

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2015
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NAME OF PROVIDER OR SUPPLIER  WILLOWDALE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 14, 15, 16, 17, 18, 2015</p> <p>Facility number: 000254 Provider number: 155363 AIM number: 100266270</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 5 Medicaid: 27 Other: 8 Total: 40</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on September 25, 2015.</p>	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit on October 18th, 2015.	

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 0225 SS=E Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <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 observation, interview, and</p>	F 0225	Resident # 8 allegation was	10/18/2015	

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	<p>record review, the facility failed identify allegations of abuse in 2 of 4 resident council monthly minutes reviewed, and immediately report allegations of abuse to the HFA [Health Facilities Administrator] or the ISDH [Indiana State Department of Health]. The facility also failed to ensure allegations of abuse were thoroughly investigated for 3 of 20 stage 1 interviews. ( Resident #1, Resident #8, Resident #17, Resident #38, Resident #200)</p> <p>Findings include:</p> <p>1. On 9/14/15 at 11:25 A.M., during an interview Resident #8 indicated a CNA on evening shift, CNA #10, tells him right after evening meal at times to brush his teeth and go to bed. Resident #8 indicated one time CNA #10 about 3 or 4 weeks ago on a Wednesday put him to bed before supper. Resident #8 had explained to CNA #10 he wanted to attend the activity of bible study. Resident #8 indicated CNA #10 had indicated he was not going to bible study that he was going to bed. Resident #8 indicated he had talked to the Social Service Director (SSD) about CNA #10 had made him go to bed. Resident #8 indicated it had happened again last night that CNA # 10 had made him go to bed. Resident #8 indicated, "I</p>		<p>immediately reported to ISDH and investigation immediately initiated.</p> <ul style="list-style-type: none"> <li>·Resident #17 allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Resident #200 anonymous allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Resident #38 allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Resident #1 allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Employee #6 was immediately suspended and investigation immediately initiated.</li> <li>·Employee #10 was immediately suspended and investigation immediately initiated.</li> <li>·Employee # 14 was immediately suspended and investigation immediately initiated.</li> <li>·SSD was immediately suspended and investigation immediately initiated.</li> <li>·Employee # 10 was terminated.</li> <li>·All staff and ED in-serviced on abuse prevention/reporting, types of abuse, and protection of residents from further abuse was completed by Nurse Consultants/designee</li> </ul>		

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	<p>think it is abuse because I have the right to be up the doctor wants me in the dining room."</p> <p>Resident #8 indicated he wanted to eat in the dining room. Resident #8 voiced a concern for choking and no CNAS in the hall even if he had his call light.</p> <p>The Administrator was made aware of the above allegation on 9/14/15 at 11:30 A.M. The Administrator indicated at that time there had been an issue in the past with CNA #10 and Resident #8. She indicated that Resident #8 had a nurse witness that he wanted to stay up late and wanted CNA #10 to be aware of him wanting to stay up late.</p> <p>On 9/15/15 at 2:53 P.M., Resident #8's clinical record was reviewed. His current Quarterly Minimum Data Set (MDS) dated 8/20/15, indicated a cognitive summary score of 15 (cognition intact). His diagnoses included, but were not limited to, diabetes mellitus, Parkinson's Disease, anxiety, depression, and schizophrenia.</p> <p>On 9/17/15 at 11:55 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident 9) on 9/14/15 at 11:40 A.M. The documentation included but was not limited to, "...9/14/2015</p>		<ul style="list-style-type: none"> <li>·All residents have the potential to be affected by alleged deficient practice. System in place to prevent abuse per policy.</li> <li>·All residents were interviewed by ED/designee using QIS and all allegations of abuse were investigated and reported immediate per policy by ED.</li> <li>·All staff will be in-serviced on abuse abuse prevention/reporting, types of abuse, and protection of residents from further abuse policy by ED/designee by 10/18/15</li> <li>·All allegations of abuse will be investigated and reported immediately by ED/designee.</li> <li>·Residents and families will be interviewed on abuse and reporting by 10/18/15. Any concerns received from interviews will be immediately addressed by ED/designee per policy.</li> <li>·ED will request invitation to resident council quarterly to provide ongoing education on importance of reporting concerns immediately.</li> <li>·ED/Designee will ensure all allegations of abuse, neglect or misappropriation of resident's funds/property will be reported and thoroughly investigated per the abuse policy.</li> <li>·To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation CQI Tool weekly X 4 weeks, monthly X 6 and then quarterly until</li> </ul>				

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	<p>PATIENT REPORTED TO ISDH SURVEYOR DURIN[sic] QIS [quality indicator survey] THAT A CNA PUT HIM TO BED BEFORE HE WAS READY AND HE FELT HE SHOULD BE ABLE TO STAY UP LATER AND THAT HIS RIGHTS WERE DISREGARDED..."</p> <p>On 9/15/15 at 11:52 A.M., the SSD provided hand written notes dated 7/15/15 West Hall that included the following, "... Resident #8 [Resident #8's name]- CNA # 10 [CNA #10's name]- Gets mad @ [at] me when I'm wet ie 'When I went and listened to the singers I was wet when I come back and she said That's because I went and listened to the singers. No, I'm not afraid.' [sic]"</p> <p>On 9/17/15 at 10:00 A.M., the SSD was interviewed regarding the above documentation of 7/15/15 of Resident #8 indicating that CNA #10 was mad at him when he was incontinent of urine when he had returned from attending a facility activity. The SSD indicated the dated 7/15/15 documentation was a follow up to Resident #1[another resident] voicing in a Resident Council meeting dated 6/10/15 that a CNA had been rude to her. The SSD indicated at that time she did not think the 7/15/15 allegation by Resident #8 of CNA #10 being mad at</p>		<p>continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. <b>Date of compliance: 10/18/2015</b></p>				

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	<p>him when he was incontinent was abuse. The SSD indicated she thought it was rude and she had discussed it with the Administrator. The SSD indicated she didn't think the allegation was abuse due to the resident had indicated he had not been afraid.</p> <p>On 9/17/15 at 10:00 A.M., the SSD was interviewed regarding a "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM" dated 8/27/15 at 5:00 P.M., that the SSD had received from Resident #8. The documentation indicated, "Resident states that aide told him if she had to put him in bed to change him that he could not get back up to go to bible study..." The documentation indicated on 9/2/15 the SSD had: "... Talked to ED. [Executive Director/Administrator] Also talked to aide about the allegations. She denied making the statements..." Section 3 of the report indicated the Administrator had been contacted on 9/14/15, and indicated, " Investigated report. Reports verified by other staff and residents. Took findings to Administrator..."</p> <p>During the interview with the SSD on 9/17/15 at 10:00 A.M., the SSD indicated the CNA in the 8/27/15 grievance report was CNA #10. The SSD indicated during the 9/17/15 interview at 10:00</p>			

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	<p>A.M., that she knew the 8/27/15 allegation was an allegation of abuse. The SSD indicated she had not contacted the Administrator regarding the 8/27/15 allegation until 9/2/15.</p> <p>The Follow Up report to the ISDH regarding Incident #9 on 9/14/15 at 11:40 A.M., included but was not limited to, "... investigation revealed that the staff member does not appear to have appropriate bedside manner and approach. Employee terminated..."</p> <p>On 9/17/15 at 1:30 P.M., the Administrator and the RN Consultant were made aware of allegations of abuse by Resident #8 documented on 7/15/15, and another allegation on a grievance report on 8/27/15. Documentation was lacking that the allegation of abuse on 7/15/15 had been immediately reported to the ISDH and thoroughly investigated until 9/14/15 when again the resident had verbalized an allegation regarding CNA #10 during an interview. Documentation indicated the allegation of abuse of 8/27/15 had not been reported immediately to the Administrator and the ISDH. The allegation had been reported to the Administrator on 9/2/15. A thorough investigation had not been initiated until 9/14/15.</p> <p>2. During an interview on 9/15/15 at</p>			

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	<p>10:59 A.M., Resident #17 was observed sitting up in a wheel chair in her room in no apparent distress. At that time during an interview Resident #17 indicated a few months ago during care a Certified Nursing Assistant (CNA) had restrained him/her hands by holding them tightly to keep him/her from holding onto the side rails during care. Resident #17 indicated he/she had reported the incident to the nurse and he/she had talked to the CNA. Resident #17 indicated he/she felt it was abuse however he/she did not feel unsafe in the facility since the CNA hardly worked here anymore. Resident #17 would not provide name of the staff involved in the incident or who the incident had been reported to.</p> <p>The reportable incidents for the facility were reviewed on 9/15/15 at 1:10 P.M., and included, but were not limited an incident reported by Resident #17 on 8/11/15 at 3:30 P.M. The report indicated Resident #17 had reported that CNA #14 had hurt him/her hand about 6 months ago. The report continued and indicated Resident #17 had sustained no injuries, actions taken CNA suspended pending an investigation.</p> <p>A hand written document dated 8/14/15 included in the investigation indicated during an interview with Resident #17</p>						

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	<p>he/she had indicated the former Director of Nursing Services (DNS) had spoken with CNA #14 and it had not happened again.</p> <p>The clinical record for Resident #17 was reviewed on 9/16/15 at 9:35 A.M., the diagnoses included, but were not limited to, depression, congestive heart failure, hypertension, and atrial fibrillation.</p> <p>The Minimum Data Set assessment (MDS) for dated 8/5/15 indicated Resident #17 had a Brief Interview for Mental Status (BIMS) of 15 indicating Resident #17 was cognitively intact. The MDS further indicated Resident #17 had no behavioral conditions.</p> <p>During an interview on 9/17/15 at 10:10 A.M., The Social Service Director (SSD) indicated prior to taking the position as facilities SSD in July she worked in the facility as a nurse. She indicated sometime in June of 2015 Resident #17 had reported to her the allegation of abuse involving CNA #14. She indicated at that time she had reported the incident to the previous Social Service Director and not to the Administrator.</p> <p>3. During a confidential interview on 9/15/15 at 11:56 A.M. Resident #200 was observed sitting in a wheelchair, in no</p>			

