

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00190169.</p> <p>Complaint IN00190169 - Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey dates: January 20, 21, 22, 25, &amp; 26, 2016</p> <p>Facility number: 000116 Provider number: 155209 AIM number: 100266330</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 19 Medicaid: 62 Other: 10 Total: 91</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on February 01,</p>	F 0000	Preparation and or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies The plan of correction and specific corrective actions are prepared and or executed in compliance with state and federal laws Facility respectfully requests a desk review	

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

TITLE

(X6) DATE

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

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F 0241 SS=D Bldg. 00	<p>2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident was cared for in a manner which maintained dignity related to staff failure to knock and request permission to enter a residents private space for 2 of 3 residents reviewed of the 3 residents who met the criteria for dignity. (Resident #83 and #112)</p> <p>Findings include:</p> <p>During a continuous observation on 01/20/2016 from 2:46 P.M. to 2:55 P.M., Resident #112 requested her door be closed and wanted to talk in private. Three minutes after closing the resident's door, CNA (Certified Nursing Assistant) #14 pushed open the resident's door and walked into the resident's room. CNA #14 did not knock or give any notice prior to walking into the resident's room. Resident #112 asked the CNA to give her</p>	F 0241	<p>F-241 It is the policy of the facility to promote care and services for the residents that promotes and maintains their dignity. Staff who enter the rooms of Residents #83 and #112 knock on the door and ask permission to enter prior to entering. Residents who are alert and oriented have the potential to be affected by this finding. The DON/Designee/SSD (Social Services Designee), created a targeted list of residents (based on BIMS scores) who are alert and oriented. From that targeted list, 10 various residents will be interviewed 3 days weekly to ensure that staff are knocking on their doors and receiving permission to enter prior to entering their rooms. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will continue for 10 residents weekly for a period of not less than 6 months to ensure ongoing</p>	02/25/2016

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	<p>a few minutes in private. CNA #14 returned to Resident #112's room at 2:55 P.M. CNA #14 walked into the resident's room a second time without knocking or giving any kind of verbal notice. Resident #112 asked CNA #14 to please leave and give her a few more minutes. Resident #112's roommate was not in the room during this observation.</p> <p>During an observation on 01/20/2016 at 3:21 P.M., CNA #22 walked into Resident #112's room without knocking or giving any prior notice.</p> <p>During an interview on 1/20/2016 at 02:58 P.M., Resident #112 indicated staff walk in and out of her room without notice a lot. Resident #112 indicated she did not like it when staff just walked into her room without any warning.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, dated 11/19/2015, indicated Resident #112 had a BIMS (Brief Interview of Mental Status) score of 14, which indicated the resident was alert and oriented.</p> <p>During an interview on 01/25/2016 at 3:31 P.M., Resident #83 indicated staff have entered her room without knocking on several occasions. Resident #83 further indicated she felt very</p>		<p>compliance. After that, random monitoring will continue. Note: Any concerns observed during the monitoring will be addressed and corrected as found. All alert and oriented residents have the potential to be affected by this finding. At an inservice held for all staff on February 9th, 2016., Resident Rights was reviewed. There was an emphasis placed on dignity as related to privacy and how to properly enter a resident room, bathroom or private space. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings the results of the monitoring will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. The Administrator will review any Action Plan weekly until resolution.</p>		

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F 0282 SS=D Bldg. 00	<p>uncomfortable when staff entered her room without notice.</p> <p>The most recent annual MDS assessment, dated 10/09/2015, indicated Resident #83 had a BIMS score of 15, which indicated the resident was alert and oriented.</p> <p>Record review of the current "Resident's Rights" policy, provided by the Administrator on 01/26/2016 at 1:53 P.M., indicated, but was not limited to, the following: "... privacy in your room ... " and "...privacy during your visits or meetings..."</p> <p>3.1-3(t)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure the plan of care was followed as written related to splinting and passive range of motion (Resident #23) and falls (Resident #101) for 2 of 23 residents reviewed for care plans.</p>	F 0282	F-282 It is the policy of the facility to ensure that services provided are performed by qualified persons in accordance with each individual resident's plan of care. Resident #23 receives ROM and has their splint applied in accordance with their plan of care. This appears on the treatment sheet and	02/25/2016			

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	<p>Findings include:</p> <p>1. During an observation on 01/26/2016 at 11:53 A.M., Resident #23 was lying in bed. The resident's right hand was lying on his chest with no splint in place.</p> <p>During an observation on 01/26/2016 at 3:30 P.M., Resident #23 was lying in bed. The resident's right hand was lying on his chest with no splint in place. .</p> <p>During an interview on 01/25/2016 3:26 P.M., Resident #23 indicated he had not received any range of motion or splinting of his right hand since shortly after being discharged from the therapy department.</p> <p>During an interview on 01/26/2016 at 11:54 A.M., Resident #23 indicated the splint for his right hand was lying on his bed side stand and the splint had not been used for a very long time.</p> <p>Record review, on 01/26/2016 at 9:44 A.M., of the "Restorative Nursing" list provided by the ADON did not include resident #23.</p> <p>During an interview on 01/26/2016 9:44 A.M., the ADON (Assistant Director of Nursing) indicated the list of residents receiving range of motion on the unit was complete.</p>		<p>isdocumented and care planned. Resident #101has any areas on his hands, wrists or arms treated and dressed as ordered. This appears on the treatment sheet and isdocumented and care planned. Resident#101 has non-skid strips on the floor by the bed. These strips are documented and care planned.The DON/Designee through chart review has created a list of targeted residentswho are to receive ROM (AROM/PROM), or who are to have the application of asplint or device. These interventionswere placed on the treatment sheets, care plans and CNA/Restorative worksheetsas indicated. Further, care plans werereviewed and updated to see that any interventions that are ordered and/orappropriate are on the care plan and also the treatment sheets and CNAworksheets as indicated All residents have thepotential to be affected by this finding so all care plans were reviewed. The DON/Designee willmonitor 10 residents from the targeted list to see that 3 days weekly to see that the appropriate ROM is administered and documented as well as anyappropriate splint/brace device is applied/removed appropriately anddocumented. Further, 10 residents willbe reviewed weekly to ensure that the interventions on their care plans are inplace such as non-skid strips on</p>	

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	<p>During an interview on 01/26/2016 at 1:56 P.M., RN (Registered Nurse) #60 indicated there were no treatment records for Resident #23 to have splinting or range of motion of the right hand.</p> <p>During an interview on 01/26/2016 at 2:35 P.M., LPN (Licensed Practical Nurse) #9, indicated splinting should be in the TAR (treatment administration record). LPN #9 indicated she did not see where Resident #23 was receiving any treatments on the right hand for splinting or range of motion.</p> <p>During an interview on 01/26/2016 at 3:00 P.M., the Physical Therapy Director (PTD) indicated Resident #23 was released on 06/30/2015 and the resident was not currently on case load. The resident was care planned to receive range of motion therapy from the nursing staff on his right hand and splinting 4 hours a day.</p> <p>Clinical record review on 01/26/2016 2:47 AM, indicated Resident #23 was care planned for a functional maintenance program. The resident was to wear a splint to prevent further loss of movement and to ensure proper limb alignment of the right hand. The interventions included, but were not</p>		<p>thefloor to prevent falls or any treatments for skin issues. These interventionswill appear on the treatment sheets and/ CNA assignment sheets or other flowsheets as indicated to ensure proper documentation is completed. Any infractionwill be addressed/corrected as discovered. This monitoring willcontinue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, ROM will be monitored for 10residents weekly and care plan interventions will be monitored for 5 residentsweekly for a period of not less than 6 months to ensure ongoingcompliance. At the daily CQI meetingsorders will be reviewed and follow through will be monitored for interventionsordered or for interventions that come up through discussion. Examples would be ROM,dressings or non-skid strips to be placed on the floor. These interventions will then be placed onall appropriate documents such as treatment sheets, CNA instruction sheets andcare plans. At an all staff inservice held on February 9th, 2016 , the care plan process was reviewed and discussed includingsources of information that are used to create the care plan, why it must befollowed and why it must be reviewed and updated timely. Any staff who fail to comply with the pointsof the inservice will be further educated</p>		

