

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155607	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER BETHEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 6015 KRATZVILLE RD EVANSVILLE, IN 47710
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 4, 5, 6, 7, 8, 11, 2013</p> <p>Facility number: 000436 Provider number: 155607 AIM number: 100275120</p> <p>Survey team: Amy Winingar, RN, TC Barb Fowler, RN Diane Hancock, RN</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 5 Medicaid: 37 Other: 16 Total: 58</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on March</p>	F000000	<p>By submitting the enclosed 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 any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective April 8, 2013 to the annual licensure survey conducted on March 4, 2013 through March 8, 2013 and March 11, 2013. We are requesting paper compliance/desk review.</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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	13, 2013, by Jodi Meyer, RN			

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F000164 SS=D	<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 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 interview, the facility failed to ensure personal privacy for 4 of 15 residents on the Ivy Unit, in that the privacy curtains were too short and did not provide visual privacy at the height of the bed. (Residents #28, #29, #68, #82)</p>	F000164	<p>F164</p> <p>It is the practice of Bethel Manor to assure that the personal privacy of every resident is protected.</p>	04/08/2013	

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	<p>Finding includes:</p> <p>During the medication pass on the Ivy Unit on 3/7/13 at 4:27 p.m., Resident #68 was laying in bed. The privacy curtain was observed to be short, so that the resident was observed under the curtain from the room-mate's side of the room.</p> <p>On 3/8/13 at 10:32 a.m., the Ivy Unit was toured. The following resident's rooms were observed to have curtains too short, so that any care given at the bed level could be observed from both sides of the room: Residents #68 and #82, who shared a room, and Residents #28 and #29, who shared a room.</p> <p>Upon interview of the Administrator, on 3/8/13 at 3:00 p.m., he indicated the ceilings were higher on the Ivy Unit and they must have put up the curtains from the other units.</p> <p>3.1-3(p)(4)</p>		<p><i>The corrective action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Privacy curtains for residents #68, #82, #28, and #29 were removed and replaced with the correct curtains of proper length to ensure complete privacy.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All resident rooms and privacy curtains have been inspected to ensure appropriate length/size to ensure complete privacy while in use.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All housekeeping and laundry staff have been in-serviced related to ensuring when washing and replacing curtains that the proper</p>		

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			<p>curtains are hung on the correct units and that the curtains that are hung must be long enough to ensure complete privacy of the resident while in use. Privacy curtains on the unit needing longer curtains have been tagged in order to be more easily identified.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></p> <p>A Quality Assurance Tool has been developed to ensure resident privacy is being protected and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Dining and Environmental Services or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed. We are requesting paper compliance/desk review.</p>		

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure no signs containing personal information were posted in resident's rooms, in that personal information was posted on signs and visible from the hallway for 2 of 7 residents who met the criteria for dignity. (Resident #63, #71)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #63 was reviewed on 03/06/12 at 11:48 a.m. The record indicated the diagnoses of Resident #63 included, but were not limited to, kyphoscoliosis. The record further indicated Resident #63 had no cognitive impairment.</p> <p>On 03/04/13 at 9:53 a.m., the following was observed in Resident #63's room:</p> <p>A sign was observed on the closet</p>	F000241	<p>F241</p> <p>It is the practice of Bethel Manor to assure that every resident receives services in a manner that enhances dignity.</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice include:</i></p> <p>The sign in Resident #63's room was immediately removed. The Interdisciplinary Team met to discuss necessity of sign and it was determined unnecessary due to information already a part of the Plan of Care and on the "Visual/Bedside Kardex Report" (CNA Assignment Sheet).</p> <p>Both signs in Resident #63's room were immediately removed. The</p>	04/08/2013			