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	<p>apparent distress and indicated, at that time, he/she had experienced verbal abuse from a female staff member. Resident #200 then stated, "...I told the nurse about that one particular girl that argues with me, I don't know her name, it was one of the aides that was supposed to help...I rang the bell for help, she came in here, said, 'what do you want' I said, 'I need to go to the bathroom'...she said, 'Well, go ahead'...I was sitting across the room...the CNA says, 'Well, you been doing it all day'...she opened the door and turned on the light. She was real hateful after that. She was short with me and I don't feel comfortable with her. I don't want to get anyone in trouble, but dog gone it, she didn't do what she was supposed to...I think they talked to her because she is better, she is not nice...she still works here, it just happened one time. I told a nurse...might have been a couple of months ago..." Resident #200 then indicated he/she wanted to report the allegation anonymously.</p> <p>On 9/15/15 at 12:05 P.M., a sign was observed on an interior wall of the resident's room to remind the resident to ask for help before ambulating independently. The resident's clinical record was reviewed at that time, the MDS dated 7/2015 indicated the BIMS score was 14</p>			

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	<p>of 15, cognition was slightly impaired.</p> <p>The previous 6 months of State Reportable events were reviewed and lacked any documentation related to the allegation of abuse by Resident #200.</p> <p>The HFA (Health Facilities Administrator) was notified on 9/15/15 at 12:32 P.M., an anonymous allegation of staff to resident verbal abuse had been reported.</p> <p>During an interview on 9/15/15 at 12:45 P.M., the HFA indicated the investigation had been initiated.</p> <p>On 9/17/15 at 3:50 P.M. the RN Consultant presented a staff roster with a question at the top, "Have you witnessed any form of abuse to residents of any kind at this facility..." with employee response of yes or no. The investigation lacked any further facts or observations by the employees, non-employees, or the HFA.</p> <p>4. On 9/17/15 at 1:30 P.M., the HFA provided documentation of resident interviews conducted during the investigation of resident abuse allegations. An untimed interview form for Resident #38 dated 9/15/15 indicated the following:</p>			

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	<p>"1. Has staff, a resident or anyone else here abused you-this includes verbal, physical, or sexual abuse? Yes..."If Yes: Ask who the abuser was, what happened, when it occurred, where it happened, and how often. 2. Did you tell staff? Yes...If Yes: Ask who the resident told." The form had a handwritten notation of, "...patient mentioned she thought one aide was "being lazy" about helping her to the bathroom. The form lacked any further documentation related to the allegation of abuse.</p> <p>During an interview on 9/17/15 at 1:47 P.M., the HFA indicated she had not been immediately notified Resident #38 had reported an allegation of abuse on 9/15/15 during the facility investigation and had not reviewed the Resident interviews. The HFA further indicated the staff should have immediately reported the allegation to her. The HFA then indicated an investigation had not been initiated and the allegation had not been reported to the ISDH (Indiana State Department of Health).</p> <p>During an interview on 9/17/15 at 2:15 P.M., LPN #6 indicated a Resident #38 had told her "at least 3 weeks ago" CNA #10 was "not nice...gruff voice...refused to take [Resident #38] to the bathroom". LPN #6 then stated, "...gruff, it was just</p>				

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	<p>that girl's [CNA #10] way of speaking..." LPN #6 then indicated, she had talked to CNA #10, but did not suspend CNA #10 and did not report anything to the HFA. LPN #6 further indicated, at that time, she did not consider speaking to a resident with a gruff voice and refusing to provide assistance as abusive behavior.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the HFA indicated none of the abuse allegations could be substantiated because she could not prove willful intent by the identified staff members.</p> <p>Resident #38's clinical record was reviewed on 9/15/15 at 3:06 P.M. The MDS dated 7/27/15 indicated the resident's BIMS score was 14 of 15, indicating slight cognition impairment.</p> <p>5. Resident # 1's clinical record was reviewed on 9/16/15 at 9:45 A.M. Her current annual Minimum Data Set (assessment) dated 5/25/15, indicated a cognition score of 14 (cognition intact). Her diagnoses included, but were not limited to, diabetes, multiple sclerosis, anxiety, and depression.</p> <p>On 9/16/15 at 9:53 A.M., the Administrator provided Resident Council Meeting Minutes for the past 6 months for review. The resident council minutes</p>			

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	<p>included but were not limited to, the council minutes of 6/10/15 at 10:30 A.M., hand written by the resident council president. The minutes included documentation of Resident #1 indicating aides (CNAs) were rude to her.</p> <p>A Resident Council Meeting Follow Up form dated 7/10/15 indicated, "Resident #1 [Resident #1's 1st name and last initial] STATED THAT THE CNAS WERE MEAN TO HER. THE ATTITUDE WHEN THEY TALK TO HER." The above Resident Council Meeting Follow Up dated 7/10/15 had been signed by the resident council president.</p> <p>Another Resident Council Meeting Follow Up form dated 7/10/15 was completed by the SSD with the above allegation of CNAs being mean to Resident #1. The section of the 7/10/15 form completed by the SSD included, "... Action Taken: Spoke with resident. She stated that she couldn't remember exactly which one had said something mean to her. I asked resident if she felt threatened or unsafe here and she stated 'no.'" The documentation had been signed by the Administrator on 7/20/15.</p> <p>On 9/17/15 at 10:00 A.M., during interview with the SSD, the SSD was</p>			

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	<p>made aware of Resident #1 voicing an allegation that CNAs were rude to her on the 6/10/15 Resident Council Meeting Minutes. Documentation was lacking of reporting the allegation of abuse of 6/10/15 to the Administrator or the State Department of Health or of an investigation being done. A Follow Up Resident Council Meeting report, dated 7/10/15 indicated, "...Resident #1 [Resident #1's first name and last name initial] STATED THAT THE CNAS WERE MEAN TO HER. THE ATTITUDE WHEN THEY TALKED TO HER..."</p> <p>On 9/17/15 at 10:00 A.M., during interview with the SSD, the SSD indicated she had started the SSD position on 7/1/15. The SSD indicated she had followed up on the 6/10/15 allegation on 7/10/15 when she was finishing up on SSD work left by the previous SSD. The SSD indicated she had Spoke with Resident #1 who indicated at that time that she couldn't remember "exactly" which CNA had said something mean to her. The SSD indicated at that time she didn't think it was abuse due to the resident didn't feel threatened or unsafe.</p> <p>On 9/17/15 at 1:30 P.M., the Administrator and the RN Consultant</p>			

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	<p>were interviewed. The Administrator and the RN Consultant were made aware of the problem of the abuse allegation on 6/10/15 (resident council minutes) by Resident #1 had not been reported to the Administrator or the ISDH at that time or investigated at that time. Documentation indicated the 7/10/15 abuse allegation was not reported to the Administrator until 7/20/15 and had not been reported to ISDH or thoroughly investigated until 9/17/15.</p> <p>On 9/17/15 at 1:45 P.M., during interview with the Administrator, the Administrator indicated the SSD had been suspended related to failure to report abuse.</p> <p>A facility incident report to the Indiana State Department of Health (ISDH) with incident date and time of 9/17/15 at 3:01 P.M., was received and reviewed on 9/17/15 at 5:25 P.M. The report indicated the resident involved was Resident #1. The report indicated, "... 9/17/2015 RESIDENT COUNCIL meeting minutes from June and July were reviewed and noted to state that the patient had c/o [complained] staff being rude to her..."</p> <p>The Policy and Procedure for Abuse Prohibition, Reporting, and Investigation provided by the HFA on 9/15/15 at 12:00</p>			

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	<p>P.M. indicated, "...It is the policy of [name of Corporation] to protect residents from abuse including...physical abuse...verbal abuse...mental abuse...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being... willful-the individual's action was deliberate (not inadvertent or accidental, regardless of whether the individual intended to inflict injury or harm. Physical abuse- a willful act against a resident by another resident, staff...verbal abuse-oral...language that includes disparaging...examples:...speaking to them in harsh voice tones...2. Staff to resident-any episode...Mental Abuse-Verbal...infliction...or distress that results in...emotional suffering...1. Staff to resident-any episode...Policy and Procedure: ...All abuse allegations...must be reported to the Executive Director immediately...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. The Executive</p>			

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	<p>Director/designee will report...allegations of abuse, neglect...immediately to the Long Term Care Division of the Indiana State Department of Health...It is the responsibility of every employee of [name of Corporation] to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director...Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/resident interactions, and the provision of care and services to the resident . Staff members showing any trend toward impatience or frustration in routine dealings with residents should be evaluated... Resident Abuse-It is the policy of [name of Corporation] to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained if abuse is identified or suspected...The resident(s) involved in the incident will be protected and/or removed from the situation immediately...any staff member implicated in the alleged abuse will be removed from the facility at once...The Executive Director and/or Director of Nursing will be immediately notified of the report and the initiation of the investigation...Residents will be questioned (if alert and competent ) about</p>			

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F 0226 SS=E Bldg. 00	<p>the nature of the incident and their statement will be put in writing...The investigation will include: facts and observations by involved employees...facts and observations by witnessing employees...Facts and observations by witnessing non-employees...Facts and observations from others who might have pertinent information...Facts and observations by the supervisor or individual whom the initial report was made..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 observation, interview, and record review, the facility failed follow their policy for abuse prohibition by failing to identify, report, and thoroughly investigate residents allegations of abuse for 5 of 20 residents interviewed . (Resident #1, Resident #8, Resident #17, Resident #38, Resident #200) The facility also failed to ensure employee abuse training included</p>	F 0226	<ul style="list-style-type: none"> <li>·Resident # 8 allegation was immediately reportedto ISDH and investigation immediately initiated.</li> <li>·Resident #17 allegation was immediately reportedto ISDH and investigation immediately initiated.</li> <li>·Resident #200 anonymous allegation was immediately reported to ISDH and investigation immediately initiated.</li> </ul>	10/18/2015

