

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2011
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NAME OF PROVIDER OR SUPPLIER WOODBRIAGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPOORT, IN46947
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 28, 29, 30; December 1, 2, 2011</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Survey team: Tim Long, RN, TC Julie Wagoner, RN Christine Fodrea, DeAnn Mankell, RN (11/29/11)</p> <p>Census bed type: SNF: 37 SNF/NF: 18 Residential: 20 Total: 75</p> <p>Census Payor type: Medicare: 20 Medicaid: 17 Other: 38 Total: 75</p> <p>Sample: 14 Supplemental sample: 4</p> <p>These deficiencies reflect state findings</p>	F0000		

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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F0157 SS=D	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/09/11 by Suzanne Williams, RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of an x-ray result requiring further treatment and failed to notify a family of an accident for 2 of 14 residents (#39, #44) reviewed</p>	F0157	<b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The attending physician was</b>	01/01/2012	

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	<p>for notification in a sample of 14.</p> <p>Findings include:</p> <p>1. Resident #39's record was reviewed 12-1-2011 at 11:15 a.m. Resident #39's diagnoses included, but were not limited to, osteoporosis, diabetes, and high blood pressure.</p> <p>An x-ray of Resident #39's neck and spine dated 1-17-2011, indicated fractures in the vertebrae T-3 and T-6, T-7 and T-8. The radiologist indicated the fractures were of an unknown age, but recommended clinical correlation and suggested a nuclear bone scan might be considered. The x-ray had a time date stamp from a hospital where the x-ray had been completed. The time date stamp was 2-11-2011 at 10:43 a.m. There was no initial on the x-ray to indicate the physician had reviewed the x-ray.</p> <p>A review of Resident #39's nurse's notes for 1-18 through 1-31-2011 did not indicate the physician had been notified of the results or of the recommendations for the scan.</p> <p>A fax dated 1-17-2011, with a time date stamp of 1-18-2011 at 4:55 p.m., indicated a fax had been sent to the physician informing him Resident #39</p>		<p><b>notified of the recommendations noted on the x-ray of 1/17/2011 for resident # 39. The recommended MRI was ordered for resident #39 and completed in February 2011. Resident #44's family is aware of the injury to the resident on 11/22/11. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Licensed nurses have been inserviced regarding the policy and procedure for MD/family notification by the DHS or designee. All current resident's clinical records have been reviewed to ensure any changes in condition have notifications to the MD/family. No other residents were identified. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Licensed nurses have been inserviced on the following process: Policy and procedure for physician and family notification related to resident condition changes. The nurse in charge of the resident will be responsible to document in the residents clinical record when noting the change in condition. The nurse in charge will document the notification to MD and family in the clinical record as well as on the 24 hour report sheet. Education will be</p>		

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	<p>had been sent to the emergency room, and orders received for Ben Gay and a suggestion to use Celebrex (an anti-inflammatory pain reliever). There was no note of the x-ray suggestions. The fax indicated there were what appeared to be a "2," then changed to a "3," pages sent and to see attached labs. There was no documentation what the labs were.</p> <p>A copy of Resident #39's x-ray taken 1-17-2011 at a hospital, with a time date stamp of 12-3-2011 at 1:48 a.m., provided by the Administrator on 12-2-2011 at 1:10 p.m., indicated initials in the bottom right hand corner and a hand stamp date of 1-18-2011.</p> <p>A physician's progress note dated 1-29-2011 indicated Resident #39 had chronic back pain, but did not address the x-ray findings or the suggestions made by the radiologist.</p> <p>In an interview on 12-1-2011 at 3:30 p.m., the Director of Health Services indicated she thought the physician had been notified.</p> <p>A current policy, dated 12-6-2007, titled Physician Notification Guidelines, indicated diagnostic test results, i.e. lab, or x-ray, require a response from the physician noting they have reviewed the</p>		<p>provided to the the new nurses during orientation. The Director of Health Services /designee will review the 24 Hour report sheets and change of condition sheets in the mning clinical meeting Monday through Friday. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS and nursing administration will review the clinical record of all residents with a change of condition status, Monday through Friday times three months to ensure notification to both family and MD are completed. Three clinicl records will be audited weekly times three more months to ensure 100 percent compliance. Findings of the audits will be reviewed monthly by the QA Committee for additional recommendations if indicated.</b></p>		

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	<p>test results. Test results out of range or abnormal should note whether or not treatment is indicated.</p> <p>2. Resident #44's clinical record was reviewed on 12/1/11 at 3:20 P.M.. The record indicated on 11/22/11 at 4:00 A.M. the resident was being assisted by staff to the bathroom and hit her left foot on her walker. The resident sustained a 5 centimeter (cm) x 6 cm bruise to the top of her left foot.</p> <p>An interview with the resident's daughter on 12/1/11 at 2:25 P.M., indicated the facility did not notify her of the injury, and she noticed the injury when she came to visit her on 11/22/11 at 10:00 A.M.</p> <p>Review of the resident's clinical record indicated no notification of the resident's family of the injury on 11/22/11.</p> <p>3.1-5(a)(3)</p>				

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F0164 SS=D	<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. Based on observation and interview, the facility failed to ensure visual privacy was provided for 1 of 2 residents observed receiving insulin injections (Resident #27) in a sample of 14. In addition, this deficient practice affected 3 of 6 residents in a group meeting (#111, 112, 113), regarding staff not knocking on their doors before entering their rooms.</p> <p>Finding includes:</p>	F0164	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: RN #12, RN #13, LPN # 14 and QMA #15 have been re-educated by the DHS on providing visual privacy when providing care and treatment services. Identification of other residents having the potential to be affected by the same alleged</b></p>	01/01/2012	

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	<p>1. During observation of a medication pass, conducted on 11/28/11 at 4:30 P.M., RN #12 obtained the blood glucose level of Resident #27. The resident was noted to be lying in her bed, in her room, with her son visiting. The nurse did not close the door or pull the privacy curtain. Next, RN #13 obtained an alcohol pad and an insulin pen from the medication cart and administered 6 units of insulin into Resident #27's left lower abdomen, after the resident pulled down the waistband of her pants and flipped up the bottom of her shift, without providing any visual privacy and in the presence of Resident #27's son. While the insulin was in the process of being administered, the Director of Nursing was noted to walk in the hallway and observed the practice.</p> <p>During observation of a medication pass, conducted on 11/30/11 at 11:25 A.M., LPN #14 was noted to prepare to give an insulin injection to Resident #27. Resident #27 was in her room, lying in her bed. LPN #14 did not make any attempt to pull the privacy curtain or shut Resident #27's room door. The door was pulled shut to maintain visual privacy by a non-staff member and without knocking or waiting, QMA #15 opened the door and handed his medication cart keys to LPN #14, who was in the middle of</p>		<p><b>deficient practice and corrective actions taken: A mandatory all staff inservice has been presented on privacy and dignity with emphasis on removing residents from public view when providing care or treatments, including utilizing privacy curtains, closing the door, providing appropriate clothing or draping to prevent unnecessary exposure of body parts during provisions of care. Also addressed was knocking on resident doors and waiting for approval to enter. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b>                      Inservice has been presented to all staff by the DHS/designee on providing privacy and ensuring the privacy of each resident is maintained while receiving care.  <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The ED and DHS/designee will monitor for compliance during observational rounds, rotating shifts and times. One on one education will be addressed as identified. The ED will meet with 2 alert and oriented residents weekly regarding staff knocking on doors prior to entering their rooms. Results of the observational</b></p>		

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	<p>administering the insulin injection. Also present in the room was Resident #27's daughter. Again, Resident #27 pulled down her pants waistband to allow for the insulin injection.</p> <p>2. During the resident/surveyor group interview, conducted on 11/29/11 between 2:30 P.M. - 3:15 P.M., three alert and oriented residents (#111, 112, 113) indicated staff do not always knock and wait for permission before entering their rooms.</p> <p>3.1-3(o)</p>		<p><b>rounds will be presented to QA monthly times 6 months for further recommendations if not at 100 percent compliance.</b> Completion date:1/1/2012</p>		

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported immediately to the Administrator and investigated. This affected 1 of 2 residents (#12) reviewed</p>	F0225	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The administrator met with resident #12 and his wife regarding	01/01/2012	

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	<p>for allegations of abuse in a sample of 14.</p> <p>Findings include:</p> <p>During an interview with alert and oriented Resident #12, conducted on 12/01/11 between 2:30 P.M. - 3:30 P.M., Resident #12 indicated only one staff member had not treated him with dignity and respect. He indicated the male CNA had entered his room one night and asked him if he was ready to go to bed. The resident stated he told the CNA he was not ready to go to bed yet, but the CNA ignored his request and put him in his bed. When asked if he had reported the incident, the resident indicated he had not reported it, but the resident's spouse, who was present in the room, indicated she had reported the incident. She indicated approximately 2 months ago the resident had relayed the events of this night to his wife and she told the MDS coordinator, RN #16. She indicated RN #16 instructed her to write her concerns on a Complaint Grievance form and place it in the "box" located in the hallway. She indicated she had completed the grievance form and had put it in the "box." She indicated the Administrator had spoken with her about her concerns, but she was not aware of any more follow up regarding the concerns.</p>		<p>concern/ allegation of abuse regarding male CNA which had occurred some months back. The allegation related to the male CNA indicated was not substantiated during the investigation. I have met several times with resident #12 and residents wife regarding staff services and treatment. Both resident #12 and wife feel comfortable with services. RN number15 was educated by the ED regarding prompt reporting of mistreatment or suspicion of abuse for immediate investigation. The employees are educated to the facilities policies and proceduresw regarding abuse and neglect and resident rights at the time of hire in New Employee orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt and immediate reporting of all allegations of abuse. Identification of other residents having the potential to be affcted by the same alleged deficient practiceand corrective actions taken:All other residents that are alert and oriented were interviewed by the SS Director or ED regarding care and treatment. No concerns were reported. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur;All employees are educated to the</p>				

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	<p>Interview with the Administrator and the Director of Nursing, on 12/01/11 during the exit interview and on 12/02/11 at 9:30 A.M., indicated they had not received and/or investigated any written complaint/grievance form regarding an incident between Resident #12 and a male CNA. They both denied any knowledge regarding the allegation of abuse.</p> <p>However, interview with RN #16, on 12/02/11 at 11:30 A.M. indicated she recalled the conversation with Resident #12 and his wife, was aware of the name of the alleged abuser, but indicated she had stopped the wife in the middle of telling of the concern and had instructed her to complete a grievance concern form. She indicated she did not inform the Administrator immediately of the concern and did not follow up with the Resident's spouse to ensure the Complaint/grievance form had been completed and turned in to the Administrator. She indicated the CNA indicated no longer worked at the facility but she was unsure if there had been any investigation.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>		<p>facilities policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation. All residents at the time of admission are informed of the facilities zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. An abuse Prevention and Reporting In-service has been presented to all staff. Emphasis was made on prompt reporting of allegations of abuse to ther ED or DHS. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The ED/Social Services Director will interview three alert and oriented residents weekly times two months, then two residents monthly times four months regarding staff treatment and services. The ED will interview three staff members weekly times one month and then three staff member monthly times 5 months regarding abuse prevention and reporting. Results of the interviews will be reviewed by QA for additional recommendations.</p>		

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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to ensure staff followed the facility's abuse policy and procedure regarding reporting and investigating an allegation of abuse for 1 of 2 residents (#12) reviewed for abuse allegations in a sample of 14.</p> <p>Findings include:</p> <p>During an interview with alert and oriented Resident #12, conducted on 12/01/11 between 2:30 P.M. - 3:30 P.M., Resident #12 indicated only one staff member had not treated him with dignity and respect. He indicated the male CNA had entered his room one night and asked him if he was ready to go to bed. The resident stated he told the CNA he was not ready to go to bed yet, but the CNA ignored his request and put him in his bed. When asked if he had reported the incident, the resident indicated he had not reported it, but the resident's spouse, who was present in the room, indicated she had reported the incident. She indicated approximately 2 months ago the resident had relayed the events of this night to his wife and she told the MDS coordinator, RN #16. She indicated RN #16 instructed</p>	F0226	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:RN # 12 was educated by the ED regarding the abuse policies and the need to immediately inform the ED if any suspicion or allegation of abuse is noted or communicated. All employees are educated to the facilities policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee orientation. The facility policy requires screening of employees, training of employees, prevention steps that include prompt and immediate reporting of all allegations of abuse. If an allegation is made the first priority is immediately provision of safety for residents. All residents at the time of admission are informed of the facilities' zero tolerance for abuse standard and how residents may report any concern they experience while residing at the campus. Identification Of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All other alert and oriented residents were interviewed by the Social Services Director or the ED and asked if they had any concerns regarding staff treatment or their</p>	01/01/2012	

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	<p>her to write her concerns on a Complaint Grievance form and place it in the "box" located in the hallway. She indicated she had completed the grievance form and had put it in the "box." She indicated the Administrator had spoken with her about her concerns, but she was not aware of any more follow up regarding the concerns.</p> <p>Interview with the Administrator and the Director of Nursing, on 12/01/11 during the exit interview and on 12/02/11 at 9:30 A.M., indicated they had not received and/or investigated any written complaint/grievance form regarding an incident between Resident #12 and a male CNA. They both denied any knowledge regarding the allegation of abuse.</p> <p>However, interview with RN #16, on 12/02/11 at 11:30 A.M. indicated she recalled the conversation with Resident #12 and his wife, was aware of the name of the alleged abuser, but indicated she had stopped the wife in the middle of telling of the concern and had instructed her to complete a grievance concern form. She indicated she did not inform the Administrator immediately of the concern and did not follow up with the Resident's spouse to ensure the Complaint/grievance form had been completed and turned in to the Administrator. She indicated the</p>		<p>care. No other alert and oriented residents expressed any concerns. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:In-service presented to all staff on abuse Prevention and reporting. Emphasis placed on immediately notifying the ED or Director of Health Services after providing safety for the resident (s). New employees are educated during their orientation process.Each month at Resident Council residents are educated regarding their rights including the right to be free from mistreatment including abuse and neglect and are asked if they have any concerns. The E.D./designee will interview three staff members weekly times four weeksregarding policy of reporting abuse, then three staff members monthly times five months. Results will be reviewed and discussed during the monthly QA committee times six months for additional recommendations .</p>		