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	<p>limited to, wearing a right hand splint for four hours a day after lunch, with the assistance of staff. Passive range of motion was to be performed by staff each time before applying the splint.</p> <p>Review of Resident #23's Treatment Administration Record (TAR) did not include any indication of splinting of his right hand.</p> <p>2. During an observation on 01/25/2016 at 10:07 A.M., Resident #101 was sitting in a wheelchair in the Hope Springs Unit dining room. The resident had scabbed skin tears on the back of the left hand and on the elbow and wrist of his left arm. There were no dressings on any of the skin tears.</p> <p>During an interview on 01/25/2016 at 10:02 A.M., LPN (Licensed Practical Nurse) #12 indicated Resident #101's dressings for his skin tears were to be changed on 01/23/2016, but he did not have a dressing on at the moment and the areas were scabbed over. LPN #12 indicated the orders to dress the skin tears had not been discontinued and the resident's wounds should have been dressed.</p> <p>Record review for Resident #101 was completed on 01/25/2016 at 9:59 A.M. The "Treatment Record" for Resident</p>		<p>and/or progressively disciplined as appropriate. At the monthly Quality Assurance meetings the results of the monitoring by the DON/Designee related to ROM and care plans will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee to address any patterns. Any Action Plan will be monitored by the Administrator until resolution.</p>	

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	<p>#101 indicated the treatments for the left elbow, left wrist, and left hand skin tears were not signed off which indicated the treatments were not completed on January 23, 2016.</p> <p>During an observation on 01/25/2016 at 3:18 P.M., there were no non-skid strips on the floor of Resident #101's room.</p> <p>During an interview on 01/25/2016 at 2:35 P.M., the DON (Director of Nursing) indicated Resident #101 had a history of falls and one of the fall interventions included having non-skid strips in the resident's room.</p> <p>During an interview on 01/25/2016 at 3:48 P.M., LPN #12 indicated she had never seen non-skid strips in Resident #101's room.</p> <p>Resident #101's care plan was reviewed on 1/22/2016 at 1:30 P.M. The care plan indicated the resident was at risk for falls related to dementia with confusion, poor balance and poor safety awareness. The interventions included, but were not limited to, non-skid strips to the floor at the resident's bedside. The intervention was initiated on 12/30/2014.</p> <p>The current facility policy titled, "Care Plans" and dated 2/2/15, was provided by</p>			

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F 0353 SS=E Bldg. 00	<p>the Administrator on 01/26/2016 at 11:49 A.M. and reviewed at that time. The policy indicated, but was not limited to, the following: "...It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition..."</p> <p>3.1-35(g)(2) 3.1-42(a)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p>			

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	<p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to provide sufficient staffing to meet the needs of each resident, related to the provision of range of motion and waiting long periods of time for assistance with care. This affected 3 of 36 residents interviewed (or resident's family members interviewed) regarding staffing (Residents #81, #82, and #86) and 11 of 12 staff interviewed. (Staff #31, 32, 33, 34, 35, 36, 37, 38, 39, 40, and 41). This had the potential to affect all 91 residents residing in the facility.</p> <p>Findings include:</p> <p>During a continuous observation on 01/20/2016 from 2:02 P.M. to 2:27 P.M., Resident #86 had her call light on for assistance. The call light was answered by a housekeeping staff member.</p> <p>During a confidential interview on 01/20/2016 at 12:54 P.M., Staff #38 indicated the facility had not been providing assistance for residents whom</p>	F 0353	F-353 It is the policy of the facility to provide sufficient nursing staffing to attain or maintain the highest level of care for the residents as far as their physical, mental and psycho-social well being needs. Residents #81, #82, and #86 receive adequate care and services by staff to meet their needs sufficiently. All staff members including #31, #32, #33, #34, #35, #36, #37, #38, #39, #40 and #41 are in receipt of the steps taken to ensure that recruitment and retention plans are in place to maintain adequate staffing. Resident #86 has her call light answered timely. Resident #82 and his wife are satisfied with with call light response time. Resident #81's husband is satisfied with his wife's turning and toileting needs as being met timely. There is an adequate number of mechanical lifts in the facility. All are in good working order including the batteries. There is adequate nursing staff to meet the needs of the residents daily including weekends; all shifts. This finding has the potential to affect all residents who reside in the facility. The Administrator and DON have met and discussed	02/25/2016

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	<p>were discharged from physical therapy to have restorative therapy due to shortness of staff. The CNAs (Certified Nursing Assistants) that would normally be performing restorative range of motion were working the floor.</p> <p>During a confidential interview on 01/20/2016 at 2:28 P.M., Staff #37 indicated the residents had to wait and it was hard to get the work done due to staffing issues. Staff #37 further indicated most staff try to help, but the work still does not get done in a timely manner. Staff #37 further indicated the batteries have not been working in the lifts and the residents requiring a lift have had to wait for the CNA's to find a working battery. Sometimes the wait had been 30 to 40 minutes due to sharing the batteries with other resident areas.</p> <p>During an interview on 01/20/2016 at 3:42 P.M., Resident #86 indicated residents' call lights get ignored and sometimes residents wait an hour for help.</p> <p>During a confidential interview on 01/25/2016 at 10:27 A.M., Staff #31 indicated the CNA's were pulled from being restorative aides to work as CNA's on the floor. Due to the CNA's being pulled the residents were not receiving</p>		<p>strategies to recruit and retain nursing staff. Regional corporate support is in place to seethat adequate nursing staffing goals are met ongoing. There is a revised process for writing,posting and follow up of the schedule for nursing staff. The nursing schedule will be reviewed daily(for the following day) by the Administrator/Designee to see that nursing staffis in place to meet the needs of the residents per their plans of care. Astaffing call will occur as needed weekly. This call will include corporate support staff who will review anypertinent staffing needs and assist the facility with a resolution plan. TheDON/Designee will interview 10 interviewable residents or families weekly onvarious shifts to see if they have any concerns related to getting their needsmet. Special emphasis will be placed onthe following:</p> <ol style="list-style-type: none"> <li>1. Receiving ROM/Splint or device use</li> <li>2. Mechanical lift "wait" time acceptable</li> <li>3. Timely call light response</li> <li>4. Turned/toileted timely</li> <li>5. Adequate staff daily all shifts to meet needs</li> </ol> <p>Further, 10 nursing staffmembers will be interviewed weekly on various shifts to see if they feel theyhave reasonable manpower to complete resident care tasks/needs timely.</p>				