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	<p>identification of types of abuse and protecting the residents from abuse for 10 of 10 employee files reviewed. (CNA #10, CNA #11, CNA #14, CNA #16, CNA #17, LPN #7, Social Service Director, Assistant Director of Nursing, Dietary Aide #5, Housekeeping #5)</p> <p>Findings include:</p> <p>1. On 9/14/15 at 11:25 A.M., during an interview Resident #8 indicated, a CNA on evening shift, CNA #10, tells him right after evening meal at times to brush his teeth and go to bed. Resident #8 indicated one time CNA # 10 about 3 or 4 weeks ago on a Wednesday put him to bed before supper.</p> <p>Resident #8 had explained to CNA #10 he wanted to attend the activity of bible study. Resident #8 indicated CNA #10 had indicated he was not going to bible study that he was going to bed.</p> <p>Resident #8 indicated he had talked to the Social Service Director (SSD) about CNA #10 had made him go to bed.</p> <p>Resident #8 indicated it had happened again last night that CNA # 10 had made him go to bed. Resident #8 indicated, "I think it is abuse because I have the right to be up the doctor wants me in the dining room."</p> <p>Resident #8 indicated he wanted to eat in the dining room. Resident #8 voiced a</p>		<ul style="list-style-type: none"> <li>·Resident #38 allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Resident #1 allegation was immediately reported to ISDH and investigation immediately initiated.</li> <li>·Employee #6 was immediately suspended and investigation immediately initiated.</li> <li>·Employee #10 was immediately suspended and investigation immediately initiated.</li> <li>·Employee # 14 was immediately suspended and investigation immediately initiated.</li> <li>·SSD was immediately suspended and investigation immediately initiated.</li> <li>·Employee # 10 was terminated.</li> <li>·All staff and ED in-serviced on abuse prevention/reporting, types of abuse, and protection of residents from further abuse was completed by Nurse Consultants/designee</li> <li>·All residents have the potential to be affected by alleged deficient practice. System in place to prevent abuse per policy.</li> <li>·All residents were interviewed by ED/designee using QIS and all allegations of abuse were investigated and reported immediate per policy by ED.</li> <li>·All staff will be in-service on abuse policy abuse prevention/reporting, types of</li> </ul>		

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	<p>concern for choking and no cnas in the hall even if he had his call light.</p> <p>The Administrator was made aware of the above allegation on 9/14/15 at 11:30 A.M. The Administrator indicated at that time there had been an issue in the past with CNA #10 and Resident #8. She indicated that Resident #8 had a nurse witness that he wanted to stay up late and wanted CNA #10 to be aware of him wanting to stay up late.</p> <p>On 9/15/15 at 2:53 P.M., Resident #8's clinical record was reviewed. His current Quarterly Minimum Data Set (MDS) dated 8/20/15, indicated a cognitive summary score of 15 ( cognition intact). His diagnoses included, but were not limited to, diabetes mellitus, Parkinson's Disease, anxiety, depression, and schizophrenia.</p> <p>On 9/17/15 at 11:55 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident 9) on 9/14/15 at 11:40 A.M. The documentation included but was not limited to, "...9/14/2015 PATIENT REPORTED TO ISDH SURVEYOR DURIN[sic] QIS [quality indicator survey] THAT A CNA PUT HIM TO BED BEFORE HE WAS READY AND HE FELT HE SHOULD</p>		<p>abuse, and protection of residents from further abuse by ED/designee by 10/18/15</p> <ul style="list-style-type: none"> <li>·All allegations of abuse will be investigated and reported immediately by ED/designee.</li> <li>·Residents and families will be interviewed on abuse and reporting by 10/18/15. Any concerns received from interviews will be immediately addressed by ED/designee per policy.</li> <li>·ED will request invitation to resident council quarterly to provide ongoing education on importance of reporting concerns immediately.</li> <li>·ED/Designee will ensure all allegations of abuse, neglect or misappropriation of resident's funds/property will be reported and thoroughly investigated per the abuse policy.</li> <li>·To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation CQI Tool weekly X4 weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</li> </ul>				

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	<p>BE ABLE TO STAY UP LATER AND THAT HIS RIGHTS WERE DISREGARDED..."</p> <p>On 9/15/15 at 11:52 A.M., the SSD provided hand written notes dated 7/15/15 West Hall that included the following, "... Resident #8 [Resident #8's name]- CNA # 10 [CNA #10's name]- Gets mad @ [at] me when I'm wet ie 'When I went and listened to the singers I was wet when I come back and she said That's because I went and listened to the singers. No, I'm not afraid.' [sic]"</p> <p>On 9/17/15 at 10:00 A.M., the SSD was interviewed regarding the above documentation of 7/15/15 of Resident #8 indicating that CNA #10 was mad at him when he was incontinent of urine when he had returned from attending a facility activity. The SSD indicated the dated 7/15/15 documentation was a follow up to Resident #1 voicing in a Resident Council meeting dated 6/10/15 that a CNA had been rude to her. The SSD indicated at that time she did not think the 7/15/15 allegation by Resident #8 of CNA #10 being mad at him when he was incontinent was abuse. The SSD indicated she thought it was rude and she had discussed it with the Administrator. The SSD indicated she didn't think the allegation was abuse due to the resident</p>		Date of Compliance : 10/18/15	

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	<p>had indicated he had not been afraid.</p> <p>On 9/17/15 at 10:00 A.M., the SSD was interviewed regarding a "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM" dated 8/27/15 at 5:00 P.M., that the SSD had received from Resident #8. The documentation indicated, "Resident states that aide told him if she had to put him in bed to change him that he could not get back up to go to bible study..." The documentation indicated on 9/2/15 the SSD had: "... Talked to ED. [Executive Director/Administrator] Also talked to aide about the allegations. She denied making the statements..." Section 3 of the report indicated the administrator had been contacted on 9/14/15, and indicated, " Investigated report. Reports verified by other staff and residents. Took findings to Administrator..."</p> <p>During the interview with the SSD on 9/17/15 at 10:00 A.M., the SSD indicated the CNA in the 8/27/15 grievance report was CNA #10. The SSD indicated during the 9/17/15 interview at 10:00 A.M., that she knew the 8/27/15 allegation was an allegation of abuse. The SSD indicated she had not contacted the Administrator regarding the 8/27/15 allegation until 9/2/15.</p>			

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	<p>The Follow Up report to the ISDH regarding Incident #9 on 9/14/15 at 11:40 A.M., included but was not limited to, "... investigation revealed that the staff member does not appear to have appropriate bedside manner and approach. Employee terminated..."</p> <p>On 9/17/15 at 1:30 P.M., the Administrator and the RN Consultant were made aware of allegations of abuse by Resident #8 documented on 7/15/15, and another allegation on a grievance report on 8/27/15. Documentation was lacking that the allegation of abuse on 7/15/15 had been immediately reported to the ISDH and thoroughly investigated until 9/14/15 when again the resident had verbalized an allegation regarding CNA #10 during an interview. Documentation indicated the allegation of abuse of 8/27/15 had not been reported immediately to the Administrator and the ISDH. The allegation had been reported to the Administrator on 9/2/15. A thorough investigation had not been initiated until 9/14/15.</p> <p>2. During an interview on 9/15/15 at 10:59 A.M., Resident #17 was observed sitting up in a wheel chair in his/her room in no apparent distress. At that time during the interview Resident #17 indicated a few months ago during care a</p>			

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	<p>Certified Nursing Assistant (CNA) had restrained his/her hands by holding them tightly to keep him/her from holding onto the side rails during care. Resident #17 indicated he/she had reported the incident to the nurse and she had talked to the CNA. Resident #17 indicated he/she felt it was abuse however he/she did not feel unsafe in the facility since the CNA hardly worked here anymore. Resident #17 would not provide name of the staff involved in the incident or who the incident had been reported to.</p> <p>The reportable incidents for the facility were reviewed on 9/15/15 at 1:10 P.M., and included, but were not limited an incident reported by Resident #17 on 8/11/15 at 3:30 P.M. The report indicated Resident #17 had reported that CNA #14 had hurt her hand about 6 months ago. The report continued and indicated Resident #17 had sustained no injuries, actions taken CNA suspended pending an investigation.</p> <p>A hand written document dated 8/14/15 included in the investigation indicated during an interview with Resident #17 he/she had indicated the former Director of Nursing Services (DNS) had spoken with CNA #14 and it had not happened again.</p>			

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	<p>The clinical record for Resident #17 was reviewed on 9/16/15 at 9:35 A.M., the diagnoses included, but were not limited to, depression, congestive heart failure, hypertension, and atrial fibrillation.</p> <p>The Minimum Data Set assessment (MDS) for dated 8/5/15 indicated Resident #17 had a Brief Interview for Mental Status (BIMS) of 15 indicating Resident #17 was cognitively intact. The MDS further indicated Resident #17 had no behavioral conditions.</p> <p>During an interview on 9/17/15 at 10:10 A.M., The Social Service Director (SSD) indicated prior to taking the position as facilities SSD in July she worked in the facility as a nurse. She indicated sometime in June of 2015 Resident #17 had reported to her the allegation of abuse involving CNA #14. She indicated at that time she had reported the incident to the previous Social Service Director and not to the administrator.</p> <p>3. During a confidential interview on 9/15/15 at 11:56 A.M. Resident #200 was observed sitting in a wheelchair, in no apparent distress and indicated, at that time, he/she had experienced verbal abuse from a female staff member. Resident #200 then stated, "...I told the nurse about that one particular girl that argues with me, I don't know her name, it</p>			

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	<p>was one of the aides that was supposed to help...I rang the bell for help, she came in here, said, 'what do you want', I said, 'I need to go to the bathroom'...she said, 'Well, go ahead'...I was sitting across the room...the CNA says, 'Well, you been doing it all day'...she opened the door and turned on the light. She was real hateful after that. She was short with me and I don't feel comfortable with her. I don't want to get anyone in trouble, but dog gone it, she didn't do what she was supposed to...I think they talked to her because she is better, she is not nice...she still works here, it just happened one time. I told a nurse...might have been a couple of months ago..." Resident #200 then indicated he/she wanted to report the allegation anonymously.</p> <p>On 9/15/15 at 12:05 P.M., a sign was observed on an interior wall of the resident's room to remind the resident to ask for help before ambulating independently.</p> <p>The previous 6 months of State Reportable events were reviewed and lacked any documentation related to the allegation of abuse by Resident #200.</p> <p>The HFA (Health Facilities Administrator) was notified on 9/15/15 at 12:32 P.M., an anonymous allegation of</p>			

