

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155519	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2011
NAME OF PROVIDER OR SUPPLIER GENTLECARE OF VINCENNES			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST VINCENNES, IN47591		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: August 8, 9, 10, 11, 15, 2011</p> <p>Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370</p> <p>Survey Team: Martha Saull, RN-TC Carole McDaniel, RN Terri Walters, RN Ann Marie Crays, RN</p> <p>Census By Bed Type: SNF/NF: 49 Total: 49</p> <p>Census By Payor Source: Medicare: 5 Medicaid: 37 Other: 7 Total: 49</p> <p>Stage 2 sample: 17</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 22,</p>	F0000	<p>This plan of correction is submitted to serve as allegations of compliance. Preparation and/or execution of this plan of corrections does not constitute an admission or agreement by the provider of the allegations or conclusions set forth in the statements of deficiencies.</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.

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

PRINTED: 09/23/2011

FORM APPROVED

OMB NO. 0938-0391

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	2011 by Bev Faulkner, R.N.				

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F0167 SS=C	<p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure Survey Results were made accessible to residents on 5 of 5 survey days. This deficient practice had the potential to affect all 49 residents in the facility.</p> <p>Findings include:</p> <p>On 8/8, 9, 10, 11 and 15/11 during 9:30 A.M. and 1:30 P.M. checks each day, the survey results were observed to be stored in a clear, brittle, plastic pocket permanently affixed to the wall and labeled "Survey" in bold letters. The location of the site was in a corner, above wheel chair height and behind a chair which was positioned in the corner, rendering it out of reach.</p> <p>On 8/15/11 at 1:00 P.M. in interview, the Administrator was informed of the posting problem and indicated it could be moved to an accessible area.</p>			F0167	<p>Corrective actions for residents found to have been affected: No residents were found to have been affected by this practice. Identification of Residents having the potential to be affected: Administrator identified all residents as having a potential to be affected by this practice. To correct this practice the Survey Results were relocated to an accessible area and lowered to wheelchair height for all current and future residents. Measures or systemic changes to prevent recurrence: Social Service Director will check location of Survey Results monthly to determine accessibility for all residents. Accessibility will include an unobstructed location at wheelchair height. The survey results location will be reviewed monthly during resident council meetings and the location will be noted on each residents activity calender. Corrective Action Monitored: The Social Service Director will monitor accessibility of Survey Results monthly and report findings to the facility</p>		09/14/2011

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	3.1-3(b)(1)		Coninuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review findings quarterly and modify the audit system after (3) quarters (9 months) as the information warrants.		

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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 interview and record review, the facility failed to do a complete investigation of 1 of 3 facility incidents reviewed for allegations of abuse. Resident #7</p>	F0225	Corrective action for residents found to have been affected: Resident #7 was found not to have been affected by the this practice. Identification of Residents having the potential to	09/14/2011	

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	<p>Findings include:</p> <p>A facility incident reporting form, dated 7/7/11, was reviewed on 8/15/11 at 2:00 P.M. This documentation indicated, "Wednesday July 6, 2011, Administrator received a phone call from resident (Resident #7's) sister (sister' name here). (Sister's name) voiced a concern regarding a phone conversation with her brother (Resident #7's) on 7/2/2011. Resident #7 told her an CNA #1 had answered his call light and asked 'what the hell do you want now?' (Sister's name) reported to the Administrator that Resident #7 could not remember when this incident took place..."</p> <p>This facility incident reporting form of 7/7/11, also included, "... Immediate Action Taken: Aide suspended pending outcome of investigation. Interviewed resident, staff and resident's sister..."</p> <p>On 8/15/11 at 2:25 P.M., the Administrator and the Director of Nursing (DON), were interviewed in regard to allegation of abuse incident regarding Resident #7. They indicated during the investigation it was</p>		<p>be affected:The Administrator identified all residents as having a potential to be affected by this practice. The facility "Investigation of Abuse and Protection of the Resident" policy and procedure was revised to include specific instructions for interviewing other residents (ATTACHMENT A), when conducting an abuse allegation investigation.Measures or systemic changes to prevent reoccurrence:Facility "Investigation of Abuse and Protection of the Resident" policy and procedure will be revised to include specific instructions for interviewing other residents when conducting an abuse allegation investigation (ATTACHMENT A). The "Investigation of Abuse and Protection of the Resident" Policy and Procedure will include the instruction to interview other residents regardless of an admission by the individual reporting the abuse that the abuse report was false. All staff will be in-serviced on the revised "Investigation of Abuse and Protection of the Resident" policy and procedure.Corrective Action Monitored:The Administrator and Director of Nursing will review all investigations alleging abuse, to confirm that other residents were interviewed during the investigation. The result of these reviews will be reported to the facility Continuous Quality Improvement Committee.</p>		

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	<p>determined Resident #7 had "made up" the allegation; therefore, the facility had not interviewed any other residents. The Administrator indicated once the resident admitted the allegation was not true, the facility did not interview other residents.</p> <p>An Assistant Director of Nursing (ADON) note, dated 7/6/11, in regard to the allegation of abuse regarding Resident #7 and CNA#1 was reviewed on 8/15/11 at 3:25 P.M. This note indicated, "... We informed (CNA's #1's name) he was relieved of duty until a thorough investigation was done, which included talking to (Resident #7's name), other staff members & other residents."</p> <p>3.1-28(c)</p>				<p>The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. Allegations of Abuse reviews will be done on an ongoing basis.</p>		
F0226 SS=E	<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 interview, the facility failed to ensure their policy for abuse investigation included specific instructions for interviewing</p>			F0226	<p>Corrective action for residents found to have been affected: The Director of Nursing reviewed past abuse allegation investigations and found no residents</p>		09/14/2011

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	<p>residents. This had the potential to affect all residents involved in an abuse allegation investigation.</p> <p>Findings include:</p> <p>A facility incident reporting form, dated 7/7/11, was reviewed on 8/15/11 at 2:00 P.M. This documentation indicated, "Wednesday July 6, 2011, Administrator received a phone call from resident (Resident #7's) sister (sister' name here). (Sister's name) voiced a concern regarding a phone conversation with her brother (Resident #7's) on 7/2/2011. Resident #7 told her an CNA #1 had answered his call light and asked 'what the hell do you want now?' (Sister's name) reported to the Administrator that Resident #7 could not remember when this incident took place..."</p> <p>On 8/15/11 at 2:40 P.M., the facility abuse policy was reviewed with the Administrator. The Administrator was made aware that documentation was lacking in regard to the facility abuse policy directing staff to interview other residents regarding an allegation of abuse. The Administrator indicated, at this time, he was unable to find</p>		<p>were affected by this practice. Identification of residents having the potential to be affected: The Administrator identified all residents as having a potential to be affected by this practice. The facility "Investigation of Abuse and Protection of the Resident" policy and procedure was revised to include specific instructions for interviewing other residents when conducting an abuse allegation investigation. (ATTACHMENT A) Measures or systemic changes to prevent recurrence: Facility "Investigation of Abuse and Protection of the Resident" policy and procedure will be revised to include specific instructions for interviewiing residents when conducting an abuse allegation investigation (ATTACHMENT A) These specific instructions will include the instruction to interview other residents regardless of an admission by the individual reporting the abuse that the abuse report was false. All staff will be in-serviced on revised "Investigation of Abuse and Protection of the Resident" policy and procedure. Corrective Action Monitored: The Administator and Director of Nursing will review all allegations of abuse to confirm that other residents were interviewed, regardless of an admission by the individual reporting the abuse, that the abuse report was false.</p>		

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	<p>documentation in the facility policy directing the facility to interview other residents when investigating an allegation of resident abuse.</p> <p>The facility abuse policy titled, "Investigation of Abuse and Protection of the Resident" (revised date 10/01/10) was received on 8/11/11 1:30 P.M. This policy included but was not limited to: "... 2.6. Written statements are obtained by the Administrator and/or designee from all involved parties including the suspected staff member. 2.7. Upon receipt of all statements, Administrator and/or designee reviews statement for validation of alleged concern. 2.8 If concern is validated, staff member is terminated in accordance with the Employee Handbook Discipline Policy regarding Gross Misconduct. Appropriate reporting to agencies is conducted per 'Reporting Response Abuse Policy.' 2.9. If the concern is not validated, the staff member is reinstated and paid for the suspended days.'</p> <p>3.1-28(a)</p>		<p>The results of the reviews will be reported to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. Reviews of investigations alleging abuse will be done on an ongoing basis.</p>		

