

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 2, 3, 4, 5, 6, and 9, 2013</p> <p>Facility number: 000139 Provider number: 155234 AIM number: 100266410</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 3 Medicaid: 49 Other: 8 Total: 60</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 12/13/13 by Brenda Marshall Nunan, R.N.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or</p> <p>correction set forth on the statement of deficiencies. This plan of correction</p> <p>is prepared and submitted as a requirement under state and federal law. Please</p> <p>accept this plan of correction as our credible allegation of compliance.</p> <p>Respectfully,</p> <p>Tracy Dewey</p>	

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

TITLE

(X6) DATE

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

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			Administrator	

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review, and interview the facility failed to notify resident of policy change regarding hospice care service options for 1 of 1 resident reviewed who was currently receiving hospice care. (Resident #7)</p> <p>Findings include:</p> <p>Upon review of Resident #7's clinical record on 12/9/13 at 10 a.m., documentation indicated Resident #7 was admitted on 8/14/2009. Documentation was also noted in the social service notes dated 10/23/13 of "Special care conference was held today with the local Ombudsman [name], [name] ADM [Administrator], [name] DON [Director of Nursing], and this writer to discuss concerns and issues that the resident family had about their choice of hospice services. Resident family requested [specific hospice company] while the resident was at [specific hospital]. The resident family signed admission paper work with [hospice company]. [ADM name] attempted to explain this to the resident family. Resident family left very upset and notified the local Ombudsman [name] which lead to this meeting that was held today. The family was informed that the facility</p>	F000156	<p>1. Resident #7 was affected. The facility must have a contract with the hospice company utilized in the facility in an effort to ensure coordination of services. The responsible party for resident #7 has been notified of the hospice companies with which the facility has current contracts. 2. All residents residing in the facility have the potential to be affected. All residents and/or their responsible party will be notified in writing of the hospice care service options available to be utilized in the facility when hospice services are deemed applicable (please see attachment A). 3. As a measure of ongoing compliance the Administrator or designee will complete a review monthly, (please see attachment B) regarding the Resident's rights within the facility, noting any revision in Resident's rights and ensure the Facility informs the Resident and the Resident's responsible party of the same, providing necessary advance notice. 4. As a measure of quality assurance the Administrator or designee will review any findings and subsequent corrective action, as a result of the aforementioned monthly reviews, in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	01/03/2014

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	<p>only has one contract and that contract is with [hospice name] and this writer gave the resident family information and has set up a meeting with the [name of hospice], and [ombudsman], [ADM], [DON], and this writer to discuss the services that the [name of hospice] can provide and give the family the option to decide if they still want hospice services. This meeting is to be held on October 25, 2013 at 10:00 am. [sic] This writer to continue to follow up with resident family and [ombudsman]."</p> <p>A social service notation dated 10/25/13 indicated the resident was admitted to [specific hospice name which was not the hospice service provider requested while hospitalized] today per family request. Resident was admitted to hospice with the dx [diagnosis] end stage heart disease."</p> <p>Upon interview of the Social Services Director [SSD] on 12/9/13 at 12:10 p.m., the SSD indicated during the admission process prior to 7/1/13 residents were informed several hospice companies were available if needed. The SSD stated after 7/1/13 residents and families during admission process were notified that only one hospice company was available for services when needed.</p>			

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	<p>Upon interview of the Administrator on 12/9/13 at 12:20 p.m., the Administrator indicated the facility changed their policy on 7/1/13 to allow only one hospice group to service their facility. The Administrator stated the facility only has to maintain one "umbrella" hospice, instead of several hospice contracts. The Administrator indicated prior to 7/1/13 residents were able to choose the hospice services they desired. The Administrator stated a 30 day notice of facility policy change regarding hospice services had not been given to the residents residing in the facility on 7/1/13.</p> <p>Upon interview of the Administrator on 12/9/13 at 3 p.m., the Administrator indicated the facility did not have a specific policy and procedure regarding hospice services.</p> <p>Upon review of an Admission packet on 12/9/13 at 3:30 p.m., the resident admission contract indicated "...The Facility shall inform the Resident and the Legal Representative, both orally and in writing, in a language that the Resident and the Resident's Legal Representative understands, of the Resident's rights within the Facility,</p>				