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	<p>staff to resident verbal abuse had been reported.</p> <p>During an interview on 9/15/15 at 12:45 P.M., the HFA indicated the investigation had been initiated.</p> <p>On 9/17/15 at 3:50 P.M. the RN Consultant presented a staff roster with a question at the top, "Have you witnessed any form of abuse to residents of any kind at this facility..." with employee response of yes or no. The investigation lacked any further facts or observations by the employees, non-employees, or the HFA.</p> <p>4. Resident # 1's clinical record was reviewed on 9/16/15 at 9:45 A.M. Her current annual Minimum Data Set (assessment) dated 5/25/15, indicated a cognition score of 14 (cognition intact). Her diagnoses included, but were not limited to, diabetes, multiple sclerosis, anxiety, and depression.</p> <p>On 9/16/15 at 9:53 A.M., the Administrator provided Resident Council Meeting Minutes for the past 6 months for review. The resident council minutes included but were not limited to, the council minutes of 6/10/15 at 10:30 A.M., hand written by the resident council president. The minutes included</p>			

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	<p>documentation of Resident #1 indicating aides (CNAs) were rude to her.</p> <p>A Resident Council Meeting Follow Up form dated 7/10/15 indicated, "Resident #1 [Resident #1's 1st name and last initial] STATED THAT THE CNAS WERE MEAN TO HER. THE ATTITUDE WHEN THEY TALK TO HER." The above Resident Council Meeting Follow Up dated 7/10/15 had been signed by the resident council president.</p> <p>Another Resident Council Meeting Follow Up form dated 7/10/15 was completed by the SSD with the above allegation of CNAs being mean to Resident #1. The section of the 7/10/15 form completed by the SSD included, "... Action Taken: Spoke with resident. She stated that she couldn't remember exactly which one had said something mean to her. I asked resident if she felt threatened or unsafe here and she stated 'no.' " The documentation had been signed by the Administrator on 7/20/15.</p> <p>On 9/17/15 at 10:00 A.M., during interview with the SSD, the SSD was made aware of Resident #1 voicing an allegation that CNAs were rude to her on the 6/10/15 Resident Council Meeting Minutes. Documentation was lacking of</p>			

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	<p>reporting the allegation of abuse of 6/10/15 to the Administrator or the State Department of Health or of an investigation being done. A Follow Up Resident Council Meeting report, dated 7/10/15 indicated, "...Resident #1 [Resident #1's first name and last name initial] STATED THAT THE CNAS WERE MEAN TO HER. THE ATTITUDE WHEN THEY TALKED TO HER..."</p> <p>On 9/17/15 at 10:00 A.M., during interview with the SSD, the SSD indicated she had started the SSD position on 7/1/15. The SSD indicated she had followed up on the 6/10/15 allegation on 7/10/15 when she was finishing up on SSD work left by the previous SSD. The SSD indicated she had Spoke with Resident #1 who indicated at that time that she couldn't remember "exactly" which CNA had said something mean to her. The SSD indicated at that time she didn't think it was abuse due to the resident didn't feel threatened or unsafe.</p> <p>On 9/17/15 at 1:30 P.M., the Administrator and the RN Consultant were interviewed. The Administrator and the RN Consultant were made aware of the problem of the abuse allegation on 6/10/15 (resident council minutes) by</p>			

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	<p>Resident #1 had not been reported to the Administrator or the ISDH at that time or investigated at that time. Documentation indicated the 7/10/15 abuse allegation was not reported to the Administrator until 7/20/15 and had not been reported to ISDH or thoroughly investigated until 9/17/15.</p> <p>5. On 9/17/15 at 1:30 P.M., the HFA provided documentation of resident interviews conducted during the investigation of resident abuse allegations. An untimed interview form for Resident #38 dated 9/15/15 indicated the following: "1. Has staff, a resident or anyone else here abused you-this includes verbal, physical, or sexual abuse? Yes..."If Yes: Ask who the abuser was, what happened, when it occurred, where it happened, and how often. 2. Did you tell staff? Yes...If Yes: Ask who the resident told." The form had a handwritten notation of, "...patient mentioned she thought one aide was "being lazy" about helping her to the bathroom. The form lacked any further documentation related to the allegation of abuse.</p> <p>During an interview on 9/17/15 at 1:47 P.M., the HFA indicated she had not been immediately notified Resident #38 had reported an allegation of abuse on</p>				

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	<p>9/15/15 during the facility investigation and had not reviewed the Resident interviews. The HFA further indicated the staff should have immediately reported the allegation to her. The HFA then indicated an investigation had not been initiated and the allegation had not been reported to the ISDH (Indiana State Department of Health).</p> <p>6. During an interview on 9/17/15 at 2:15 P.M., LPN #6 indicated a Resident #38 had told her "at least 3 weeks ago" CNA #10 was "not nice...gruff voice...refused to take [Resident #38] to the bathroom". LPN #6 then stated, "...gruff, it was just that girl's [CNA #10] way of speaking..." LPN #6 then indicated, she had talked to CNA #10, but did not suspend CNA #10 and did not report anything to the HFA. LPN #6 further indicated, at that time, she did not consider speaking to a resident with a gruff voice and refusing to provide assistance as abusive behavior.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the HFA indicated none of the abuse allegations could be substantiated because she could not prove willful intent by the identified staff members.</p> <p>The facility abuse policy in place in June 2015 until corporation change on July 1, 2015 (latest revision of April 2013) was</p>			

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	<p>entitled, "Prevention and Reporting Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property." The policy included definitions as indicated, "... Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability..." "...Procedure: 5. Report the results to other officials in accordance with State law(including to the State survey and certification agency)... Reporting...2. Report the incident immediately to the Administrator and DON [Director of Nursing}/designee, who will immediately report any allegations of mistreatment, neglect, abuse..."</p> <p>On 9/17/15 at 1:45 P.M., during interview with the Administrator, the Administrator indicated the SSD had been suspended related to failure to report abuse.</p> <p>A facility incident report to the Indiana State Department of Health (ISDH) with incident date and time of 9/17/15 at 3:01 P.M., was received and reviewed on 9/17/15 at 5:25 P.M. The report indicated the resident involved was</p>			

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	<p>Resident #1. The report indicated, "... 9/17/2015 RESIDENT COUNCIL meeting minutes from June and July were reviewed and noted to state that the patient had c/o [complained] staff being rude to her..."</p> <p>7. The Employee Files were reviewed on 09/18/15 at 11:00 A.M. and the following was noted:</p> <p>CNA #10 hire date 8/22/13: The file indicated abuse training was provided by the previous corporate facility owner on 11/10/14 and indicated, "...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." The training lacked any specific information related to what constitutes physical, verbal, or mental abuse, how to protect residents from immediate danger, or intervention techniques. The file lacked any documentation CNA #14 received training from the current corporate facility owner.</p> <p>Dietary Assistant #5 hire date 3/2/15: The file indicated abuse training was provided by the previous corporate</p>			

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	<p>facility owner on 3/2/14 and indicated, "...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." The training lacked any specific information related to what constitutes physical, verbal, or mental abuse, how to protect residents from immediate danger, or intervention techniques. The file lacked any documentation Dietary Assistant #5 received training from the current corporate facility owner.</p> <p>CNA #16 hire date 6/22/15 : The file indicated abuse training was provided by the name of previous corporate facility owner on 7/10/15 and indicated, "...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." The training lacked any specific information related to what constitutes physical, verbal, or mental abuse, how to protect residents from immediate danger, or intervention</p>			

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	<p>techniques. The file lacked any documentation CNA #16 received training from the current corporate facility owner.</p> <p>CNA #17 hire date: 4/6/15: The file indicated abuse training was provided by the previous corporate facility owner on 4/6/15 and indicated, "...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." The training lacked any specific information related to what constitutes physical, verbal, or mental abuse, how to protect residents from immediate danger, or intervention techniques. The file lacked any documentation CNA #17 had received training from the current corporate facility owner.</p> <p>CNA #11 hire date: 3/23/15: The file indicated abuse training was provided by the former corporate facility owner on 3/23/15 and indicated, "...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, neglect means failure to provide goods and</p>			

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	<p>services necessary to avoid physical harm, mental anguish, or mental illness..." The training lacked any specific information related to what constitutes physical, verbal, or mental abuse, how to protect residents from immediate danger, or intervention techniques. The file lacked any documentation CNA #11 had received training from the current corporate facility owner.</p> <p>CNA #14 hire date 11/10/14: The file included an Abuse &amp; Neglect post quiz dated 1/19/15 that indicated, "...Abuse is the willful infliction of injury...If a staff member suspects abuse, neglect...they must report it to their supervisor...non-physical examples of abuse are: confinement, intimidation, threats of punishment and mental anguish...Neglect is the failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness...Failure to report an alleged/witnessed incident could result interdisciplinatory action..." The file lacked any documentation CNA #10 received abuse training from the former or current corporate facility owner.</p> <p>LPN #7 hire date 4/6/15: The file lacked any documentation LPN #7 received abuse training from the former or current</p>			

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	<p>corporate facility owner.</p> <p>Housekeeper #5 hire date 2/11/15: The file lacked any documentation Housekeeper #5 received abuse training from the former or current corporate facility owner.</p> <p>Social Services Director hire date 4/3/14: The file lacked any documentation Social Services Director received abuse training from the former or current corporate facility owner.</p> <p>Assistant Director of Nursing hire date 7/26/15: The file lacked any documentation Assistant Director of Nursing received abuse training from the former or current corporate facility owner.</p> <p>During an interview on 9/18/15 at 12:10 P.M., the Business Office Assistant indicated the the new corporation had taken ownership on 7/1/15, most of the employees had been hired by the former corporate owner and further indicated, no documentation could be provided to indicate the employees had received any further abuse training. The Business Office Assistant then indicated, at that time, she did not know what the abuse training should include and no documentation could be provided to</p>			