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F0247 SS=A	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure a resident was notified of a roommate change, for 1 of 3 residents interviewed regarding notification of room and/or roommate changes, in a sample of 3	F0247	Corrective action for residents found to have been affected: Resident #37 was found to have been affected by this practice. The Social Service Director interviewed resident #37 regarding her roommate.	09/12/2011

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	<p>who met the criteria for admission/transfer/discharge rights in the Stage 2 sample of 17. Resident #37</p> <p>Findings include:</p> <p>1. On 8/8/11 at 12:41 P.M., during interview with Resident #37, she indicated she had a change in roommate in the previous 9 months, and had not been given a notice prior to the change in roommate.</p> <p>On 8/15/11 at 9:00 A.M., during interview with LPN # 1, she indicated Resident # 37 had a resident move in with her "approximately 5-6 weeks ago."</p> <p>The clinical record of Resident # 37 was reviewed on 8/15/11 at 9:00 A.M. Documentation of notification of a roommate change was lacking in the record.</p> <p>On 8/15/11 at 9:15 A.M., during interview with the Social Services Director [SSD], he indicated he would notify a resident that they would be getting a new roommate, and then have the resident sign a verification letter that they had been told. The SSD indicated Resident # 37 received a new roommate in June 2011. The</p>		<p>Resident #37 felt the roommate was acceptable and would inform Social Service Director if there were issues in the future. Identification of Residents having the potential to be affected: The Social Service Director identified residents receiving new roommates as having the potential to be affected. To ensure that a resident is notified of a roommate change, the Social Services Director will continue to use the facility form titled, "Notification of Receiving New Roommate". This form requires resident or resident representative's signature, verifying they have been informed of a change in roommates. Measures or systemic changes to prevent recurrence: The Social Service Director will report all roommate changes to the Administrator as they occur. The Social Services Director will provide the Administrator with a copy of a signed "Notification of Receiving New Roommate" form to verify resident has been informed of a change in roommate. Corrective Action Monitored: The Administrator will review and sign the "Notification of Receiving New Roommate" form as they are presented. Social Service will provide "Notification of Receiving New Rommate" to facility Continuous Quality Improvement Committee. The Quality Assurance Committee will review</p>		

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F0248 SS=D	<p>SSD indicated he did not see documentation of notification of a roommate change in Resident # 37's clinical record. The SSD indicated he did speak to the resident regarding the roommate change, but "must have forgotten to write it."</p> <p>2. On 8/15/11 at 9:55 A.M., the Administrator provided the current facility policy on "Notification of Change," dated 10/90. The policy included, "Policy: A resident will be notified immediately of any of the following changes:...Change in roommate or room...."</p> <p>3.1-3(v)(2)</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an ongoing individualized activity program was provided for 1 of 3 residents reviewed for activities, in a sample of 12 residents who met the criteria for activities. Resident #50</p>	F0248	<p>"Notification of Receiving New Roommate" forms quarterly and modify the forms and/or system after three quarters (nine months) as the information warrants.</p> <p>Corrective action for residents found to have been affected:The Activity Director completed a new Activity Aseessment and updated the Plan of Care for resident #50. Resident #50 will be provided one-on-one visits by the Activity Director or the Activity Assistant. The facility will contract with an Activity Consultant to review</p>	09/12/2011	

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	<p>Findings include:</p> <p>The clinical record of Resident # 50 was reviewed on 8/10/11 at 1:15 P.M. Diagnoses included, but were not limited to, Dementia.</p> <p>The most recent activity progress note, dated 3/1/11, indicated, "...Res. [resident] awake x 3 dly [daily] [with] occasional cat naps in afternoon. Res. cont. [continues] to propel herself in for coffee daily. Res. enjoys talking to others. Res. alert [with] confusion...Res. cont. to be act 3 x wkly in act. ie: coffee time, church, etc. thru next eval. Note complete. C/P [care plan] updated."</p> <p>The Minimum Data Set [MDS] assessment, dated 5/29/11, indicated the resident scored a 6 out of 15 on a cognitive test, with 15 indicating no mental impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff to transfer, and did not ambulate.</p> <p>A Care Plan, dated 6/11, indicated a problem of "Pot. [potential] for low activity part. [participation] R/T [related to] Res. [resident] will come in [and] out of activity before activity is completed...Res STM [short term memory] loss deficit d/t [due to]</p>		<p>Resident #50's activity program. This review will determine resident #50's requirements for individualized activities. Identification of Residents having the potential to be affected: The Activity Director identified residents participating in small group activity therapy and one-on-one activity therapy as having the potential to be affected by this practice. The Activity Director and the Activity Consultant will complete new Activity Assessments and review (update if necessary) Plans of Care for identified residents. The Activity Consultant will review the assessments and revised Plan of Care for the identified residents. The Activity Consultant will determine if the Activity program for the identified residents is designed to meet their interests and the physical, mental and psychosocial well being of each resident. Measures or systemic changes to prevent recurrence: The Activity Director will complete an Activity Assessment for each resident upon admission, re-admission, change of condition and annually thereafter and provide the Administrator with a copy of each Activity Assessment. The Activity Director will develop an Activity Plan of Care for all residents within 14 days of admission, and review/revise (if indicated) each resident's Activity Plan of Care upon re-admission, changing</p>		

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	<p>dementia...Resid. [sic] likes coffee [and] cookies." The Goals indicated, "Resident will part. [sic] in small group act. 2xs weekly thru next eval. Resident will verbalize satisfaction relating to activity." The Approaches indicated: "Resident likes to talk to staff. Engage in conversation as much as possible. Reorient res. to person, place [and] time. Praise resident for accomplishments. Hug or pat resident [and] smile at resident when approaching resident."</p> <p>The resident was not observed to participate in activities on 8/8/11 or 8/9/11.</p> <p>On 8/11/11 at 9:00 A.M., Resident #50 was observed lying in bed, with her eyes open and talking to herself. At 10:00 A.M., Resident #50 was observed lying in bed with her eyes closed. An activity of news/coffee was taking place in the dining room. At 11:00 A.M., the resident was lying in bed with her eyes closed. At 12:00 P.M., the resident was lying in bed. Neither a TV nor a radio was turned on.</p> <p>On 8/11/11 at 12:00 P.M., the activity logs for Resident # 50 were reviewed. The "Group Activities" for August 2011 indicated the resident attended: 8/5,</p>		<p>condition and quarterly thereafter. The Activity Consultant will review Activity Assessments and Plans of Care monthly with recommendations provided to Administrator. Corrective Action Monitored: The Administrator will review activity assessments and Activity Consultant recommendations monthly. The results of these will be presented to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Activity Consultants monthly recommendations regarding activity assessments and care plans will be presented to the Administrator on an ongoing basis.</p>		

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	<p>Cookout on Patio, 8:30 Joke of the Day, and 8/7 Easy Listening. "Independent Daily Activities," dated August 2011, indicated the resident watched TV, had visitors, and had "Chit-Chat" daily. Had room visits on 8/3 and 8/6.</p> <p>Small group notes, dated August 2011, indicated the resident participated on 8/4 and 8/5; on 8/6 the resident was asleep. The small group notes, dated July 2011, indicated 13 entries; 2 times the resident was asleep, and several entries indicated staff attempted an activity but the resident was not interested.</p> <p>On 8/15/11, the resident was observed lying in bed at 9:00 A.M., 10:00 A.M., 11:00 A.M., and 12:00 P.M. Neither a TV nor a radio was turned on. An activity of news/coffee took place at 10:15 A.M. in the dining room.</p> <p>On 8/15/11 at 9:30 A.M., during interview with the Activity Director [AD], she indicated Resident # 50 had an activity program of small groups 2-4 x weekly, her family visited daily, and she went to the beauty shop weekly. The AD indicated the resident attended occasional church activities, and liked coffee and food. The AD indicated the resident was more of an</p>				

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F0279 SS=D	<p>"evening person," and indicated that should have been on the resident's care plan.</p> <p>3.1-33(a)</p> <p>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 interview, observation, and record review, the facility failed to ensure individualized care plans were developed regarding activities, weight loss and the use of a psychotropic drug, for 2 of 17 residents reviewed with care plans in the Stage 2 sample of 17. Resident # 50 # 58</p>	F0279	Corrective action for residents found to be affected:1. The Activity Director and Activity Consultant updated Plan of Care for Resident #50. The Plan of Care revision was based on a new Activity Assessment to determine the individual needs of Resident #50. 2a. Food Service Supervisor updated Plan of Care for resident #58. Plan of Care	09/14/2011	