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	<p>the required range of motion therapy as ordered.</p> <p>During an interview on 01/25/2015 at 11:10 A.M., Resident #82's wife indicated her husband had to wait for assistance with turning and toileting on several occasions longer then 30 minutes. She further indicated on couple occasions, she walked up and down the hallway and could not find any staff.</p> <p>During an interview on 01/25/2015 at 11:58 A.M., Resident #81's husband indicated the facility was often short staffed and the staff did not always have time to turn his wife every two hours. He indicated there were days, depending on who was working, that he did not have to worry, knowing the staff would turn his wife routinely. Resident #81's husband indicated he was concerned for his wife due to the frequent number of days his wife was not getting turned.</p> <p>During a confidential interview on 01/25/2015 at 3:08 P.M., Staff #32 indicated the facility was down to one lift that worked and the residents requiring the use of a mechanical lift had to wait for long periods. Staff #32 further indicated the facility was under staffed on most weekends and they had up to six resident at a time that required two staff</p>		<p>This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, 3 interviewable residents or family members and 3 nursing staff members will be interviewed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Any concerns will be addressed as discovered. At an inservice held for nursing staff on February 9th 2016, Resident Rights, ADLs and Accommodation of Needs was reviewed. In addition, the necessity of being timely with all care needs as cited in the survey was discussed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings any concerns or patterns will be addressed. Any identified patterns will be identified. If needed, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution</p>		

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	<p>members for assistance.</p> <p>During a confidential interview on 01/25/2016 at 3:40 P.M., Staff #33 indicated it was difficult not being able to help the residents the way they deserved. Staff #33 indicated residents have had to wait up to 45 minutes for a call light to be answered to use the restroom.</p> <p>During a confidential interview on 01/26/2016 at 12:43 A.M., Staff #34 indicated there were only two CNA's until 2:00 A.M., then one CNA till 6:00 A.M. The unit had 43 residents. Staff #34 further indicated it was very hard to care for all the residents with so few staff and more residents fall at night when there were less staff working.</p> <p>During a confidential interview on 01/26/2016 at 2:37 A.M., Staff #35 indicated residents had long waits and the work load was not completed the way it should have been due to lack of staff. Staff #35 further indicated a few weeks ago he/she was the only staff member working in the area for over 40 residents.</p> <p>During a confidential interview on 01/26/2016 at 2:40 A.M., Staff #36 indicated he/she worked 6 days a week due to lack of staff. Staff #36 further indicated staff do not have the time to</p>						

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	<p>properly care for the residents. Staff do their best but residents have to wait up to an hour at times. Staff #36 indicated several residents were not receiving restorative range of motion, as in walking, due to the lack of staff.</p> <p>During a confidential interview on 01/26/2016 at 8:19 A.M., Staff #39 indicated one of the units had several residents who wandered and were at risk for falls. The department needed more staff to safely monitor the residents. Staff #39 further indicated he/she could not properly complete his/her job with all the requirements of medication passing, charting, contacting physicians, behavior issues of residents, answering call lights, and the number of residents requiring two staff members for assistance due to lack of staff. The department has had an increase in falls on the weekends because of lack of staff.</p> <p>During a confidential interview on 01/26/2016 at 11:45 A.M., Staff #40 and #41 indicated they can not help the residents in a timely manner due to lack of staff. Staff #40 indicated residents requiring two staff members for assistance have had to wait up to 45 minuets for help.</p> <p>During an interview on 01/26/2016 at</p>			

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F 0364 SS=E Bldg. 00	<p>11:20 A.M. the Executive Director indicated the facility was trying to hire additional staff.</p> <p>3.1-17(a)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure residents received palatable food that was acceptable in flavor and temperature. This affected 6 of 12 residents interviewed for food quality and had the potential to affect 89 of 91 residents who receive meals prepared in the facility kitchen. (Residents #39, #140, #23, #141, #63, and #33)</p> <p>Findings include:</p> <p>During an observation on 01/20/2016 at 12:08 P.M., Activity Aide #26 was assisting Resident #39 to consume her meal. Resident #39 kept turning her head</p>	F 0364	F-364 It is the policy of the facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance, and that food is palatable, attractive and served at the proper temperature. Resident #39, Resident #140, Resident #23, Resident #141, Resident #63 and Resident #33 are all satisfied with their meals served. Residents who receive meals prepared in the dietary department of the facility have the potential to be affected by this finding. The Administrator and the Dietary Manager have met with the residents cited on the survey and also will meet with the Resident Council at their monthly	02/25/2016

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	<p>and saying, "Yuck" and "No".</p> <p>During an observation on 01/20/2016 at 12:46 P.M., CNA (Certified Nursing Assistant) #27 was taking food trays out of the food cart. The food cart was running a little late according the scheduled meal time. While the CNA was removing the food tray she stated to RN (Registered Nurse) #8, "At least the food is hot today."</p> <p>During an interview on 01/20/2016 at 12:47 P.M., CNA #27 indicated on some occurrences some of the hot food items were lukewarm.</p> <p>During an observation on 01/20/2016 at 12:51 P.M. with the DM (Dietary Manager), a test tray was observed and tested. The puree noodles were a sticky, paste-like texture and the puree noodles tested 108 degrees Fahrenheit. The noodles were taste-tested and were lukewarm, bland and sticky.</p> <p>During an interview on 01/20/2016 at 1:07 P.M., the DM tested the puree noodles for taste and consistency. The DM indicated she would not enjoy eating the noodles due to the flavor and consistency.</p> <p>During an interview on 01/20/2016 at</p>		<p>meeting on February 17th. The purpose of the meeting with the Dietary Manager and the residents cited and in attending the Resident Council meeting is to compile a list of dietary concerns. When the list is compiled the Dietary Manager and the Administrator will meet with the Dietician to address all concerns and prepare a plan to address the concerns. The concerns will be addressed specifically, but generally and for monitoring purposes they will include:</p> <ol style="list-style-type: none"> <li>1. Meal/food "taste"</li> <li>2. Meal/food palatability</li> <li>3. Food appearance</li> <li>4. Food temps</li> <li>5. Preferences honored/Tray cards Ex: Not served coffee if doesn't like coffee The Dietary Manager/Designee will interview 10 interviewable residents 3 days weekly (including some weekend days) at various meals to ensure that the meals meet expectations in the above listed areas. Any concerns will be addressed as discovered. Further, the Dietary Manager/Designee will review all tray cards to see that the likes and dislikes are accurate. Additionally, the last tray delivered on various halls carts will be a "test" tray for acceptable temperature parameters and will be tested by the DM/Designee. This temp taking will be done for 2 meals</li> </ol>		

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	<p>2:01 P.M., Resident #140 indicated she did not like the food's taste at all. She indicated she does not like coffee and they bring her coffee on the tray constantly. Resident #140 further indicated the kitchen consistently serves bad meals that are usually cold.</p> <p>During an interview on 01/20/2016 at 2:16 P.M., Resident #23 indicated the food tasted bad and he had trouble eating the food.</p> <p>During an interview on 01/21/2016 at 9:19 A.M., Resident #141 indicated she didn't like the food. Resident #141 further indicated some food items are just "yucky". She also indicated on several occasions the food was cold when received.</p> <p>During an interview on 01/21/2016 at 10:26 A.M., Resident #63 indicated the food taste was not to her liking and she was having a hard time eating.</p> <p>During an interview on 01/25/2016 at 12:00 P.M., Resident #33 indicated the food was, "terrible, it is just not good food."</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p>		<p>daily 5 days weekly (including some weekend days) to ensure that temps are maintained within acceptable parameters. At least 2 trays will be temped at the designated meals (2) 5 days weekly. Any concerns will be addressed as discovered. All monitoring will be documented. The monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, 5 residents will be interviewed weekly as to meal satisfaction. Additionally, cart trays will have a test tray (last tray served from a hall cart) temped 3 meals weekly. This monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Any concerns will be addressed as discovered. An inservice for the dietary staff was held on February 9th 2016, at which time the following was reviewed: A. Food preparation to enhance taste and palatability B. Food appearance and presentation C. Maintaining Food Temps/test trays D. Preferences/Updated tray cards Note: Nursing staff was inserviced February 9th 2016, on timely tray delivery. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meeting the results of the</p>		