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	<p>indicate the employees had been inserviced on the abuse policy of the current Corporation.</p> <p>The Policy and Procedure for Abuse Prohibition, Reporting, and Investigation provided by the HFA on 9/15/15 at 12:00 P.M. indicated, "...It is the policy of [name of Corporation] to protect residents from abuse including...physical abuse...verbal abuse...mental abuse...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being... willful-the individual's action was deliberate (not inadvertent or accidental, regardless of whether the individual intended to inflict injury or harm. Physical abuse- a willful act against a resident by another resident, staff...verbal abuse-oral...language that includes disparaging...examples:...speaking to them in harsh voice tones...2. Staff to resident-any episode...Mental Abuse-</p>			

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	Verbal...infliction...or distress that results in...emotional suffering...1. Staff to resident-any episode...Policy and Procedure: 3. Employees...receive instruction/training on abuse during orientation...training will include: ...What constitutes abuse...How to protect residents from immediate danger...Intervention techniques to be used with residents exhibiting aggressive or catastrophic reaction...His/her responsibility upon witnessing abuse...His/her role in an investigation...All abuse allegations...must be reported to the Executive Director immediately...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. The Executive Director/designee will report...allegations of abuse, neglect...immediately to the Long Term Care Division of the Indiana State Department of Health...It is the responsibility of every employee of [name of Corporation] to not only report abuse situations, but also suspicion of			

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	<p>abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director...Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/resident interactions, and the provision of care and services to the resident . Staff members showing any trend toward impatience or frustration in routine dealings with residents should be evaluated... Resident Abuse-It is the policy of [name of Corporation] to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained if abuse is identified or suspected...The resident(s) involved in the incident will be protected and/or removed from the situation immediately...any staff member implicated in the alleged abuse will be removed from the facility at once...The Executive Director and/or Director of Nursing will be immediately notified of the report and the initiation of the investigation...Residents will be questioned (if alert and competent ) about the nature of the incident and their statement will be put in writing...The</p>			

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F 0248 SS=D Bldg. 00	<p>investigation will include: facts and observations by involved employees...facts and observations by witnessing employees...Facts and observations by witnessing non-employees...Facts and observations from others who might have pertinent information...Facts and observations by the supervisor or individual whom the initial report was made..."</p> <p>3.1-28(a)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</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 cognitively impaired residents were placed in appropriate activities according to their activities plan of care for 2 of 3 residents who met the criteria for review of activities. (Resident #27, Resident #29)</p> <p>Findings include:</p>	F 0248	<ul style="list-style-type: none"> <li>·Resident #27 was provided equipment for listening to music, wall hangings, a sound machine in room, and was assisted by staff during small group activities.</li> <li>·Resident #29 was provided equipment for listening to music, wall hangings, a sound machine in room, and was assisted by staff during small group sensory stimulation activities.</li> <li>·All cognitively impaired residents have the potential to be</li> </ul>	10/18/2015

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NAME OF PROVIDER OR SUPPLIER  WILLOWDALE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
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	<p>1. Resident #29 was observed on 9/14/15 at 1:58 P.M., sitting up in a broda chair in the main dining room of the facility during a game of bingo. The dining room was full with a large group of residents in attendance.</p> <p>Resident #29 was observed to not actively be participating in the activity.</p> <p>Resident #29's room was observed on 9/16/15 at 1:40 P.M. The room contained a small television set located on a high shelf and 4 x 6 family photograph across the room taped to a wall.</p> <p>On 9/16/15 from 2:00 P.M. to 2:49 P.M., Resident #29 was observed sitting in the middle of the facility main dining room during a bingo game. Resident #29 was observed to not be sitting near a table and was not participating in the bingo game. At that time Resident #29 was overheard to let out several loud yells.</p> <p>The clinical record for Resident #29 was reviewed on 9/16/15 at 2:56 P.M., diagnoses included, but were not limited to, Alzheimer 's dementia with behavioral disturbances.</p> <p>The Minimum Data Set assessment (MDS) dated 8/5/15 for Resident #29 indicated he was severely cognitively</p>		<p>affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> <li>·An audit was completed by Activity Director by10/09/15 to determine any cognitively impaired residents with specialized needs</li> <li>·All Activities staff and direct care staff will be in-serviced by ED/designee on appropriate supervision of cognitively impaired residents requiring specialized activities needs during small group or sensory activities. ED/designee will monitor activities for cognitively impaired residents requiring specialized activities needs daily to ensure residents are placed in appropriate activities</li> <li>·To ensure compliance the ED/designee is responsible for the completion of the Activities CQI Tool weekly X 4 weeks,monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</li> </ul> <p><b>Date of compliance: 10/18/2015</b></p>		

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	<p>impaired and experienced inattention and disorganized thinking. The MDS further indicated Resident #29 experienced behavioral symptoms including but not limited to, physical symptoms directed at others, kicking, pushing, grabbing and verbal behavioral symptoms directed at others including but not limited to screaming at others.</p> <p>The "ACTIVITY PURSUIT CARE PLAN" dated 8/5/15 included, but was not limited to, small group and sensory stimulation activities including mass, bible study, provide support as needed. The care plan also included resident does not like loud noises, sit towards the back of the crowd, and provide resident equipment needed to listen to music.</p> <p>2. During an observation on 9/14/15 at 1:58 P.M., Resident #27 was observed sitting in the facility's main dining room during bingo. Bingo was attended by a large number of residents. Resident #27 was observed to not be interacting in the activity.</p> <p>Resident #27's room was observed on 9/16/15 at 1:40 P.M. The room contained a small television set located on a high shelf and a picture hanging on the wall to the right of Resident #27's bed.</p>			

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	<p>The clinical record for Resident #27 was reviewed on 9/16/2015 at 12:23 P.M., The diagnoses included, but were not limited to, Alzheimer's disease, and dementia with behavioral disturbances.</p> <p>The Minimum Data Set assessment (MDS) dated 7/18/15 indicated a staff interview for Mental Status was conducted and Resident #27's cognition was severely impaired indicating he never/rarely made decisions. The MDS further indicated Resident #27 experienced inattention and has disorganized thinking.</p> <p>Section F (Activities) of the MDS assessment dated 7/18/15, lacked any documentation (was incomplete)when reviewed on 9/16/15.</p> <p>An "Activity Pursuit Care Plan" dated 9/8/15 included indicated Resident #27's participation in activities was limited by dementia, Alzheimer's, and limited mobility. The goal for Resident #27 was to participate in low functioning activity per resident need.</p> <p>Interventions include, but were not limited to, assist resident to participate in groups including church, bible study and music.</p> <p>The care plan also included " Provide resident equipment needed to listen to music"</p>			

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F 0282 SS=D Bldg. 00	<p>During an interview on 9/17/15 at 2:40 P.M., the Activity director indicated, she had been out of the facility driving residents to appointments on 9/16/15 from 8 A.M., to 4 P.M. She further indicated at times she did have Resident #27 and Resident #29 attend groups such as bingo with assistance, when attending these activities without assistance they were not appropriate and they did not go with the care plans for the residents.</p> <p>A policy titled "Activities" was provided by the Nurse Consultant on 9/18/15 at 9:10 A.M., included, but was not limited to, "It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident in accordance with the comprehensive assessment.</p> <p>3.1-33(a) 3.1-33(d)(2)</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.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to ensure restorative services were provided according to the care plan for 2 of 22 residents who met the criteria for review care plans for range of motion. (Resident #14, Resident #2)</p> <p>Findings include:</p> <p>1. During an interview on 9/15/15 at 10:12 A.M., LPN #5 indicated Resident #14 experienced impairment to the right hand, ankle and foot and further indicated, at that time, Resident #14 did not receive range of motion services or utilize splints or braces.</p> <p>On 9/15/15 at 12:01 P.M., Resident #14 was observed sitting in a wheelchair. Resident #14 was observed to have right hand impairment and to not be utilizing splints or braces.</p> <p>The clinical record of Resident #14 was reviewed on 9/17/15 at 3:02 P.M. The record indicated the diagnoses included, but were not limited to, "...(R) [right] hemiparesis r/t [related to] congenital deficit [sic]..."</p> <p>A Physician's Telephone Order dated 7/16/15 indicated an order was received for, "D/C [discontinue] from PT</p>	F 0282	<p>·Resident # 14 received screen by occupational therapist for right upper extremity impairment and was provided with range of motion services per care plan.</p> <p>·Resident # 2 received screen by occupational and physical therapy for potential changes in upper and lower extremity impairment and was provided with range of motion services per care plan.</p> <p>·All residents receiving restorative nursing services have the potential to be affected by the alleged deficient practice.</p> <p>·MDS/designee to complete audit of all residents receiving restorative services by 10/9/15 to ensure responsibilities are assigned to specific staff, that care plan goals are appropriate, and to ensure documentation of progress towards goals is present and complete.</p> <p>·All direct care staff to be in-serviced by MDS/designee by 10/18/15 on ensuring that restorative responsibilities are completed per schedule, and ensuring documentation of progress towards restorative nursing care plan goals is present and complete.</p> <p>·MDS/designee to ensure restorative nursing responsibilities are assigned to specific staff daily.</p> <p>·MDS/designee to audit restorative nursing flowsheets daily to ensure to ensure documentation of progress</p>	10/18/2015			

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	<p>[Physical Therapy] @ [at] this time. Restorative program in place + [and] to start 7/17/15..."</p> <p>A Care Plan for "ADL [Activities of Daily Living]/Mobility...right hemiparesis..." included, but was not limited to, interventions of, "...See Restorative Resident Summary Report..."</p> <p>The Restorative Program Summary Report dated 7/8/15 included, but was not limited to, interventions of, "...Cue and demonstrate as needed for resident to complete 2 sets of 20 repetitions of AROM [active range of motion] to bilateral lower extremities using green theraband [a resistance band] to complete seated exercises...do 2 sets of 20 repetitions to right shoulder, elbow wrists, and digits..."</p> <p>A Restorative Program Summary Report from 8/3/15 through 9/18/15 lacked any documentation Resident #2 received restorative nursing services on the following dates: 8/3/15, 8/11/15 through 8/13/15, 8/18/15 through 8/30/15, and 9/1/15 through 9/17/15.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the Restorative Nurse/MDS</p>		<p>towards goals is present and complete.</p> <ul style="list-style-type: none"> <li>·ED/designee to review MDS restorative nursing audits daily.</li> <li>·To ensure compliance the ED/designee is responsible for the completion of the Restorative Nursing CQI Tool weekly X 4weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</li> </ul> <p><b>Date of compliance: 10/18/2015</b></p>				