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	<p>Findings include:</p> <p>1. The clinical record of Resident # 50 was reviewed on 8/10/11 at 1:15 P.M. Diagnoses included, but were not limited to, Dementia.</p> <p>The most recent activity progress note, dated 3/1/11, indicated, "...Res. [resident] awake x 3 dly [daily] [with] occasional cat naps in afternoon. Res. cont. [continues] to propel herself in for coffee daily. Res. enjoys talking to others. Res. alert [with] confusion...Res. cont. to be act 3 x wkly in act. ie: coffee time, church, etc. thru next eval. Note complete. C/P [care plan] updated."</p> <p>A Care Plan, dated 6/11, indicated a problem of "Pot. [potential] for low activity part. [participation] R/T [related to] Res. [resident] will come in [and] out of activity before activity is completed...Res STM [short term memory] loss deficit d/t [due to] dementia...Resid. [sic] likes coffee [and] cookies." The Goals indicated, "Resident will part. [sic] in small group act. 2xs weekly thru next eval. [evaluation]. Resident will verbalize satisfaction relaying to activity." The Approaches indicated: "Resident likes to talk to staff. Engage in conversation as much as possible.</p>		<p>reflective of interventions to prevent further weight loss and stabilize resident #58 at or near Ideal Body Weight.2b. Plan of Care for Resident #58 was revised utilizing a Hypnotic Medication Flowsheet (Attachment B) and a Sleep Pattern History Assessment (Attachment C).Identification of Residents having the potential to be affected:1. The Activity Director identified residents participating in small group activity therapy and one-on-one activity therapy as having the potential to be affected by the practice. The identified Resident's Plan of Care will be reviewed and updated (if indicated) by the Activity Director. The Activity Consultant will review identified Resident's Plan of Care to assure they correspond to their individualized needs. 2a. The Food Service Supervisor identified residents at high risk for unplanned weight loss as having the potential to be affected of this practice. The identified resident's Plan of Care will be reviewed and revise (if indicated) by the Food Service Supervisor.2b. The Assistant Director of Nursing identified residents receiving hypnotics as having the potential to be affected by this practice. The indentified resident's Plan of Care will be reviewed as revised (if indicated) utilizing a Hypnotic Medication Flow Sheet (Attachment B) and a sleep</p>		

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	<p>Reorient res. to person, place [and] time. Praise resident for accomplishments. Hug or pat resident [and] smile at resident when approaching resident."</p> <p>On 8/15/11 at 9:30 A.M., during interview with the Activity Director [AD], she indicated Resident # 50 had an activity program of small groups 2-4 x weekly, her family visited daily, and she went to the beauty shop weekly. The AD indicated the resident attended occasional church activities, and liked coffee and food. The AD indicated the resident was more of an "evening person," and indicated that should have been on the resident's care plan.</p> <p>2.a. The clinical record of Resident #58 was reviewed on 8/11/11. The 7/01/11 MDS (Minimum Data Set Assessment) Diagnoses included but were not limited to Anemia, GERD (Gastroesophageal Reflux Disease), Insomnia and Depression. The 7/20/11 diet order was Regular with No Added Salt (NAS).</p> <p>The resident was 62 inches tall with a 7/15/09 admission weight of 143.2. The resident's 2011 descending weights were 122.6 in March, 119.8 in April, 117.9 in May, 114.9 in June,</p>		<p>Pattern History Assessment (Attachment C).Measures or systemic changes to prevent recurrence:1. The Activity Director will complete on individualized Plan of Care for each new resident within 14 days of admission. The Activity Director will review and revise each Resident's Plan of Care upon readmission, change of condition and quarterly thereafter. The Activity Consultant will provide monthly oversight of the Activity Director regarding reviewed and revised Activity Plans of Care.2a. The Food Service Supervisor and Registered Dietician will review and revise (if indicated) Plans of Care for residents at high risk for unplanned weight loss and all newly admitted residents. Review Care Plans will occur monthly during the Nutritional Risk Program meeting. The Nutritional Risk Program is a multi-disciplinary approach to provide intensive management to meet the nutritional needs of specific residents. Residents are usually managed short term on the program until deemed stable and then on-going through the overall Plan of Care.2b. The facility will utilize the Hypnotic Medication Flow Sheet (Attachment B) and the Sleep Pattern Assesment (Attachment C) to develop and update the Plans of Care for residents receiving hypnotics. The</p>		

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	<p>114.9 in July and 112.9 in August. The resident's ideal body weight was calculated by the Registered Dietician (RD) on 8/11/11 to be 110 lbs.</p> <p>The Nutritional risk Assessment of 7/11/11 was calculated to be a score of 6 with 3-7 being moderate risk.</p> <p>The Care Plan, initiated 4/17/11, addressed a problem of potential for altered nutrition with 4 unchanged approaches; Determine food preferences and serve as able. Monitor weight as ordered. Monitor food intake daily. Serve Regular NAS diet and encourage food intake 75-100%. On 7/5/11, there was a problem of "gradual weight loss 7.7 lbs this year" added to the care plan without any approach /intervention changes/ revisions.</p> <p>On 8/11/11 at 1:00 P.M., the Food Service Supervisor (FSS) was interviewed regarding the resident's weight loss management. She indicated the resident was still in ideal body weight, was very independent and very weight conscience, not wanting to gain any weight at all. She indicated she had not considered enhancing or increasing the nutritional or caloric values of foods the resident did take, in an effort to prevent further</p>				<p>Assistant Director of Nursing (MDS Coordinator) will review care plans upon admission, once a month during the first quarter and quarterly thereafter for residents receiving an hypnotic. Licensed Nursing Staff will be inserviced on the Hypnotic Medication Flow Sheet (Attachment B) and the Sleep Pattern Assessment (Attachment C). Correction Action Monitored: 1. The Activity Director will present care plans to the Activity Consultant monthly, with recommendations from the consultant provided to the Administrator. The Administrator will report to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Activity Consultants recommendations will be on an ongoing basis. 2a. The Food Service Supervisor and Registered Dietician will review and revise (if Indicated) Care Plans for residents at high risk for unplanned weight loss and all newly admitted residents. The reviews will be conducted monthly and reported to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p>		

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	<p>losses, but she thought she could talk to the RD and try that.</p> <p>On 8/11/11, a second FSS entry (no time recorded) was then made. "Talked with RD and she said IBW (Ideal Body Weight) is 110# will put resident on a (care)plan to receive Hi Cal foods daily. RD will monitor monthly until weight is stable. Prepare cream soup with whole milk, offer fruit with syrup instead of juice, full fat cottage cheese and increase calories."</p> <p>2.b. Resident #58 had a physician's order 7/09/10 for Temazepam (generic for Restoril) reduction to 15 mg at bedtime as needed for insomnia.</p> <p>The 7/11 Care Plan had unchanged interventions or approaches since 7/09 to address the problem of insomnia although the problem continued despite planned interventions. The concern or problem section indicated "Resident has prn (as needed) Temazepam, uses nightly per her choice and sleeps well." Interventions did not address sleep enhancing bedtime rituals or prior life habits. One intervention was "Attempt drug reduction per nursing home</p>		<p>The monthly reviews preformed by the Food Service Supervisor and Registered Dietician will be ongoing.2b. The Assistant Director of Nursing (MDS Coordinator) will review care plans upon admission, once a month during the first quarter and quarterly thereafter for residents receiving hypnotics. Results of these reviews will be presented to the facilty's Continuous Quality Improvement Committee. The Continuous Quality Improvement comitee meets monthly with the findings reported to the quarterly Quality Assurance Committee. Reviews of Care Plans for residents receiving hypnotics will be ongoing.</p>		

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F0282 SS=D	<p>guidelines."</p> <p>The Medication Administration Records of June, July and August 2011 indicated the Temazepam 15mg was being administered over 90 % of the nights in June and July and 100% in the first 8 days of August.</p> <p>On 8/15/11 at 11:45 A.M., the Director and Assistant Director of Nursing indicated, on interview, that the drug administration was a matter of resident choice and no other interventions had been planned.</p> <p>3.1-35(a)</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, interview, and record review, the facility failed to provide incontinence care as care planned for 1 of 3 residents reviewed for following incontinent care plans, in a sample of 7 residents who were incontinent, in the Stage 2 sample of 17. Resident # 71</p>	F0282	<p>Corrective action for residents found to have been affected:Resident #71 was assessed by the Director of Nursing for negative outcomes from this practice (no negative outcomes noted). CNA #4 and CNA #2 were inserviced regarding facility policy on "Incontinent Briefs/Care". CNA #4 and CNA #2 were inserviced on</p>	09/14/2011	