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to provide a clean and sanitary kitchen related to the cleanliness of air filters, vents and the three compartment sink. This deficient practice had the potential to affect 89 of 91 residents served meals from the facility kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 01/20/2016 at 10:46 A.M., with the Dietary Manager (DM), the following was observed:</p> <p>1. The air vent located above the dish</p>	F 0371	<p>DM/Designee monitoring for food satisfaction as well as the results of the test tray temps will be reviewed. Any patterns will be identified, however any concerns will have been corrected as found. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution.</p> <p>F-371 It is the policy of the facility to maintain a clean and sanitary kitchen. The air filters, vents and the three compartment sink have all been thoroughly cleaned and placed on a routine cleaning schedule. The frame around the filter cited in the survey has been repaired. The filter now covers the area it was designed to cover. There is a maintenance staff person who is monitoring the dietary kitchen. Filters have been ordered. The 3 compartment sink is being utilized properly. Sanitizing solution is being used properly and at the proper strength. Large pots and pans and all other dietary supplies including bowls, spoons and flatware are being washed</p>	02/25/2016

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	<p>washing area was covered with dark brown and black particles, the filter frame was slightly twisted and bent in, two to three inches on both sides, the filter was not covering the entire area due to the bent frame.</p> <p>2. The air vent above the stove and located on the ceiling, had an area of black residue, 4 to 5 inches wide, circling the entire vent.</p> <p>During an interview on 01/20/2016 at 11:02 A.M., the DM indicated the maintenance man was terminated and the vents were not being cleaned. The DM further indicated she was not sure if replacement filters were ordered.</p> <p>During a second observation on 01/25/2016 at 11:21 A.M., the following was observed:</p> <p>3. Dietary Aid (DA) #61 was washing pots and pans in a three compartment sink. The DA was only using two compartments of the three compartment sink. The middle rinse compartment of the three compartment sink was empty with no water in the sink. The DA #61 took the pan out of the first washing compartment sink and placed it directly into the sanitizing solution. Next, DA #61 took a lid out of the wash</p>		<p>properly and in the proper area. All residents who consume food or drink from the dietary department have the potential to be affected by this finding. The Dietary Manager will monitor the cleaning schedules daily 5 days weekly to see that all cleaning is taking place per policy. Included in this monitoring will be observations as to the proper use of the 3 compartment sink. Additionally, the strength of the sanitizing solution will be verified. This monitoring will occur on various shifts. The Maintenance Supervisor will make rounds in the dietary kitchen to check for needed repairs, filters and so on. This monitoring will be ongoing. Any concerns found during the monitoring in the dietary kitchen will be addressed as found. The monitoring done by the Dietary Manager will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will take place 3 days weekly on various shifts for a period of not less than 6 months to ensure ongoing compliance. After that monitoring will occur randomly. At an in-service for dietary held, February 9th, 2016, the following was reviewed:</p> <ol style="list-style-type: none"> <li>1. Cleaning/cleaning schedules in dietary</li> <li>2. Proper washing/rinsing/drying—pots, pans, dinnerware, bowls, utensils etc.</li> </ol>		

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	<p>compartment and placed it directly into the sanitizing solution, skipping the rinse compartment. Two large cookie sheets, a bowl and a serving spoon were sitting on the drying tray.</p> <p>During an observation on 01/25/2016 at 11:34 A.M., the DM tested the sanitizing solution in the three compartment sink. The sanitizing solution tested in the "0" range on the test strip. This indicated there was not enough sanitizing solution in the sanitizing compartment of the three compartment sink.</p> <p>During an interview on 01/25/2016 at 11:26 A.M., DA #61 indicated she was washing the large pots and pans in the hand sink. When asked about the middle rinse compartment she indicated it was drained earlier and she did not refill it. The DA indicated the dishes were washed and rinsed in the sanitizing solution.</p> <p>During an interview on 01/25/2016 at 11:38 A.M., the DM indicated the sanitizing solution should have tested in the 200 range on the test strip. The DM further indicated the cookie sheets, bowl, serving spoon, lid and pan would have to be properly rewashed since DA #61 did not use the three compartment sink correctly.</p>		<p>3. 3 compartmentsink-proper use</p> <p>4. Sanitizingsolution-strength/tracking At an inservice for theMaintenance Supervisor held February 9th 2016, the necessity of monitoring thedietary department including checking vents and filters weekly was reviewed andis to be part of the Preventive Maintenance Program. Any failure to comply with the points of theinservice will require further education and or progressive discipline asindicated. At the monthly QA meetingthe results of the monitoring by the DM and the Maintenance Supervisor will bereviewed and any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly bythe Administrator until resolved.</p>		

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F 0441 SS=E Bldg. 00	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <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</p>			

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	<p>for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure proper infection control practices and standards were maintained related to hand washing, wound care, linen handling, and isolation precautions for 2 of 3 observations of wound care (Residents #177, #80), 5 of 5 observations of staff working in isolation rooms (LPN #11, Laundry Aide #10, CNA #14, CNA #23, CNA #24) and 1 of 3 observations of linen handling (HSK #13).</p> <p>Findings include:</p> <p>1. During an observation of wound care treatment on 01/21/2016 at 3:10 P.M., the following was observed prior to, during and after the treatment:</p> <p>RN (Registered Nurse) #8 opened a carton of Ready Care drink, using her thumb to pull open the inner tip of the carton and poured it into a glass. The RN opened a second carton of Ready Care drink, again using her thumb to pull open the inner tip of the carton and poured it</p>	F 0441	F-441 It is the policy of the facility to see that there is an Infection Control Program in place which provides a safe, sanitary environment for the residents and helps prevent the spread of infection. All staff are practicing safe (accepted by CMS) hand washing techniques while at work. Nurses are practicing wound care and dressing changes using proper hand hygiene and glove usage per policy. Any resident who requires isolation precautions has those precautions implemented and practiced per policy. Staff do not contaminate tray items such as milk containers by touching them with their hands. Further, nurses use proper hand hygiene during all med passes. Clean linen is handled per policy with special care not to allow the linen to touch anything that would cause it to be considered contaminated. Soiled linen is handled per policy with special care to keep it contained so as not to spread any organism or disease. All residents who reside in the facility have the potential to be affected by this finding. The DON/Designee will monitor all staff and they will be	02/25/2016