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	<p>Coordinator indicated Resident #14 had not received Restorative Nursing Services because the Restorative CNA had been re-assigned to work on the floor as a CNA. The Restorative Nurse/MDS Coordinator further indicated, at that time, Restorative Services were not provided when a Restorative CNA was not available.</p> <p>2. During an interview on 9/15/15 at 10:18 A.M., LPN #5 indicated the legs of Resident #2 were "fixed and set" and further indicated, at that time, Resident #2 did not receive range of motion services or utilize splints or braces.</p> <p>On 09/15/15 at 11:05 A.M., Resident #2 was observed sitting in a wheelchair. Resident #2 was observed to have bilateral lower extremity impairment and to not be utilizing any splints or braces.</p> <p>The clinical record of Resident #2 was reviewed on 9/16/15 at 9:29 A.M. The record indicated Resident #2 was admitted on 10/17/14 with diagnoses including, but not limited to, paraplegic spinal injury.</p> <p>A Care Plan for, "Restorative Program" dated 7/08/15 included, but was not limited to, interventions of, "Cue and direct resident to complete 20 reps</p>			

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	<p>[repetitions] of ROM with a red theraband [a resistance band] to bilateral upper extremities...complete 20 reps of PROM [passive range of motion] to bilateral lower extremity joints daily..."</p> <p>A Restorative Program Summary Report from 7/8/15 through 9/18/15 lacked any documentation Resident #2 received restorative nursing services on the following dates: 7/14/15, 7/15/15, 7/18/15, 7/19/15, 7/21/15, and 8/2/15 through 9/17/15.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the Restorative Nurse/MDS Coordinator indicated Resident #2 had not received Restorative Nursing Services because the Restorative CNA had been re-assigned to work on the floor as a CNA due to call-ins and staffing issues. The Restorative Nurse/MDS Coordinator further indicated, at that time, Restorative Services were not provided when a Restorative CNA was not available.</p> <p>3.1-35(g)(2)</p>			

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F 0318 SS=D Bldg. 00	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure restorative services were provided for 2 of 2 residents who met the criteria for review of range of motion. (Resident #14, Resident #2)</p> <p>Findings include:</p> <p>1. During an interview on 9/15/15 at 10:12 A.M., LPN #5 indicated Resident #14 experienced impairment to the right hand, ankle and foot and further indicated, at that time, Resident #14 did not receive range of motion services or utilize splints or braces.</p> <p>On 9/15/15 at 12:01 P.M., Resident #14 was observed sitting in a wheelchair. Resident #14 was observed to have right hand impairment and to not be utilizing splints or braces.</p> <p>The clinical record of Resident #14 was reviewed on 9/17/15 at 3:02 P.M. The</p>	F 0318	<ul style="list-style-type: none"> <li>·Resident # 14 received screen by occupational therapist for right upper extremity impairment and is being provided with range of motion services per care plan.</li> <li>·Resident # 2 received screen by occupational and physical therapy for potential changes in upper and lower extremity impairment and is being provided with range of motion services per care plan.</li> <li>·All residents receiving restorative nursing services have the potential to be affected by the alleged deficient practice.</li> <li>·MDS/designee to complete audit of all residents receiving restorative services by 10/9/15 to ensure responsibilities are assigned to specific staff, that care plan goals are appropriate, and to ensure documentation of progress towards goals is present and complete.</li> <li>·All direct care staff to be in-serviced by MDS/designee by 10/18/15 on ensuring that restorative responsibilities are completed per schedule, and ensuring documentation of</li> </ul>	10/18/2015	

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	<p>record indicated the diagnoses included, but were not limited to, "...(R) [right] hemiparesis r/t [related to] congenital deficit [sic]..."</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 7/11/15 indicated Resident #14 experienced moderate cognitive impairment, one-sided impairment to bilateral upper and lower extremities, and received active and passive range of motion services 1 of 7 days and did not require splint or brace assistance.</p> <p>The most recent Physician Order Recap dated 8/9/15 lacked any orders related to range of motion services or splint/brace use.</p> <p>A Physician's Telephone Order dated 7/16/15 indicated an order was received for, "D/C [discontinue] from PT [Physical Therapy] @ [at] this time. Restorative program in place + [and] to start 7/17/15..."</p> <p>A Care Plan for "ADL [Activities of Daily Living]/Mobility...right hemiparesis..." included, but was not limited to, interventions of, "...See Restorative Resident Summary Report..."</p> <p>The Restorative Program Summary</p>		<p>progress towards restorative nursing care plan goals is present and complete.</p> <ul style="list-style-type: none"> <li>·MDS/designee to ensure restorative nursing responsibilities are assigned to specific staff daily.</li> <li>·MDS/designee to audit restorative nursing flowsheets daily to ensure to ensure documentation of progress towards goals is present and complete.</li> <li>·ED/designee to review MDS restorative nursing audits daily.</li> <li>·To ensure compliance the ED/designee is responsible for the completion of the Restorative Nursing CQI Tool weekly X 4weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</li> </ul> <p><b>Date of compliance: 10/18/2015</b></p>				

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	<p>Report dated 7/8/15 included, but was not limited to, interventions of, "...Cue and demonstrate as needed for resident to complete 2 sets of 20 repetitions of AROM [active range of motion] to bilateral lower extremities using green theraband [a resistance band] to complete seated exercises...do 2 sets of 20 repetitions to right shoulder, elbow wrists, and digits..."</p> <p>A CNA Assignment sheet dated 9/15/15 indicated Resident #14 required, "...PROM to affected arm, AROM to unaffected side and bilateral lower extremities..."</p> <p>A Restorative Program Summary Report from 8/3/15 through 9/18/15 lacked any documentation Resident #2 received restorative nursing services on the following dates: 8/3/15, 8/11/15 through 8/13/15, 8/18/15 through 8/30/15, and 9/1/15 through 9/17/15.</p> <p>During an interview on 9/18/15 at 8:45 A.M., the Restorative Nurse/MDS Coordinator indicated no further documentation could be provided to indicate Resident #14 received range of motion services on the identified dates.</p>			

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	<p>During an interview on 9/18/15 at 11:15 A.M., Resident #14 indicated range of motion services were not provided daily.</p> <p>2. During an interview on 9/15/15 at 10:18:14 A.M., LPN #5 indicated the legs of Resident #2 were "fixed and set" and further indicated, at that time, Resident #2 did not receive range of motion services or utilize splints or braces.</p> <p>On 09/15/15 at 11:05 A.M. Resident #2 was observed sitting in a wheelchair. Resident #2 was observed to have bilateral lower extremity impairment and to not be utilizing any splints or braces.</p> <p>The clinical record of Resident #2 was reviewed on 9/16/15 at 9:29 A.M. The record indicated Resident #2 was admitted on 10/17/14 with diagnoses including, but not limited to, paraplegic spinal injury.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 6/15/15 indicated Resident #2 experienced no cognitive impairment, impairment to the bilateral lower extremities, received active and passive range of motion daily and did not require splint or brace assistance.</p>			

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	<p>The most recent Physician Order Recap dated 09/03/15 lacked any orders related to range of motion services or splint/brace use.</p> <p>An OT (Occupational Therapy) Progress note dated 12/25/15 indicated, "...The patient's steadily increasing level of independence with UE [upper extremity] strength through participation in therapeutic exercises...the patient demonstrates deficits with UE strength ...continue with current plan of care focusing on...UE strength ..."</p> <p>A Multi-Disciplinary Therapy Screening Tool dated 3/30/15 indicated, "...ROM [range of motion] &amp; strength...on RNP [Restorative Nursing Program]..."</p> <p>A Care Plan for, "Restorative Program" dated 7/08/15 included, but was not limited to, interventions of, "Cue and direct resident to complete 20 reps [repetitions] of ROM with a red theraband [a resistance band] to bilateral upper extremities...complete 20 reps of PROM [passive range of motion] to bilateral lower extremity joints daily..."</p> <p>A CNA Assignment sheet dated 9/15/15 indicated Resident #2 required, "...AROM...PROM-day shift..."</p>			

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	<p>A Restorative Program Summary Report from 7/8/15 through 9/18/15 lacked any documentation Resident #2 received restorative nursing services on the following dates: 7/14/15, 7/15/15, 7/18/15, 7/19/15, 7/21/15, and 8/2/15 through 9/17/15.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the Restorative Nurse/MDS Coordinator indicated Resident #14 had not received Restorative Nursing Services because the Restorative CNA had been re-assigned to work on the floor as a CNA due to call-ins and staffing issues. The Restorative Nurse/MDS Coordinator further indicated, at that time, Restorative Services were not provided when a Restorative CNA was not available.</p> <p>During an interview on 9/18/15 at 8:45 A.M., the Restorative Nurse/MDS Coordinator indicated restorative services were provided as a nursing measure and a physician's order was not required. The Restorative Nurse/MDS Coordinator further indicated no further documentation could be provided to indicate Resident #2 received range of</p>			

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	<p>motion services on the identified dates.</p> <p>During an interview on 9/18/15 at 8:50 A.M., the Rehabilitation Manager indicated Resident #2 was discharged from Physical Therapy services in December 2014 and needed to continue therapeutic exercises to maximize strength and independence.</p> <p>During an interview on 9/18/15 at 11:00 A.M. the Rehabilitation Manager indicated therapy screens were conducted every quarter, but the Restorative Program was not monitored by the therapy department.</p> <p>During an interview on 9/18/15 at 11:15 A.M., the Restorative Nurse/MDS Coordinator indicated she did not know who was responsible to monitor a resident in the restorative program.</p> <p>During an interview on 9/18/15 at 11:20 A.M., Resident #2 indicated range of motion services were not provided daily.</p> <p>The Policy and Procedure for Restorative Nursing Program provided by the Restorative Nurse/MDS Coordinator on 9/18/15 at 11:30 A.M. indicated, "...Purpose...To provide a nursing program for residents who no longer need skilled therapy, but still have functional</p>			