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	<p>Findings include:</p> <p>On 8/11/11 at 11:44 A.M., the clinical record of Resident # 71 was reviewed. The resident was admitted to the facility on 8/4/11. Diagnoses included, but were not limited to, End Stage Alzheimer's Disease.</p> <p>An Initial Care Plan, dated 8/4/11, indicated, "Bladder, Incontinent, Total Care; Bowel, Incontinent, Total Care...."</p> <p>On 8/15/11 at 11:00 A.M., CNA # 4 and CNA # 2 indicated they were going to transfer Resident # 71. CNA # 4 and CNA # 2 were observed to transfer Resident # 71 from a reclining chair to the bedside commode. The resident's brief was observed to be wet. The resident's buttocks were slightly reddened. CNA # 4 changed the resident's brief, and then sat her in a wheelchair. The CNAs were not observed to clean the resident or provide perineal care.</p> <p>On 8/15/11 at 3:00 P.M., during interview with the Director of Nursing [DON], she indicated it was "common sense" for staff to have provided incontinence care for the resident.</p> <p>3.1-35(g)(2)</p>		<p>Resident #71's Care Plan requiring total incontinent care. Identification of Residents having the potential to be affected: The Director of Nursing identified residents with a Plan of Care requiring total incontinent care as having a potential to be affected. The Inservice Coordinator will inservice all CNA's regarding the facility "Incontinent Briefs/Care policy". Measures or systemic changes to prevent recurrence: The Director of Nursing or Inservice Coordinator will inservice and test all CNA's regarding incontinent care. Inservice and exams will be administered monthly for current CNA's and during orientation for CNA new hires. CNA's failing to successfully pass the exam (after three attempts) will be suspended until a positive exam is achieved. Correction action monitored: The Director of Nursing will monitor the results of CNA testing regarding "Incontinent Briefs/Care" monthly and report results to the facility Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. CNA testing and reports of testing results will continue for three quarters (nine months) and may be modified as the information warrants.</p>		

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F0309 SS=D	<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 interview and record review, the facility failed to ensure 1 of 2 residents reviewed for dialysis services was adequately assessed in regards to the dialysis shunt, and failed to ensure care plans were developed in regards to monitoring for insomnia and Coumadin, in the Stage 2 sample of 17.</p> <p>Resident # 18, #71</p> <p>Findings include:</p> <p>On 8/11/11 at 2 P.M., the clinical record of Resident #18 was reviewed.</p>	F0309	<p>Corrective action for residents found to have been affected:1. Resident #18 was assessed by the Director of Nursing for negative outcomes from this practice (no negative outcomes noted).2. Resident #71 was assessed by the Director of Nursing for negative outcomes from this practice (no negative outcomes noted). A Comprehensive Care Plan was developed with the monitoring of Temazepam and Coumadin included. Identification of Residents having the potential to be affected:1. The Director of Nursing identified residents with dialysis shunts as having the</p>	09/14/2011	

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	<p>Diagnoses included, but were not limited to, the following: renal failure and hypertension.</p> <p>The care plan, most recently dated 6/6/11, addressed the problem of "Potential for complications d/t (due to) dialysis." Approaches included, but were not limited to, the following: "...monitor condition of access site and report problem to dialysis unit/MD..."</p> <p>On 8/15/11 at 9:38 A.M., RN #1 was interviewed. She indicated she was currently caring for Resident #18. She indicated in regards to Resident #18 having a dialysis shunt, the only thing they do for Resident #18 is to check her left arm for thrill and bruit. She stated they do this by palpating for the thrill to make sure it feels like a buzzing. Stated she thinks they document the assessment of the thrill on the MAR (Medication Administration Record). At this time, RN #1 reviewed the current MAR and TAR (Treatment Administration Record) and indicated documentation was lacking on the MAR and/or TAR of assessment of the thrill and bruit to the resident's dialysis site. RN #1 indicated checking the thrill and bruit is "something they just do."</p>		<p>potential to be affected. Director of nursing assessed all residents with dialysis shunts and inserviced licensed nursing staff on assessment of shunts and documentation of shunt assessment, as well as updating resident #18's Care Plan.2. The Assistant Director of Nursing (MDS coordinator) identified all residents as having the potential to be affected. The Assistant Director of Nursing reviewed all residents Care Plans with no negative outcomes identified.Measures or systemic changes to prevent recurrence:1. The Inservice Coordinator will inservice licensed nursing staff regarding assessment of shunts and documentation of shunt assessment, as well as care plan requirements for residents receiving dialysis. Newly hired licensed nursing staff will be inserviced on the above items during orientation. All licensed nursing staff will be inserviced semi-annually on the above items. The Director of Nursing or her Designee will review MARS daily on scheduled work days x 4 weeks, then weekly x 4 weeks and then monthly thereafter. 2. An addendum (Attachment D) to policy "Resident Care Plan" was developed and licensed nursing staff was inserviced regarding how to provide the highest quality care until a Comprensive Care Plan can be</p>		

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	<p>On 8/15/11 at 12 P.M., the DON (Director of Nursing) was interviewed. She indicated the bruit and thrill should be documented in the MAR (Medication Administration Record) or the nurse's notes and should be done on dialysis residents with a shunt every shift. The DON indicated documentation of an assessment of the resident's shunt was lacking on the MAR and/or nurses notes.</p> <p>On 8/15/11 at 3 P.M., a current copy of the facility policy and procedure for "Care of Dialysis Patient" was received from the DON (Director of Nursing). This policy included, but was not limited to, the following: "...check AV fistula (dialysis access device where an artery and vein are fused) site for thrill (feels like water running through a hose) and bruit (sounds like a swish/swoosh directly on the fistula) q (every) shift and prn (as needed)...monitor site for pain-redness-increased warmth..."</p>		<p>developed. Corrective Action Monitored:1. The Director of Nursing or her designee will review MARS regarding assessment of shunts and documentation of shunt assessment daily on scheduled work days x 4 weeks, then weekly x 4 weeks and then monthly thereafter. The results of MARS reviews will be presented to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review results quarterly and modify monthly review system after nine months as information warrants.2. The Assistant Director of Nursing will monitor the success of the addendum to facility policy "Resident Care Plan" for the guidance of providing the highest quality of care until a Comprehensive Care Plan can be developed. The Assistant Director of Nursing will report effectiveness to the facility Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Assistant Director of Nursing will monitor for three quarters (nine months) and may modify audit system as the information warrants.</p>		

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	<p>The clinical record of Resident # 71 was reviewed on 8/11/11 at 11:44 a.m. Diagnoses included but were not limited to, End Stage Alzheimer's Disease, History of Atrial Fibrillation and Hypertension.</p> <p>Physician orders, dated 8/4/11, indicated "Temazepam (generic for Restoril) give 15 mg [one] po [by mouth] @ HS [bedtime] for insomnia..." An additional physician's order, dated 8/8/11, indicated, Coumadin [decreases clotting time] 3 mg [one] po qd [every day]."</p> <p>The Nursing Spectrum Drug Handbook, dated 2010, indicated the following:</p> <p>"Temazepam... Precautions. Use cautiously in...elderly or debilitated patients...Monitor neurological status carefully. Check for paradoxical reactions, especially in elderly patients...."</p> <p>"Coumadin...Drug may cause major or fatal bleeding...Instruct patients about measures to minimize risk of bleeding and advise them to immediately report signs and</p>	F0309	<p>Corrective action for residents found to have been affected:1. Resident #18 was assessed by the Director of Nursing for negative outcomes from this practice (no negative outcomes noted).2. Resident #71 was assessed by the Director of Nursing for negative outcomes from this practice (no negative outcomes noted). A Comprehensive Care Plan was developed with the monitoring of Temazepam and Coumadin included. Identification of Residents having the potential to be affected:1. The Director of Nursing identified residents with dialysis shunts as having the potential to be affected. Director of nursing assessed all residents with dialysis shunts and inservice licensed nursing staff on assessment of shunts and documentation of shunt assessment, as well as updating resident #18's Care Plan.2. The Assistant Director of Nursing (MDS coordinator) identified all residents as having the potential to be affected. The Assistant Director of Nursing reviewed all residents Care Plans with no negative outcomes identified.Measures or systemic changes to prevent recurrence:1. The Inservice Coordinator will inservice licensed nursing staff regarding assessment of shunts and documentation of shunt assessment, as well as care plan requirements for</p>	09/14/2011	