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F0274 SS=D	<p>CNA indicated no longer worked at the facility but she was unsure if there had been any investigation.</p> <p>A current policy dated 11-2010, titled Guidelines for Investigation, indicated an accident or incident should be thoroughly investigated including interviews of witnesses, and the person involved in the incident, and reviewing nursing notes, and medications.</p> <p>3.1-28(a)</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>Based on record review and interview, the facility failed to ensure a significant change MDS assessment was completed timely for 1 of 14 residents reviewed for assessments in a sample of 14 (Resident #3).</p> <p>Finding includes:</p>	F0274	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident 3 has had a significant change MDS</b></p>	01/01/2012	

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	<p>During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #3 was alert and oriented, was pushed in her wheelchair by staff, required total staff assistance for transferring, dressing, and hygiene needs, was incontinent of her bowels and bladder and was toileted by staff.</p> <p>Review of the clinical record on 12/1/11 at 10:00 A.M., indicated the annual Minimum Data Set (MDS) assessment, completed on 05/20/11, indicated the resident scored 14 out of 15 on a BIMS test, which indicated the resident was mostly alert and oriented, and required limited assistance staff assistance for wheelchair locomotion, dressing, and hygiene needs. However, the most recent quarterly MDS assessment, completed on 10/26/11, indicated the resident had declined, and her cognitive BIMS score was only 5/15, and she required extensive staff assistance for wheelchair locomotion, dressing, and hygiene needs. A significant change MDS assessment had not been completed at this time.</p> <p>Interview with the MDS Coordinator, RN #16, on 12/02/11 at 9:45 A.M. indicated the declines were accurate, and a significant change MDS assessment</p>		<p><b>completed and submitted.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><b>An audit of all current residents MDS's via the MDS Intelligence software has been completed to identify any significant changes.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>MDS software, MDS Intelligence, reviews the MDS and will identify any significant changes from the current assessment to the previous MDS assessment.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p>	

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F0278 SS=D	<p>should have been completed.</p> <p>3.1-31(d)(1)</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interviews, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate for 2 of 14 residents reviewed for MDS accuracy in a sample of 14</p>	F0278	<p><b>DHS/designee will review residents via the 24 hour report in clinical meeting Mon – Fri for any significant changes as part of the ongoing QA process.</b></p> <p><b>Corrective actions accomplished for those resident found to have been affected by the alleged deficient practice:</b></p> <p>The MDS for resident #3 and 25</p>	01/01/2012	

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	<p>(Residents #3, 25).</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #3 was alert and oriented, was pushed in her wheelchair by staff, required total staff assistance for transferring, dressing, and hygiene needs, fed herself, was incontinent of her bowels and bladder and was toileted by staff.</p> <p>Review of the clinical record on 12/1/11 at 10:00 A.M. indicated the annual Minimum Data Set (MDS) assessment, completed on 05/20/11, indicated the resident was always incontinent of her bowels and required supervision and set up assistance only for eating needs. However, the most recent quarterly MDS assessment, completed on 10/26/11, indicated the resident had improved and was now continent of her bowels but had declined in eating needs and required staff assistance to eat.</p> <p>Interview with the MDS Coordinator, RN #16, on 12/02/11 at 9:45 A.M. indicated the 05/20/11 bowel incontinence was inaccurate and should have been coded a "1" and the eating needs for the 10/26/11 quarterly assessment was inaccurate and</p>		<p>had been miscoded and were corrected during the survey process.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All MDS reports from the last 6 months have been audited for accuracy in wound coding and in ADL coding. The MDS report was modified when discrepancies were identified.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>Nurses have been inserviced on completion of the wound sheets to ensure accuracy in staging wounds. The DHS/designee will accompany the nurse when measuring pressure wounds to assist in staging wounds properly. The MDS coordinator will audit all MDS reports for ADL and wound coding for accuracy.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The MDS coordinator/designee will audit all MDS reports for 6 months for accuracy in wound</p>		

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	<p>should have indicated the resident only required set up and supervision for eating needs.</p> <p>2. Resident #25's record was reviewed on 11-30-2011 at 10:09 a.m. Resident #25's diagnoses included, but were not limited to, osteoporosis, high blood pressure, and anxiety.</p> <p>Resident #25's Minimum Data Set assessment, dated 11-3-2011, indicated Resident #25 had two stage 2 pressure areas, and two stage 3 pressure areas.</p> <p>A review of Pressure/Stasis/Arterial/Diabetic Ulcer assessment records for 11-1-2011 indicated Resident #25 had an open area on her left buttock staged as a 3, a second area slightly lower than the first on her left buttock staged as a 3, a third area on her left buttock slightly higher than the first two areas staged as a 3, a fourth area on he left buttock at the base of the buttock and top of her left leg staged as a 3, and an area on her coccyx staged as a 4.</p> <p>In an interview on 12-1-2011 at 11:35 a.m. the MDS coordinator indicated the MDS should have been coded as three stage three areas and one stage 4 area. She was unable to state why the coding was incorrect or why a correction had not been</p>		<p>and ADL coding. The MDS coordinator will report monthly to the QA committee for 6 months for additional recommendations if indicated.</p>				

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F0279 SS=D	<p>completed.</p> <p>In an interview on 12-1-2011 at 3:00 p.m. the MDS coordinator indicated there was no specific company policy regarding the accuracy of the MDS, but the facility followed the Resident Assessment Instrument rules and it was understood the information was to be coded correctly.</p> <p>3.1-31(g) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, the facility failed to ensure a care plan for incontinence was initiated for 1 of 8 residents reviewed for incontinence care plans in a sample of 14 (Resident #18).</p>	F0279	<p><b>Corrective actions accomplished for those resident found to have been affected by the alleged deficient practice:</b></p> <p>Care plans were reviewed and updated for the residents</p>	01/01/2012	

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	<p>Finding includes:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #18 was confused, ambulated independently, and was continent of her bowels and bladder.</p> <p>Review of the resident's clinical record on 11/30/11 at 2:00 P.M., indicated the most recent MDS assessment, completed on 11/02/11, indicated the resident's bladder continence had declined and she was now occasionally incontinent of her bladder.</p> <p>The Care Area Assessment worksheet, completed on 11/02/11 for Resident #18 indicated the following: "resident has dx (diagnosis) of Alzheimer's, depression, paranoid delusional and osteoarthritis. She needs staff assistance with some ADLs and has had occasional episodes of urinary incontinence during this observation period." The form indicated the facility was going to proceed to care plan to prevent episodes of urinary incontinence.</p> <p>Review of the current health care plans for Resident #18, current through 01/11/12, indicated there was no plan to address the resident's bladder incontinence.</p>		<p>identified at the time of survey. Res #18</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All current residents care plans have been reviewed and updated to reflect current status of the resident. CNA assignment sheets have been updated with any changes that were made to the residents plan of care.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>All nurses have been inserviced in regards to updating the resident care plan when new orders are received or changes occur. All nursing staff have been inserviced on the CNA communication sheet when plan of care changes are made. The Nursing administration will review the current care plan information Monday through Friday during clinical meeting. .</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The DHS/designee will review</p>		

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F0280 SS=E	<p>3.1-35(a)</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure care plans were updated, related to noncompliance, pain and falls, for 4 of 14</p>	F0280	<p>resident information such as physician orders ,personal preferences and the care plan,as well as the CNA assignment sheets to ensure the updates are current and accurate.This review will be completed Monday through Friday during the morning clinical meeting.This will be an ongoing QA process. Results will be reviewed monthly by the QA committee for 6 months for additional reccomendations as indicated.</p> <p><b>Corrective actions accomplished for those resident found to have been affected by the alleged</b></p>	01/01/2012	

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	<p>residents (Resident #25,#27, 42 and 44) reviewed for care plans in a sample of 14.</p> <p>Findings include:</p> <p>1. Resident #25's record was reviewed 11-30-2011 at 10:09 a.m. Resident #25's diagnoses included but were not limited to osteoporosis, high blood pressure, and anxiety.</p> <p>Resident #25's skin impairment circumstance assessment dated 1-12-2011 indicated Resident #25 was non compliant with treatment interventions.</p> <p>Resident #25's Clinically At Risk monitoring sheet dated 11-4-2011 indicated Resident #25 was non compliant with returning to bed,and repositioning.</p> <p>A review of Resident #25's current care plans indicated no care plan indicating noncompliance was an issue.</p> <p>In an interview on 12-1-2011 at 11:35 p.m. the MDS coordinator indicated skin care plans should have been updated to include Resident #25's noncompliance.</p> <p>2. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included but were not limited to diabetes, high blood pressure, and chronic</p>		<p><b>deficient practice:</b></p> <p>Care plans were reviewed and updated for the residents identified at the time of the survey. Resident # 25,27, and 44. #42 has been discharged from the facility.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>. All current residents care plans have been reviewed and updated to reflect current status of the resident. CNA assignment sheets have been updated with any changes that were made to the residents plan of care.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>Nurses have been inserviced on updating care plans and making additions to the CNA communication sheets.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The DHS/designee will review the resident information such as physician orders, personal</p>		

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	<p>lung disease</p> <p>A current physician's order dated 11-1-2011 indicated Resident #27 was to receive nectar thick liquids.</p> <p>In an observation on 11-30-2011 at 12:28 p.m. Resident #27 received and was drinking clear thin liquids with her lunch.</p> <p>In an interview on 11-30-2011 at 12:30 p.m. CNA #3 indicated Resident #27 refused thickened liquids and had signed a waiver.</p> <p>A document, dated 7-9-09, titled Diet Consistency Waiver, was reviewed and was noted to have been signed and dated.</p> <p>In an observation on 12-1-2011 at 8:45 a.m., Resident #27 was observed to have received and was drinking thin orange juice with ice cubes.</p> <p>A review of Resident #27's current care plans indicated no care plan regarding thickened liquids ordered or that Resident #27 had signed a waiver or refused thickened liquids.</p> <p>In an interview in 12-1-2011 at 2:45 P.M. the MDS coordinator indicated Resident #27's care plans should have been updated with thickened liquid order and Resident</p>		<p>preferences or clinical team recommendations, the plan of care and CNA assignment sheets will be updated Monday thru Friday during clinical meeting to ensure residents plan of care is followed as part of the ongoing QA process. The results will be reviewed monthly by the QA committee for 6 months for additional recommendations as needed.</p>		

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	<p>#27's wishes.</p> <p>In an interview on 12-1-2011 at 3:00 p.m. the MDS coordinator indicated there was no specific company policy regarding the updating of care plans, but the facility followed the Resident Assessment Instrument rules updating care plans quarterly and when resident conditions changed to accurately reflect current resident problems and interventions.</p> <p>3. Resident #44's clinical record was reviewed on 12/1/11 at 3:20 P.M.. The record indicated the resident was readmitted to the facility on 10/17/11 and had a recent hip fracture with surgical repair. The resident had a health care plan dated 10/27/11 for pain related to recent hip fracture with surgical repair. The resident had physician's orders for pain medication of Fentanyl 12 micrograms (mcg) per hour patch dated 10/18/11 and Hydrocodone/APAP 5 milligrams(mg)/500mg three times a day for pain.</p> <p>On 11/22/11 the resident had an accident at 4:00 A.M. where she hit the top of her left foot on top of her walker while going to the bathroom with staff. The injury was initially assessed as a 5 centimeter (cm) x 6 cm bruise to the top of her left foot. An observation on 12/1/11 at 2:25 P.M.</p>				

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	<p>indicated the bruise was approximately 8 cm x 12 centimeters and the left foot was significantly edematous.</p> <p>An interview with the resident on 12/1/11 at 2:25 P.M. indicated the resident was experiencing pain in the left foot of a 5-6 on a scale from 1-10.</p> <p>Review of the resident's health care plans indicated the health care plan for pain was not updated from the injury of 11/22/11 related to her left foot.</p> <p>An interview with the Director of Health Services (DHS) on 12/2/11 at 10:50 A.M. indicated the resident was already receiving routine medications for pain of the Fentanyl patch and Hydrocodone before the accident on 11/22/11.</p> <p>4. Resident #42's clinical record was initially reviewed on 11/29/11 at 10:45 A.M.. The record indicated on 11/28/11 at 2:20 A.M. the resident was found on the floor of her bedroom. Review of the facility's fall review on a nurse's note on 11/28/11 at 5:10 P.M. indicated the resident stated she attempted to go to the bathroom without assistance and slipped out of bed. The nurse's note indicated the resident will be toileted at 2:00 A.M. every morning.</p>				

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F0282 SS=E	<p>Review of the resident's health care plan dated 10/11/11, for falls, indicated it had not been updated to include the intervention of toileting the resident every morning at 2:00 A.M..</p> <p>An interview with the DHS on 12/1/11 at 3:00 P.M. indicated toileting at 2:00 A.M. was not added to the resident's CNA assignment sheet and the intervention of toileting the resident at 2:00 A.M. would have had to been word of mouth.</p> <p>An interview with LPN #8 on 11/30/11 at 11:35 A.M. indicated no documentation was noted indicating the resident had been toileted by staff on 11/30/11 at 2:00 A.M..</p> <p>3.1-35(d)(2)(B)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the health care plans and physician's orders were followed, related to restorative ambulation, dining and toileting, fall prevention interventions, oxygen administration and weekly faxing the physician blood sugars results, for 4 of 14 residents reviewed for care plans and physician orders in the sample of 14 (#12,</p>	F0282	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>Resident #12, 10, 27 and 52 were reviewed at the time of survey to ensure restorative ambulation, dining and toileting, fall prevention interventions, oxygen administration and weekly faxing the physician blood sugar results</p>	01/01/2012	

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	<p>10, 27, 52).</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #12 was alert and oriented, was incontinent of his bowels and bladder, was toileted by staff, and propelled himself and was pushed by staff in his wheelchair.</p> <p>Resident #12 was observed on 11/29/11 at 9:00 A.M., being pushed in his wheelchair by staff from the assisted dining room. The resident remained in his room in his wheelchair facing his bed from 9:00 A.M. - 10:30 A.M., when a CNA transferred the resident from his wheelchair into a recliner in his room. He remained in his room in his recliner until 11:55 A.M., when his wife transferred him to his wheelchair, toileted him, and pushed him to the dining room in his wheelchair.</p> <p>Resident #12 was observed on 11/30/11 at 9:30 A.M., in his recliner in his room asleep. The resident remained in his room until 12:07 P.M., when he was pushed by staff to the dining room. The resident was noted at 12:30 P.M., in the Restorative dining room eating his lunch. There was no plate guard noted on the resident's</p>		<p>were completed. The CNA assignment sheets, MAR and TAR were updated as needed.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All current residents have the potential to be affected by the same alleged deficient practice and were audited for follow through with the resident plan of care. The plan of care and the CNA assignment sheet was revised as needed.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>All Nursing staff were inserviced on updates to plan of care and CNA Communication sheet. The CNAs were inserviced on the importance of the assignment sheet. This information will be incorporated into the new orientee process for all new nursing staff.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>DHS/designee will review resident information such as physician</p>		