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	<p>into a glass. She passed one cup to Resident #113 and the second cup to Resident #115. The RN then touched her stethoscope, tucked hair behind her right ear, pulled a knife from one of the cabinets and cut up Resident #44's sandwich without touching the sandwich. The RN then scratched her forehead, tucked hair behind her ear with her right hand, opened another carton of Ready Care drink, touching the inner lip of the carton. She poured the shake into a cup, gave the cup to Resident #126, took milk from the refrigerator and poured Resident #44 a cup.</p> <p>RN #8 then went to the nurse's station, opened the medication cart, rubbed at her nose with her right hand, pulled supplies from the cart, and headed to room 305. The RN washed her hands for 12 seconds, turned the water off with her bare hands, dried her hands with paper towels, and donned gloves. RN #8 opened a package of gauze, sprayed the gauze with wound cleaner, wiped Resident #177's skin tear on his left arm to clean the wound, removed her gloves, donned new gloves, opened a bandage, taped down the bandage, removed her gloves, pulled a pen out of her pocket, and wrote the date and her initials on the bandage. The RN then threw away the used supplies, touched her stethoscope,</p>		<p>"checked off" after having demonstrated proper hand washing technique. Additionally, nurses will be "checked off" after having demonstrated proper hand hygiene and glove usage during a mockdressing change. The DON/Designee will monitor 10 staff members 3 days weekly from different departments to see that they are practicing proper hand hygiene. Any concerns will be corrected as observed. The DON/Designee will monitor 2 med passes 3 days weekly on different shifts to see that the nursing staff is practicing proper hand hygiene. Any concerns will be corrected as found. Additionally, the DON/Designee will monitor 3 dressing changes 3 days weekly on various shifts to see that proper hand hygiene and glove usage takes place. Any concerns will be addressed as found. The DON/Designee will monitor tray delivery 1 meal daily, 5 days weekly to see that proper hand hygiene takes place during tray pass. Any concerns will be corrected as observed. The DON/Designee will observe 5 staff 3 days weekly as they enter and exit any rooms with isolation precautions to ensure that proper technique is practiced. Any concerns will be corrected as observed. The Housekeeping Supervisor will monitor linen delivery to the floor at least once daily 5 days a week to see that it is delivered with no breach</p>	

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	<p>touched Resident #177's shoulder and hair, pulled up her pants, touched her own hair, and touched her lip. RN #8 moved Resident #177's bedside table in front of him, put his meal tray on the table, uncovered his sandwich, applesauce, and chips. The RN took the bag of chips and cup of milk off of the tray at the request of the resident, picked up her wound care supplies, hooked arms with Resident #115, who had wandered into the room, and led her out of the room. The RN then rubbed her nose, offered the bag of chips from Resident 177's tray to Resident #115, which she refused, and offered the milk to Resident #115, which she accepted and drank. RN #8 proceeded to the medication cart, opened the MAR (Medication Administration Record), picked up a stack of empty medication cards, and headed to the nurse's station. The RN did not wash or sanitizer her hands after leaving the resident's room.</p> <p>During an interview on 01/25/2016 at 4:01 P.M., LPN (Licensed Practical Nurse) #12 indicated hands should be washed for at least 20 seconds.</p> <p>During an interview on 01/26/2016 at 9:42 A.M., the ADON (Assistant Director of Nursing) indicated hands should be washed for 20-30 seconds.</p>		<p>in infectioncontrol. Any concerns will be corrected as observed. This monitoring will continue until 4consecutive weeks of zero negative findings are achieved. Afterwards, the DON/Designee will monitor 5staff members weekly for proper hand hygiene. Two med passes weekly will be monitored for proper hand hygiene. Twodressing changes will be monitored weekly for proper hand hygiene and gloveusage. Two meals (tray passes) will bemonitored weekly for proper hand hygiene. Two staff members will be monitored weekly for infection controlpractices in an isolation setting. And,the Housekeeping Supervisor will monitor linen pass to the floors two timesweekly. Any breach will be corrected asobserved. This monitoring will continuefor a period of 6 months to ensure ongoing compliance. After that timeframe, random monitoring willoccur. At an all staffinservice held February 9th, 2016, thefollowing was reviewed:</p> <ol style="list-style-type: none"> <li>1.Hand washing/hand hygiene (general)</li> <li>2.Hand hygiene during meal service</li> <li>3.Linen handling</li> <li>4.Isolation Precaution practices/technique</li> <li>5.(Nurses) hand hygiene during dressing changes and medpasses Anystaff who fail to comply with the points of the inservice will be furthereducated</li> </ol>		

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	<p>The current facility policy titled, "Treatment of Skin Tears" and dated 7/1/11, was provided by the DON (Director of Nursing) on 01/25/2016 at 4:40 P.M. and was reviewed at that time. The policy indicated, but was not limited to, the following: "...2. Wash hands and apply gloves...5. Carefully remove and discard soiled dressing...6. Remove gloves, wash hands and apply new gloves..."</p> <p>2. During an observation and interview on 01/25/2016 at 11:06 A.M., LPN #11 used hand sanitizer, gathered supplies for a treatment, and went to Resident #80's room. LPN #11 indicated Resident #80 was not in isolation, but his roommate, Resident #185 was in isolation for clostridium difficile (C-Diff). The LPN indicated she only used standard precautions for Resident #80. LPN #11 entered the room, placed the supplies on the resident's bedside table, washed her hands appropriately for 32 seconds, donned gloves, unfastened Resident #80's brief, uncovered the wound, used adhesive remover around the edges of the dressing, peeled off the soiled dressing, and threw away the dressing. The LPN then opened a package of sterile gauze, applied wound cleaner to the gauze, wiped the wound, allowed the wound to</p>		and/or progressively disciplined as necessary. At the monthly QA meeting the results of the monitoring will be reviewed for patterns and trending. However, any concerns will have been addressed as observed. If necessary an Action Plan will be written by the committee. Any Action Plan will be reviewed by the Administrator weekly until resolved.				

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	<p>dry, opened another package of gauze, applied bacitracin ointment to the gauze, applied the ointment to the wound, applied a new dressing to the wound, and put the used supplies into a trashbag. The LPN then removed her gloves, wrote the date, time, and her initials on the new dressing, threw away the trashbag in the restroom, took a new pair of gloves from Resident #185's side of the room, donned the gloves, redid the resident's brief, pulled up the resident's blanket, removed her gloves, and washed her hands appropriately for 25 seconds before leaving the room.</p> <p>During an interview on 01/25/2016 at 4:01 P.M., LPN #12 indicated isolation precautions should be used when entering an isolation room even if the resident you are working with is not the one with the infection. The LPN indicated gloves should be removed after you take the old dressing off and new ones should be donned before applying the treatment.</p> <p>During an interview on 01/26/2016 at 9:42 A.M., the ADON (Assistant Director of Nursing) indicated contact isolation precautions should be followed by wearing a gown and gloves for any room where a resident has clostridium difficile, even if it is not the resident you are directly working with.</p>			

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	<p>The current, undated facility policy titled, "Dressing Change: Nonsterile (Clean) and Sterile (Aseptic)", was provided by the DON on 01/25/2016 at 4:40 P.M. and was reviewed at that time. The policy indicated, "...Perform hand hygiene...remove soiled dressing and discard in trash bag...remove latex free non-sterile gloves and discard in trash bag...perform hand hygiene...apply...clean pair of latex free non-sterile gloves..."</p> <p>3. During an observation on 01/25/2016 at 8:31 A.M., CNA (Certified Nursing Assistant) #23 entered Resident #131's isolation room, took Resident #131's cup from her room, walked into the hall, filled it with ice, and returned the cup to the resident. The CNA then washed her hands appropriately before reentering Resident #131's room, the CNA picked up Resident #8's cup, filled it with ice and returned the cup to the resident. CNA #23 left the room and moved to room 205 where she took Resident #99's cup, filled it with ice, and returned it to the resident. The CNA used hand sanitizer before leaving room 205.</p> <p>During an observation on 01/26/2016 at 3:21 P.M., CNA #14 walked into room 204, took Resident #131's cup from her bedside table, took it into the hall, filled</p>			