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	<p>door. The sign indicated, "Be sure to lay [name of Resident #63] down after lunch every day."</p> <p>2. The clinical record of Resident #71 was reviewed on 03/07/13 at 10:01 a.m. The record indicated the diagnoses of Resident #71 included, but were not limited to, acute Ill-defined cerebrovascular disease-affect dominant side [stroke], pathologic fracture of humerus, and osteoporosis. The record further indicated Resident #71 experienced mild cognitive impairment.</p> <p>On 03/04/13 at 10:14 a.m. the following was observed in Resident #71's room:</p> <p>A sign was observed on the closet door. The sign indicated, "Please do not put any clothes in the facility barrel. All clothes are to be placed in residents clothes basket in her room. Family does her laundry. Thanks."</p> <p>A sign with three photos of the Resident #71's torso was observed on the wall above the bed. The sign indicated, "...This splint to be worn when up in w/c [wheelchair], ...black cloth sling to be used with this splint during transfers ...hand splint to be worn when in bed."</p>		<p>Interdisciplinary Team met to discuss necessity of these signs.</p> <p>It was determined that the sign related to laundry would be changed into a picture of a basket of laundry with no writing that could still visually prompt staff that her family does her laundry, but would not reveal that information to others. Staff was in-serviced that this photo would indicate those in which the facility does not perform laundry services.</p> <p>It was determined that the information on the sign showing splint placement was needed, but would be placed in the "ADL/Communication Book" for CNAs so that dignity of resident would be protected. The Plan of Care and the "Visual/Bedside Kardex Report" (CNA Assignment Sheet) was updated to reflect that this information could be found in the CNA "ADL/Communication Book".</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p>				

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	<p>During an interview on 03/08/13 at 9:43 a.m., the DoN [Director of Nursing] indicated, signs with personal information were not to be posted unless the family is insistent. She further indicated, at that time, it was the policy of the facility to keep personal information confidential.</p> <p>During an interview on 03/11/12 at 8:52 a.m. the HFA [Health Facilities Administrator] indicated signs containing personal information should be covered or removed to protect personal information.</p> <p>The policy and procedure for Quality of Life-Dignity provided by the DoN on 03/08/13 at 1:00 p.m. indicated, "Policy Interpretation and Implementation...9. Staff shall maintain an environment in which confidential clinical information is protected....b. Signs indicating the resident's ...care needs shall not be openly posted in the resident's room...".</p> <p>3.1-3(t)</p>		<p>All resident rooms were inspected to ensure that no other signs containing personal information were present. Any signs found were removed and reviewed by the Interdisciplinary Team for appropriateness and any needed changes were made to the Plan of Care and "Visual/Bedside Kardex Report" (CNA Assignment Sheet).</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All staff has been in-serviced that signs containing personal information are not allowed and facility policy reviewed. Facility policy related to dignity and sign placement has been reviewed and revised.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></p> <p>A Quality Assurance Tool has been developed to ensure resident dignity is protected and that the above</p>		

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			corrective actions and changes are being followed. This tool will be completed by the Privacy Officer or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed. We are requesting paper compliance/desk review.		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview, the facility failed to provide a shower with ADL [activities of daily living] care in that 3 of 19 resident's reviewed for bathing preferences did not receive a shower as per their preference. (Resident #14, Resident #25, Resident #60)</p> <p>Findings include:</p> <p>1. Resident #14 was interviewed on 3/4/13 at 8:22 p.m. Resident #14 indicated she had not received a shower since being admitted to the facility in December, 2012. She indicated she preferred a shower but always received a bed bath.</p> <p>Resident #14's record was reviewed on 3/6/13 at 1:50 p.m. Resident #14's BIMS [Basic Interview for Mental Status] was a 13/15 indicating slight cognitive impairment. Resident #14's care plan indicated the resident was to receive 2 showers a week and</p>	F000242	<p>F242</p> <p>It is the practice of Bethel Manor to assure that every resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice include:</i></p> <p>MDS Coordinator met with Resident #14 on 3/8/13 to review bathing preferences. Resident indicated that she prefers to take a bed bath as it wears her out to get up and in the shower. Hospice aide is scheduled to come 3x/week to provide bed bath. Facility staff will provide desired bath all other days. Plan of Care and "Visual/Bedside Kardex Report" (CNA Assignment Sheet) were</p>	04/08/2013			