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	<p>and the rules governing the Resident's conduct as well as the Resident's obligations while a Resident of the Facility. In the event any Resident's rights are altered, amended, or new right awarded, the Facility shall inform the Resident and the Resident's Legal Representative of the alteration, amendment, or addition..."</p> <p>3.1-4(a)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and record review the facility failed to provide care that enhanced the resident's dignity for 1 of 4 residents observed receiving care. (Resident # 28)</p> <p>Findings include:</p> <p>On 12/9/13 at 9:15 am CNA #'s 3 and 4 provided care to resident #28. The CNAs removed the resident's sweat pants and soiled incontinent brief. The resident remained uncovered, with his lower half exposed while CNA #3 left the room to get washcloths. The resident requested "cover me up" and CNA #4 indicated "we are going to wipe you off real quick then I will."</p> <p>Resident # 28 's clinical record was reviewed on 12/9/13 at 11:09 a.m.</p> <p>A significant change assessment dated, 7/17/13, identified the resident as requiring extensive assist of one for personal hygiene care.</p>	F000241	<p>1. Involved caregivers were addressed and re-educated following the observation of care during which the resident was left exposed while supplies were secured.2. As all residents could be affected, all nursing staff shall be provided inservice training regarding privacy/dignity and providing personal care in a manner to preserve resident dignity, including but not limited to, providing privacy and limiting exposure, as possible, during incontinent care, etc.3. As a means to ensure ongoing compliance with the provision of care in a manner to preserve resident dignity, following aforementioned inservice training, observations will be conducted randomly at least five times weekly at varied times. Should non-compliance with provision of care in a manner to provided resident privacy/dignity be observed, the caregiver will be addressed and/or re-educated upon observation.4. As a means of quality assurance, the results of the aforementioned observations and any corrective actions taken will be reported to the Quality Assurance Committee</p>	01/03/2014	

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	A policy titled "Care, Pre and Post Nursing Skills" dated 9/05, was received from the DON (Director of Nursing) on 12/9/13 at 4:10 p.m. Documentation indicated during care "...Keep Resident covered. Expose only the area of Resident's body necessary to do procedure." 3.1-3(t)		on an, at least, quarterly basis and the plan revised, as warranted.		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review, and interview the facility failed to allow resident choice of hospice care for 1 of 1 resident reviewed who was currently receiving hospice care. (Resident #7)</p> <p>Findings include:</p> <p>Upon review of Resident #7's clinical record on 12/9/13 at 10 a.m., documentation indicated Resident #7 was admitted on 8/14/2009.</p> <p>Documentation was also noted in the social service notes dated 10/23/13 of "Special care conference was held today with the local Ombudsman [name], [name] ADM [Administrator], [name] DON [Director of Nursing], and this writer to discuss concerns and issues that the resident family had about their choice of hospice services. Resident family requested [specific hospice company] while the resident was at [specific hospital]. The resident family signed admission</p>	F000242	<p>1. Resident #7 was affected. The facility must have a contract with the hospice company utilized in the facility in an effort to ensure coordination of services. The responsible party for resident #7 has been notified of the hospice companies with which the facility has current contracts.2. All residents residing in the facility have the potential to be affected. All residents and/or their responsible party will be notified in writing of the hospice care service options available to be utilized in the facility when hospice services are deemed applicable (please see attachment A). 3. As a measure of ongoing compliance the Administrator or designee will complete a review monthly, (please see attachment B) regarding the Resident's rights within the facility, noting any revision in Resident's rights and ensure the Facility informs the Resident and the Resident's responsible party of the same, providing necessary advance notice.4. As a measure of quality</p>	01/03/2014	