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	<p>the cup with ice, touching the handle of the ice scoop, and took the cup back into the resident's room. The CNA took the roommate, Resident #8's, cup from her bedside table, filled the cup with ice and returned it to the resident. Upon leaving the room for the last time, CNA #14 used hand sanitizer.</p> <p>During an interview on 01/26/2016 at 3:22 P.M., CNA #14 indicated Resident #131 was in isolation for clostridium difficile and that she should have worn a gown and gloves when entering the room. The CNA further indicated she only had to wash her hands if she had direct contact with the residents.</p> <p>During an observation on 01/20/2016 at 3:30 P.M., CNA #24 was changing Resident #74's brief, with her uniform top and pants resting against the resident's bare side. Resident #74's room required contact isolation precautions due to Resident #74's roommate having clostridium difficile.</p> <p>During an observation and interview on 01/20/2016 at 3:40 P.M., CNA #24 walked into Resident #127's room. After exiting the resident's room, the CNA indicated she had been helping Resident #127 off the toilet. The CNA was wearing the same top and pants she was</p>			

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	<p>wearing during the observation with Resident #74.</p> <p>During an interview on 01/20/2016 at 3:41 P.M., the MDS (Minimum Data Set) Coordinator indicated that when a contact isolation room was entered, you should wear a gown and gloves, but if you were just standing by the door then gloves alone would work. She further indicated you should wash your hands when you leave the room.</p> <p>The current, undated facility policy titled, "Isolation - Contact", was provided by the DON on 01/26/2016 at 1:50 P.M. and reviewed at that time. The policy indicated, "Contact Isolation practices are designed to prevent the spread of microorganisms among patients, hospital personnel, and visitors by direct or indirect contact...necessary isolation equipment...gloves, gowns..." and when entering a contact isolation room, all staff "...7. Performs Hand Hygiene. 8. Dons appropriate personal protective equipment before entering patient room. 9. Changes gloves after contact with infective material containing high concentration of microorganisms, such as wound drainage...11. Removes personal protective equipment upon leaving patient room taking care not to contaminate self. 12. Performs hand</p>			

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	<p>hygiene..."</p> <p>4. During an observation on 01/22/2016 at 8:41 A.M., Resident #45 was sitting in the main lobby with Residents #131, #63, #61, #46, #43, and #7. During an interview at the same time, SLP (Speech Language Pathologist) #25 indicated she did not know if any of the residents in the lobby were under isolation precautions.</p> <p>During an interview on 01/22/2016 at 8:45 A.M., CNA #17 indicated Resident #45 was in isolation for an infection in his urine.</p> <p>5. During an observation on 01/21/2016 at 3:28 P.M., an unidentified nurse slid the keys to the med cart across the floor of the main hall to LPN (Licensed Practical Nurse) #9. LPN #9 picked up the keys, opened the med cart, pulled out a box of DuoNeb treatments, pulled one treatment from the box, touched her hair, and walked to Resident #140's room. The LPN donned gloves, attached a pulse oximeter to the resident's finger, removed the monitor because it was not working, removed her gloves, and left the room, using hand sanitizer as she left.</p> <p>The current facility policy titled, "Nebulizer Therapy" and dated 2/28/12, was provided by the Administrator on</p>			

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	<p>01/26/2016 at 11:49 A.M. and was reviewed at that time. The policy indicated, "...3. Wash you hands..."</p> <p>6. During a continuous observation on 01/20/2016 from 11:51 A.M. to 11:58 A.M., Laundry Aide #10 entered and exited rooms 222, 214, 218, 215, 321, 320, 318, 305, and 308 without washing her hands at any point. Room 218 was an isolation room for a resident with clostridium difficile and required use of contact precautions.</p> <p>7. During an observation on 01/20/2016 at 10:50 A.M., HSK (Housekeeper) #13 walked down the hall while holding a stack of clean linens to her chest. (In direct contact with her uniform.)</p> <p>The current facility policy titled, "Handling Clean and Soiled Linen" and dated 7/1/11, was provided by the DON on 01/21/2016 at 4:16 P.M. and was reviewed at that time. The policy indicated, "...Carry clean linen away from your uniform..."</p> <p>During an interview on 01/21/2016 at 2:13 P.M., the ADON indicated he believed handwashing was the number one cause of facility acquired infections and was probably the cause of the several cases of clostridium difficile in the</p>			

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	<p>facility.</p> <p>The "Residents with C-Diff" list was provided by the DON on 01/20/2016 at 2:05 P.M. The list indicated seven residents currently had clostridium difficile and all seven had acquired the infection since 11/27/2015.</p> <p>The current facility policy titled, "Hand Hygiene" and dated 8/21/13, was provided by the DON on 01/21/2016 at 2:16 A.M. and was reviewed at that time. The policy indicated, "...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations...before and after contact with residents...if moving from a contaminated body site to a clean body site during resident care...after contact with an inanimate object in the immediate vicinity of the resident...after removing gloves..." and "...rub hands together vigorously for at least 20 seconds...use towel to turn off faucet..."</p> <p>3.1-18(a) 3.1-18(j) 3.1-18(l) 3.1-19(g)</p>			

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to maintain a safe and functional environment related to damaged walls and missing baseboards for 7 of 40 residents reviewed for environment. (Residents #7, #56, #33, #112, #12, #40, and #22)</p> <p>Findings include:</p> <p>During an observation on 01/20/2014 at 2:17 P.M., Resident #7's bathroom walls had peeling paint on the door.</p> <p>During an observation on 01/20/2014 at 2:46 P.M., Resident #56's wall had a white patched area on the wall 10" (inches) x 15" that needed painting. The resident indicated it had been like that since he was admitted 2 years ago.</p> <p>During an observation on 01/20/2014 at 3:07 P.M., Resident #33 had two white pipe covers laying on the floor under the sink in the bathroom. Resident #33</p>	F 0465	<p>F-465 It is the policy of the facility to provide a safe, functional, comfortable environment for the residents, staff and public. Residents #7, #56, #33, #112, #12, #40 and #22 have rooms and bathrooms in good repair. Resident #7's bathroom walls and door have been repaired from peeling paint. Resident #56's room has the white patch painted. Resident #33 does not have white pipe under the bathroom sink. Resident #112 has had their room doors painted. Resident #12 has had the baseboard replaced in the bathroom. Resident #40 has had the hole in their bathroom wall repaired. Resident #22 has had the screw holes in their bathroom wall repaired. A tour was conducted by the Administrator and the Maintenance Supervisor at which time a list was made of any needed repairs of walls, doors or baseboards of resident rooms or resident bathrooms. The list was put on a schedule for completion. The Administrator will review the list weekly with the Maintenance Supervisor to track progress. All residents have</p>	02/25/2016