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	<p>plate.</p> <p>On 12/01/11 at 11:50 A.M., the resident was again pushed by his wife from his room to the assisted dining room. The resident's wife was overheard asking the restorative CNA, employee #18, if he had ambulated the resident yet today. CNA #18 indicated he had walked him to breakfast and the resident had ambulated very well. Interview with the resident and his wife, on 12/01/11 at 2:30 P.M., indicated the resident was only walked by Restorative once a day, if any, and only from his room to the dining room or from the dining room to his room. The resident was also only toileted once, if any, in between meals and was never toileted at night. The resident indicated it was a "no, no" but if he had to go to the restroom at night he would attempt to take himself. The resident's wife indicated she was concerned he was not walked enough at the facility, and the plate guard was not put on his plate very often. The resident indicated he did not feel he had any problems feeding himself.</p> <p>On 12/02/11 at 8:55 A.M., Resident #12 was observed in the Restorative dining room. There was a small china serving bowl and a plate in front of him and no plate guard or scoop bowl noted. At 9:22 A.M., the resident was observed</p>		<p>orders, personal preferences, clinical team recommendations, plan of care and CNA assignment sheets Monday thru Friday during clinical meeting to ensure residents plan of care and physician orders are followed as part of the ongoing QA process. The results will be reviewd monthly by the QA committee for 6 months for additiona recommendations.</p> <p><b>F-279</b> <b>Date certain: January 1, 2012</b> <b>Corrective actions accomplished for those resident found to have been affected by the alleged deficient practice:</b></p> <p>Care plans were reviewed and updated for the residents identified at the time of survey. Res #18</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All current residents care plans have been reviewed and updated to reflect current status of the resident. CNA assignment sheets have been updated with any changes that were made to the residents plan of care.</p> <p><b>Measures put into place and</b></p>		

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	<p>propelling himself back to his room from the Restorative dining room in his wheelchair.</p> <p>The resident was not observed to be ambulated during the day time hours on 11/29, 11/30, 12/1, or 12/2/11. Interview with the Restorative CNA, employee #18, on 11/30/11 at 11:10 A.M. indicated he usually ambulated the resident in the early morning before breakfast.</p> <p>Interview with MDS nurse, RN #16, on 11/30/11 at 10:00 A.M., indicated she was responsible for the Restorative Nursing Program. She indicated the Restorative CNA, employee #18, was working 6 1/2 hours 6 days a week, and the facility had recently hired another Restorative CNA, but she had not yet started working yet.</p> <p>The clinical record for Resident #12 was reviewed on 11/28/11 at 3:15 P.M. Resident #12 had diagnoses, including but not limited to, Parkinson's, tremors, and history of a CVA (cerebral vascular accident). The most recent Minimum Data Set (MDS) assessment, completed for a significant change in condition on 10/06/11, indicated the resident had declined and was nonambulatory, required extensive staff assistance for transferring and wheelchair locomotion, required extensive staff assistance for hygiene and</p>		<p><b>systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>All nurses have been inserviced in regards to updating the resident care plan when new orders are received or changes occur. All nursing staff have been inserviced on the CNA communication sheet when plan of care changes are made. The Nursing administration will review the current care plan information Monday through Friday during clinical meeting. .</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The DHS/designee will review resident information such as physician orders ,personal preferences and the care plan,as well as the CNA assignment sheets to ensure the updates are current and accurate.This review will be completed Monday through Friday during the morning clinical meeting.This will be an ongoing QA process. Results will be reviewed monthly by the QA committee for 6 months for additional reccomendations as indicated.</p>				

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	<p>toileting needs, and had declined in bladder continence.</p> <p>The current health care plans, including the restorative care plans, current through 01/06/12, indicated the resident was to be toileted between 5 - 5:30 A.M., before and after meals, and bedtime, was to be ambulated by restorative twice a day 300 feet 6 of 7 days per week, and was to have cueing, and a plate guard in the Restorative dining room 6 - 7 days a week for 15 minutes.</p> <p>Review of the restorative electronic documentation for the ambulation care plan indicated the resident had ambulated from 11/15/11 - 11/29/11 only 12 of the 15 days was he documented as having been ambulated, 3 of the 12 days he ambulated less than 20 feet, and only 1 of 15 days did the resident meet his 300 feet goal even though the documentation indicated he tolerated the ambulation activity well. One of 15 days the resident was documented as having been out of the facility. There was no reason given as to why he was only ambulated a short distance on three of the days, not ambulated at all on three of the days, and only documented the planned amount of one of the days.</p> <p>2. During the initial tour of the facility,</p>			

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	<p>conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #10 was confused, ambulated independently in her room, propelled her wheelchair herself, required maximum staff assistance for activities of daily living, and toileted herself. Resident #10 was observed ambulating from the bathroom in her room with her pants around her knees and her underwear exposed. LPN #17 rushed into Resident #10's room to assist her to pull up her pants as she had forgotten to do so before exiting the bathroom.</p> <p>Resident #10 was observed on 11/28/11 at 2:30 P.M. transferring herself from her wheelchair into her recliner. The resident's wheelchair was noted to be left in her room. On 11/29/11 at 11:15 A.M., Resident #10 was noted to transfer herself from her recliner into her wheelchair, which had been in her room since 11:00 A.M. when she had put herself into her recliner. Resident #10 was observed, on 11/30/11 at 1:45 P.M., toileting herself in her room, ambulating with her walker. There were no staff noted to be assisting the resident.</p> <p>The clinical record for Resident #10 was reviewed on 11/28/11 at 3:15 P.M. Review of the most recent Minimum Data Set (MDS) assessment for Resident #10,</p>				

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	<p>completed on 10/06/11, indicated the resident required limited staff assistance for transferring needs, ambulation needs in her room, dressing needs, and hygiene needs.</p> <p>Review of the current health care plans for Resident #10, current through 01/22/12, indicated the resident was to be assisted to toilet on demand, per schedule, and required staff assistance for transferring, walking, wheelchair locomotion, and toileting needs. The fall health care plan indicated the resident's wheelchair was to be removed from the room when she was seated in her recliner. In addition, the falls care plan indicated the resident was to be toileted upon rising, before and after meals, and before bed.</p> <p>Interview with MDS nurse #16, on 11/30/11 at 10:30 A.M. indicated Resident #10 could usually ambulate with her walker in her room independently, toileted herself, and transferred herself. When asked how the CNAs knew how much help the resident needed and why the health care plans indicated the resident needed transferring assistance and was on a toileting schedule, RN #16 indicated they knew by the way she was when they got her up in the morning as to what kind of day she was going to have. RN #16 indicated the care plans were accurate</p>			

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	<p>because there were times when the resident required more assistance.</p> <p>Interview with QMA #15, on 12/01/11 at indicated Resident #10 needed extensive staff assistance first thing in the morning with dressing and getting cleaned up but was then usually independent with transferring, ambulation in her room, and toileting needs. QMA #15 indicated Resident #10 only occasionally had incontinence episodes.</p> <p>3. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included, but were not limited to, diabetes, high blood pressure, and chronic lung disease</p> <p>A current physician's order dated 9-1-2010 indicated Resident #27 was to receive oxygen at 1 liter per minute continuous.</p> <p>In an observation on 11-30-2011 at 12:28 p.m., Resident #27's oxygen was observed to be between 1 and 2 liters. Resident #27 indicated oxygen was coming out.</p> <p>In an observation on 12-1-2011 at 8:45 a.m. Resident #27's oxygen was noted to be on at 2 liters per minute.</p> <p>In an interview on 12-1-2011 at 9:10 a.m., LPN #4 indicated Resident #27's oxygen</p>				

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	<p>should have been on at 1 liter per minute.</p> <p>4.A. Resident #52's record was reviewed 11-28-2011 at 11:50 a.m. Resident #52's diagnoses included, but were not limited to, chronic lung disease, respiratory insufficiency, and pneumonia.</p> <p>A current physician's order dated 11-12-2011, indicated Resident #52 was to receive oxygen at 4 liters per minute continuous.</p> <p>Skilled Nursing documentation indicated Resident #52 received oxygen at 3 liters per minute on 11-19-2011 at 7:50 a.m., and on 11-20-2011 at 7:40 a.m.</p> <p>Nurse's notes dated 11-21-2011 at 6:00 p.m., indicated oxygen saturations were 84% and the nurse increased the oxygen to four liters per minute.</p> <p>In an interview on 11-29-2011 at 8:45 a.m., LPN # 1 indicated Resident #52's oxygen should have been on at 4 liters per minute.</p> <p>4.B. A current physician's order dated 11-12-2011, indicated resident #52's blood sugars were to be faxed to the physician weekly.</p> <p>A review of the Medication</p>				

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F0309 SS=G	<p>Administration Record, dated 11-2011, indicated the blood sugars had been faxed on 11-18-2011, but the blood sugars were not documented as faxed on 11-25-2011.</p> <p>In an interview on 11-28-2011 at 12:10 p.m., LPN #2 indicated Resident #52's blood sugars should have been faxed to the physician, but there was no fax to indicate the blood sugars had been sent.</p> <p>In an interview on 11-29-2011 at 9:00 a.m. the Director of Health Services indicated there was no specific policy for following physician orders, but it was understood orders were to be followed.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to assess and treat an injury in a timely manner, resulting in unrelieved pain, for 1 of 6 residents (#44) reviewed for pain in a sample of 14.</p> <p>Findings include:</p>	F0309	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident 44 was assessed for pain and bruising and edema of her left foot during time of survey.</b></p>	01/01/2012	

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	<p>On 12/1/11 at 2:35 P.M., an interview with the resident and the resident's daughter indicated the resident had an accident on 11/21/11 in which she hit her left foot on her walker and had an injury (the DNS later clarified the actual date of the accident as 11/22/11 at 4:00 A.M.). The resident's daughter indicated she was not contacted concerning the injury but first found out about the injury when she went for a routine visit on 11/22/11 at 10:00 A.M. The resident's daughter indicated when she saw the injury on 11/22/11 at 10:00 A.M., the left foot had a moon shaped open area and it was purple. Resident #44's daughter was concerned the foot was not x-rayed until 11/25/11. When resident #44 was asked to rate her pain in her left foot during the interview, the resident indicated it was a 5-6 on a scale of 1-10. At the end of the interview, the resident's left foot was observed with significant edema and a reddish/purple bruise approximately 8 centimeters (cm) x 12 cm on the top of the foot.</p> <p>Review of an accident report from 11/22/11 at 4:00 A.M., provided by the Assistant Director of Health Services (ADHS), on 12/2/11 at 9:45 A.M., indicated the resident hit her foot on her walker causing a bruise while transferring to the bathroom. Left foot edema was noted, and the resident complained of pain</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><b>Current residents have been assessed for any unrelieved pain. Pain circumstance assessment form completed for any resident identified with unrelieved pain. Physician notified of unrelieved pain with review of pain medication regime to treat pain including PRN pain medication usage. Orders for pain medication obtained and family notified of current treatment of pain.</b></p> <p><b>Current residents with any bruising and or edema have been assessed using skin impairment assessment circumstance form. Physician has been notified of any bruising and or edema with an injury for treatment orders as well as family notification.</b></p>		

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	<p>but not any more than normal.</p> <p>Resident #44's clinical record was reviewed on 12/1/11 at 3:20 P.M. The record indicated the resident was admitted to the facility on 10/17/11 and was post hip surgery and at the facility for rehabilitation.</p> <p>Review of a skin impairment assessment, dated 11/22/11, indicated the resident had a bruise on the top of her left foot, 5 cm x 6 cm. The report indicated the color was purple and the resident complained of pain. The report indicated the treatment was to monitor. The skin impairment assessment sheet indicated a second assessment was conducted on 11/29/11 but not documented until 12/2/11. The assessment indicated the foot was purple and less edema today than previous, 1+. The assessment did not include any measurements of the bruising.</p> <p>Review of a skin impairment circumstance, assessment and intervention form, dated 11/22/11, indicated the location of impairment as left foot and type of impairment as bruise. Treatment required type was "observe bruise." Under prevention update, the interventions were listed as staff training and check circulation, edema. The form was filled out 3 times daily for 72 hours</p>		<p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Nursing staff have been inserviced to identify any resident with complaint of pain with completion of pain circumstance assessment form with review of current pain medication regime to treat pain including PRN pain medication usage. Notification of physician for treatment of pain. Family notification.</b></p> <p><b>Nursing staff have been inserviced of any resident with an injury to complete skin impairment assessment circumstance form for completion and notification of physician for treatment if indicated as well as family notificaion.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will review pain and skin circumstance</b></p>		

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	<p>and each entry indicated assessment completed and no complaints of pain. The form ended on 11/24/11.</p> <p>Review of the nurse's notes indicated no entries from 11/16/11 at 5:40 P.M. until 11/23/11 at 3:30 P.M.</p> <p>The nurse's note on 11/23/11 indicated physician's orders received to x-ray left foot 11/28/11.</p> <p>On 11/25/11 at 7:40 P.M., a nurse's note indicated the x-ray of the left foot had been completed and was negative.</p> <p>A nurse's note on 11/28/11 at 1:35 P.M. indicated a physician's order for a Doppler ultra sound of the left foot was received along with laboratory blood tests for a Chem 7 and a complete blood count and to elevate foot.</p> <p>A nurse's note on 11/28/11 at 2:30 P.M. indicated a Doppler ultra sound had been completed and laboratory blood tests had been drawn.</p> <p>A nurse's note from 11/29/11 at 1:30 P.M. indicated a physician's order for Keflex 500 mg (antibiotic) four times daily for seven days had been received.</p> <p>A nurse's note dated 11/30/11 at 5:30</p>		<p><b>forms during clinical meeting Mon –Fri to ensure residents are treated for pain and injury as part of the ongoing QA process. Results will be followed monthly at QA meeting for further recommendations.</b></p>		