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	<p>paper work with [hospice company]. [ADM name] attempted to explain this to the resident family. Resident family left very upset and notified the local Ombudsman [name] which lead to this meeting that was held today. The family was informed that the facility only has one contract and that contract is with [hospice name] and this writer gave the resident family information and has set up a meeting with the [name of hospice], and [ombudsman], [ADM], [DON], and this writer to discuss the services that the [name of hospice] can provide and give the family the option to decide if they still want hospice services. This meeting is to be held on October 25, 2013 at 10:00 am. [sic] This writer to continue to follow up with resident family and [ombudsman]."</p> <p>A social service notation dated 10/25/13 indicated the resident was admitted to [specific hospice name which was not the hospice service provider requested while resident was hospitalized] today per family request. Resident was admitted to hospice with the dx [diagnosis] end stage heart disease."</p> <p>Upon interview of the Social Services Director [SSD] on 12/9/13 at 12:10 p.m., the SSD indicated during the</p>		assurance the Administrator or designee will review any findings and subsequent corrective action, as a result of the aforementioned monthly reviews, in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.				

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	<p>admission process prior to 7/1/13 residents were informed several hospice companies were available if needed. The SSD stated after 7/1/13 residents and families were notified during admission process that only one hospice company was available for services when needed.</p> <p>Upon interview of the Administrator on 12/9/13 at 12:20 p.m., the Administrator indicated the facility changed their policy on 7/1/13 to allow only one hospice group to service their facility. The Administrator stated the facility only has to maintain one "umbrella" hospice, instead of several hospice contracts. The Administrator indicated prior to 7/1/13 residents were able to choose the hospice services they desired. The Administrator stated a 30 day notice of facility policy change regarding hospice services had not been given to the residents residing in the facility on 7/1/13.</p> <p>Upon interview of the Administrator on 12/9/13 at 3 p.m., the Administrator indicated the facility did not have a specific policy and procedure regarding hospice services.</p> <p>Upon review of an Admission packet</p>			

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	<p>on 12/9/13 at 3:30 p.m., the resident rights were reviewed. The rights included but were not limited to "You have the right to: ...Contact and meet with certain agency representative or individuals who provide health, legal, social, or other services..."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation and record review the facility failed to ensure a resident unable to perform own personal hygiene received services to maintain good hygiene for 1 of 1 incontinence resident observed receiving peri-care in that a cleanser was not used to cleanse the urine from the resident's skin. (Resident 28)</p> <p>Findings include:</p> <p>On 12/9/13 at 9:15 am CNA #'s 3 and 4 provided care to resident #28. The CNAs removed the resident's sweat pants and incontinence brief soiled with urine. The brief was soiled around the lower buttocks, and posterior upper thigh area.</p> <p>CNA #2 left the room to get washcloths. CNA #3 returned with a washcloth, and wet the cloth under the faucet in the adjoining bathroom sink. A cleanser was not used. The CNA, while resident was laying prone, washed the resident's peri-area and</p>	F000312	<p>1. Resident #28 was affected. Perineal care was provided per facility policy upon being informed of the deficient practice. CNA's #3 & 4 were re-educated on the facility's procedure for providing perineal care.2. All residents' dependent upon staff for perineal care have the potential to be affected. Thus, all nursing staff will be in-serviced on the facility's policy on perineal care and pre/post steps, (please see attachment C) including but not limited to appropriate cleansing of the perineal area using soap or similar cleansing product.3. As a means to ensure ongoing compliance the DON or designee will complete an audit, (please see attachment D) to ensure residents are receiving perineal care per facility policy. A perineal care observation will be completed daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Should concerns with performance be observed, immediate correction and re-education shall be implemented.4. As a means of quality assurance, the DON or</p>	01/03/2014			

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	<p>inner thighs. The resident's buttocks or posterior thighs were not cleansed.</p> <p>Resident # 28 's clinical record was reviewed on 12/9/13 at 11:09 am.</p> <p>A significant change assessment dated, 7/17/13, identified the resident as requiring extensive assist of one for personal hygiene care.</p> <p>A policy titled "PERINEAL CARE" [no date] was received from the DON (Director of Nursing), on 12/9/13 at 4:10 p.m. Documentation indicated during care "Wet and soap washcloth or obtain wipe."</p> <p>3.1-38(a)(3)(A)</p>		<p>designee will review any findings and subsequent corrective action(s) during the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>		