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	<p>symptoms of bleeding. Precautions...Use cautiously in;...elderly or debilitated patients. Interactions...Drug-food. Vitamin K rich foods...watch for signs and symptom of bleeding..."</p> <p>Care plans regarding the monitoring of Temazepam or Coumadin were lacking in the clinical record. Care plans regarding alternative interventions besides medications to relieve insomnia were lacking.</p> <p>On 8/15/2011 at 11:00 a.m., the Assistant Director of Nursing was interviewed. She indicated the facility does initiate a care plan on the Kardex, and then completes the care plan when they get to know the resident better, within 14 days.</p> <p>3.1-37(a)</p>		<p>residents receiving dialysis. Newly hired licensed nursing staff will be inserviced on the above items during orientation. All licensed nursing staff will be inserviced semi-annually on the above items. The Director of Nursing or her Designee will review MARS daily on scheduled work days x 4 weeks, then weekly x 4 weeks and then monthly thereafter. 2. An addendum (Attachment D) to policy "Resident Care Plan" was developed and licensed nursing staff was inserviced regarding how to provide the highest quality care until a Comprensvie Care Plan can be developed. Corrective Action Monitored:1. The Director of Nursing or her designee will review MARS regarding assessment of shunts and documentation of shunt assessment daily on scheduled work days x 4 weeks, then weekly x 4 weeks and then monthly thereafter. The results of MARS reviews will be presented to the facility Continous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review results quarterly and modify monthly review system after nine months as information warrants.2. The Assistant</p>		

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F0312 SS=D	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to provide perineal care for an incontinent resident for 1 of 3 residents observed for incontinence care, in a sample of 7 residents who were incontinent in the Stage 2 sample of 17. Resident # 71</p> <p>Findings include:</p> <p>On 8/11/11 at 11:44 A.M., the clinical record of Resident # 71 was reviewed. The resident was admitted to the facility on 8/4/11. Diagnoses included, but were not limited to, End</p>	F0312	<p>Director of Nursing will monitor the success of the addendum to facility policy "Resident Care Plan" for the guidance of providing the highest quality of care until a Comprehensive Care Plan can be developed. The Assistant Director of Nursing will report effectiveness to the facility Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Assistant Director of Nursing will monitor for three quarters (nine months) and may modify audit system as the information warrants.</p> <p>Corrective action for residents found to have been affected:Resident #71 was Assessed by the Director of Nursing for negative outcomes from this practice (No negative outcomes noted). CNA #4 and CNA #2 inserviced on facility policy "Incontient Briefs/Care", and instructed to follow this policy when providing incontinent care for Resident #71. Identification of Residents having the potential to be affected:The Director of Nursing identified residents requiring total incontinent care as having a potential to be affected. The Inservice Coordinator will inservice all CNA's on the facility</p>	09/14/2011	

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	<p>Stage Alzheimer's Disease.</p> <p>An Initial Care Plan, dated 8/4/11, indicated, "Bladder, Incontinent, Total Care; Bowel, Incontinent, Total Care...."</p> <p>On 8/15/11 at 11:00 A.M., CNA # 4 and CNA # 2 indicated they were going to transfer Resident # 71. CNA # 4 and CNA # 2 were observed to transfer Resident # 71 from a reclining chair to the bedside commode. The resident's brief was observed to be wet. The resident's buttocks were slightly reddened. CNA # 4 changed the resident's brief, and then sat her in a wheelchair. The CNAs were not observed to clean the resident or provide perineal-care.</p> <p>On 8/15/11 at 3:00 P.M., during interview with the Director of Nursing [DON], she indicated it was "common sense" for staff to have provided incontinent care for the resident.</p> <p>On 8/15/11 at 4:00 P.M., the DON provided the current facility policy on "Incontinent Briefs/Care," dated 1/11. The policy included: "...Procedure:...Obtain incontinent brief...Clean and dry resident...Fasten each brief and adjust for comfort...."</p>		<p>policy "Incontinent Briefs/Care". Measures or systemic changes to prevent recurrence: The Inservice Coordinator will test (by means of a written exam) all CNA's on the facility policy "Incontinent Briefs/Care". This testing (by means of a written exam) will be done monthly and will require all CNA's to exhibit proficiency regarding facility policy "Incontinent Brief/Care". Failure to successfully pass this exam after three attempts will result in the suspension of the CNA until a successful exam is achieved. Newly hired CNA's will be tested during orientation. Corrective Action Monitored: The Director of Nursing will review results of CNA written exams regarding facility policy "Incontinent Briefs/Care" monthly. The results will be reported to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The CNA written exams will be administered monthly for three quarters (nine months) and quarterly thereafter.</p>		

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F0323 SS=E	<p>3.1-38(a)(3)(A)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 25 of 48 mattresses safely fit the bed frames of 48 occupied beds in the facility.</p> <p>Findings include:</p> <p>During tour of the facility on 8/8/11 at 2:40 P.M., 25 beds in the facility were observed with the following concern: over 4 3/4 inch gap from the headboard to the head of the mattress. These measurements were obtained when the head of the bed was flat. The mattresses were observed to not easily be moved on the bed when they were flat.</p> <p>The following beds had</p>	F0323	<p>Corrective action for residents found to have been affected:No residents were found to have been affected by this practice.Identification of Residents having the potential to be affected:Administrator identified all residents as having the potential to be affected. Facility purchased mattress extenders for all resident beds occupied and unoccupied. Nursing and Housekeeping staff were inserviced on proper placement of mattress extenders.Measures or systemic changes to prevent recurrence:Nursing and Housekeeping staffs will be inserviced monthly regarding the correct placement of all mattress extenders. Housekeeping staff will add "correct placement of mattress extenders" to its daily</p>	09/12/2011	

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	<p>inappropriately fitting mattresses:</p> <p>Rm (room) 29 B, Rm 29 A, Rm 30 A, Rm 32 A, Rm 26 A, Rooms 6-B, 7-B, 3-A, 3-B, 8 -A, 8-B, 2-A, 2-B, 9-A, 9-B, 10-A, 1-B, 17-A, 19-A, 19-B, 16-A, 15-B, 20-A, 20-B, 21-A.</p> <p>On 8/8/11 at 4:30 P.M., the Administrator was made aware of the gaps between mattress and headboard and/or foot of bed totaling over 4 3/4 inches.</p> <p>On 8/9/11 at 9:25 A.M., the Administrator was interviewed. He indicated as a temporary measure for the gaps between mattresses and head/foot of beds, rolls were placed in the gaps. He indicated all staff have been inserviced regarding the gaps and also that extenders for the low beds will be delivered today. He indicated the remainder of the extenders to fill in the gaps will be here tomorrow. At this time, the Administrator provided a copy of a order, which was dated 8/8/11 at 6:05 P.M., for the following: "mattress extender."</p> <p>The document "Guidance for Industry and FDA (Food and Drug Administration) Staff, Hospital Bed System Dimensional and Assessment</p>		<p>check list of duties (ATTACHMENTS E, F, G). The Housekeeping Checklist applies to all resident rooms in the facility. The Housekeeping Supervisor or her designee will perform random weekly audits to ensure mattress extenders are in use and placed properly on the resident beds. The Housekeeping Supervisor will review Housekeeping checklists and present to the Administrator the results of those reviews and the results of random weekly audits. Corrective Action Monitored: The Administrator will monitor monthly inservices and the Housekeeping Supervisor's audits regarding correct placement of mattress extenders. The Administrator will report monitoring results to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The monthly inservices and the Housekeeping Supervisor audits on the correct placement of mattress extenders will be ongoing</p>		

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F0325 SS=D	<p>Guidance to Reduce Entrapment" dated 3/10/06 included, but was not limited to, the following: "FDA is therefore using a head breadth dimension of...4 3/4 inches as the basis for its dimensional limit recommendations..."</p> <p>3.1-45(a)(1)</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F0325	Corrective action for residents found to have been affected:The	09/12/2011	