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	<p>P.M. indicated the physician came to see the resident and assessed her left foot. The note indicated the left foot continues to be discolored, swollen and warm to touch. Physician's orders were received to do an arterial venous Doppler to left foot, lower leg and to call the physician with a progress update on 12/5/11.</p> <p>Review of skilled nursing assessment and data collection forms indicated the following: On 11/22/11 at 6:30 A.M., in the skin section, the resident had no skin impairment (the box for bruise was not checked) and in the pain section the resident had no pain. The same form's nursing notes/comments dated 11/22/11, no time listed, indicated the resident had pain med (medication) upon request. Another nursing notes/comments dated 11/23/11 at 5:00 A.M., indicated no complaints of pain at this time and left foot bruise continues.</p> <p>On 11/23/11 at 7:45 A.M., in the skin section, the resident had no skin impairment (the box for bruise was not checked) and in the pain section the resident had no pain. The same form's nursing notes/comments dated 11/23/11, 2-10, indicated no change with assessment and indicated no complaints and no signs and symptoms of distress.</p>				

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	<p>Another nursing notes/comments dated 11/23/11, 10-6, indicated the resident complained of left foot pain and area swollen and bruising noted.</p> <p>On 11/24/11 at 10:30 A.M., in the skin section, the resident had no skin impairment (the box for bruise was not checked) and in the pain section the box indicating scheduled pain regime was checked. The frequency boxes for pain were unchecked. The frequency boxes in the pain section included: none; occasionally; frequently; constantly. Pain intensity boxes were unchecked also. The pain intensity boxes included: mild; moderate; severe; horrible/excruciating; scale of 1-10. The same form's nursing notes/comments dated 11/24/11, no time listed, indicated the resident had pain med upon request.</p> <p>On 11/25/11 at 6:30 A.M., in the skin section, the resident had no skin impairment (the box for bruise was not checked) and in the pain section the resident had no pain. The same form's nursing notes/comments dated 11/25/11, 2:25 P.M. indicated the resident had no pain at present.</p> <p>On 11/26/11 at 7:00 A.M., in the skin section, the resident had skin impairment, and the bruise box was checked. In the</p>				

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	<p>pain section, the box indicating scheduled pain regime was checked. The frequency boxes for pain and pain intensity boxes were unchecked. The same form's nursing notes/comments dated 11/26/11, 8:45 A.M., indicated the resident had no signs or symptoms of distress. Another nursing notes/comments dated 11/27/11 at 5:00 A.M. indicated left foot edema and bruising remains.</p> <p>On 11/27/11 at 7:15 A.M., in the skin section, the resident had skin impairment, and the bruise box was checked. In the pain section, the box indicating scheduled pain regime was checked. The frequency boxes for pain and pain intensity boxes were unchecked. The same form's nursing notes/comments dated 11/27/11, 2-10, indicated the resident had no signs or symptoms of distress. Another nursing notes/comments dated 11/28/11 at 5:00 A.M., indicated left foot edema and bruising remains.</p> <p>On 11/29/11 at 8:10 A.M., in the skin section, the resident had no skin impairment (the box for bruise was not checked) and in the pain section the resident had no pain. The same form's nursing notes/comments dated 11/29/11, no time noted, indicated the resident had PRN (as needed) pain medications upon request. Another nursing</p>				

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	<p>notes/comments dated 11/29/11, 11:40 P.M., indicated the resident was resting quietly and denies pain.</p> <p>A fax, dated 11/27/11, to the physician indicated the left foot remains dark purple-brown with 2+ non-pitting edema. The fax indicated the resident has Lortab 5/500 (a pain medication) order routinely three times daily and resident complains of pain to left foot and leg as well as weak and light headed. The fax indicated the aides who help her regularly state she is reversing in progress as she has difficulty bearing weight, whereas prior to injury she was ambulating with walker and one assist. The fax noted no PRN's (as needed) pain medications were on-board. No response regarding PRN pain medications was received.</p> <p>A review of the resident's most recent medication orders, dated 11/27/11, indicated the resident had no PRN pain medications ordered. She did have a physician's order, dated 11/2/11, for routine Lortab 5mg/500mg three times daily. She also had a physician's order dated 10/18/11, for Fentanyl 12 micrograms/hour patch applied topically every three days routinely for pain.</p> <p>An interview with the Director of Health Services (DHS) on 12/2/11 at 9:05 A.M.,</p>				

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F0311 SS=D	<p>indicated the delay in the x-ray was due to the mobile x-ray company chose the original date of 11/28/11 but actually did the x-ray on 11/25/11. The DHS did not know why the x-ray was not ordered and completed before 11/25/11.</p> <p>An interview with the DHS on 12/2/11 at 10:50 A.M., indicated the resident already had routine pain medications ordered before the accident on 11/22/11. The DHS did not have any information why the resident did not have PRN pain medications ordered after the accident.</p> <p>3.1-37(a)</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review, and interview, the facility failed to consistency provide restorative services for 1 of 3 residents reviewed for restorative nursing services in a sample of 14 (Resident #12).</p> <p>Finding includes:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #12 was alert and oriented, was incontinent of his bowels and bladder,</p>	F0311	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident 12 has been reviewed for restorative services and plan developed.</b></p> <p><b>Identification of other residents having the potential to be affected by</b></p>	01/01/2012	

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	<p>was toileted by staff, and propelled himself and was pushed by staff in his wheelchair.</p> <p>Resident #12 was observed on 11/29/11 at 9:00 A.M., being pushed in his wheelchair by staff from the assisted dining room. The resident remained in his room in his wheelchair facing his bed from 9:00 A.M. - 10:30 A.M., when a CNA transferred the resident from his wheelchair into a recliner in his room. He remained in his room in his recliner until 11:55 A.M., when his wife transferred him to his wheelchair, toileted him, and pushed him to the dining room in his wheelchair.</p> <p>Resident #12 was observed on 11/30/11 at 9:30 A.M., in his recliner in his room asleep. The resident remained in his room until 12:07 P.M., when he was pushed by staff to the dining room. The resident was noted at 12:30 P.M., in the Restorative dining room eating his lunch. There was no plate guard noted on the resident's plate.</p> <p>On 12/01/11 at 11:50 A.M., the resident was again pushed by his wife from his room to the assisted dining room. The resident's wife was overheard asking the restorative CNA, employee #18, if he had ambulated the resident yet today. CNA #18 indicated he had walked him to</p>		<p><b>the same alleged deficient practice and corrective actions taken:</b></p> <p><b>Residents currently receiving restorative services have been reviewed and plan updated for restorative services.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Nursing staff including restorative aide have been inserviced in regards to restorative services residents are receiving and their plan updated on C.N.A assignment sheets.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will meet weekly with MDS coordinator and restorative aide to review residents on a restorative plan to ensure plan is appropriate for resident and changes made accordingly to restorative plan.</b></p>		

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	<p>breakfast and the resident had ambulated very well. Interview with the resident and his wife, on 12/01/11 at 2:30 P.M., indicated the resident was only walked by Restorative once a day, if any, and only from his room to the dining room or from the dining room to his room. The resident was also only toileted once, if any, in between meals and was never toileted at night. The resident indicated it was a "no, no" but if he had to go to the restroom at night he would attempt to take himself. The resident's wife indicated she was concerned he was not walked enough at the facility, and the plate guard was not put on his plate very often. The resident indicated he did not feel he had any problems feeding himself.</p> <p>On 12/02/11 at 8:55 A.M., Resident #12 was observed in the Restorative dining room. There was a small china serving bowl and a plate in front of him and no plate guard or scoop bowl noted. At 9:22 A.M., the resident was observed propelling himself back to his room from the Restorative dining room in his wheelchair.</p> <p>The resident was not observed to be ambulated during the day time hours on 11/29, 11/30, 12/1, or 12/2/11. Interview with the Restorative CNA, employee #18, on 11/30/11 at 11:10 A.M. indicated he</p>		<p><b>This is part of the ongoing QA process and will be reviewed monthly during QA meeting for further recommendations.</b></p>		

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	<p>usually ambulated the resident in the early morning before breakfast.</p> <p>Interview with MDS nurse, RN #16, on 11/30/11 at 10:00 A.M., indicated she was responsible for the Restorative Nursing Program. She indicated the Restorative CNA, employee #18, was working 6 1/2 hours 6 days a week, and the facility had recently hired another Restorative CNA, but she had not yet started working yet.</p> <p>The clinical record for Resident #12 was reviewed on 11/28/11 at 3:15 P.M. Resident #12 had diagnoses, including but not limited to, Parkinson's, tremors, and history of a CVA (cerebral vascular accident). The most recent Minimum Data Set (MDS) assessment, completed for a significant change in condition on 10/06/11, indicated the resident had declined and was nonambulatory, required extensive staff assistance for transferring and wheelchair locomotion, required extensive staff assistance for hygiene and toileting needs, and had declined in bladder continence.</p> <p>The current health care plans, including the restorative care plans, current through 01/06/12, indicated the resident was to be toileted between 5 - 5:30 A.M., before and after meals, and bedtime, was to be ambulated by restorative twice a day 300</p>			

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F0315 SS=E	<p>feet 6 of 7 days per week, and was to have cueing, and a plate guard in the Restorative dining room 6 - 7 days a week for 15 minutes.</p> <p>Review of the restorative electronic documentation for the ambulation care plan indicated the resident had ambulated from 11/15/11 - 11/29/11 only 12 of the 15 days was he documented as having been ambulated, 3 of the 12 days he ambulated less than 20 feet, and only 1 of 15 days did the resident meet his 300 feet goal even though the documentation indicated he tolerated the ambulation activity well. One of 15 days the resident was documented as having been out of the facility. There was no reason given as to why he was only ambulated a short distance on three of the days, not ambulated at all on three of the days, and only documented the planned amount of one of the days.</p> <p>3.1-38(a)(2)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>						

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	<p>Based on observation, record review, and interview, the facility failed to ensure bladder incontinence was thoroughly assessed and interventions attempted to restore as much bladder continence as possible, for 4 of 8 residents reviewed for incontinence needs in a sample of 14 (Residents #3, 12, 10, and 27).</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #12 was alert and oriented, was incontinent of his bowels and bladder, was toileted by staff, and propelled himself and was pushed by staff in his wheelchair.</p> <p>Resident #12 was observed on 11/29/11 at 9:00 A.M., being pushed in his wheelchair by staff from the assisted dining room. The resident remained in his room in his wheelchair facing his bed from 9:00 A.M. - 10:30 A.M., when a CNA transferred the resident from his wheelchair into a recliner in his room. He remained in his room in his recliner until 11:55 A.M., when his wife transferred him to his wheelchair, toileted him, and pushed him to the dining room in his wheelchair.</p> <p>Interview with the resident and his wife,</p>	F0315	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Residents 3, 12, 10 and 27 have been assessed for bladder incontinence and plan of care updated.</b></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><b>All current residents that are incontinent of bladder have been assessed to ensure interventions for incontinence is appropriate</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Nursing staff have been inserviced on the elimination assessment circumstance form to assess resident bladder</b></p>	01/01/2012	

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	<p>on 12/01/11 at 2:30 P.M. indicated the resident was only toileted once, if any, in between meals and was never toileted at night. The resident indicated it was a "no, no," but if he had to go to the restroom at night he would attempt to take himself.</p> <p>The clinical record for Resident #12 was reviewed on 11/28/11 at 3:15 P.M. Resident #12 had diagnoses, including but not limited to, Parkinson's, tremors, and history of a CVA (cerebral vascular accident). The most recent Minimum Data Set (MDS) assessment, completed for a significant change condition on 10/06/11, indicated the resident had declined and was nonambulatory, required extensive staff assistance for transferring and wheelchair locomotion, required extensive staff assistance for hygiene and toileting needs, and had declined in bladder continence.</p> <p>Review of the elimination section of an assessment form, dated 11/01/11 indicated the resident was always continent of his bowels and frequently incontinent of clear, yellow urine. The assessment indicated the resident wore briefs and toileted in the bathroom. The assessment form also indicated the resident was unable to recognize the urge to void at time, had no impairments with sitting on the toilet, communicating the</p>		<p><b>continence. A 72 hour bladder form initiated for a pattern</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>All admissions/readmissions will have the elimination assessment and 72 hour voiding form reviewed during clinical meeting Mon – Fri as part of ongoing QA process. The results reviewed at monthly QA meetings for 5 months for further recommendations. Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p><b>Resident 12 has been reviewed for restorative services and plan developed.</b></p> <p><b>Identification of other residents having the potential to be affected by</b></p>		

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	<p>need to void, stress or urge incontinence issues, no dribbling or difficulties starting a stream, did not refuse care, but did have Parkinson's disease. There was no other assessment completed regarding any possible causative factors for the resident's significant decline in bladder continence. The assessment form indicated the resident was to be on a "check and change" incontinence maintenance program.</p> <p>The current health care plans, including the restorative care plans, current through 01/06/12, indicated the resident was to be toileted between 5 - 5:30 A.M., before and after meals, and bedtime. The previous health care plan regarding incontinence, from 07/26/11 - 09/28/11 indicated the resident had previously been toileted every two hours.</p> <p>The elimination record, completed from 09/28/11 - 10/01/11 indicated the form had not been consistently completed on all shifts for all days, but indicated the resident had a pattern of incontinence around 1:00 A.M. and voided at 10:00 A.M. on 3 of the 4 days documented even after having voided at 8:00 A.M. There was no indication the bladder incontinence assessment was accurate, thorough, or was utilized, nor was the elimination record utilized, or any</p>		<p><b>the same alleged deficient practice and corrective actions taken:</b></p> <p><b>Residents currently receiving restorative services have been reviewed and plan updated for restorative services.</b></p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><b>Nursing staff including restorative aide have been inserviced in regards to restorative services residents are receiving and their plan updated on C.N.A assignment sheets.</b></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><b>DHS/designee will meet weekly with MDS coordinator and restorative aide to review residents on a restorative plan to ensure plan is appropriate for resident and changes made accordingly to restorative</b></p>		

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	<p>possible causative factors causing the resident's significant decline assessed to use to ensure the resident's health careplan was individualized to meet the resident's needs and attempt to restore as much bladder continence as possible.</p> <p>2. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #10 was confused, ambulated independently in her room, propelled her wheelchair herself, required maximum staff assistance for activities of daily living, and toileted herself. Resident #10 was observed ambulating from the bathroom in her room with her pants around her knees and her underwear exposed. LPN #17 rushed into Resident #10's room to assist her to pull up her pants as she had forgotten to do so before exiting the bathroom.</p> <p>Resident #10 was observed, on 11/30/11 at 1:45 P.M., toileting herself in her room, ambulating with her walker. There were no staff noted to be assisting the resident.</p> <p>The clinical record for Resident #10 was reviewed on 11/28/11 at 3:15 P.M. Review of the most recent Minimum Data Set (MDS) assessment for Resident #10, completed on 10/06/11, indicated the resident required limited staff assistance</p>		<p><b>plan. This is part of the ongoing QA process and will be reviewed monthly during QA meeting for further recommendations.</b></p>		