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review the facility failed to ensure or prevent further pressure ulcers for 1 of 4 residents reviewed that met the criteria for pressure sores, in that, a resident with a current pressure ulcer, and with a history of pressure ulcers did not receive services to cleanse the skin soiled with urine. (Resident #28)</p> <p>Findings include:</p> <p>On 12/4/13 at 11:15 am LPN #2 provided treatment to resident #28's right lower buttocks area. The resident's area was open with part of the opening observed to have a slightly dark brown area. The nurse washed the area with soap and water, rinsed with water and dried the area. The nurse then applied "Vasolex" ointment to the area.</p>	F000314	<p>1. Resident #28 was affected. Perineal care was provided per facility policy upon being informed of the deficient practice. CNA's #3 & 4 were re-educated on the facility's procedure for providing perineal care. Resident #28 had preventative measures to prevent pressure ulcers in place. Treatment was applied per physician orders. A clarification order was obtained to address re-application of treatment following incontinent episodes. 2. As all residents dependent upon staff for perineal care have the potential to be affected. All nursing staff will be in-serviced on the facility's policy on perineal care and pre/post steps, (please see attachment C) to include but not be limited to proper cleansing and notification of licensed nursing staff should perineal care result in a need for dressing re-application or treatment/ointment re-application. 3. As a means of</p>	01/03/2014			

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	<p>On 12/9/13 at 9:15 am CNA #'s 3 and 4 provided care to resident #28. The CNAs removed the resident's sweat pants and and incontinence brief soiled with urine. The brief was soiled around the lower buttocks and posterior upper thigh area.</p> <p>CNA #3 used a wet washcloth without a cleanser and while the resident was laying supine, washed the resident's peri-area and inner thighs. The resident's buttocks or posterior thighs were not cleansed.</p> <p>Resident #28's clinical record reviewed on 12/9/13 at 11:09 a.m.</p> <p>A significant change assessment dated 7/17/13, indicated the resident had an unhealed stage 3 pressure ulcer to the right lower buttocks measuring 1.4 cm x 0.5 cm x depth of 0.1 cm. The assessment identified the resident as incontinent of urine.</p> <p>A physician's order was noted, dated 10/25/13, of discontinue "Vasolex ointment [Topical debriding agent] apply to area on lower right buttocks q shift til healed."</p> <p>A physician's telephone order was noted, 11/20/13, of "Vasolex ointment</p>		<p>ensuring ongoing compliance, the DON or designee will complete an audit, (please see attachment D) to ensure residents are receiving perineal care per facility policy and appropriate wound care is provided thereafter, as applicable. A perineal care observation will be completed daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30days, then monthly ongoing. Should non-compliance be observed corrective action and re-education shall be implemented upon observation.4. As a means of quality assurance, the DON or designee will review any findings and any subsequent corrective action during the facility's quarterly quality assurance meeting. The plan will then berevised as warranted.</p>		

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	<p>apply to area on lower right buttocks q [every] shift until healed"</p> <p>A plan of care was noted, identifying "Pressure Ulcer", with an initial date of 11/20/13, and an update of 12/5/13. The plan of care identified "The resident has a pressure ulcer" "Location [lower] (R) [right] buttock stage 2." An approach was noted, to apply ointment per "MD"order. The plan of care did not identify what to do when the resident was incontinent of urine to prevent further damage to the resident's skin.</p> <p>On 12/9/13 at 12:19 p.m., a form titled "Initial Pressure Ulcer Assessment" was received from the ADON (assistant director of nursing).</p> <p>Documentation indicated the following;</p> <p>11/20/13 stage 2 1 cm (centimeter) x .8 cm (right lower buttock)</p> <p>11/22/13 stage 2 1 cm X 0.8 cm, depth less than 0.1 cm</p> <p>11/29/13 stage 2 1.5 cm x 1.5 cm, no depth</p> <p>12/05/13 stage 2 1.1 cm x 1 cm, no depth</p>			

