium difficile) for 1 of 1 residents who met the criteria for review of contact isolation. (Resident #30)</p> <p>Findings include:</p> <p>1. On 4/14/15 at 2:57 P.M., Resident #30 was observed sitting in her room in her wheelchair with no distress noted. An alert sign informing staff and visitors to report to the nurses station for further instructions, was observed not to be displayed.</p>	F 441	<p>It is the intent of this facility is to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1).<i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident who was found affected by the alleged deficient practice is Resident #30 who remains in the facility and remains in contact isolation.</i><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who develop C-Diff in the future have the potential to be affected. The</i></p>	05/15/2015	

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	<p>On 4/14/15 at 1:55 P.M., Resident #30's clinical record was reviewed. A physician's order dated 4/10/15 indicated, "Stool for C-diff. Dx: loose stools. A physician's orders dated 4/13/15 indicated, "Flagyl [antibiotic] 500 mg po [by mouth] TID [three times a day] x 10 days C-Diff. Isolation precautions until C-Diff resolved." A lab report dated 4/10/15 indicated, "...C. DIFF. TOXIN A/B\ TOXIN DETECTED A..."</p> <p>On 4/14/15 at 11:00 A.M. during interview with the Health Facility Administrator (HFA), the HFA indicated Certified Nursing Assistants (CNAs) did not utilize CNA assignment sheets. The HFA indicated the CNAs utilized the Resident Census Status sheets that were kept in a binder at the nurse's stations.</p> <p>On 4/14/15 at 11:42 A.M., during interview with the LPN #1 indicated Resident #30 was in contact isolation. LPN #1 indicated the facility routinely posted a sign on the resident's door to alert in regard to isolation treatment.</p> <p>LPN #1 during interview on 4/14/15 at 3:05 P.M., indicated she had talked to administrative staff and indicated a sign posted to alert staff and visitors to report to the nurses station in regard to contact</p>		<p><i>measures that have been put into place to ensure that the deficient practice does not recur is that Policy on C-Diff has been reviewed and updated. All staff is in-serviced on Clostridium Difficile, Contact Isolation, and Appropriate Cleaning of Isolation environment for residents with C-Diff. Yellow "alert" signage has been developed and posted on any C-Diff isolation rooms, which will be HIPPA appropriate instructing staff or visitors to "See Nurse Before Entering Room".The corrective action taken to monitor to ensure the deficient practice does not recur is that monitoring of above will be the responsibility of the DON or designee 3x/wk x1wk then 1xweekly for the duration of the isolation. Monitoring will occur on day and night shifts and on weekends and will resume with any new isolation issues x next 3 months. Results of the monitoring will be taken to QA to determine if further interventions warranted.</i></p>	

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	<p>isolation for Resident #30 had not been posted due to "HIPPA [Health Insurance Portability and Accountability Act] reasons"</p> <p>On 4/14/15, 4/15/15, and 4/16/15, Resident #30's room lacked the posting of an alert sign to notify staff or visitors of reporting to nurse's station before entering in regard to contact isolation.</p> <p>The DON (Director of Nursing) was interviewed on 4/16/15 at 2:50 P.M., regarding lack of an alert sign posted in regard to Resident #30 who resided in contact isolation. The DON indicated no alert sign had been posted d/t (due /to)she felt that was a violation of HIPPA. The DON was made aware an alert sign posted to report to nurses station would provide necessary information to new facility staff, staff of other agencies , visitors, etc without providing personal information. She indicated CNAs of the facility would have isolation information documented on their Resident Status Sheet kept at the nursing stations. On 4/16/15 at 2:55 P.M., the DON reviewed Resident #30's current Resident Status Sheet and indicated it lacked documentation regarding current contact isolation status.</p> <p>2. On 4/16/15 at 10:45 A.M.,</p>			

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	<p>Housekeeping Staff #3 was observed cleaning hall floors on Resident #30's unit. She was interviewed at that time in regard to the cleaning of a resident room which had housed a resident with C.diff. Housekeeping Staff #3 indicated she cleaned all rooms including isolation rooms with the detergent PH7Q. She indicated she used PH7Q to clean all floors, night stands, door knobs, heating units, etc. She indicated she didn't use a different detergent to clean a resident isolation room from a non resident isolation room.</p> <p>The Housekeeping Supervisor was interviewed on 4/16/15 at 3:56 P.M., in regard to cleaning of an isolation room which housed a resident with C.diff. She indicated the cleaner used for all floors including C. diff rooms were PH7 and for hard surfaces such as bed side tables were PH7Q. She was unaware at that time if detergent PH7 or PH7Q would be effective against the pathogen C.diff.</p> <p>On 4/17/15 at 8:16 A.M., during interview with the Housekeeping Supervisor, she indicated the facility sanitizer PH7 was not effective in killing the pathogen C.diff. The Housekeeping Supervisor indicated the facility was going to use a solution of one-part bleach to nine-parts water to clean in regard to</p>			

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	<p>the pathogen C. diff.</p> <p>On 4/17/15 at 8:48 A.M., the Housekeeping Supervisor provided documentation entitled, "The Bleach to Water Ratio for Cleaning C-Diff." She indicated at that time housekeeping staff would be inserviced on the bleach and water solution for cleaning C. diff.</p> <p>A facility policy (undated) entitled, "MANAGEMENT OF THE RESIDENT WITH MRSA [Methicillin Resistant Staph Aureus] OR OTHER RESISTANT ORGANISM" was provided on 4/16/15 at 3:00 P.M. The policy included but was not limited to, "...J. Clean horizontal environmental surfaces with an approved disinfectant daily..."</p> <p>3.1-18(b)(2) 3.1-18(1)</p>			