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	<p>for transferring needs, toileting needs, ambulation needs in her room, dressing needs, and hygiene needs.</p> <p>The elimination section of an assessment, completed on 11/01/11, indicated the resident was continent of her bladder. There was no further assessment documentation provided.</p> <p>Review of the current health care plans for Resident #10, current through 01/22/12, indicated the resident was to be assisted to toilet on demand per schedule, and required staff assistance for transferring, walking, wheelchair locomotion, and toileting needs. The fall health care plan indicated the resident was to be toileted upon rising, before and after meals, and before bed.</p> <p>Interview with MDS nurse #16, on 11/30/11 at 10:30 A.M. indicated Resident #10 could usually ambulate with her walker in her room independently, toileted herself, and transferred herself. When asked how the CNAs knew how much help the resident needed and why the health care plans indicated the resident needed transferring assistance and was on a toileting schedule, RN #16 indicated they knew by the way she was when they got her up in the morning as to what kind of day she was going to have. RN #16</p>				

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	<p>indicated the care plans were accurate because there were times when the resident required more assistance.</p> <p>Interview with QMA #15, on 12/01/11 at indicated Resident #10 needed extensive staff assistance first thing in the morning with dressing and getting cleaned up but was then usually independent with transferring, ambulation in her room, and toileting needs. QMA #15 indicated Resident #10 only occasionally had incontinence episodes.</p> <p>The incontinence assessment was not accurate, the care plans conflicted on the resident's toileting needs, and the facility was not consistently providing toileting assistance at all.</p> <p>3. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #3 was alert and oriented, was pushed in her wheelchair by staff, required total staff assistance for transferring, dressing, and hygiene needs, was incontinent of her bowels and bladder and was toileted by staff. She indicated the resident had been having behavior issues at night related to wanting her brief changed and got angry with staff when informed her brief was not wet.</p>				

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	<p>Review of the resident's clinical record on 12/1/11 at 10:00 A.M. indicated the most recent full Minimum Data Set (MDS) assessment on , completed on 05/20/11, indicated the resident was frequently incontinent of her bladder. The quarterly MDS assessment, completed on 10/26/11 indicated the resident was still frequently incontinent of her bladder.</p> <p>The elimination section of an assessment, completed on 10/04/11, indicated the resident was frequently incontinent of yellow urine, utilized briefs, exhibited a voiding pattern upon rising, after meals, before bed, and night, dribbled after voiding, and was often non-compliant. The resident also had recurrent urinary tract infections. The assessment indicated a plan was unable to be re-established through a retraining or structured program due to the assessment risk factors. It was not clear exactly which risk factors prevented the initiation of an individualized program. Handwritten in the comments section was "Res demands brief changed even when not wet at times."</p> <p>Review of a copy of a fax, sent to the physician on 09/12/11, indicated the resident's anxiety, and urge to urinate had been elevated over the past 2 weeks and an order for Pyridium, a medication to</p>				

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	<p>control bladder spasms, was ordered to two days. Nursing noted, from 09/12/11 - 09/18/11 indicated the urgency and anxiety behaviors surrounding the resident's frequent request to have her brief changed at night continued. The resident was started on Melatonin and Benadryl to induce sleep and also her anti-anxiety medication, Ativan, was increased.</p> <p>Review of the resident's current health care plan, initiated on 10/23/11 and current through 01/23/12, indicated the resident was to be toileted before and after meals, upon rising in the AM and before bed at night. There was no plan to address the resident's increased need to void during the night time hours or a plan to ensure the resident's symptoms were not a result of a continued urinary tract infection.</p> <p>4. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included but were not limited to diabetes, high blood pressure, and chronic lung disease.</p> <p>A current toileting assessment dated 11-12-2011 indicated to toilet upon rising, after meals, before bed and when Resident 327 awakens at night.</p> <p>Resident #27's elimination record</p>				

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F0323 SS=G	<p>indicated Resident #27 was incontinent at midnight, 2 a.m., and 5 a.m.</p> <p>Resident #27's current care plan dated 11-22-2011 indicated Resident #27 was to be toileted before and after meals, upon rising and before bed at night.</p> <p>In an interview on 12-1-2011 the MDS coordinator indicated Resident #27's toileting plan should have been more individualized.</p> <p>3.1-41(a)(1)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to prevent a fall resulting in fractures for 1 of 8 residents reviewed with falls (Resident #39) in a sample of 14.</p> <p>Findings include:</p> <p>1. During an interview on 11-29-2011 at 2:55 p.m., Resident #39's family member indicated RNA #5 (Restorative Nursing Assistant) had raised Resident #39's feet, to put her feet on pillows, and tipped her wheelchair over backwards. Resident #39's family member further indicated</p>	F0323	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:An review of resident #39 has been completed to identify hazards and risks which could contribute to an injury. The care plan team did analyze the individual risks and developed interventions based on that data. Leg risers had been applied to her wheelchair to promote rising of her legs when she has edema which has been a successful intervention. Identification of other residents having the potential to be affected by the same alleged</p>	01/01/2012

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	<p>there had been no leg risers on the wheelchair, and the facility failed to further investigate the occurrence.</p> <p>Resident #39's record was reviewed on 12-1-2011 at 11:15 a.m. Resident #39's diagnoses included, but were not limited to, osteoporosis, diabetes, and high blood pressure.</p> <p>A review of nurse's notes, dated 1-17-2011 at 11:15 a.m., indicated Resident #39 had been receiving Restorative care. After completing the program for the morning, RNA #5 attempted to elevate Resident #39's feet onto the seat of a reclining chair in her room. Resident #39 had been seated in a wheel chair to receive her Restorative care. While elevating Resident #39's feet to the seat of the recliner, Resident #39's wheelchair tipped backwards, and she fell back onto the floor. Resident #39 remained in the wheelchair.</p> <p>An x-ray report of Resident #39's spine, taken 1-17-11, indicated Resident #39 had fractures of undetermined age to the vertebrae T-3 and T-6, T-7 and T-8. A follow up MRI on 2-22-2011 indicated fractures of the vertebrae T-3 and T-6 were likely to be related to osteoporosis and trauma.</p>		<p>deficient practice and corrective actions taken:All other residents have been reviewed with "risk" factors identified for that individual resident. Individual interventions based on those risk factors have been added to the residents plan of care to avoid hazards which can influence the risk of injury. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The interdisciplinary team will review individual hazards and risks which could influence the possibility of an injury upon admission based on data collected from resident history, and assessments . They will develop interventions to reduce the potential for accidents. The interdisciplinary care plan team will monitor the effectiveness and modify the interventions. With any injury/accident the nurse in charge fills out a falls circumstance form with an immediate investigation. The charge nurse will implement an intervention based on the circumstance. Monday through Friday the Nursing administration will review the investigation and analyze the circumstances and review and revise the plan of care as necessary. With any fall or accident, an investigation will be conducted to attempt to identify the root cause so that the care plan interventions can be modified accordingly. How the</p>		

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	<p>The fall circumstance report, dated 1-17-2011, indicated Resident #39 had a witnessed fall, wheelchair brakes were not locked, but no further information was documented on the form regarding where the resident was in the room, circumstances of the fall nor statements from the witness. The preventative measure to be taken was indicated to place anti tip bars on the wheel chair.</p> <p>An Interdisciplinary Fall Team note, dated 1-19-2011, indicated RNA #5 had been lifting Resident #39's feet to place them in the recliner. The wheel chair tipped back. The Restorative CNA indicated he had assisted the chair backward and Resident #39 had not hit her head. There was no further investigation noted on the form.</p> <p>The nurse's notes indicated the Interdisciplinary Fall Team review met on 1-18-2011 at 10:45 a.m. The note further indicated Resident #39 had indicated RNA #5 had placed the pillows too high, but there was no further indication of review of Resident #39's wheelchair.</p> <p>In an interview on 12-1-2011 at 4:07 p.m., the Executive Director indicated she had spoken with Resident #39 in February after Resident #39's family asked RNA #5 not work with Resident #39 again. Then, in August, Resident #39's family member</p>		<p>corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS and clinical team will review new admissions for appropriate interventions to the residents care plan for appropriate follow up. Monday through Friday as an ongoing QA process. Three Individual care plans will be reviewed by the DHS/designee two times weekly times 4 weeks, then two times monthly times five months. Results will be presented to QA times six months for additional recommendations.</p>	

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	<p>indicated the desire to talk to the highest person available in the facility. The Executive Director indicated she had the Regional Director speak with her.</p> <p>An internal memo dated 10-3-2011, provided by the Executive Director on 12-2-2011 at 10:10 a.m., indicated the Regional Director had spoken with Resident #39's family member, but was referring more in depth investigation to a clinical support person. The clinical support person had replied on 10-18-2011. The memo indicated she had called Resident #39's family member, but had terminated the call. There was no indication of further action taken.</p> <p>An accident/incident investigation report was provided by the Executive Director on 12-2-2011 at 11 a.m. The form indicated the fall had occurred due to RNA #5 had elevated Resident #39's feet and her wheelchair fell backwards with her in it. An interview with Resident #39, written in the Executive Director's hand, dated 1-18-2011, indicated Resident #39 had felt the pillows were too high and she had hit her head. There was no further investigation into these statements.</p> <p>In an interview on 12-2-2011 at 9:45 a.m., RNA #5 indicated Resident #39 was to have her legs elevated because of</p>				

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	<p>swelling, so the staff had been placing Resident #39's feet up in her recliner chair. RNA #5 further indicated there were no leg risers on Resident #39's chair or the staff would have used them.</p> <p>In an interview on 12-2-2011 at 10:00 a.m., LPN #16 indicated staff had been placing Resident #39's feet up in the reclining chair because her legs needed elevated due to increasing edema the week prior. LPN #16 indicated there were no leg risers on Resident #39's chair because she would not use them.</p> <p>Resident #39's most recent Minimum Data Set (MDS) assessment, dated 11-12-2011, indicated she was alert and oriented. The MDS also indicated the resident required maximum assist with two staff members to transfer and was non-ambulatory.</p> <p>In an interview on 12-2-2011 at 10:50 a.m., Resident #39 indicated she had told RNA #5 she thought the pillows were too high and he had acted in a hurry, not really talking to her very much that day. Resident #39 further indicated she did not recall RNA #5 slowing the wheelchair during the fall, and she felt she hit her head. Resident #39 additionally indicated her wheel chair did not have leg risers on the chair at the time of her fall, she further</p>			

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	<p>indicated no one had talked to her about leg risers, but she would have used them if they would have been on her chair. Resident #39 further indicated she did not recall talking with the Executive Director about the fall.</p> <p>A review of care plans, dated 1-13-2011, indicated Resident #39 was at risk for falls due to osteoporosis, weakness and she used a wheelchair. The care plan indicated to provide and monitor the use of the wheelchair and to lock brakes before transferring. Leg risers were not mentioned in the care plan.</p> <p>A current policy dated 11-2010, titled Guidelines for Investigation, indicated an accident or incident should be thoroughly investigated including interviews of witnesses, contributed to the occurrence, who had, residents, witnesses, and the person involved in the incident, reviewing nursing notes, and medications.</p> <p>3.1-45(a)(2)</p>				

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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure oxygen was administered as ordered by the physician for 2 of 4 residents reviewed with physician's orders for oxygen (Resident # 27, Resident #52) in a sample of 14.</p> <p>Findings include:</p> <p>1. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included, but were not limited to, diabetes, high blood pressure, and chronic lung disease</p> <p>A current physician's order, dated 9-1-2010, indicated Resident #27 was to receive oxygen at 1 liter per minute continuous.</p> <p>In an observation on 11-30-2011 at 12:28 p.m., Resident #27's oxygen was observed to be between 1 and 2 liters. Resident #27 indicated oxygen was coming out.</p>	F0328	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Res 27 and 52 were assessed for the correct liter flow of oxygen per physician order. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current resident on Oxygen have been assessed for correct liter flow per physician order. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced to ensure oxygen is on the correct liter flow per physician order and document the liter flow of oxygen. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review residents on oxygen three times per week to ensure</b></p>	01/01/2012	

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	<p>In an observation on 12-1-2011 at 8:45 a.m., Resident #27's oxygen was noted to be on at 2 liters per minute.</p> <p>In an interview on 12-1-2011 at 9:10 a.m., LPN #4 indicated Resident #27's oxygen should have been on at 1 liter per minute.</p> <p>2. Resident #52's record was reviewed 11-28-2011 at 11:50 a.m. Resident #52's diagnoses included, but were not limited to, chronic lung disease, respiratory insufficiency, and pneumonia.</p> <p>A current physician's order dated 11-12-2011, indicated Resident #52 was to receive oxygen at 4 liters per minute continuous.</p> <p>Skilled Nursing documentation indicated Resident #52 received oxygen at 3 liters per minute on 11-19-2011 at 7:50 a.m., and on 11-20-2011 at 7:40 a.m.</p> <p>Nurse's notes dated 11-21-2011 at 6:00 p.m., indicated oxygen saturations were 84% and the nurse increased the oxygen to four liters per minute.</p> <p>In an interview on 11-29-2011 at 8:45 a.m., LPN # 1 indicated Resident #52's oxygen should have been on at 4 liters per minute.</p>		<p><b>correct liter flow of oxygen is being delivered to the resident as well as documented correct liter flow.</b> The results of the audits will be presented to the Quality Assurance Committee monthly for at least six months for additional recommendations if indicated.</p>	

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F0329 SS=D	<p>A current undated policy, titled Guidelines for Administration of Oxygen, provided by the Administrator on 12-1-2011 at 4 p.m., indicated turn the oxygen on at the liter flow ordered by the physician.</p> <p>3.1-47(a)(6)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure there was adequate indications to support the use of a hypnotic medication and adequate</p>	F0329	<p><b>Corrective actions accomplished for those resident found to have been affected by the alleged deficient practice:</b></p>	01/01/2012	