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	<p>provide alternative interventions in an effort to prevent unplanned weight loss for 1 of 4 residents who met the weight loss criteria in a Stage II sample of 17. Resident # 58</p> <p>Findings include:</p> <p>The clinical record of Resident # 58 was reviewed on 8/11/11. The 7/01/11 MDS (Minimum Data Set Assessment) Diagnoses included but were not limited to Anemia, GERD (Gastroesophageal Reflux Disease) and Depression. The 7/20/11 diet order was Regular with No Added Salt (NAS).</p> <p>The resident was 62 inches tall with a 7/15/09 admission weight of 143.2. The resident's 2011 descending weights were 122.6 in March, 119.8 in April, 117.9 in May, 114.9 in June, 114.9 in July and 112.9 in August. The resident's ideal body weight was calculated by the Registered Dietician (RD) on 8/11/11 to be 110 lbs.</p> <p>The Nutritional risk Assessment of 7/11/11 was calculated to be a score of 6 with 3-7 being moderate risk.</p> <p>The Care Plan initiated 4/17/11 addressed a problem of potential for altered nutrition with 4 unchanged</p>		<p>Registered Dietician assessed Resident #58 and found resident was still within Ideal Body Weight and will monitor resident #58 monthly until weight is stable. Food Service Supervisor counseled resident #58 on actual weight loss and the need to stabilize resident's weight near the ideal Body Weight. Resident #58 offered high cal foods to stabilize weight loss and as part of a therapeutic diet. Identification of Residents having the potential to be affected: The Food Service Supervisor and Registered Dietician identified residents at high risk for unplanned weight loss as having the potential to be affected. Identified residents will be placed in the facility Nutritional Risk Program. The Nutritional Risk Program is a multi-disciplinary approach to provide intensive management to meet the nutritional needs of specific residents. Residents are usually managed short term in the program until deemed stable and then on-going through the overall Plan of Care. Measures or systemic changes to prevent recurrence: The Food Service Supervisor and Registered Dietician will review residents with the potential to be affected during the Nutritional Risk Program monthly meeting. The multi-disciplinary team will review the Plan of Care of each resident with a high risk for unplanned weight loss during the monthly</p>		

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	<p>approaches; Determine food preferences and serve as able. Monitor weight as ordered. Monitor food intake daily. Serve Regular NAS diet and encourage food intake 75-100%. On 7/5/11, there was a problem of "gradual weight loss 7.7 lbs this year" added to the care plan without any approach /intervention changes/ revisions.</p> <p>A Food Service Supervisor (FSS) progress note on 7/2/11 indicated the resident had asked to have the "2 cal" (high value low volume) supplement discontinued since she did not like it without alternative caloric/nutritional supplement attempted.</p> <p>On 8/11/11 (no time recorded), the FSS documented "continues to be very independent likes to sleep in. August weight is 112.9 down 2 lbs from July... has lost 7.6 lbs this year.</p> <p>On 8/11/11 at 1:00 P.M., the FSS was interviewed regarding the resident's weight loss management. She indicated the resident was still in ideal body weight, was very independent and very weight conscience, not wanting to gain any weight at all. She indicated she had not considered enhancing or increasing the nutritional or caloric values of foods the resident</p>				<p>Nutritional Risk Program meeting. The Food Service Supervisor or Registered Dietician will recommend interventions to manage weight loss and report recommendations to the Administrator. Corrective Action Monitored: The Food Service Supervisor and Registered Dietician will review residents at risk for unplanned weight loss during the monthly Nutritional Risk Program Meeting. Recommendations for interventions will be forwarded to the Administrator who will report to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The monthly recommendations for interventions by the Food Service Supervisor and Registered Dietician will be ongoing.</p>		

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	<p>did take in an effort to prevent further losses, but she thought she could talk to the RD and try that.</p> <p>Documentation was lacking to indicate resident awareness and counseling regarding actual weight loss occurring rather than weight gain, which she considered undesirable.</p> <p>On 8/11/11, a second FSS entry (no time recorded) was then made. "Talked with RD and she said IBW (Ideal Body Weight) is 110# will put resident on a plan to receive Hi Cal foods daily. RD will monitor monthly until weight is stable. Prepare cream soup with whole milk, offer fruit with syrup instead of juice, full fat cottage cheese and increase calories."</p> <p>3.1-46(a)(1)</p>						

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

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FORM APPROVED

OMB NO. 0938-0391

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F0329 SS=D	<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 the rationale for the lack of a gradual dose reduction of an anti-anxiety medication [Lorezepam] and/or hypnotic (Temzaepam) was given, adequate monitoring of lab values for a resident on an anti-hypertensive medication [Diovan], failed to administer an anti-hypertensive medication [Spironolactone] with food</p>	F0329	<p>Corrective action for residents found to have been affected:1. Resident #50 was reviewed by the Director of Nursing, Pharmacy and Physician to ensure medications are appropriate and adequate monitoring is in place to prevent unnecessary side effects.2. Resident #58 care plan revised and updated Re: use of hypnotic (Temazepam). Hypnotic Medication Flowsheet (ATTACHMENT B) created to assist in monitoring side effects,</p>	09/14/2011	

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	<p>as recommended, and failed to develop an interim plan of care regarding the administration of a hypnotic [Temazepam], Diovan and Ativan and/or failed to monitor medication side effects for 2 of 10 residents reviewed for unnecessary medication use. Resident #50, #58</p> <p>Findings include:</p> <p>1.a The clinical record of Resident # 50 was reviewed on 8/10/11 at 1:15 P.M. Diagnoses included, but were not limited to, Dementia, Chronic Kidney Disease Stage III, Hypertension and Chronic Anemia..</p> <p>A Physician's order, initially dated 2/24/11 and on the current August 2011 orders, indicated, "Lorazepam [an anti-anxiety medication] 0.5mg every 8 hours (agitation)." An additional physician's order, dated 7/31/10 and on the current August 2011 orders, indicated, "Lorazepam 0.5mg, Take 1/2 tablet (0.25mg) by mouth every day as needed for agitation."</p> <p>A Care Plan, initially dated 9/10 and updated 5/11, indicated a problem of "Resident propels w/c aimlessly up and down hallways at times. Receives routine Ativan [Lorazepam]." The</p>		<p>educating resident of side effects, and offering of alternative night time ritual to aid in possible drug reduction (per nursing home guidelines). SLEEP PATTERN HISTORY ASSESSMENT (Attachment C) created to assess past history of sleep and previous bedtime rituals. Identification of Residents having the potential to be affected:1. All residents have had a medication regimen review to insure appropriate medication, monitoring and care plans are in place.2. The Director of Nursing identified residents receiving hypnotics as having the potential to be affected will receive the same as those actions being done for Resident #58.Measures or systemic changes to prevent recurrence:1. a. "A Medication Risk/Benefit Policy" (ATTACHMENT H) has been developed and all appropriate staff have been inserviced. b. Director of Nursing or Designee will review Medical Doctors orders daily during scheduled working days to ensure medications are appropriate with adequate monitoring and care plans are in place.2. SLEEP PATTERN HISTORY ASSESSMENT (ATTACHMENT C) will be done upon admission, once a month during the first quarter and then quarterly thereafter, this will assist in the development and updating of care plan. A Hypnotic Medication Flowsheet (ATTACHMENT B) will</p>		

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	<p>Approaches included: "Encourage her to attend activities of interest. Redirect with magazine, drink or snack cake or cookie. Ask if she is in pain, needs to toilet, etc. Provide praise for all of her accomplishments. Provide Ativan per MAR. Monitor for S/E. Attempt drug reduction per NH guidelines."</p> <p>The most recent Social Services progress note, dated 5/29/11, indicated, "...Some increased restlessness as she wanders up and down her hallway to lobby to DR and then back again with no real purpose. Not always easily altered...is not disruptive to other residents..."</p> <p>A "Request for Gradual Dosage Reduction," dated 4/13/11, indicated, "...Medication & Current Dose: Ativan 0.5mg TID [three times daily]. Previous dose & date of tapering attempt: [Line drawn indicating no answer]...Do not attempt to taper the dose of this drug...Clinical Rationale: [Left blank]...."</p> <p>On 8/15/11 at 11:55 A.M., during interview with the Assistant Director of Nurses [ADON], she indicated she had no further information regarding the dose reduction. The ADON indicated the physician was aware of</p>		<p>be used on all residents receiving a hypnotic, to assist in the monitoring of side effects and educating residents on side effects and offer alternate non-pharmacological measures to enhance sleep. Appropriate staff will be inserviced and new policies implemented by 9-14-11. Corrective Action Monitored: 1a. The Director of Nursing will review all "Medication Risk/Benefit Policy" forms returned by physicians and report information from these forms to the facility Continuous Quality Improvement Committee. 1b. The Director of Nursing or Designee will review all daily physician telephone orders weekly to ensure medications are appropriate with adequate monitoring and care plans in place. This review of physician telephone orders will be reported to the facility Continuous Quality Improvement Committee. 1a & b. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review the results quarterly and modify the audit system after (3) quarters (nine months) if necessary. 2. The Social Service Director and Assistant Director of Nursing will monitor the "Sleep Pattern History Assessment" and the "Hypnotic Medication Flowsheet" respectively, each month. The</p>		