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	<p>indicated they had been laying there "forever".</p> <p>During an observation on 01/20/2014 at 3:09 P.M., Resident #112 had two 12" x 12" areas of paint missing, one on both of the doors.</p> <p>During an observation on 01/20/2014 at 3:31 P.M., Resident #12 had a 4" x 6" area of baseboard missing in the bathroom.</p> <p>During an observation on 01/20/2014 at 4:47 P.M., Resident #40 had a 5" x 5" hole in the wall behind the toilet.</p> <p>During an observation on 01/21/2014 at 10:32 A.M., Resident #22 had eight screw holes in the bathroom walls.</p> <p>During an interview and second observation with the Floor Tech, who was acting as the Interim Maintenance Director, on 01/26/2016 at 4:13 P.M., he indicated no work orders had been filed for the above listed issues but he would add them to the current list of work to be done.</p> <p>3.1-19(f)</p>		<p>thepotential to be affected by this finding. The Maintenance Supervisor will make rounds 2 times monthly to checkresident rooms and bathrooms for any needed repairs. These repairs will beadded to the schedule of repairs kept by the Maintenance Supervisor. Theserounds will be ongoing as part of the Preventive Maintenance Program. At an inservice held February 9th 2016,for the maintenance staff the necessity of making twice a month rounds in theresident rooms and resident bathrooms to check for needed repairs wasreviewed. Further, the concept of thePreventive Maintenance Program was reviewed. Any staff who fail tocomply with the points of the inservice will be further educated and/orprogressively disciplined as indicated. At the monthly QA meetings,the result of the rounds by the maintenance department and the progress towardsmaking needed repairs will be discussed. Any concerns will be addressed. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by theAdministrator weekly until resolution.</p>		

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F 0520 SS=E Bldg. 00	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify concerns and successfully implement a plan of action to address infection control practices, restorative care, routine maintenance repairs and tuberculosis screening for employees.</p> <p>This deficient practice had the potential to affect 91 of 91 residents who resided in the facility.</p>	F 0520	F-520 It is the policy of the facility to see that the Quality Assurance Committee meets at least quarterly to identify any issues or trending of concern and to implement action plans to achieve compliance. The facility has addressed infection control practices as well as restorative care. The facility has addressed needed maintenance repairs as well as TB screening for the	02/25/2016

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	<p>Findings include:</p> <p>1. During an observation and interview on 01/25/2016 at 11:06 A.M., LPN (Licensed Practical Nurse) #11 applied hand sanitizer, gathered supplies for a treatment, and went to Resident #80's room. LPN #11 indicated Resident #80 was not on isolation, but his roommate, Resident #185 was on isolation for clostridium difficile (C-Diff). The LPN indicated she only uses standard precautions for Resident #80. LPN #11 entered the room, placed the supplies on the resident's bedside table, washed her hands appropriately for 32 seconds, donned gloves, undid Resident #80's brief, uncovered the wound, used adhesive remover around the edges of the dressing, peeled off the soiled dressing, and threw away the dressing. The LPN then opened a package of sterile gauze, applied wound cleaner to the gauze, wiped the wound, allowed the wound to dry, opened another package of gauze, applied bacitracin ointment to the gauze, applied the ointment to the wound, applied a new dressing to the wound, and put the used supplies into a trashbag. The LPN then removed her gloves, wrote the date, time, and her initials on the new dressing, threw away the trashbag in the restroom, took a new pair of gloves from</p>		<p>employees. All of these topics have been added to the facility's current QAPI program agenda (these areas are to be tracked as part of the overall QAPI program ongoing). These specific areas will be reviewed and addressed as stated prior in this plan of correction. TB screening has been completed for all staff and all staff are "current" on this screening. The DON/Designee will monitor all staff from the initial hiring process on through the yearly requirements of timely PPD testing. This testing will be kept current and will be logged for review. Staff who are not properly screened with acceptable results will not be scheduled to work. All residents have the potential to be affected by this finding. At an inservice held February 10th, 2016, the Administrator and the leadership team (Dept. Heads) were inserviced by a Regional team member on the QAPI (Quality Assurance) process and the way the committee is to function. The following was reviewed:</p> <ol style="list-style-type: none"> <li>1. What is the definition/purpose of QAPI?</li> <li>2. Data collection/forms/tools</li> <li>3. Review results</li> <li>4. Identify areas of concern for deficient practice</li> <li>5. Patterns/Trending</li> <li>6. Action Plan formation and roll out</li> <li>7. Follow up</li> <li>8. Resolutions substantiated</li> </ol>	

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	<p>Resident #185's side of the room, donned the gloves, redid the resident's brief, pulled up the resident's blanket, removed her gloves, and washed her hands appropriately for 25 seconds before leaving the room.</p> <p>During an interview on 01/25/2016 at 4:01 P.M., LPN #12 indicated isolation precautions should be used when entering an isolation room even if the resident you are working with is not the one with the infection. The LPN indicated gloves should be removed after you take the old dressing off and new ones should be donned before applying the treatment.</p> <p>During an interview on 01/26/2016 at 9:42 A.M., the ADON (Assistant Director of Nursing) indicated contact isolation precautions should be followed by wearing a gown and gloves for any room where a resident has clostridium difficile, even if it is not the resident you are directly working with.</p> <p>The current, undated facility policy titled, "Dressing Change: Nonsterile (Clean) and Sterile (Aseptic)", was provided by the DON on 01/25/2016 at 4:40 P.M. and was reviewed at that time. The policy indicated, "...Perform hand hygiene...remove soiled dressing and discard in trash bag...remove latex free</p>		<p>Any staff who fail to comply with the points of the inservice will be further educated and progressively disciplined as indicated. Note: A Regional team member will attend the monthly Quality Assurance meetings for the next 3 months to ensure that the process is accurate. Any concerns will be addressed as noted. Afterwards, a Regional team member will attend the QA meeting randomly for at least 6 months to ensure ongoing compliance.</p>	

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	<p>non-sterile gloves and discard in trash bag...perform hand hygiene...apply...clean pair of latex free non-sterile gloves..."</p> <p>During an observation on 01/25/2016 at 8:31 A.M., CNA (Certified Nursing Assistant) #23 entered Resident #131's isolation room, took Resident #131's cup from her room, walked into the hall, filled it with ice, and returned the cup to the resident. The CNA then washed her hands appropriately before reentering Resident #131's room, the CNA picked up Resident #8's cup, filled it with ice and returned the cup to the resident. CNA #23 left the room and moved to room 205 where she took Resident #99's cup, filled it with ice, and returned it to the resident. The CNA used hand sanitizer before leaving room 205.</p> <p>During an observation on 01/26/2016 at 3:21 P.M., CNA #14 walked into room 204, took Resident #131's cup from her bedside table, took it into the hall, filled the cup with ice, touching the handle of the ice scoop, and took the cup back into the resident's room. The CNA took the roommate, Resident #8's, cup from her bedside table, filled the cup with ice and returned it to the resident. Upon leaving the room for the last time, CNA #14 used hand sanitizer.</p>			

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	<p>During an interview on 01/26/2016 at 3:22 P.M., CNA #14 indicated Resident #131 was in isolation for clostridium difficile and that she should have worn a gown and gloves when entering the room. The CNA further indicated she only has to wash her hands if she had direct contact with the residents.</p> <p>During an observation on 01/20/2016 at 3:30:26 P.M., CNA #24 was changing Resident #74 with her uniform top and pants resting against the resident's bare side. Resident #74's room required contact isolation precautions due to Resident #74's roommate having clostridium difficile.</p> <p>During an observation and interview on 01/20/2016 at 3:40 P.M., CNA #24 walked into Resident #127's room. After exiting the resident's room, the CNA indicated she had been helping Resident #127 off the toilet. The CNA was wearing the same top and pants she was wearing during the observation with Resident #74.</p> <p>The current, undated facility policy titled, "Isolation - Contact", was provided by the DON on 01/26/2016 at 1:50 P.M. and was reviewed at that time. The policy indicated, "Contact Isolation practices are designed to prevent the spread of</p>			