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	<p>a partial bath on all other days.</p> <p>The "Visual/Bedside Kardex Report", obtained on 3/6/13 at 2:51 p.m. from the MDS [Minimum Data Set Assessment] Coordinator, for the CNAs [certified nursing assistant] indicated the resident was to have a shower 2 times a week and a partial bath on all other days.</p> <p>Resident #14's bathing documentation, obtained from the MDS Coordinator on 3/7/13 at 9:10 a.m., indicated the resident had not received a shower from 1/7/13 through 3/7/13.</p> <p>Resident #14's bath given by the hospice CNA was observed on 3/5/13 and 3/7/13. Resident #14 received a full bed bath. The hospice care plan was reviewed on 3/7/13 at 3:00 p.m. The hospice care plan indicated the resident was to receive a complete bed bath with each visit.</p> <p>2. Resident #25's was interviewed on 3/4/13 at 2:38 p.m. Resident #25 indicated she was to receive a shower 2 times a week. Resident #25 indicated she would like to have a shower more but does not always receive showers 2 times a week now. The resident indicated the staff</p>		<p>updated, "Bed bath per hospice aide 3x/week; bath as resident prefers all other days".</p> <p>Director of Nursing met with Resident #25 on 3/8/13 to review bathing preferences. Resident indicated that she would like showers more frequently. Plan of Care and "Visual/Bedside Kardex Report" (CNA Assignment Sheet) were updated, "Ask resident daily if she wants a shower. If no, ask her bathing preference and provide it. Resident requires assistance for completion of partial and full bathing."</p> <p>Activity Director met with Resident #60 on 3/8/13 to review bathing preferences. Resident indicated that current bathing routine meets her preferences. Review of Resident #60's Plan of Care and "Visual/Bedside Kardex Report" (CNA Assignment Sheet) was performed with no changes made. Education of staff and monitoring of this resident's bathing will be performed to ensure her preferences are met.</p> <p><i>Other residents that have the potential to be affected have been</i></p>		

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	<p>awakens her at 4:30 a.m. in the morning but will often tell her they are too busy to assist her with a shower. She indicated she normally does a partial bath herself and the staff will only wash her legs. She indicated the staff does not always assist her with pericare and she is unable to do it as she has a catheter.</p> <p>Resident #25's record was reviewed on 3/6/13 at 9:15 a.m. The resident's BIMS was a 15/15 indicating the resident did not have any cognitive impairment. The resident's care plan indicated the resident was to receive 2 shower a week and a partial bath on the other days.</p> <p>The "Visual/Bedside Kardex" was obtained from the MDS Coordinator on 3/6/13 at 2:51 p.m. The Kardex indicated the resident was to have 2 showers a week and a partial bath all other days.</p> <p>The bathing documentation, obtained on 3/7/13 at 9:10 a.m. from the MDS Coordinator, indicated, between 1/7/13 and 3/7/13, the resident received a shower on 1/10/13, 1/14/13, 1/17/13, 1/21/13, 1/31/13,2/4/13, 2/7/13, 2/11/13,2/22/13,2/25/13,3/3/13, and 3/4/13. The other days days the</p>		<p>identified by:</p> <p>All residents have been reviewed to assure that each resident's bathing choices and preferences are being followed.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Bathing choices and preferences will be reviewed at each quarterly care conference. Bathing choices and preferences will also be discussed at the monthly Resident Council Meetings. A form has been created to obtain bathing preference information for new residents that will be used in creation of their Plan of Care.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Quality Assurance Tool has been developed to ensure resident choices and preferences</p>				

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	<p>resident received a partial or full bed bath.</p> <p>3. Resident #60 was interviewed on 3/4/13 at 9:37 a.m. Resident #60 indicated she prefers a shower but usually takes a partial bath. Resident #60 indicated the staff is usually to busy to help her take a shower.</p> <p>Resident #60's record was reviewed on 3/5/13 at 3:46 p.m. The resident's BIMS [basic interview for mental status] was a 15/15 indicating the resident to have no cognitive impairment. Resident #60's care plan indicated the resident was to receive a shower 2 times a week and a partial bath the other days.</p> <p>The "Visual/Beside Kardex Report" for the CNAs was obtained from the MDS Coordinator on 3/6/13 at 2:51 p.m. It indicated the resident was to have a shower 2 times a week.</p> <p>Resident #60's bathing documentation report, obtained on 3/7/13 at 9:10 a.m. from the MDS Coordinator, indicated, between 1/7/13 and 3/7/13, the resident received a shower on 1/14/13, 1/21/13, 2/18/13, 3/4/13, and 3/6/13. The documentation indicated the resident received either a partial bed</p>		<p>are respected and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed. We are requesting paper compliance/desk review.</p>		

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	<p>bath or a full bed bath on the other days she received care.</p> <p>Interview with CNA # 1 on 3/6/13 at 8:33 a.m. indicated the residents receive 2 showers a week. CNA #1 indicated if the resident requests an extra shower, the staff will give it.</p> <p>Interview with CNA #2 on 3/7/13 at 8:55 a.m., indicated the resident are assigned 2 shower a week but they could have more if they like.</p> <p>Interview with the DoN [Director of Nursing] and the ADoN [Assistant Director of Nursing] on 3/7/13 at 5:10 p.m. indicated the residents can have as many showers a week as they like, but most of the resident are care planned for 2 showers a week. They indicated they did not know why the residents had not received a shower but they would do a follow-up of all the resident's shower schedules.</p> <p>Interview with the ADM [Administrator] on 3/11/13 at 8:50 a.m., indicate all resident's were interviewed on 3/8/13 for their shower preferences and the resident's care plans were updated to reflect their preferences. He indicated the resident's bathing preferences are to be reviewed quarterly and the bathing</p>			