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	<p>During interview of the ADON on 12/9/13 at 12:19 p.m., the ADON indicated the resident's pressure area on the lower right buttocks had healed, and reopened on 11/20/13.</p> <p>3.1-40(a)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to provide supervision to prevent falls for 1 of 3 resident reviewed who met the criteria for falls [Resident #29] in that the resident was left unattended utilizing a toilet riser in the bathroom and had a fall attempting to self transfer and 1 of 1 random observation of a mechanical lift transfer was not done in accordance with manufacturer's guidelines [Resident #28.]</p> <p>Findings include:</p> <p>1. On 12/3/13 at 10:27 a.m. LPN # was interviewed. The nurse indicated Resident #29 had fallen on 12/2/13. The nurse indicated the resident attempted to transfer self from the toilet to a wheelchair when the CNA who assisted her onto the toilet exited the room to answer another call light. The LPN indicated the resident had put the call light on but did not wait for assistance.</p>	F000323	<p>1. Resident # 28 & #29 were affected. Resident # 29's care plan was reviewed and updated with current interventions. The toilet riser in resident # 29's bathroom was adjusted to fit properly. CNA's # 3 & 4 were re-educated on proper utilization of the mechanical lift.2. As all Residents who require a mechanical lift for transfers and residents at risk for falls have the potential to be affected. Nursing staff will be in-serviced on fall prevention, including but not limited to, remaining with residents identified as "at risk" of falls while toileting, ensuring any assistive equipment is secure and in good repair, and the facility's policy on Hoyer lift transfers, including but not limited to not moving the legs over cords or objects when the resident is elevated in the sling (please see attachment C).3. As a means of ensuring ongoing compliance, the DON or designee will complete an audit, (please see attachment E) to ensure Hoyer lift transfers are completed per facility policy. A Hoyer lift observation will be completed daily on regularly scheduled days</p>	01/03/2014			

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	<p>On 12/6/13 at 2:00 p.m. the DON was interviewed. The DON indicated a CNA had placed the resident in the bathroom, removed the wheelchair from the room to prevent the resident from self transferring, shut the door and exited the room to answer another call light. The resident stood up when finished in the bathroom and fell.</p> <p>Resident #29 was observed daily during the survey propelling self around the facility in a wheelchair. The resident utilized a right leg brace, and right arm splint. The resident was observed daily ambulating in the corridor with assistance of three staff members.</p> <p>On 12/06/13 at 12:50 p.m. the resident's bathroom was observed. A toilet riser was observed in place. The riser had one screw on the front to secure to the stool. The device easily moved from side to side.</p> <p>Resident #29's clinical record was reviewed on 12/6/13 at 1:15 p.m. The resident's diagnosis included, but was not limited to, late effects of cerebral vascular accident (CVA.) The resident had right sided hemiplegia.</p> <p>A Minimum Data Set [MDS] dated</p>		<p>for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. Should concerns be observed, applicable staff members will be re-educated immediately and corrective action taken, as warranted. The DON or designee will complete an audit, (please see attachment F) on five residents weekly for 30 days, then monthly ongoing to ensure all fall prevention interventions are implemented as care planned. Additionally the Maintenance director or designee will complete a preventative maintenance audit on a weekly basis ongoing to ensure toilet risers (and other such adaptive equipment used for fall prevention) are in place as indicated and maintained appropriately, (please see attachment G). Should concerns be observed, applicable staff members will be re-educated immediately and corrective action taken, as warranted.4. As a means of quality assurance, the DON and Maintenance Director or designee will review any findings and any subsequent corrective actions taken in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>		

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	<p>10/25/13 coded the resident with extensive cognitive impairment, non-ambulatory in the room and required extensive assistance of two for ambulation in the corridor. The assessment coded the resident with unsteady balance without assistance, limited range of motion to upper and lower extremities one side related to CVA, uses walker and wheelchair.</p> <p>A plan of care with most recent review date of 11/20/13, addressed a risk for falls related to hypertension, migraines, diabetes, edema, seizures, history of CVA depression use of anti-depressant, diuretic, required assistance with activities of daily living, decreased safety awareness, non compliant with assistance. Approaches included, but were not limited to, use toilet riser, and on 10/3/12, do not leave the resident in room unattended.</p> <p>2. On 12/9/13 at 9 am CNAs #'s 3 and 4 transferred resident #28 from a wheelchair to a bed with a "Medline" mechanical lift. While attempting to position the lift under the bed, the CNAs rolled the legs of the lift over an electrical cord, causing the sling of the lift, holding the resident, to sway back and forth.</p>						