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F 0353 SS=E Bldg. 00	<p>goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment...The program is coordinated, supervised and carried by nursing staff preferably the MDS Coordinator or MDS assistant... Restorative nursing programs include ...Active or Passive range of motion..."</p> <p>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> <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</p>			

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	<p>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 ensure staffing was adequate, to meet the needs of residents in the facility for 6 of 7 confidential resident interviews and 1 of 3 family interviews conducted. (Resident #300, Resident #310, Resident #320, Resident #330, and Resident #340, Resident #350 and Resident #360)</p> <p>Findings include:</p> <p>1. During a confidential interview on 9/14/15 at 11:36 A.M., with a family member of Resident #360, indicated they were only able to visit with Resident #360 one time a week. The family member continued indicating they had requested for Resident #360 to be assisted out of bed at 10:40 A.M., and they were still not up. At that time Resident #360 was observed to be lying supine in the bed. At 12:01 P.M., the family member was observed to get upset and leave while Resident #360 was still lying in bed.</p> <p>2. On 9/16/15 at 2:00 P.M., Resident #29 and Resident #27, who were both cognitively impaired and dependent for all care were observed in the main dining</p>	F 0353	<ul style="list-style-type: none"> <li>·Resident #360 is being provided ADL assistance per preferences.</li> <li>·Residents # 27 and #29 are being provided with staff assistance and supervision during small group activities.</li> <li>·Resident #300 is being offered ADL assistance per preferences.</li> <li>·Resident #310 is being provided restorative exercises per plan of care.</li> <li>·Resident #320 is being provided restorative exercises per plan of care.</li> <li>·Resident #340 is being provided restorative exercises per plan of care.</li> <li>·Resident #350 is being provided ADL assistance as needed.</li> <li>·Residents # 2 and # 14 are being provided restorative exercises per plan of care.</li> <li>·Resident # 330 is being provided ADL assistance as needed.</li> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·Staff is reviewed daily by ED/designee and adjusted per census and ADL needs.</li> <li>- Staff is reviewed daily by ED/designee and adjusted per census and ADL needs.</li> <li>·Nurse on call list was developed by IDT and implemented to ensure adequate</li> </ul>	10/18/2015

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	<p>room during a game of bingo. The dining room was full with other residents playing bingo. Neither resident was observed to be actively participating in the activity. During the observation Resident #29 was heard to be making disruptive noises. No staff intervention was observed.</p> <p>During an interview on 9/17/15 at 2:40 P.M., the Activity Director indicated, she had been out of the facility driving residents to appointments on 9/16/15 from 8 A.M., to 4 P.M. She further indicated she was the only activity staff at the facility and on 9/16/15 she was unable to supervise resident activities to ensure appropriateness of residents (Resident #29, Resident #27) attending the large group activities.</p> <p>The clinical record for Resident #29 was reviewed on 9/16/15 at 2:56 P.M., diagnoses included, but were not limited to, Alzheimer's dementia with behavioral disturbances.</p> <p>The MDS dated 8/5/15 for Resident #29 indicated he was severely cognitively impaired and experienced inattention and disorganized thinking.</p> <p>The MDS further indicated Resident #29 experienced behavioral symptoms</p>		<p>staffinglevels.</p> <ul style="list-style-type: none"> <li>·Weekly review of resident ADLs per unit will be reviewed by DNS or designee,adjustment to staffing will be made to reflect changes in resident ADL needs.</li> <li>·All direct care staff will be in-serviced byED/designeeon provision of appropriate ADL care.</li> <li>·ED/designee will conduct room rounds daily toensure appropriate provision of ADL care.</li> <li>·All direct care staff to be in-serviced byMDS/designee by 10/18/15 on ensuring that restorative responsibilities are completed per schedule, and ensuring documentation of progress towards restorative nursing care plan goals is present and complete.</li> <li>·MDS/designee to ensure restorative nursing responsibilities are assigned to specific staff daily.</li> <li>·MDS/designee to audit restorative nursing flowsheets daily to ensure to ensure documentation of progress towards goals is present and complete.</li> <li>·To ensure compliance the ED/designee isresponsible for the completion of the Accommodation of needs CQI Tool weekly X4 weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed be the CQI</li> </ul>				

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	<p>including but not limited to, Physical symptoms directed at others, kicking, pushing, grabbing and verbal behavioral symptoms directed at others including but not limited to screaming at others.</p> <p>The clinical record for Resident #27 was reviewed on 09/16/2015 at 12:23 P.M., The diagnoses included, but were not limited to, Alzheimer's disease, and dementia with behavioral disturbances.</p> <p>The Minimum Data Set assessment (MDS) dated 7/18/15 indicated a staff interview for Mental Status was conducted and Resident #27's cognition was severely impaired indicating he never/rarely made decisions. The MDS further indicated Resident #27 experienced inattention and has disorganized thinking.</p> <p>3. During a confidential interview on 9/14/15 at 10:40 A.M., Resident #300 indicated he/she had to wait up to 20 minutes at time for his/her call light to be answered. Resident #300 further indicated he/she often had to stay in bed until 11:00 A.M. although he/she would like to get up sooner.</p> <p>During a confidential interview on</p>		<p>committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p><b>Date of compliance: 10/18/2015</b></p>		

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	<p>9/14/15 at 11:58 A.M., Resident #310 indicated he/she was not receiving his/her restorative exercises since the facility did not have enough staff to provide the services.</p> <p>During a confidential interview on 9/14/15 at 12:06 P.M., Resident #320 indicated the facility did not have enough staff. Resident #320 further indicated he/she was not receiving restorative services because the Restorative aides were always pulled to the floor.</p> <p>During a confidential interview on 9/15/15 at 11:03 A.M., Resident #340 indicated he/she was not receiving the range of motion (ROM) services. He/she indicated it had been going on for a long time.</p> <p>During a confidential interview on 9/15/15 at 1:06 P.M., Resident #350 indicated he/she had to wait to go to the restroom. Resident #350 further indicated he/she would have an accident and the staff would tell him/her they just have too many patients to take care of.</p> <p>During an interview on 9/17/15 at 4:00 P.M., the Restorative Nurse/MDS Coordinator indicated Resident #14 and Resident #2 had not received Restorative Nursing Services because the Restorative</p>			

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	<p>CNA had been re-assigned to work on the floor as a CNA due to call-ins and staffing issues. The Restorative Nurse/MDS Coordinator further indicated, at that time, Restorative Services were not provided when a Restorative CNA was not available.</p> <p>The facility schedule, as worked, was reviewed for August and September 2015. The documentation indicated the restorative aide was either not scheduled or moved to the fill another position for 28 of 49 days reviewed.</p> <p>4. During a confidential interview on 9/15/15 at 10:48 A.M., Resident #330, the facility needed more staff. Resident #330 indicated at one time he/she had to wait 40 minutes to be assisted to the restroom following an accident.</p> <p>The facility Certified Nursing Assistant (CNA) assignment sheets were provided by the Director of Nursing on 9/14/15 at 9:21 A.M. and indicated the following:</p> <p>East unit- (20 Residents) 19 requiring assistance with Activities of Daily Living (ADL's) 15 requiring assistance with Range of Motion (ROM) programs 9 requiring assistance of 2 staff members for transfers</p>			

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F 0412 SS=D Bldg. 00	<p>6 requiring mechanical lift for transfers 9 residents that are on a toileting program 8 on a check and change toileting plan 4 residents requiring assistance to turn and reposition</p> <p>West unit-(19 Residents) 16 residents requiring assistance with ADL's 12 residents requiring assistance with ROM programs 9 residents requiring assistance of 2 staff members for transfers 6 residents requiring assistance of a mechanical lift for transfers 10 residents on a scheduled toileting program 3 residents on a check and change toileting program 2 residents requiring assistance with turning and repositioning 1 resident requiring assistance with catheter care 2 residents requiring assistance with colostomy care</p> <p>3.1-17(a) 3.1-17(b)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain</p>			

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	<p>from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record, the facility failed to ensure a resident with dentures at the facility maintained her dental status for 1 of 3 residents reviewed for dental services that met the criteria for dental services in the stage 2 sample. (Resident #5)</p> <p>Findings include:</p> <p>On 9/16/15 at 10:20 A.M., Resident #5 was observed, sitting in her wheelchair in the restorative dining room. Resident #5 was observed to be edentulous.</p> <p>Resident #5's clinical record was reviewed on 9/15/15 at 12:07 P.M. The Quarterly Minimum Data Set (MDS) assessments dated 5/22/15 and 8/22/15 indicated no dentures or partials and no natural teeth or tooth fragments. The 8/22/15 MDS indicated a cognitive score of 15 (cognition intact). The 8/22/15 MDS diagnoses included, but were not limited to, hypertension, cerebrovascular accident, and hemiplegia.</p>	F 0412	<ul style="list-style-type: none"> <li>·Resident #5 has been scheduled with facility dentist for potential denture replacement.</li> <li>·All edentulous residents with dentures have the potential to be affected by alleged deficient practice.</li> <li>·All edentulous residents with dentures were interviewed by ED/designee (family interviews for non-interviewable residents)to determine if dental consultation for denture evaluation is desired.</li> <li>·Licensed nursing staff will be in-serviced on weekly oral assessment responsibilities and dental referral process for identified dental problems.</li> <li>·All resident's oral status will be assessed weekly by licensed nursing staff and referred to Social Services Director/designee to schedule dental services.</li> <li>·All residents to be assessed for dental needs on admission, quarterly, or on emergency basis by Social Services Director.</li> <li>·Dentist routinely scheduled at facility every other month but will utilize outside dentist for emergency needs per residents preference.</li> </ul>	10/18/2015