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	<p>indications to support the increase of an anti-anxiety medication for 2 of 7 residents (Resident's #3, 27) reviewed for psychoactive medications in a sample of 14.</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 11/28/11 between 10:40 A.M. - 11:25 A.M., LPN #17 indicated Resident #3 was alert and oriented, was pushed in her wheelchair by staff, required total staff assistance for transferring, dressing, and hygiene needs, was incontinent of her bowels and bladder and was toileted by staff. She indicated the resident had been having behavior issues at night related to wanting her brief changed and got angry with staff when informed her brief was not wet.</p> <p>Resident #3's clinical record was reviewed on 12/1/11 at 10:00 A.M. Review of the most recent Minimum Data Set (MDS) assessment, completed on 10/26/11, indicated the resident was frequently incontinent of her bladder, had no mood or behavior issues, was cognitively impaired, and required extensive staff assistance for toileting and hygiene needs.</p> <p>Review of the nurse's notes initiated on 08/29/11 indicated the resident had</p>		<p>Resident #3 had an order for Benadryl for insomnia that was discontinued during the survey process.</p> <p>The ambien ordered PRN for Resident #27 has been made routine during the survey process.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All residents taking PRN psychotropic medications has the potential for being affected by the same alleged deficeint practice.</p> <p>All residents with PRN psychotropic medications were audited for use and unused medications were discontinued.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>All Nurses were inserviced by the Social Services Director/Designee for proper documentation of PRN</p>		

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	<p>exhibited urinary frequency and had a urinary tract infection. The resident was placed on the antibiotic Cipro initially and was changed to the antibiotic, Keflex to be given for 7 days. A copy of a fax, sent to the physician on 09/12/11, indicated the resident's anxiety, and urge to urinate had been elevated over the past 2 weeks and an order for Pyridium, a medication to control bladder spasms, was ordered for two days. Nursing notes, from 09/12/11 - 09/18/11, indicated the urgency and anxiety behaviors surrounding the resident's frequent request to have her brief changed at night continued. A physician's order was received on 10/12/11 for Melatonin, a natural supplement, given to induce sleep. On 10/27/11, a physician's order was received to discontinue the as needed Benadryl, an antihistamine mediation, which had originally been ordered on 8/4/11 for itching and hives, and an order to administer Benadryl routinely for sleep was ordered. In addition, the physician examined the resident on 09/27/11 and increased the resident's Ativan medication from 0.25 mg twice daily to 0.5 mg twice daily. The physician documented the resident denied any concerns, but the nursing staff said she was more anxious. The physician indicated he could "see that." He indicated the resident's previous gradual dose reduction for the Ativan,</p>		<p>usage. The yellow PRN form will be utilized to document PRN psychotropic medication use. The inservice will be included in the New hires orientation process.</p> <p>The Social Service Director will Audit for any psychotic medication used and for proper documentation PRN usage.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>Social Service Director/designee will audit the PRN psychotropic medications for appropriate use and proper documentation daily Monday thru Friday for 4 weeks then weekly for 5 months. The results will be reported to the QA committee monthly for 6 months to give further recommendations if indicated.</p>		

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	<p>completed in September 2010, had not worked.</p> <p>Review of the nurse's notes, from 09/09/11 - 10/27/11, indicated there was no documentation of specific issues related to insomnia. There were 5 entries related to wanting her brief changes frequently and one issue regarding the resident's concerns with other residents leaving lights on at night. There was no behavior tracking for insomnia. The medication administration record for the month of October 2011 indicated the resident was given Benadryl 25 mg for itching 6 times from 10/01/11 - 10/25/11. A nurse's note, dated 09/19/11 at 3:45 A.M., indicated the resident had been on her call light frequently during the night and requested her brief be changed. The resident was informed she could take some Benadryl medication to help her "relax...so can rest and not be concerned with having brief changed so frequently...." The behavior tracking form completed by the nursing staff regarding pacing and need to toilet, for October 2011, only documented 3 nights with behaviors of needing to toilet. The interventions were only documented on 1 of the 3 nights and no outcomes for interventions were documented.</p> <p>There was no documentation of the</p>				

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	<p>resident's behavior issues in the Behavior Detail Report until November 2011 after all of the medication changes had already been made.</p> <p>Review of the resident's current health care plan, initiated on 10/23/11 and current through 01/23/12, indicated the resident was to be toileted before and after meals, upon rising in the AM and before bed at night. There was no plan to address the resident's increased need to void during the night time hours or a plan to ensure the resident's symptoms were not a result of a continued urinary tract infection.</p> <p>2. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included, but were not limited to, diabetes, high blood pressure, and chronic lung disease</p> <p>A current physician's order dated 10-27-2010, indicated Resident #27 was to receive Ambien 5 mg at bedtime as needed.</p> <p>A review of medication tracking, dated 11-2011, indicated Resident #27 received Ambien on 11-3, 11-4, 11-5, and 11-7-2011 at 8 p.m. each evening. The reason noted on the medication tracking sheet was insomnia.</p>				

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F0333 SS=D	<p>Behavior detail reports do not indicate insomnia had been noted on 11-3, 11-4,11-5, and 11-7.</p> <p>Nurse's notes did not indicate insomnia on 11-3, 11-4, 11-5 and 11-7.</p> <p>The monthly behavior tracking log indicated there was no insomnia on 11-3, 11-4, 11-5, and 11-7.</p> <p>In an interview on 12-1-2011 at 11:50 a.m., the Assistant Director of Health Services indicated insomnia should have been charted if the medication Ambien was given.</p> <p>3.1-48(a)(6)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure residents were free from significant medication administration errors, for 1 of 2 residents observed receiving insulin injections (Resident #27) in a sample of 14 residents.</p> <p>Finding includes:</p> <p>During observation of a medication pass, conducted on 11/28/11 at 4:30 P.M., RN #13 obtained the blood glucose level of</p>	F0333	<p><b>Corrective actions accomplished for those resident found to have been affected by the alleged deficient practice:</b></p> <p>Resident # 27 blood sugar was rechecked after the evening meal and was 411 after the short acting insulin had been given. Nurses were inserviced on ensuring residents ate or insulin was given no more than 15 minutes prior to a meal during</p>	01/01/2012	

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	<p>Resident #27. The resident's blood glucose level was noted to be 146 dg/ml. RN #13 then indicated she was going to wait to administer insulin to Resident #27, but changed her mind and indicated she was going to go ahead and give the routine insulin to Resident #27. RN #13 then obtained an alcohol pad and an insulin flexi pen from the medication cart and administered 6 units of Novolog into Resident #27's left lower abdomen at 4:35 P.M.</p> <p>Resident #27 did not receive her evening meal until 5:46 P.M., over 1 hour after she had received her insulin injection.</p> <p>Review of the physician orders for Resident #27, on 11/28/11 at 5:00 P.M., indicated an order for Novolog 6 units to be given with meals.</p> <p>During observation of a medication pass, conducted on 11/30/11 at 11:25 A.M., LPN #14 was noted to prepare to give an insulin injection to Resident #27. LPN #14 administered 6 units of Novolog insulin to Resident #27 at 11:27 A.M. The resident did not receive her lunch tray until 12:40 P.M. in the main dining room, over 1 hour after her insulin was administered.</p> <p>Review of the manufacturer's instructions</p>		<p>the survey process.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All other residents that have orders for short acting insulin have the potential for being affected by this alleged deficeint paractice.</p> <p>All Nurses were inserviced on ensuring residents with short acting insulin orders ate at the time of the injection or give the insulin no more that 15 minutes prior to the meal.</p> <p><b>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>All nurses were inserviced on short acting insulin to ensure the resident eats at the time of the injection or give the insulin no more than 15 minutes prior to a meal. The inservice will be included in the orientation process for all new nurse hires.</p> <p>The Pharmacy was notified to add to the MAR not to give the</p>		

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	<p>for the administration of the Novolog insulin, noted to be stored along with the Novolog flexipen in the medication cart, indicated the following: "...Novolog should generally be given immediately (within 5 - 10 minutes) prior to the start of a meal...."</p> <p>Interview with the Director of Nursing, on 12/01/11 at 9:30 A.M., indicated she was unaware of the timing instructions for Novolog insulin.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>		<p>short acting insulin more than 15 minutes prior to a meal.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The DHS/designee will audit the diabetics MAR that has short acting insulin orders for compliance with timeliness of the injections three times weekly for 1 month, then weekly for 5 months. The results will be reported monthly for 6 month to the QA committee to give further recommendations if indicated.</p>		

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

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	<p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to ensure consent was given for an immunization prior to the immunization being given for 1 of 6 residents reviewed for immunization consents in a sample of 14 (Resident #25).</p> <p>Findings include:</p> <p>Resident #25's record was reviewed 11-30-2011 at 10:09 a.m. Resident #25's diagnoses included, but were not limited to, osteoporosis, high blood pressure, and anxiety.</p> <p>A Resident information sheet dated 9-9-2010, indicated Resident #25 had declined to receive the pneumovax</p>	F0334	<p><b>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 25 had pneumovax vaccine consent form reviewed and signed on 12/22/11. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents have been reviewed to ensure the consent forms for influenza and pneumovax vaccines have been reviewed and signed. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p>	01/01/2012

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F0363 SS=F	<p>vaccine. There were no other consents on the chart indicating Resident #25 wanted to receive the pneumovax vaccine.</p> <p>A physician's order dated 6-6-2011, indicated Resident #25 could have pneumovax vaccine as appropriate.</p> <p>The immunization record indicated on 6-6-2011, Resident #25 had received pneumovax vaccine in her left arm as an IM injection.</p> <p>In an interview on 12-1-2011 at 2:45 p.m., the Assistant Director of Health Services indicated a consent should have been obtained prior to the vaccine being given.</p> <p>A current, undated policy, titled Guidelines for Influenza and Pneumococcal Immunizations, provided by the Administrator on 12-1-2011 at 11:30 a.m., indicated each resident will receive vaccines per their request.</p> <p>3.1-13(a)</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and</p>	F0363	<p><b>Nursing staff have been inserviced on the influenza/pneumovax consent forms for review with the residents prior to obtaining an order from the physician for administration of either the influenza/pneumovax vaccine or the refusal of the vaccine. Influenza vaccine currently through March 31, 2012. Pneumovax throughout the year. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review all admission/readmission chart at the clinical meeting Mon – Fri to ensure the influenza/pneumovax consent form is completed. If resident wants either vaccine the order is the physician order is obtained before administration of influenza from current date through March 31, 2012. Pneumovax throughout the year. This is part of the ongoing QA process and will be reviewed monthly during QA meeting for further recommendations.</b></p> <p>Corrective actions accomplished</p>	01/01/2012	

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	<p>interview, the facility failed to ensure menus were utilized, were available, were followed and accurate portion sizes and food items were served. This potentially affected all 56 residents in the facility.</p> <p>Findings include:</p> <p>During observation of the noon meal, conducted on 11/28/11 between 11:35 A.M. - 12:48 P.M., Cook #6 was noted to serve 1/2 cup cooked spaghetti with 3 - 6 meatballs coated with sauce and a small amount of red sauce on top of the spaghetti. The cook was noted to serve a #12 (3 ounce) scoop of ground meat balls, an unmeasured small amount of sauce and 4 ounces of cooked spaghetti noodles. There was no spreadsheet available at any time during the service of the noon meal on 11/28/11. Interview with the Food Service Supervisor, employee #12, on 11/28/11 during the meal service indicated the spreadsheets were not available because she was adjusting them to better meet the needs of the residents. The spread sheets were again requested, even if they had not been totally adjusted and it was revealed they were not available but would be retrieved from another facility.</p> <p>Cook #10, who served the food to residents in the main dining room, was</p>		<p>for those residents found to have been affected by the alleged deficient practice: Cook #6 and Cook # 10 were educated by the Dining services Support and the Director of Food services on 2/2/11 on accurate portion sizes, following the menus as planned and serving accurate food items. The Director of Food Services was educated to have the menus approved ahead and ensure menus are available and in use. Identification of other residents having the potential to be affected by the same alleged deficient practice: No residents were negatively affected. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: The Dining Services Support and the Director of Food Services inserviced all cooks on appropriate portion sizes, following the menus and serving accurate food items. Emphasis was placed on following the menus and use of appropriate scoop measures for accuracy. The Director of Food Services will be making adjustments to the menus from resident requests and submitting for approval prior to ensure menus and spread sheets are available to follow. The Dining Services Support and the Director of Food Services have completed performance checks on all cooks for demonstration of understanding</p>		

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	<p>noted to utilize a #10 scoop (2 1/2 ounces) for the pureed spaghetti noodles and meatball mixture. Interview with Cook #6, who had directed the scoop size to Cook #10, indicated she had placed approximately 2 ounces of cooked spaghetti with meatballs. She indicated she had chosen a #10 scoop for the pureed spaghetti and a #12 ounce scoop for the ground meat serving size because it "just seemed right."</p> <p>Cook #10 was noted to serve the 3 residents who required a pureed diet, a #10 scoop of pureed meatball and spaghetti noodle mixture with a 2 ounce ladle of very concentrated, lumpy beef gravy. The residents who required a pureed diet did not receive any garlic bread.</p> <p>Cook #10 was noted to serve the 5 residents who required a mechanical soft diet, a #12 scoop of ground meatball mixture over top 4 ounces of cooked spaghetti with a few splatters of spaghetti sauce she flicked from one side of the tongs she was using to serve the meatballs to the residents with regular diets.</p> <p>Cook #10 was also noted to place unmeasured amounts of spaghetti noodles onto plates, and very little, unmeasured amounts of sauce. Toward the end of the</p>		<p>and appropriate procedures followed. All new cooks will have a performance check successfully completed during the orientation. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Food Services will complete performance checks on 2 cooks weekly times 6 months. One on one education will be addressed as necessary. The Dining Services Support will review menus monthly for accuracy. Results will be presented to the QA Committee monthly times 6 months or until 100 percent compliance is achieved.</p>		

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	<p>meal service, the food service supervisor gave Cook #10 a 4 ounce ladle spoon for the spaghetti sauce and Cook #10 ran out of sauce. While more sauce was being prepared by Cook #6, Cook #10 continued the food service placing only splatters of sauce onto the ground meat trays and regular diet's trays.</p> <p>Review of the spread sheet for the meal served on 11/28/11 at lunch, made available on 11/29/11 in the A.M. indicated the following was to be served:</p> <p>Meatballs with spaghetti sauce - regular - 3 meatballs, 1/2 cup sauce, 4 ounce spoodle noodles, no added sugar or concentrated carbohydrates - 2 meatballs, 1/3 cup sauce, and 3 ounces spoodle of noodles. Mechanical soft - #8 (4 ounces) ground meat, 4 ounces sauce, and 4 ounces noodles</p> <p>Pureed - 1 each serving pureed spaghetti recipe, #20 scoop pureed garlic toast.</p> <p>Fortified food diets - same a regular except 4 ounces fortified pasta instead of regular spaghetti</p> <p>During observation of the evening meal service, conducted on 11/28/11 between 5:06 P.M. , Cook #10 was noted to serve a #12 scoop of pureed vegetable, a #12 scoop of pureed meat, and a #8 scoop of pureed potatoes to the 3 residents who required pureed food. She was also noted</p>				