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	<p>microorganisms among patients, hospital personnel, and visitors by direct or indirect contact...necessary isolation equipment...gloves, gowns..." and when entering a contact isolation room, all staff "...7. Performs Hand Hygiene. 8. Dons appropriate personal protective equipment before entering patient room. 9. Changes gloves after contact with infective material containing high concentration of microorganisms, such as wound drainage...11. Removes personal protective equipment upon leaving patient room taking care not to contaminate self. 12. Performs hand hygiene..."</p> <p>During a continuous observation on 01/20/2016 at 11:51 A.M. to 11:58 A.M., Laundry Aide #10 entered and exited rooms 222, 214, 218, 215, 321, 320, 318, 305, and 308 without washing her hands at any point. Room 218 was an isolation room for a resident with clostridium difficile and required use of contact precautions.</p> <p>During an interview on 01/21/2016 at 2:13 P.M., the ADON indicated he believed handwashing was the number one cause of facility acquired infections and was probably the cause of the several cases of clostridium difficile in the facility.</p>			

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	<p>The "Residents with C-Diff" list was provided by the DON on 01/20/2016 at 2:05 P. M. The list indicated seven residents currently had clostridium difficile and all seven had acquired the infection since 11/27/2015.</p> <p>The current facility policy titled, "Hand Hygiene" and dated 8/21/13, was provided by the DON on 01/21/2016 at 4:16 A.M. and was reviewed at that time. The policy indicated, "...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations...before and after contact with residents...if moving from a contaminated body site to a clean body site during resident care...after contact with an inanimate object in the immediate vicinity of the resident...after removing gloves..." and "...rub hands together vigorously for at least 20 seconds...use towel to turn off faucet..."</p> <p>2. During an observation on 01/20/2016 at 1:10 P.M., a ten foot section of hand rail between rooms 105 and 106 was cracked and loose.</p> <p>During an observation on 01/20/2014 at 2:17 P.M., Resident #7's bathroom walls had peeling paint on the door.</p>			

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	<p>During an observation on 01/20/2014 at 2:46 P.M., Resident #56's wall had a white patched area on the wall 10"x 15" that needed painting. The resident indicated it had been like that since he was admitted 2 years ago.</p> <p>During an observation on 01/20/2014 at 3:07 P.M., Resident #33 had two white pipe covers laying on the floor under the sink in the bathroom. Resident #33 indicated they had been laying there "forever".</p> <p>During an observation on 01/20/2014 at 3:09 P.M., Resident #112 had two 12" x 12" areas of paint missing, one on both of the doors.</p> <p>During an observation on 01/20/2014 at 3:31 P.M., Resident #12 had a 4" x 6" area of baseboard missing in the bathroom.</p> <p>During an observation on 01/20/2014 at 4:47 P.M., Resident #40 had a 5" x 5" hole in the wall behind the toilet.</p> <p>During an observation on 01/21/2014 at 10:32 A.M., Resident #22 had eight screw holes in the bathroom walls.</p> <p>During an interview and second observation with the Floor Tech, who</p>			

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	<p>was acting as the Interim Maintenance Man, on 01/26/2016 at 4:13 P.M., he indicated no work orders had been filed for the above listed issues but he would add them to the current list of work to be done.</p> <p>3. On 01/26/2016 at 4:15 P.M., the employee records were reviewed. CNA (Certified Nursing Assistant) #16's "TB Testing Consent Form" did not document any tuberculin testing as being done. CNA #16 worked on January 18, 19, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>CNA #17's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #17 worked on January 18, 19, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>CNA #18's "TB Testing Consent Form" documented a completed first step tuberculin test, but did not document a second step test as being done. CNA #18 worked on January 18, 19, 20, 22, 23 and 24, 2016 as a CNA.</p> <p>CNA #19's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #19 worked on January 17,</p>			

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	<p>18, 19, 21, 22, 24, and 25, 2016 as a CNA.</p> <p>CNA #20's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #20 worked on January 17, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>During an interview on 01/26/2016 at 5:24 P.M., the DON (Director of Nursing) indicated that CNAs #16, #17, #18, #19, and #20 have all worked without the proper two step tuberculin testing since being hired. The DON indicated it had been the job of the scheduler to keep track of the tuberculin testing for new hires. When the scheduler was terminated, that job had fallen to her and it had not gotten done.</p> <p>The current facility policy titled, "Tuberculosis Surveillance" and dated 7/1/11, was provided by the Medical Records Director on 01/26/2016 at 5:07 P.M. and was reviewed at that time. The policy indicated, "...Employees and volunteers must be tested prior to employment and annually thereafter..."</p> <p>During an interview on 01/26/2016 at 5:10 P.M., The Director of Nursing (DON) and Administrator indicated the</p>			

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F 9999  Bldg. 00	<p>Quality Assessment and Assurance committee meets monthly. She further indicated the restorative program was currently in a transition. The Administrator indicated when she first started there were two restorative aides. The first of January 2016, she did training with all of the CNAs on restorative care and documentation. The committee looks at facility issues like falls, wounds, and coumadin therapy monthly. The DON indicated if an area continues to be a concern or doesn't resolve or improve "we continue to follow it".</p> <p>3.1-52(b)(2)</p>	F 9999	<p>The response to F9999 regarding TB Screening for employees is contained in the response for F 520</p> <p>TB screening has been completed for all staff and all staff are "current" on this screening. The DON/Designee will monitor all staff from the initial hiring process on through the</p>	02/25/2016
	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having</p>			

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	<p>documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1)At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure each employee had completed a two step tuberculin skin test upon hire. This</p>		<p>yearly requirements of timely PPD testing. This testing will be kept current and will be logged for review. Staff who are not properly screened with acceptable results will not be scheduled</p>	

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	<p>affected 5 of 10 employees reviewed for tuberculin skin testing. (CNA #16, CNA #17, CNA #18, CNA #19, CNA #20)</p> <p>Findings include:</p> <p>On 01/26/2016 at 4:15 P.M., the employee records were reviewed. CNA (Certified Nursing Assistant) #16's "TB Testing Consent Form" did not document any tuberculin testing as being done. CNA #16 worked on January 18, 19, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>CNA #17's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #17 worked on January 18, 19, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>CNA #18's "TB Testing Consent Form" documented a completed first step tuberculin test, but did not document a second step test as being done. CNA #18 worked on January 18, 19, 20, 22, 23 and 24, 2016 as a CNA.</p> <p>CNA #19's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #19 worked on January 17, 18, 19, 21, 22, 24, and 25, 2016 as a</p>			

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	<p>CNA.</p> <p>CNA #20's "TB Testing Consent Form" documented a first step tuberculin test as being given, but not read. The form did not document a second step test as being done. CNA #20 worked on January 17, 20, 21, 23, and 24, 2016 as a CNA.</p> <p>During an interview on 01/26/2016 at 5:24 P.M., the DON (Director of Nursing) indicated that CNAs #16, #17, #18, #19, and #20 have all worked without the proper two step tuberculin testing since being hired. The DON indicated it had been the job of the scheduler to keep track of the tuberculin testing for new hires. When the scheduler was terminated, that job had fallen to her and it had not gotten done.</p> <p>The current facility policy titled, "Tuberculosis Surveillance" and dated 7/1/11, was provided by the Medical Records Director on 01/26/2016 at 5:07 P.M. and was reviewed at that time. The policy indicated, "...Employees and volunteers must be tested prior to employment and annually thereafter..."</p> <p>3.1-14(t)(1)</p>			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155209	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/26/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	