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	<p>the dose reduction request, and denied it.</p> <p>On 8/11/11 at 12:15 P.M., during interview with CNA # 4, she indicated Resident # 50 was able to propel herself in her wheelchair at times. She indicated the resident did not wander.</p> <p>On 8/11/11 and 8/15/11, the resident was observed in bed at 9:00 A.M., 10:00 A.M., 11:00 A.M., and 12:00 P.M. The resident was not observed to propel herself in the wheelchair.</p> <p>1.b. A Physician's order, initially dated 8/21/10 and on the current August 2011 orders, indicated, "Diovan [for high blood pressure] tab 160 mg, Take 1 tablet by mouth every day."</p> <p>A Pharmacy recommendation, dated 7/11, indicated a request for lab work, as the resident did not have labs since 6/10.</p> <p>A Physician's order, dated 7/14/11, indicated, "No lab work."</p> <p>The "Nursing Spectrum Drug Handbook," 2010, indicated, "Diovan...Precautions, Use cautiously in:...hepatic or renal [kidney]</p>		<p>results will be reported to the facility Continuous Qaulity Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review the results quarterly and modify the audit system after (3) quarters (9 months) if necessary.</p>		

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	<p>impairment...Patient Monitoring...Assess potassium level. Stay alert for hyperkalemia [elevated potassium]...."</p> <p>During interview on 8/15/11 at 11:55 A.M., the ADON indicated she spoke to the nurse who received the order for "no labs", and asked for clarification. The ADON indicated the physician told the nurse the labs were not necessary.</p> <p>2. The clinical record of Resident # 58 was reviewed on 8/11/11 at 9:00 A.M. Diagnoses included but were not limited to Insomnia and Depression. There was a physician's order 7/09/10 for Temazapam 30mg at bedtime as needed for insomnia. On 7/09/10, the dose was reduced to Temazapam 15 mg at bedtime as needed for insomnia without further reduction in excess of a year.</p> <p>Documentation was lacking to indicate the resident's sleep pattern, character of sleep or hours of sleep per night or prior life long sleep habits had been assessed or considered prior to or during drug therapy.</p> <p>The 7/11 Care Plan had unchanged interventions or approaches since 7/09 to address the problem of insomnia. The concern or problem</p>						

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	<p>section indicated "Resident has prn (as needed) Temazepam, uses nightly per her choice and sleeps well. Interventions did not address sleep enhancing bedtime rituals or prior life habits. One intervention was "Attempt drug reduction per nursing home guidelines."</p> <p>On 7/13/11 at 6:45 P.M. a nurse note entry documented "Resident reported she has very dry mouth through the night that drinks of water does not alleviate very long. She states it's not as bad during the day." The doctor was paged to report twice and a return call was awaited. Documentation was lacking of any follow up.</p> <p>The 7/15/11 Dietary department notes indicated the resident preferred to "sleep in every morning until approximately 10:00 A.M." The resident was observed on to sleep in as noted on 8/09, 10, and 11, 2011. Documentation was lacking of consideration to distinguish resident choice from "hangover" side effects of drugs.</p> <p>Facility drug reference books included information related to Temazepam.</p> <p>The Davis's Drug Guide for Nurses</p>				

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	<p>12th edition, page 1193, directs "Assess sleep patterns before and periodically throughout therapy.</p> <p>The Nursing Drug Handbook 2010, page 773, shows the drug is indicated for "Short term treatment (7-10 days) and identifies "dry mouth" and "morning hangover" as potential adverse reaction to the drug.</p> <p>The Medication Administration Records of June, July and August 2011 indicated the Temazepam 15mg was being administered over 90 % of the nights in June and July and 100% in the first 8 days of August.</p> <p>On 7/13/11, the Pharmacy drug review resulted in a request for gradual dosage reduction of the hypnotic. The pharmacist noted Temazepam 15mg was ordered prn but was being used nightly. The physician responded by checking the option "Do not attempt to taper the dose of this drug." The physician wrote "Patient stable on present Rx(treatment.)</p> <p>On 8/15/11 at 11:45 A.M., the Director and Assistant Director of Nursing indicated, on interview, that the drug administration was a matter of resident choice and no other</p>				

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	<p>interventions had been planned.</p> <p>On 8/15/11 at 12:15 P.M., the ordering physician indicated he believed the resident may well be able to tolerate a reduction in the dose to 7.5 mg; however the cost of the lower dose capsules was so much higher than the 15mg dose that it would be cost prohibitive, to order the lower dose or switch to another drug, such as Ambien.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure totaled working hours of licensed and unlicensed nursing hours were posted for 5 of 5 survey days.</p> <p>Findings include:</p>	F0356	Corrective action for residents found to have been affected: No residents were found to have been affected by this practice. Identification of Residents having the potential to be affected: The Director of Nursing identified all residents as having a potential to be affected from this practice. To correct this	09/14/2011	

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	<p>On 8/8/11 at 9:45 A.M. ,during initial tour of the facility, nursing staffing hours were observed posted on wall by the nurses station. The information posted included: the name and the address of the facility, date, and the census number of 49. Information also included the licensed nursing staff of 1 RN, 3 LPNs (7:00 A.M.- 7:00 P.M.= 11.5 hours) and unlicensed nursing staff of 6 (7:00 A.M.-3:00 P.M. = 7.5 hours.) Documentation was lacking of the posted totaled licensed and unlicensed nursing hours on 8/8/11.</p> <p>The posting of nursing staff hours were also observed on day shifts 8/9/11, 8/10/11, 8/11/11, and 8/15/11, without a total of licensed and unlicensed nursing hours posted.</p> <p>On 8/15/11 at 3:00 P.M., the Administrator and Director of Nursing were made aware of documentation lacking all survey days of the posted total licensed and unlicensed nursing hours. The DON indicated at this time the facility was unaware of the need for posting of the totaled licensed and unlicensed nursing hours.</p> <p>3.1-13(a)</p>				<p>practice; the posted Nurse Staffing information was revised to include the total number of hours worked by Registered Nurses, Licensed Practical Nurses and Certified Nurses Aides.Measures or systemic changes to prevent recurrence:The Director of Nursing will report the nurse staffing data to the Administrator weekly. The nurse staffing data will include (along with other required data) the total number of hours worked by Registered Nurses, Licensed Practical Nurses and Certified Nurses AidesCorrective Action Monitored:The Administrator will report the weekly Nurse Staffing Data provided by the Director of Nursing to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Administrator reports will be done for the first three quarters (nine months) and the audit system modified as the information warrants.</p>		

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

PRINTED: 09/23/2011

FORM APPROVED

OMB NO. 0938-0391

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F0441 SS=D	<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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure hands were washed after giving resident care, and during</p>	F0441	Corrective action for residents found to have been affected: The Assistant Director of Nursing assessed resident #5, #50 and #12 for negative outcomes from this practice (no negative	09/14/2011	

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	<p>medication administration for 1 of 1 residents reviewed for gastrostomy tube medication administration, and for 2 of 6 observations of resident care. Resident # 5, Resident # 50, Resident #12</p> <p>Findings include:</p> <p>1. On 8/11/11 at 11:49 A.M., CNA # 2 and CNA # 3 indicated they were going to provide care for Resident # 5. The CNAs assisted the resident up from her recliner, hanging her Foley catheter bag on her walker, and ambulated her to her wheelchair that was sitting in the hall. CNA # 2 attached the Foley catheter bag underneath the wheelchair. CNA # 2 then propelled the resident to the front lobby area. Neither CNA was observed to wash her hands after assisting the resident.</p> <p>2. On 8/11/11 at 12:17 P.M., CNA # 4 and CNA # 2 indicated they were going to transfer Resident # 50. CNA # 4 indicated the resident's Foley catheter bag had already been changed to a leg bag. The CNAs assisted the resident from the bed to the wheelchair. CNA # 2 then wheeled the resident to the front lobby area. Handwashing was not observed. CNA # 4 was observed to straighten up</p>				<p>outcomes noted). To correct this practice the In-service Coordinator in-serviced CNA's #2, #3, #4 and RN #1 regarding facility policy on "Handwashing and Hand Asepsis". Identification of Residents having the potential to be affected: The Assistant Director of Nursing identified residents receiving care from CNA's #2, #3, #4 and RN #1 as having the potential to be affected by this practice. To correct this practice the Inservice Coordinator will inservice all CNA's and Nurses on the facility policy, "Handwashing and Hand Asepsis" monthly. Measures or systemic changes to prevent recurrence: The Inservice Coordinator will inservice CNA's and Nurses monthly on facility policy "Hand Washing and Hand Asepsis". These inservices will be followed by a written exam. CNA's and Nurses must pass the written exam each month. Staff unable to pass the written exam after three attempts will be suspended until a successful exam is achieved. The results of all written exams will be reviewed by the Administrator. Corrective Action Monitored: The Assistant Director of Nursing (Infection Control Nurse) will monitor results of written exams regarding "Hand Washing and Hand Asepsis" monthly. The results will be reported to the facility Continuous Quality Improvement Committee.</p>		