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F0369 SS=D	<p>to serve a #12 scoop of ground meat to the 5 residents who required mechanically soft food.</p> <p>Review of the spread sheet, on 11/29/11 in the A.M., for the evening meal served on 11/28/11 indicated Cook #10 should have served a #6 (6 ounce) serving of meat for the pureed diets and a #6 scoop of meat for the mechanically soft diets. The vegetable, Brussel Sprouts, had been substituted for the menued cooked peppers, mushrooms, and onions so there was no serving sizes on the spread sheets. The menu also indicated a #8 scoop of whipped sweet potatoes was to have been served but regular mashed potatoes were substituted.</p> <p>3.1-20(i)(4) The facility must provide special eating equipment and utensils for residents who need them.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a plate guard was consistently provided as planned for 1 of 14 residents reviewed for dining in a sample of 14 (Resident# 12).</p> <p>Finding includes:</p> <p>Resident #12 was observed on 11/30/11 at 9:30 A.M., in his recliner in his room asleep. The resident remained in his room</p>	F0369	<p>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:Resident #12 does have a plate guard applied for all meals as indicated by the plan of care. Identification of other residents having the potential to be affected by the same alleged deficient practice:An audit was completed by nursing administration for all residents requiring adaptive equipment as indicated by the residents plan of</p>	01/01/2012	

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	<p>until 12:07 P.M., when he was pushed by staff to the dining room. The resident was noted at 12:30 P.M., in the Restorative dining room eating his lunch. There was no plate guard noted on the resident's plate.</p> <p>Interview with the resident and his wife, on 12/01/11 at 2:30 P.M. indicated the facility did not always put guard on his plate. The resident indicated he did not feel he had any problems feeding himself.</p> <p>On 12/02/11 at 8:55 A.M., Resident #12 was observed in the Restorative dining room. There was a small china serving bowl and a plate in front of him and no plate guard or scoop bowl noted. .</p> <p>The clinical record for Resident #12 was reviewed on 11/28/11 at 3:15 P.M. Resident #12 was admitted to the facility on 03/12/09 with diagnosis, including but not limited to, Parkinson's, tremors, and history of a CVA (cerebral vascular accident). The most recent Minimum Data Set (MDS) assessment, completed for a significant change condition on 10/06/11, indicated the resident had declined and was nonambulatory, required extensive staff assistance for transferring and wheelchair locomotion, required extensive s 6 - 7 staff assistance for hygiene and toileting needs, and had</p>		<p>care. The adaptive utensiles are being placed for all meals by the dietary staff with tray set up. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: An inservice has been presented by the Food Service Director to all kitchen staff regarding placing the adaptive equipment or special utensils on the identified residents plate, tray etc. The Food Services Director has added any adaptive equipment on the residents tray card information for kitchen staff when setting up. The CNA's will ensure that the equipment is in place and utilized as ordered. The special eating equipment will be on the CNA assignment sheets as well. The DHS/designee inserviced all nursing staff on the system of checking to ensure equipment is in use for all meals. Changes in adaptive equipment will be communicated to the Director of Food Services from nursing. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Food Services will monitor four meals weekly to ensure the adaptive devices are being placed as indicated times one month, then two meals weekly times 5 months. The restorative nurse /designee will monitor three meals weekly times one month ,then two meals weekly times five months to</p>		

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F0371 SS=F	<p>declined in bladder continence.</p> <p>The current health care plans, including the restorative care plans, current through 01/06/12, indicated the resident was to have cueing, and a plate guard in the Restorative dining room 6 - 7 days a week for 15 minutes.</p> <p>3.1-21(h) The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was prepared, stored, and served under sanitary conditions, failed to ensure an ice machine was cleaned in the nutrition pantry, and further failed to ensure outdated food supplies were discarded from the main storage area and opened food supplies in the nutrition pantry were labeled when opened. This had the potential to affect 56 of 56 residents in the facility.</p> <p>Findings include:</p> <p>1. During the dietary sanitation tour, conducted on 11/28/11 between 10:05 A.M. - 10:30 A.M., the following was noted:</p>	F0371	<p>ensure compliance. Results will be presented to the QA committee monthly times 6 months for additional recommendations or continuation.</p> <p>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: The steam table pans, the shelf above the stove, the deep fryer, the standing mixer, the three wheeled bins, the top of the microwave, meat slicer , underneath the steam table, and the food preparation area and ice machine were all cleaned during the week of survey. Cook 3 6,7,8,9 were inserviced on appropriate food handling protocols by the Regional Dining Support and the Food Service Director during the survey process. The outdated ,unopened containers of Nepro were discarded during the survey week. The opened , undated juices identified in the nourishment pantry were</p>	01/01/2012	

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	<p>There were 3 steam table pans stacked and put away as clean with soiled food substances on the inside surfaces.</p> <p>The shelf above the stove had a heavy, greasy accumulation of dust.</p> <p>The deep fryer had a heavy accumulation of food debris floating on the top and a heavy accumulation of grease buildup on the outside edge.</p> <p>The standing mixer, put away as clean, was dirty with dried yellow food splatters.</p> <p>There were three wheeled bins used to store staples, which were covered with crumbs and dried food splatters.</p> <p>The top of the inside of the microwave had a heavy accumulation of multi colored food splatters.</p> <p>The meat slicer, put away as clean, had dried bits of meat on the underside of the blade and attached safety device.</p> <p>The ice machine had a plastic drainage pipe on the underside of the machine which was heavily covered with a black substance. There was also a slight growth of fuzzy, black substance on the inside of the ice machine.</p> <p>The edges of the open shelves, underneath the steam table, and food preparation area utilized to store spices, steam table pans, and cooking trays had a heavy accumulation of dust and food crumbs.</p> <p>During observation of the food service for the noon meal, conducted on 11/28/11</p>		<p>discarded during the survey week. The ice machines and drain pipe were cleaned during the survey week by the Director of Maintenance. Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken: All residents have the potential to be affected. No residents have been affected. All dietary staff were inserviced on appropriate food handling protocols with emphasis placed on infection control by the Director of Food Services. Education included hand washing, use of gloves and sanitary food handling. protocols. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Performance checks were conducted on all cooks. When individual issues were identified, education was provided during the process. All new cooks will have a operformance check successfully completed during their orientation. All dieatry staff have been inserviced on the proper cleaning procedures and schedules by the Director of Food Service. Staff are to sign the cleaning schedule for the shift when completed. Central Supply staff have been educated by the DHS/designee on auditing and discarding outdated products. All nursing staff have been inserviced by the DHS/designee</p>		

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	<p>between 11:35 A.M. - 12:48 P.M., the following was noted:</p> <p>Cook #6, after washing her hands and donning plastic gloves, proceeded to touch the outside of the stove, steam table pans, her apron, handles of spoodles and large spoons and then touched spaghetti noodles directly to place them back onto the serving plate. She also touched garlic bread directly with her contaminated gloved hands and placed them onto the plates. At one point, a piece of garlic bread fell off of a plate onto a paper menu, and the cook picked up the garlic bread and put it onto the plate and served it to a resident.</p> <p>Cook #7 washed her hands, donned plastic gloves, and touched the outsides of pans, the lid to the ice machine, the microwave handle, and then touched parsley garnish directly and placed the parsley directly onto the residents' plates.</p> <p>Cook #8 washed her hands, donned gloves, and touched the skillet handle, the outside of the bread wrapper, the box holding the plastic wrap, and then touched bread and cheese slices directly with her contaminated gloved hands.</p> <p>Cook #9 washed her hands for 20 seconds, donned plastic gloves, and then opened the walk in freezer, handled the outside of packages of frozen food, handled the deep fryer basket, and then reached into the bag and then touched</p>		<p>to date juices when opened and discard them after three days after opening. The Director of Maintenance was inserviced by the ED on the ice machine sanitation policy. The Director will clean all ice machines quarterly or as necessary. The ice machine will be checked weekly by the DFS during weekly sanitation check. The evening Supervisor will check weekly for outdated unopened supplements in the nourishment pantry refrigerator and discard as appropriate. This will be an ongoing responsibility. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Food Services /designee will monitor daily sanitation of the kitchen Monday through Friday and complete a sanitation check review weekly for an ongoing QA process. The Dining Service Support will complete an in depth sanitation check monthly times six months. All results of audits will be reviewed by the QA Committee for additional recommendations and until 100 per compliance reached.</p>		

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	<p>french fries directly and placed them into the deep fryer.</p> <p>Cook #6, after washing her hands and donning ill fitting gloves, touching the outside of handles, lid to steam table, and then ran the thumb of her gloves through the soup and served the soup to the resident.</p> <p>Cook #10 was observed preparing food to transfer to a steam table in the dining room. Cook #10 washed her hands and placed trays of salad onto a cart, then she donned a pair of gloves and transferred a pan of meat from the steam table in the kitchen to a cart. Next, without removing or changing her gloves, she handled a stack of plates, touching both the bottom and sides of the stack of plates with her contaminated gloves. She also set the serving spoodles on top of paper menus on the cart. After setting up her steam table in the dining room, cook #10 proceeded to serve the food. Cook #10 was noted to touch the paper menus, various trays, handles of spoodles and then touched green beans from a mixed vegetable blend directly with her gloved hands and served the food to the residents. She also utilized her contaminated gloved hands for 3/4 of the serving of the noon meal to pick of garlic bread and place it on the plates.</p> <p>During observation of the service of the</p>				

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	<p>evening meal, conducted on 11/28/11 at 5:06 P.M., Cook #10 was noted to touch the outsides of dishes, scoops, steam table lids, paper menus with gloved hands, then without changing her gloves, was noted to be handling buns directly.</p> <p>During observation of the puree process, conducted on 11/29/11 between 11:30 A.M. - 11:45 A.M., Cook #6 was noted to wash her hands, don a pair of gloves, and handled the meat scale, the outsides of the food processor, and then touched the inside spoon surface of both the teaspoon and tablespoon measuring spoons. She was also noted to touch the inside blade top with her contaminated gloved hands to adjust it after washing the food processor between the meat and vegetable preparation.</p> <p>Interview with the Registered Dietician, on 11/30/11, indicated she was not involved in routinely checking the kitchen for sanitation or food preparation issues.</p> <p>Interview, on 12/01/11, with the Regional Clinical Dining Support staff member, a chef and certified dietary manager, employee #11, indicated he was responsible for assisting the facility's food service supervisor with any food sanitation issues and/or food preparation issues. He indicated he was aware of</p>				

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	<p>some of the issues and was inservicing staff. He indicated the facility's food service supervisor was new to the position.</p> <p>2. During environmental tour on 11-29-2011 at 9:10 a.m., the ice machine in the nutrition pantry was noted to have black spots on the white water supply tube. The black spots were wet and could easily be wiped off.</p> <p>In an interview on 11-29-2011 at 9:12 a.m., the Maintenance Director indicated the ice machine was to be cleaned on a monthly basis and the black spots should not have been there.</p> <p>A current listing of residents requiring thickened liquids was provided by the Director of Health Services on 12-2-2011 at 9:30 a.m. The listing indicated 5 residents required thickened liquids.</p> <p>A policy, dated 2009, indicated the cleaning to scrub all machine surfaces and door gaskets inside and out with a hot detergent solution.</p> <p>3. During environmental tour on 11-29-2011 at 9:13 a.m., in the nourishment pantry refrigerator, the following was observed to be open without dates: one quart honey thick cranberry juice, one quart honey thick</p>				

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	<p>apple juice half full, one quart honey thick orange juice 1/4 full, and one quart honey thick orange juice 3/4 full.</p> <p>In an interview on 11-29-2011 at 9:14 a.m., LPN #1 indicated the juices should be dated when opened.</p> <p>A current listing of residents requiring thickened liquids was provided by the Director of Health Services on 12-2-2011 at 9:30 a.m. The list indicated 5 residents required thickened liquids.</p> <p>A current policy dated 2009, titled Date Marking, indicated foods were to be marked with an open date.</p> <p>4. During environmental tour on 11-29-2011 at 9:20 a.m., in the nourishment pantry, the following was observed: three bottles of Nepro (a food supplement) with a manufacturer's expiration dated of 5-1-2011, thirteen bottles of Nepro with a manufacturer's expiration date of 8-1-2011, 1 case of Nepro with a manufacturer's expiration date of 7-1-2011, and three cases of Nepro with a manufacturer's expiration date of 10-1-2011.</p> <p>In an interview on 11-29-2011 at 9:25 a.m., the maintenance Director indicated expired food supplements should be</p>				

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	<p>discarded when expired.</p> <p>A current listing of residents requiring liquid food supplements was provided by the MDS Coordinator on 12-2-2011 at 2:50 p.m. The current list indicated 10 residents were taking liquid food supplements.</p> <p>A current policy dated 2009, titled Date Marking, indicated foods were to be discarded when the expiration date with which the manufacturer guarantees the food will no longer meet quality standards is reached.</p> <p>3.1-21(i)(3)</p>				

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, the interview, the facility failed to ensure infection control procedures were followed regarding catheter care for 1 of 2 residents reviewed with a catheter in a</p>	F0441	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #25's catheter is being positioned so that it is not touching the floor. The	01/01/2012

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	<p>sample of 14 (Resident # 25). The facility also failed to maintain medical equipment in a clean manner for 1 feeding tube pump in a clean storage area, and an IV pump for 1 of 1 resident reviewed with IV medications (Resident # 25) in the sample of 14.</p> <p>In addition, the facility failed to ensure the infection control program contained the current procedures, was easily accessible, was maintained in a timely fashion, and the information utilized in a manner to assist the facility to investigate, control, and prevent the spread of infections. This deficient practice potentially affected all 56 residents in the facility.</p> <p>Findings include:</p> <p>1. During the daily exit conference, conducted on 12/01/11 at 4:30 P.M., the facility was asked to be prepared to show and discuss their infection control policies and tracking with the surveyors on 12/02/11. On 12/02/11 at 3:00 P.M., the Director of Nursing, who was responsible for the facility's infection control program, informed the surveyors her computer access was not available to retrieve her "forms" for the Infection Control program. The DON indicated she would utilize the business office computer in order to try to access her forms.</p>		<p>DHS immediately updated the infection log to ensure current information for surveillance. The feeding pump and IV pump identified was cleaned during the survey. Identification of other residents having the poential to be affected by the same alleged deficient practiceand corrective actions taken: An inservice has been presented by the DHS/ designee to all nuring staff on appropriate care of the residents with indwelling catheters. All medical equipment has been cleaned. The DHS/designee is currently tracking the surveillance of resident infections to ensure the infection control program investigated, controls and prevents infections in the facility. Measures put into place and systemic changes made to ensure the aleged deficient practice does not recur: All nursing staff inserviced by the DHS/designee on care of the resident with an indwelling catheter, including appropriate precautions with tubing placement. Monday through Friday the DHS/ designee will review physicians orders, 24 hour report information for residents with possible infections. If a resident has been identified with an infection, the information will be entered on the infection control log to ensure we collate and analyze dates on nosocomial infections to prevent rises, clusters and to plan preventative</p>		