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	<p>preferences will be discussed at the monthly Resident Council meetings.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were completed to accurately reflect the dental status of 2 of 3 residents</p>	F000272	F272 It is the practice of Bethel Manor to assure that comprehensive assessments are accurate. <i>The corrective action taken for those residents found to be affected</i>	04/08/2013

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	<p>sampled for dental issues, in the sample of 3 who met the criteria. (Resident #22, #60)</p> <p>Findings include:</p> <p>1. During interview with Resident #22 on 3/5/13 at 10:14 a.m., she indicated she had problems with her upper and lower teeth. She indicated they were sore, especially the upper teeth. She indicated she had an appointment with a dental surgeon.</p> <p>The resident was observed on 3/5/13 at 10:19 a.m. to have decayed and missing teeth.</p> <p>Resident #22's clinical record was reviewed on 3/6/13 at 10:07 a.m. The annual Minimum Data Set [MDS] assessment, dated 6/12/12, indicated the resident had a Brief Interview of Mental Status score of 14 out of 15, indicating minimal cognitive impairment. The oral/dental status assessment indicated the resident had no problems with her teeth. The quarterly MDS assessment, dated 12/11/12, indicated the resident had no problems with her teeth.</p> <p>A dental visit dated 10/17/2011 indicated, "clinical exam reveals several areas of decay and fractures.</p>		<p>by the deficient practice include: Both Resident #22's and Resident #60's MDSs were updated and resubmitted to CMS to reflect their dental status at the time the assessment was performed. Other residents that have the potential to be affected have been identified by: All current residents' most recent MDSs have been reviewed for accuracy. Any areas identified have been corrected and resubmitted to CMS. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: MDS Coordinator was in-serviced regarding accurate completion of MDS. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure accurate completion of MDS and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are</p>				

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	<p>Pt does not want to pursue treatment..."</p> <p>The resident had a dental consult note, dated 7/23/12. The dentist indicated, "clinical exam reveals heavy pl [plaque] and subg calc [?]. Mod [moderate] bone loss evident. Recorded PDs. Heavy BOP [?].several areas of decay evident...several fractured teeth evident. Pt asked about having partials made. Explained that broken teeth need to be extracted prior to partial fabrication to prevent infection. Her doctor states that she will not tolerate anesthesia, therefore teeth cannot be extracted..."</p> <p>A nurses' note, dated 12/26/12 14:53 [2:53 p.m.], indicated, "Resident c/o [complaint of] tooth pain...gums red, teeth decayed to gum line...notified MD..." The resident received treatment for an oral infection and pain, and was followed up by a dentist.</p> <p>A physician's order, dated 1/10/13 0950 [9:50 a.m.], indicated, "OK to proceed with Dr. [name] removal of teeth under local anesthetic."</p> <p>Upon interview of the Administrator on 3/11/13 at 9:00 a.m., he indicated</p>		needed. We are requesting paper compliance/desk review.				

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	<p>the MDS coordinator thought the resident's teeth problems started after the assessments and were not enough to warrant a significant change. He was unaware of the dental assessments prior to the assessment date.</p> <p>2. Resident #60 was interviewed on 3/4/13 at 9:55 a.m. Resident #60 indicated her bottom dentures were loose. She indicated she was supposed to be getting new dentures as she had not had a new set for twenty years.</p> <p>Observation of Resident #60 on 3/4/13 at 9:55 a.m., indicated the resident's bottom teeth were loose fitting.</p> <p>Resident #60's record was reviewed on 3/5/13 at 3:46 p.m. The admission MDS [Minimum Data Set], dated 10/15/12, indicated the resident did not have any dental issues. The quarterly MDS, dated 1/2/13, indicated the resident did not have any loose fitting dentures.</p> <p>Interview with the ADM [Administrator] on 3/11/13 at 8:50 a.m., indicated changes had been made to resident's MDS regarding</p>				

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	<p>dental issues to reflect the resident's issues.</p> <p>3.1-31(c)(9)</p>			