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	<p>During review of the "Medline" manufacturer's guidelines concerning the mechanical lift, received from the DON (Director of Nursing) on 12/9/13 at 4:15 PM, documentation indicated under "Safety Instructions" the following but not limited to, "Do not roll casters over any object while the resident is in a sling."</p> <p>3-1.45(a)(2)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to prepare food under sanitary conditions for 1 of 2 kitchen observations.</p> <p>Findings include:</p> <p>1. On 12/6/13 at 11:00 a.m., Dietary Aide #10 was observed preparing eight servings of pureed ravioli. The staff member indicated it would be prepared in two batches. After washing hands and donning gloves, the aide dipped four cups of cooked ravioli into a measuring cup, added it to the puree processor, added two cups of tomato juice, opened a Ziploc bag lying on the counter which contained eight slices of bread, picked up four bread slices with the gloved hands and tore into pieces, adding to the mixture. The aide picked up the lid to the processor, placed on the device, pushed the start button, touching the exterior of the device. After puree was</p>	F000371	IDR Rationale for F371 - (483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY) The facility respectfully requests this citation be reviewed. F371 states “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” The 2567 further alleges “This REQUIREMENT is not met as evidenced by:Based on observation, interview, and record review, the facility ailed to store and prepare foodunder sanitary conditions for 1 of 2 kitchen observations and 6 of 6 personal refrigerators containing food and fluids lacked a means to monitor the refrigeration temperatures.(Residents #42, #43, #66, #7, #19, and #68).”In response to the aforementioned allegation, the facility concurs that an employee was observed preparing pureed diets for seven (7) residents of a census of fifty-two (52) total residents during which gloves were not changed as appropriate. This involved	01/03/2014			

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	<p>prepared, the aide poured the mixture into a steam table pan. The aide then went to the other area of the counter and repeated the process to prepare the second batch touching other surfaces. With the same gloves on the aide handled four slices of bread tour into pieces and added to the puree mixture.</p> <p>A facility policy titled "Hand Washing Policy," dated 11/12/08 and provided by the Administrator on 12/9/13 at 4:06 p.m., included but was not limited to, "Policy: It is the policy of the Dietary Department to prevent the spread of infection through proper handwashing. Han sanitizer may not be used. Procedure: 1. Hands are washed: b. After handling soiled dishes and utensils. d. Before and after handling foods. ..."</p>		<p>13.5% of the total resident population. In regard to personal refrigerators maintained by six (6) residents, the facility had elected to observe the resident's right to house personal belongings in the facility. The facility had in place a policy regarding the possession and maintaining of personal refrigerators at the discretion/choice of the resident/responsible party. Ongoing maintenance/cleaning of the refrigerator (i.e., the property of the individual resident) was the obligation of the resident/responsible party (See Attachment #1). The food items stored in the personal refrigerators were foods normally supplied by family members and were not procured, prepared nor distributed by the facility (as described in F371). The facility does not agree that it is deficient in procuring, storing and preparing foods under sanitary conditions, when a resident has elected the personal choice/right of owning/maintaining a personal refrigerator to house food items of his/her personal choice provided by the family or obtained by the resident by another means. Further, the 2567 does not state that any refrigerator, when observed for the presence of a thermometer, was noted to appear of substandard temperature, thus, presenting potential hazard, nor was a temperature obtained by the</p>		

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			<p>surveyor at the time of observation. One should note that when thermometers were placed in each personal refrigerator, no temperature was observed to be substandard (i.e., above 41 degrees) thus, food items were not housed by the resident at a temperature indicating unsafe storage of potentially hazardous foods. The facility respectfully requests the basis of the F371 citation at widespread level, although significantly relative to a resident's choice of food items stored in his/her room and not procured by the facility, be reviewed. Thank you for your consideration.</p> <p>1. Resident #42, #43, #66, #7, #19, and #68 were affected. Dietary Aide #10 was immediately re-educated on preparing food under sanitary conditions, including but not limited to changing of gloves, upon observation. Thermometers were placed in said personal refrigerators, which indicated the</p>		