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	<p>A CNA assignment sheet for Resident #5 was received and reviewed on 9/15/15 at 9:00 A.M. The CNA assignment sheet indicated Resident #5: "...Has upper and lower dentures she does not wear. Set up for oral care..."</p> <p>Her current care plan dated 8/28/15 addressed the problem of: "Resident has some or all of natural teeth lost. Does not have or use dentures or partials related to lost them at some point..." Interventions included but were not limited to, "... Obtain dental consult..."</p> <p>On 9/17/15 at 8:45 A.M., during interview, Resident #5 indicated she doesn't have dentures. Resident #5 indicated she lost her dentures approximately 6 months ago at the facility. Resident #5 indicated she had told the previous Director of Nursing (DON) and nothing had been done.</p> <p>On 9/17/15 at 8:55 A.M., during interview with Resident #5, she indicated, she had routinely taken her dentures out at night and handed her dentures to the CNAs. Resident #5 had indicated the CNAs would rinse her dentures and place in a denture cup and place the cup on her night stand.</p>		<p>·Social Services Director/designee will schedule dental consult for any resident that has lost or ill-fitting dentures and wishes to be evaluated by dentist.</p> <p>·To ensure compliance the ED/designee is responsible for the completion of the Dental Services CQI Tool weekly X 4weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p><b>Date of compliance: 10/18/2015</b></p>	

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	<p>On 9/18/15 at 11:28 A. M., the DON was interviewed regarding Resident #5's dentures. The DON indicated Resident #5 goes out of facility for dental services.</p> <p>On 9/18/15 at 11:50 A.M. during interview the DON indicated, Resident #5 was seen by the facility On Health Dental Services in 2014. The DON indicated the facility lacked documentation of the 2014 dental visit but had requested the dental office to send the last dental report.</p> <p>On 9/18/15 at 12:30 P.M., the DON indicated if Resident #5 lost her dentures at the facility then the facility would pay for new dentures. The DON indicated, she would take the resident's word for it.</p> <p>On 9/18/15 at 12:35 P.M., the current facility admission packet (from corporation change on 7/1/15) indicated the facility would not be responsible for lost personal items such as dentures.</p> <p>On 9/18/15 at 12:40 P.M., the Administrator provided a document that indicated, "Since [Resident # 5's name] lost her dentures here at the facility, [the facility's name] will cover any cost associated with or required for replacing them."</p>			

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F 0441 SS=D Bldg. 00	<p>An out of facility dental progress note dated 9/2/14 for Resident #5 was received and reviewed on 9/18/15 at 12:45 P.M. The progress note indicated, "... PATIENT WANTED NEW DENTURES. SHE SAID SHE LOST HER DENTURES. HER DENTURES WERE MADE APPROX [approximately] 3 YEARS AGO..."</p> <p>3.1-24(a)</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</p>			

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 clean technique was followed during a dressing change and proper handwashing or glove changes were performed for 2 of 2 residents who met the criteria for review of contact isolation (Resident #2, Resident #32)</p> <p>Findings include:</p> <p>1. During an interview on 9/18/15 at 9:30 A.M. the DON (Director of Nursing) indicated RN #5 was preparing to change wound dressings for Resident #2. The DON further indicated, at that time, the wound contained MRSA (Methicillin- Resistant Staphylococcus Aureus), the MRSA was contained in the secondary dressing, and Resident #2 was</p>	F 0441	<ul style="list-style-type: none"> <li>·Resident #2 is receiving wound care per infection control policy.</li> <li>·Resident # 32 is receiving ADL care per infection control policy</li> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·All staff will be re-educated by DNS/designee on hand washing and the infection control policy using skills validation.</li> <li>·All licensed staff will be re-educated by DNS/designee on dressing change using skills validation.</li> <li>·All licensed staff will be re-educated by DNS/designee on glove change procedure using skills validation.</li> <li>·DNS/designee will conduct rounds each shift to ensure staff hand washing completed per policy. DNS/designee will observe one dressing change daily to ensure glove changing and hand</li> </ul>	10/18/2015

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	<p>in contact isolation.</p> <p>During an observation of care on 9/18/15 at 9:35 A.M., RN #5 and the DON were observed to perform handwashing and apply clean gloves. RN #5 was then observed to remove the wound dressings and touch the inside of the soiled dressing with gloved fingertips. The DON was then observed to cleanse the wound. RN #5 was observed to not perform handwashing and to not apply clean gloves. RN #5 was then observed to paint the wounds with a betadine swab, apply a clean primary dressing directly to the wound beds with gloved fingertips. RN #5 was then observed to remove soiled gloves and perform handwashing for 10 seconds, apply new gloves and apply a clean secondary dressing. RN #5 was then observed to remove soiled gloves and perform handwashing for 8 seconds.</p> <p>During an interview on 9/18/15 at 9:50 A.M. , the DON indicated handwashing should be performed for 15 seconds.</p> <p>The clinical record of Resident #2 was reviewed on 9/16/15 at 9:29 A.M. The record indicated Resident #2 was admitted on 10/17/14 with diagnoses including, but not limited to, pressure ulcer.</p>		<p>washing occurs per policy.</p> <ul style="list-style-type: none"> <li>·In-service will be completed by DNS/designee for all licensed staff on hand washing procedure by 10/18/2015.</li> <li>·In-service will be completed by DNS/designee for all licensed nursing staff on dressing change procedure by 10/18/2015.</li> <li>·In-service will be completed cy DNS/designee for all licensed nursing staff on glove change procedure by 10/18/2015</li> <li>·To ensure compliance the DNS/designee is responsible for the completion of the Infection Control CQI tool weekly X 4weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</li> </ul> <p><b>Date of compliance: 10/18/2015</b></p>		

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	<p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 6/15/15 indicated Resident #2 experienced no cognitive impairment, no infections, two Stage 3 pressure wound present on admission, and received no antibiotics during the assessment period.</p> <p>The most recent Physician Order Recap dated 09/03/15 included, but was not limited to, orders for, "...Doxycycline [an antibiotic] 100 mg [milligram] ...give 1 capsule by mouth 2 times a day for MRSA of (R) buttock wound...Cleanse o/a [open area] to sacral area w [with]/NS [normal saline] , pat dry, apply AquAG [Aquacel Silver] [a primary wound dressing] to wounds, then Meplilex [a secondary dressing] sacral gentle border...Contact isolation..."</p> <p>2. Resident #32's clinical record was reviewed on 9/14/15 at 1:25 P.M. His current physician orders dated 9/1/15 thru 9/30/15 included, but were not limited to, diagnoses of : diabetes mellitus type 2 non compliance, chronic venous stasis, depression and anxiety. His physician orders also included a 8/20/15 telephone order that indicated, " Initiate contact isolation d/t MRSA ( Methicillin -Resistant Staphylococcus Aureus) of wound on foot.</p>			

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	<p>A Pressure Wound Skin Evaluation form dated 9/10/15, indicated a stage 3 right heel pressure wound. Current treatment was a football dressing. "... Wound previously + [positive for MRSA] awaiting new culture results..." A Pressure Wound Skin Evaluation form dated 9/10/15, indicated a stage 3 right lateral foot- 5th metatarsal wound.</p> <p>On 9/17/15 at 3:50 P.M., during interview with the Director of Nursing (DON), the DON indicated Resident #32 remains on an antibiotic for MRSA of the right heel. She indicated Resident #32 returns to the wound center tomorrow. The DON indicated the resident remains in contact isolation. She indicated the resident 's right foot has a football type dressing which was being changed by the wound center outside the facility. The DON indicated the facility was not viewing the wounds or changing dressings of the right foot at present.</p> <p>On 9/17/15 at 10:45 A.M., CNA #12 and CNA #13 washed their hands and applied gloves before using a hooyer (mechanical) lift to transfer Resident #32 from his wheelchair to his speciality air loss bed. CNA #13 assisted Resident #32 by guiding his legs during the transfer with her uniform observed against Resident #32's clothing during transfer.</p>			

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	<p>CNA #13 began the resident's bath with her gloves on using a head and body soap, a wash cloth and basin of water. The Resident's face, head, chest, arms , and peri-area and buttocks were washed and dried and protective ointment was applied to the coccyx area. Then CNA #13 using a clean wash cloth and not changing gloves washed and dried the resident's left and right lower extremities and the left foot. During the removal of the resident's clothes and during bathing both CNAs uniforms were observed in contact with the mattress of the bed and the resident. Resident was transferred to his wheelchair after the bath had been completed. With her gloves still on CNA #13 handed Resident #32 his comb to comb his hair. CNA #13 with gloves still on collected linen from bath and placed into a large plastic bag and proceeded out of resident room touching room door knob and the shower door where soiled linen containers were kept. She deposited her plastic bag and removed her gloves and washed her hands in shower room sink.</p> <p>During an interview on 9/16/15 at 2:19 P.M., the HFA (Health Facilities Administrator) presented Skills Validation-CNA Hand Hygiene and Gloves checklists and stated, "The skills</p>			

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	<p>checklists are our policy."</p> <p>The Skills Validation-CNA Handwashing checklist indicated, "...6. Use friction for at least 20 seconds...Note:...Moment of required hand hygiene...Before an aseptic task, after body fluid exposure risk, after patient contact..."</p> <p>The Skills Validation-CNA Gloves checklist indicated, "...Put on gloves...Perform procedure...Dispose of gloves...wash hands..."</p> <p>During an interview on 9/18/15 at 12:00 P.M., the DON (Director of Nursing) indicated gloves should be changed between clean and dirty procedures, handwashing should be performed between glove changes, and handwashing should be performed for at least 20 seconds.</p> <p>The facility policy entitled, "Transmission-Based Guidelines [last revision May 2015]" was received and reviewed on 9/17/15. The policy included but was not limited to, "...Contact Precautions: refers to measures that are intended to prevent transmission of infectious agents wither by direct or indirect contact with the resident or the resident's environment...STANDARD PRECAUTIONS: Assume that every</p>			

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	<p>resident is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. The following infection control practices should be used during the delivery of care to all residents: ...Gloves: Change gloves during care if hands will move from a contaminated site to a clean site...CONTACT PRECAUTION: Used for resident(s) with known or suspected infection(s) or evidence of symptoms(s) related to infection(s) that have not been confirmed but may be associated with the spread of infection(s)...Gloves: Maintain standard Precautions...Use of Personal Protective Equipment-Gown:...Put on gown upon entry to room/cubicle, Gown protects clothing from potential contamination from direct contact with resident, environment surfaces or equipment..."</p> <p>On 9/18/15 at 8:21 A.M., the DON was made aware of facility's Precaution policy in regard to CNAs not wearing gowns when providing bathing to a resident in contact isolation, gloves not changed during bath, and gloves worn out of room after bathing care provided. The DON indicated at that time she understood.</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(j)</p>				

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

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