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	<p>Resident # 50's roommate's bed, and then take the trash from the room without washing her hands.</p> <p>3. On 8/15/11 at 12:15 P.M., CNA # 4 and CNA # 2 were observed to transfer Resident # 50 from the bed to the wheelchair. CNA # 2 was wearing gloves. CNA # 4 brushed the resident's hair. CNA # 2 removed her gloves and propelled the resident to the dining room, and then entered another resident room. CNA # 4 was observed to pass another resident's room tray. Neither CNA were observed to wash their hands.</p> <p>4. On 8/11/11 at 12:05 P.M., RN #1 was preparing liquid medications for gastric-tube (G/T) medication administration for Resident #12. At this time, RN #1 dropped a plastic medication cup on the floor and picked the cup up off the floor and continued to pour a protein supplement for G/T administration, without handwashing.</p> <p>5. On 8/15/11 at 3:30 P.M., the Assistant Director of Nursing provided the current facility policy on "Handwashing & Hand Asepsis," dated 11/10. The policy included, "Policy: Handwashing will be done before and after direct resident care,</p>				<p>The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The monthly written exams regarding "Hand Washing and Hand Asepsis" will be ongoing.</p>		

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F0469 SS=D	<p>after removal of gloves and on completion of each job/task. Purpose: To prevent the spread of infection and disease from resident to resident, staff to resident and resident to staff. Specific Indications for Handwashing:...After handling items such as dressing, bedpan, catheters, urinals, etc...After removing gloves...Between contact of different residents. Before and after completion of any resident care/procedures...."</p> <p>3.1-18(l)</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to provide effective fly control in 2 of 12 resident rooms affecting 2 of 18 residents and in 1 of 1 dining rooms during an activity with 8 residents on 3 of 5 survey days. Resident #12, Resident #22</p> <p>Findings include:</p> <p>1. On 8/08/11 at 10:00 A.M., dependant Resident #12 was</p>	F0469	<p>Corrective action for residents found to have been affected:Residents #12 and #20 were assessed by Assistant Director of Nursing (Infection Control Nurse) for negative outcomes due to this practice (no negative outcomes noted).Identification of Residents having the potential to be affected:Administrator identified residents with the potential to be affected by this practice and enacted the following corrective</p>	09/14/2011	

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	<p>observed in bed with her eyes closed. She was stirring and startled by four flies on and about her upper torso as different ones landed on her face, eye or mouth area.</p> <p>2. On 8/08/11 at 12:15 P.M., Resident #12 was noted to have flies on her shoulder, arm, pillow and food tray, as CNA #4 picked up the tray and shooed the flies. The CNA stated "those are pesky aren't they?" The resident responded, "yes" as the aide shooed them away momentarily and took the tray. The flies remained in the resident area without staff intervention.</p> <p>3. On 8/08/11 at 3:30 P.M., there were 3 flies on cantaloupe in the dining room which was being served to residents as part of the "Melon Monday " activity . There was no staff intervention to remove the flies or was the melon covered.</p> <p>4. On 8/10/11 at 12:35 P.M., Resident #22 was observed eating her lunch in her room with a fly on and about her upper torso and food tray. She stated she needed a fly swatter and had meant to ask for one, but let it go earlier but now just really wanted a swatter. She indicated the flies had been "thick this week."</p>		<p>action. Facility Pest Control Program (ATTACHMENT I) was revised to include a more rapid method of eradicating flies in a specific area (resident rooms or dining areas). Administrator will utilize Housekeeping and Maintenance Departments ro resolve fly problems in specific areas of the facility.Measures or systemic changes to prevent recurrence:Housekeeping and Maintenance will be inserviced on revised facility Pest Control Program (ATTACHMENT I). Housekeeping and Maintenance will report to Administrator all fly problems throughout facility and the effectiveness of the revised Pest Control Program.Corrective Action Monitored:The Administrator will monitor effectiveness of revised facility "Pest Control Program" through the information provided by the Housekeeping Supervisor and Maintenance Supervisor. Effectiveness of the Pest Control Program will be reported to the facility Continous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Administrator will monitor during the time of year flies are active.</p>		

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	<p>5. On 8/11/11 at 2:10 P.M., during gastrostomy tube (GT) medication administration for Resident #12, a fly was observed on the resident's blanket on the resident's chest area. On 8/11/11 at 2:15 P.M., during medication administration for Resident #12, two flies were now observed on the resident's face and forehead. RN #1 returned from the resident's bathroom and now a fly was observed on the resident's eye area. Resident #12 indicated, at this time, the fly was bothering her. RN #1 then indicated she would have to get someone with a flyswatter to take care of the fly.</p> <p>On interview with the facility Administrator on 8/15/11 at 2:45 P.M., he indicated the pest control program had been increased to include Vector lights, fly bait, and monthly "Bug Doctor" visits to treat including a misting program. He attributed the recent increase in the fly population to the removal of fly swatters with his understanding they were not "allowed" in Long Term Care.</p> <p>3.1-19(f)(4)</p>				

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F0514 SS=D	<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 1 of 2 residents reviewed for dialysis services in the Stage 2 sample of 17 had adequate documentation of assessment of the dialysis shunt. Resident # 18</p>	F0514	<p>Corrective action for residents found to have been affected: Resident #18 was assessed by the Director of Nursing for negative outcomes from this practice. (No negative outcomes noted) Documentation of Thrill and Bruitt was placed on resident #18 MAR (Medication Administration Record). Identification of Residents having the potential to</p>	09/12/2011			

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	<p>Findings include:</p> <p>On 8/11/11 at 2 P.M., the clinical record of Resident #18 was reviewed. Diagnoses included, but were not limited to, the following: renal failure and hypertension.</p> <p>The care plan, most recently dated 6/6/11, addressed the problem of "Potential for complications d/t (due to) dialysis." Approaches included, but were not limited to, the following: "...monitor condition of access site and report problem to dialysis unit/MD..."</p> <p>On 8/15/11 at 9:38 A.M., RN #1 was interviewed. She indicated she was currently caring for Resident #18. She indicated in regards to Resident #18 having a dialysis shunt, the only thing they do for Resident #18 is to check her left arm for thrill and bruit. She stated they do this by palpating for the thrill to make sure it feels like a buzzing. Stated she thinks they document the assessment of the thrill on the MAR (Medication Administration Record). At this time, RN #1 reviewed the current MAR and TAR (Treatment Administration Record) and indicated documentation was lacking on the MAR and/or TAR of assessment of the thrill and bruit to</p>				<p>be affected:The Director of Nursing identified one additional resident with the potential to be affected. The identified resident was assessed by the Director of Nursing for negatvie outcomes from this practice (no negative outcomes noted).Measures or systemic changes to prevent recurrence:The policy "Care of Diaylsis Patients" (Attachment J) was revised and all licensed Nursing Staff were inserviced regarding policy revision. The Director of Nursing or Designee will review Medication Administration Records and Treatment Administration Records daily during scheduled working days x 4 weeks, then weekly x 4, then monthly thereafter. Corrective Action Monitored:The Director of Nursing or Designee will review Medication Administration Records and Treatment Administration Records daily during scheduled working days x 4 weeks, then weekly x 4 weeks, then monthly. The results of these reviews will be reported to the facility Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee. The Quality Assurance Committee will review the results of the monthly MAR/TAR audits quarterly and</p>		

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	<p>the resident's dialysis site. RN #1 indicated checking the thrill and bruit is "something they just do."</p> <p>On 8/15/11 at 12 P.M., the DON (Director of Nursing) was interviewed. She indicated the bruit and thrill should be documented in the MAR (Medication Administration Record) or the nurse's notes and should be done on dialysis residents with a shunt every shift.</p> <p>The DON indicated documentation of an assessment of the resident's shunt was lacking on the MAR and/or nurses notes.</p> <p>3.1-50(f)(2)</p>		<p>modify the audit system after three quarters (nine months) as the information warrants.</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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