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			<p>refrigerator temperatures were appropriate.</p> <p>2. All residents have the potential to be affected. All personal refrigerators shall have a thermometer in place inside which will be monitored daily to ensure it is an appropriate temperature for food storage. Any problems noted with the temperature will be addressed as indicated. Housekeeping staff will be in-serviced on monitoring and documenting refrigerator temperatures as well as action to take if the temperature is not in the appropriate range, (please see attachment H). All dietary staff will be in-serviced on preparing food under sanitary conditions including but not limited to hand washing and appropriate glove change (please see attachment I).</p> <p>3. As a means to ensure ongoing compliance, the Dietary Manager will complete an audit, (please see attachment J) daily on</p>		

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	3.1-21(i)(3)		regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing to ensure food is prepared under sanitary conditions with appropriate changing of gloves. Additionally, housekeeping staff will monitor the temperature of personal refrigerators daily and document on a refrigerator temperature log ongoing. Any temperatures noted out of the appropriate rage will be addressed as indicated. The Administrator will sign off on the personal refrigerator logs monthly ongoing. 4. As a means of quality assurance, the aforementioned audits/observations and any corrective actions taken shall be addressed with the Quality Assurance Committee during quarterly meetings and the plan revised, if indicated.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F000460 SS=D	<p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to equip shared bedrooms with full visual privacy for 1 of 3 resident (Resident #28) who met the criteria for privacy and 1 of 1 random observation (Resident #58) in that privacy curtains were lacking for the second bed in the room.</p> <p>Findings include:</p> <p>1. On 12/3/13 at 11:59 a.m. Resident #58 was observed in the bedroom with Resident #42. Resident #58 was the second bed in the room. Privacy curtain tracks for the second bed were observed, in another area of the room, not where the resident's bed was positioned. Curtains to afford the resident privacy were lacking.</p> <p>On 12/9/13 at 3:00 p.m. with the Administrator, Maintenance and Housekeeping supervisors the room was observed without a curtain to</p>	F000460	<p>1. Resident #28 and resident #58 were affected. Privacy curtains have been placed in rooms as appropriate to ensure full visual privacy.2. As all residents have the potential to be affected, all resident rooms were checked to ensure privacy curtains are in place as appropriate to provide full visual privacy. All nursing staff will be in-serviced on providing privacy for residents, (please see attachment C).3. As a means to ensure ongoing compliance, the DON or designee will complete an audit, (please see attachment K) daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing to ensure privacy is maintained during resident care and privacy curtains are in place and utilized as appropriate. Should non-compliance be observed, applicable staff members will be re-educated, and/or maintenance staff will be notified, as indicated.4. As a means of quality assurance, the DON or designee</p>	01/03/2014			