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	<p>Interview with the DON, on 12/02/11 at 5:00 P.M. indicated she had printed off an example of a monthly tracking form from the computer. She also brought her infection control binder with the policies and procedures related to infection control.</p> <p>Review of the monthly infection control report, indicated of the 20 infections reviewed, no applicable culture information was documented, no applicable x-ray information was documented, no organisms were documented, no reculture or isolation was documented. The form listed the resident's name, room number, admission date, infection onset date, the type of infection, whether the infection was nosocomial or not, the infection related diagnosis, the antibiotic, and a resolution date. Fourteen of the 20 infections listed on the form were from October 2011, the form was incomplete for all 20 infections. Interview with the Director of Nursing, on 12/02/11 at 5:00 P.M. indicated she had been really busy, had the information on her desk, but had not had a chance to input the data into the computer. She indicated the facility had recently been having frequent computer issues.</p> <p>Interview with the DON indicated the computer would break down and compare the type of infection and the "shift" of the</p>		<p>control activities and educational programs. This is an ongoing process. Infection data is also reviewed with further analysis monthly during the QA Committee. The evening supervisor will be responsible to ensure that all medical equipment is clean and sored appropriately. Inservicing presented to all nurses regarding cleaning medical equipment as needed and after usage. Only clean equipment will be stored in the clean utility. The evening supervisor will audit all medical equipment for cleanliness weekly. This will be ongoing. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS/designee will monitor for appropriate catheter tube placement three times weekly times three months, then weekly times three months. The DHS will bring the infection control log Monday through Friday to the morning clinical meeting for review and entries. The evening supervisor will monitor all medical equipment for cleanliness. This will be an ongoing QA process. Results of the audits will be reviewed monthly by the QA Committee monthly for at least six months for any additional recommendations or continued further.</p>		

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	<p>infection, but the computer did not further analyze the type of organism or location of the resident to look for patterning. The DON indicated the individual infection circumstance forms was utilized on an individual basis to ensure the symptoms, physician notification, antibiotic use, and any isolation needs were documented and a care plan was initiated. She indicated the unit managers were responsible for reviewing infection circumstance forms for their units.</p> <p>Review of the facility's infection control policy, titled, "Infection Control Surveillance" included the following: "The facility shall regularly conduct surveillance to collect, collate, and analyze data on nosocomial infections to prevent rises, clusters, and to plan prevention control activities and educational programs...Surveillance data is part of the facility's ongoing CQI program...A infection surveillance. The Infection Control Practitioner (ICP) 1. Collects data, at least weekly, on suspected or diagnosed infections on forms ICS - A or ICS - B. 2....3. Enters results of Laboratory Culture Reports on Culture Log, or uses culture summary report from the laboratory. 4. Tabulates data and prepared summary Facility infection report at least monthly....6. Compared current incidence rates with</p>						

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	<p>past rate...." The facility's policy included Form ICS - A, ICS - B, and the Nosocomial Infection Report form. Interview with the Director of Nursing, on 12/02/11 at 5:00 P.M. indicated she had not been utilizing the forms in the facility's current policy because she had been utilizing the computer form. She indicated she was going to start documenting her infection control information on paper because she had so many issues with computer availability.</p> <p>Review of the computerized form for October and November 2011 infections did not indicate any type of patterning or cluster had been attempted to ensure effective infection control measures. The documentation provided and the interview with the DON confirmed infections were analyzed on an individual basis and by type of infection only.</p> <p>2. Review of the current policy and procedure related to the "Management of Residents with Clostridium Difficile", current as of 01/11/11, indicated there were no specific instructions related to the type of disinfection required to treat the infected residents' rooms. The DON obtained the Environmental Services policy, dated 03/2011, which did contain the updated information regarding the use of a bleach based disinfectant to clean the</p>						

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	<p>rooms affected by Clostridium Difficile.</p> <p>3. During environmental tour on 11-29-2011 at 9:25 a.m., a feeding pump was noted in the clean equipment area. The feeding pump was observed to have had numerous splatters of tannish brown substance on the pump and pole.</p> <p>In an interview on 11-29-2011 at 9:25 a.m., the Maintenance Director indicated the area was for clean equipment to be stored until use, and equipment in the area was to be kept stored after being cleaned. He further indicated a pump with brown splatters should not have been stored in the clean area.</p> <p>A current policy dated 10-9-2007 titled return demonstration check off for equipment cleaning indicated the equipment should be kept clean.</p> <p>4. During environmental tour on 11-29-2011 at 9:40 a.m., an IV pump in Resident #25's room was noted to have brown, round dry substances on the IV pole. The substance could be rubbed off.</p> <p>In an interview on 11-29-2011 at 9:25 a.m., the Maintenance Director indicated the IV pole should be kept clean.</p> <p>5. Resident #25's record was reviewed on 11-30-2011 at 10:09 a.m. Resident #25's</p>				

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	<p>diagnoses included, but were not limited to, osteoporosis, seizures, and anxiety.</p> <p>On 11-29-2011 at 10:20 a.m., Resident #25 was observed sitting in her room in a wheelchair. Resident #25's catheter tubing was noted to be touching the floor under her wheelchair.</p> <p>On 11-30-2011 at 9:50 a.m., Resident #25 was observed in her room in her wheel chair. Resident #25's catheter tubing was observed on the floor under her wheelchair.</p> <p>On 12-1-2011 at 8:45 a.m., Resident #25 was observed in the dining room during the breakfast meal. Resident #25's catheter tubing was observed on the floor under her wheelchair.</p> <p>On 12-1-2011 at 12:15 p.m., Resident #25's catheter tubing was observed on the floor under her wheelchair.</p> <p>In an interview on 12-1-2011 at 2:45 p.m., the Assistant Director of Health Services indicated catheter tubing should not be on the floor.</p> <p>A current undated policy, titled Guidelines for Urinary Catheter Care, provided by the Administrator on 12-2-2011 at 9:30 a.m., indicated to be</p>				

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F0511 SS=D	<p>sure catheter tubing and drainage bag are kept off the floor.</p> <p>3.1-18(b) 3.1-18(j)</p> <p>The facility must promptly notify the attending physician of the findings. Based on interview and record review, the facility failed to notify the physician of an x-ray result requiring further treatment 1 of 7 residents reviewed with x-rays in a sample of 14(Resident #39).</p> <p>Findings include:</p> <p>1. Resident #39's record was reviewed 12-1-2011 at 11:15 a.m. Resident #39's diagnoses included, but were not limited to, osteoporosis, diabetes, and high blood pressure.</p> <p>An x-ray of Resident #39's neck and spine dated 1-17-2011, indicated fractures in the vertebrae T-3 and T-6, T-7 and T-8. The radiologist indicated the fractures were of an unknown age, but recommended clinical correlation and suggested a nuclear bone scan might be considered. The x-ray had a time date stamp from a hospital where the x-ray had been completed. The time date stamp was 2-11-2011 at 10:43 a.m. There was no initial on the x-ray to indicate the</p>	F0511	<p>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:The attending physician was notified of the x-ray results for resident 39#Identification of other residents having the potential to be affected by the same deficient practiceand corrective actions:An audit was completed by nursing administration. No other residents were identified as being affected. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Inservice present to licensed nurses on physician notification of radiology finding. The nurse in charge is responsible to notify the attending physician of any radiology findings promptly. The nurse who is notifying the results to the attending physician will document in the clinical record and note any changes in orders as well. This communication will also be recorded on the 24 hour communication report sheet. Diagnostic test results require a response from the attending</p>	01/01/2012	

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	<p>physician had reviewed the x-ray.</p> <p>A review of Resident #39's nurse's notes for 1-18 through 1-31-2011 did not indicate the physician had been notified of the results or of the recommendations for the scan.</p> <p>A fax dated 1-17-2011, with a time date stamp of 1-18-2011 at 4:55 p.m., indicated a fax had been sent to the physician informing him Resident #39 had been sent to the emergency room, and orders received for Ben Gay and a suggestion to use Celebrex (an anti-inflammatory pain reliever). There was no note of the x-ray suggestions. The fax indicated there were what appeared to be a "2," then changed to a "3," pages sent and to see attached labs. There was no documentation what the labs were.</p> <p>A copy of Resident #39's x-ray taken 1-17-2011 at a hospital, with a time date stamp of 12-3-2011 at 1:48 a.m., provided by the Administrator on 12-2-2011 at 1:10 p.m., indicated initials in the bottom right hand corner and a hand stamp date of 1-18-2011.</p> <p>A physician's progress note dated 1-29-2011 indicated Resident #39 had chronic back pain, but did not address the x-ray findings or the suggestions made by</p>		<p>physician noting they have reviewed the test resultsThe Director of Health Services and nursing administration will review the 24 hour report sheets and circumstance changes as well as physician orders.Any radiology result will be varified by record review that the radiology report has been promptly reported to the MD.This will be an ongoing process. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS and nursing administration will review the clinical record of all residents with a radiology lab to assure the attending physician has been notified promptly Monday through Friday. This will be an ongoing QA process. The results of the audits will be presented to the monthly QA for at least six months for additional recommendations.</p>		

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F0514 SS=D	<p>the radiologist.</p> <p>In an interview on 12-1-2011 at 3:30 p.m., the Director of Health Services indicated she thought the physician had been notified.</p> <p>A current policy, dated 12-6-2007, titled Physician Notification Guidelines, indicated diagnostic test results, i.e. lab, or x-ray, require a response from the physician noting they have reviewed the test results. Test results out of range or abnormal should note whether or not treatment is indicated.</p> <p>3.1-49(j)(2)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure accurate documentation for 3 of 14 residents</p>	F0514	<p><b>Corrective actions accomplished for those resident found to have been affected by the alleged</b></p>	01/01/2012	

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	<p>(Residents #52, 27, 23) reviewed for clinical records in the sample of 14.</p> <p>Findings include:</p> <p>1. Resident #52's record was reviewed 11-28-2011 at 11:50 a.m. Resident #52's diagnoses included, but were not limited to, chronic lung disease, respiratory insufficiency, and pneumonia.</p> <p>A current physician's order dated 11-12-2011, indicated Resident #52 was to receive oxygen at 4 liters per minute continuous.</p> <p>Skilled Nursing documentation indicated Resident #52 received oxygen at 3 liters per minute on 11-19-2011 at 7:50 a.m., and on 11-20-2011 at 7:40 a.m.</p> <p>Documentation included on Resident #52's Medication Administration Record on 11-19-2011 for the shift 6 a.m.-2 p.m. and on 11-20-2011 for the shift 6 a.m.- 2 p.m. indicated Resident #52's oxygen was running at 4 liters per minute</p> <p>In an interview on 11-28-2011 at 12:10 p.m., LPN #2 indicated the oxygen should have been accurately documented in the nurses notes and on the MAR.</p> <p>A current undated policy titled Guidelines</p>		<p><b>deficient practice:</b></p> <p>The documentation for oxygen liter administration for resident #52 is being documented accurately. The ambulation order for resident 27 has been discontinued. Hospice records were obtained from the Hospice company during the survey process for Resident # 23.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken.</b></p> <p>All current residents have the potential for being affected by the same alleged deficient practice. All residents receiving oxygen have been reviewed to ensure accuracy in documentation of flow rate. No other residents were identified.</p> <p>All resident MAR/TAR have been reviewed for refusals to ensure proper documentation.</p> <p>All hospice residents records have been reviewed to ensure current and complete documentation is in the records. No other residents were identified.</p> <p><b>Measures put into place and systemic changes made to</b></p>		

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	<p>for Administration of Oxygen provided by the Administrator 12-1-2011 at 4 p.m. did not indicate how to document the Administration of oxygen</p> <p>2. Resident #27's record was reviewed 11-30-2011 at 3:20 p.m. Resident #27's diagnoses included, but were not limited to, diabetes, high blood pressure, and chronic lung disease</p> <p>A current physician's order dated 4-22-2011, indicated Resident #27 was to be walked twice daily for 15 minutes.</p> <p>The Medication Administration Record dated 11-2011, indicated under the walking area each day was initialed and all initials were circled. There was no documentation on the back of the Medication Administration Record to indicate why Resident #27 had not been walked.</p> <p>In an interview on 12-1-2011 at 11:50 a.m., the Assistant Director of Health Services indicated Resident #27 had been refusing walking attempts and her refusals were circled on the Medication record. She additionally indicated the circled initials were to be explained on the back of the Medication Record.</p> <p>In an interview on 12-1-2011 at 11:50</p>		<p><b>ensure the alleged deficient practice does not recur:</b></p> <p>All nurses have been inserviced on documentation accuracy and refusal documentation. New Hires will be inserviced during the orientation process.</p> <p>The Social Service Director has informed all current hospice providers of need for current documentation to be in file in the facility for all hospice residents.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The Medical Records/designee will audit 10 resident records Monday thru Friday for accuracy and completeness in clinical documentation and proper documentation of refusals for 4 weeks, then 10 records twice weekly for 5 months.</p> <p>The Social Service Director/designee will audit all hospice residents to ensure current and complete documentation is available in the facility records weekly.</p> <p>Results of these audits will be provided to the QA committee monthly for 6 months for additional recommendations if indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/02/2011
NAME OF PROVIDER OR SUPPLIER  WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPOBT, IN46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m., the Assistant Director of Health Services indicated the policy for documenting refusals included documentation on the back of the Medication Record, but the facility had no specific policy for documenting refusals.</p> <p>3. Resident #23's clinical record was reviewed on 12/1/11 at 9:15 A.M.. The record indicated the resident was receiving hospice services since 4/7/11.</p> <p>Review of the resident's hospice care record did not indicate a service health care plan. The record did not contain records for the past three months for hospice health aides and did not contain any records for chaplain services or social services.</p> <p>An interview with RN #7, from the hospice provider, on 12/1/11 at 3 p.m., indicated the resident had been receiving services from a hospice health aide, chaplain and social services since admit to hospice services on 4/7/11. RN #7 indicated the records from hospice health aides, chaplain and social services were all available from the company's office and had the records faxed to the facility.</p> <p>3.1-50(a)(2)</p>				