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	<p>ensure privacy.</p> <p>2. During observation on 12/3/13 at 2:53 p.m., resident #28 was observed to be one of two residents sharing a room, and to not have privacy curtains available around his bed.</p> <p>During observation of resident #28 receiving incontinence care on 12/9/13 at 9 am, performed by CNA #'s 3 and 4 as well as a treatment provided by LPN #2 on 12/4/13 at 1:15 PM to the resident's right lower buttocks area, the resident did not have a privacy curtain available.</p> <p>During interview of CNA's # 3 and 4, on 12/9/13 at 9:30 AM, the CNAs verified the resident did not have his own privacy curtains to pull around his bed.</p> <p>During interview of LPN #2 on 12/9/13 at 1:30 PM, the LPN verified the resident did not have his own privacy curtain.</p> <p>3.1-19(k)(1)</p>		will review any findings and subsequent corrective action during the aforementioned audits in the facility's quarterly quality assurance meeting. The plan will then be revised as warranted.				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure a functional and/or sanitary environment for 7 of 30 residents reviewed. (Residents #32, #28, #66, #14, #42, #33, and #31)</p> <p>Findings include:</p> <p>1. On 12/4/13 at 11:18 a.m., Resident #32's exhaust fan was turned on. The fan made a loud audible noise. The fan was electrically connected to the single light switch in the bathroom.</p> <p>Resident # 32 indicated on 12/4/13 at 11:18 a.m. the fan noise was loud, but that it turned off when the bathroom light was turned off.</p>	F000465	<p>1. Residents #32, #28, #66, #14, #42, #33, and #31 were affected. The exhaust fan in the room of resident # 32 was repaired and placed on a separate switch from the light. The plastic coverover the fluorescent light mounted on the wall beside resident #28's bed was replaced and the wall was cleansed. Resident #66's bathroom floor was thoroughly cleaned. Resident #14's wall was repaired. Resident #42's room walls were repaired and painted and the sink was replaced. Resident #33's woodwork and walls were repaired and painted and the flooring was repaired. Resident #31's wall was repaired and painted, the closet doors wererepaired and knobs were replaced, the wallpaper was replaced, and the sinkwas replaced. The exterior of the East Wing shower room door and exteriorkitchen door were repaired and painted.2. As all residents have the potential to be affected, environmental rounds were completed in the facility for needed repairs. Needed repairs were noted and placed on a list by priority to becompleted. The Maintenance Director will be in-serviced on completing environmental rounds and</p>	01/03/2014	

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	<p>2. During observation of resident #28's room, on 12/3/13 at 2:53 PM, the plastic cover over the florescent light mounted on the wall beside resident #28's bed, was cracked and broken.</p> <p>The wall directly beside resident #28's bed was heavily soiled with splatters of a brown substance. The light cover was observed cracked and broken</p>		<p>preventative maintenance schedules, (please see attachment L). 3. As a means to ensure ongoing compliance, the Administrator or designee and Maintenance Director or designee will complete an environmental audit, (please see attachment M) daily onregularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing to ensure the facility isproviding a safe, functional, sanitary, and comfortable environment for residents, staff and the public.Concerns identified will be noted per maintenance requisition and repairs scheduled accordingly.4. As a means of quality assurance, the Administrator or designee will review any findings and subsequent repairs made/scheduled during the facility's quarterly quality assurance meeting. Any revision to the plan will be made, if indicated.</p>		

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	<p>and the wall soiled on 12/4/13 and 12/5/13.</p> <p>3. During observation of resident #66's bathroom on 12/4/13 at 12:20 p.m., a dark brown substance was noted around the base of the toilet.</p> <p>4. On 12/3/13 at 11:17 a.m., Resident #14's room was observed with a hole in the center of the hollow core bathroom door.</p> <p>5. On 12/3/13 at 11:59 a.m., Resident #42's room was observed with marred and missing paint from the room door edges. The overflow drain in the bathroom sink had an accumulation of rust extending down the interior of the sink. A hole in the wall was observed behind the toilet. During environmental tour, on 12/9/13 at 3:00 p.m., the Administrator acknowledged the areas.</p> <p>6. On 12/3/13 at 10:32 Resident #33's room was observed. The woodwork on the exterior and interior of the bathroom was heavily marred and scuffed with missing paint. An area of the flooring around the base of the toilet was lacking.</p> <p>7. On 12/3/13 at 2:41 p.m. Resident</p>			

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	<p>#31's room was observed. A hole at the bottom of the wall behind the head of the bed was noted. One of two closet door knobs was lacking. The doors were heavily marred and scuffed. The wallpaper on the wall next to the resident's bed was ripped and torn. The bathroom drain and overflow drains had heavy accumulations of rust and the porcelain sink had chipped areas. On 12/9/13 at 5:00 p.m. the Administrator indicated the resident had a hole in the wall.</p> <p>On 12/9/13 at 3:00 p.m. with the Administrator, Maintenance and Housekeeping supervisors, the exterior of the East Wing shower room door and the exterior of the kitchen door were observed with heavily marred painted surfaces. The Administrator indicated she knew the surfaces were marred.</p> <p>3.1-19(f)</p>			