

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2012
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NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F0000	<p>This visit was for the investigation of Complaint IN00109756.</p> <p>This visit was done in conjunction with the Recertification and State Licensure survey which included the investigation of Complaint IN00108190.</p> <p>Complaint IN00109756 Substantiated, Deficiencies related to the allegations are cited at F309, F323, and F353.</p> <p>Survey dates: June 11, 12, 13, 14, and 15, 2012</p> <p>Facility number: 000136 Aim number: 100275450 Provider number: 155231</p> <p>Survey team: Betty Retherford RN TC Karen Lewis RN Ginger McNamee RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 11 Medicaid: 46</p>	F0000		

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

TITLE

(X6) DATE

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

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	<p>Other: 16 Total: 73</p> <p>Sample: 12</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/20/12 Cathy Emswiller RN</p>				

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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the nursing staff assessed a resident after a large bruised area was noted (Resident #F), failed to obtain and provide timely treatment to a skin tear (Resident #C), failed to transfer a resident in a manner to prevent discomfort (Resident #E) and failed to ensure a resident was re-evaluated for a possible diet change after his dentures were repaired and returned to the facility (Resident #D).</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident (stroke) with left sided weakness and hemiparesis, osteoarthritis, and</p>	F0309	<p>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.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 07/09/12.</p> <p>It is the practice of this provider to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # F was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive follow up documentation related</p>	07/09/2012			

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	<p>diabetes mellitus.</p> <p>The April 2012 recapitulation of physician's orders for Resident #F indicated "May use Hoyer lift as needed for transfers for safety." The original date of this order was 8/25/10. The orders also indicated the resident received Coumadin (a medication given to thin the blood) 2.5 milligrams daily. The original date of the Coumadin order was 12/29/11.</p> <p>The clinical record indicated the resident had a PT/INR (a test completed to monitor the thinness of the resident's blood) completed on 5/1/12. The lab report indicated the resident's INR level was 2.5. This is within the normal therapeutic range of 2.0 to 3.5 and the physician did not change the resident's Coumadin dose.</p> <p>A health care plan problem, with a "team conference date" of 4/18/12, indicated the resident was a risk for falls related to "impaired mobility and cognition due to hemiparesis and dementia." One of the approaches for this problem was "Hoyer lift for transfers."</p> <p>A Investigation Report, dated 5/5/12, indicated an investigation has been</p>		<p>to any change in resident's status.</p> <p>Resident # C was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive follow up related to skin tears or any change in resident's status.</p> <p>Resident # E was not identified by the Indiana Department of Health survey team, however, the facility ensures that residents are transferred utilizing a gait belt when a mechanical lift is not utilized.</p> <p>Resident # D was not identified by the Indiana Department of Health survey team, however, the facility ensures that residents that receive dentures are re-evaluated after the receipt of new dentures to ensure a proper diet is obtained.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents who have a change in health status have the potential to be affected by the alleged deficient practice.</p> <p>Residents who are transferred without the use of a mechanical lift have the potential to be affected by the alleged deficient practice.</p> <p>Licensed nurses were re-educated to documentation with changes in status by the Director of Nursing Services,</p>		

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	<p>initiated on 5/5/12 at 5:15 p.m. related to the staff noting a 9 cm by 8 cm yellow discolored area on the center of the Resident #F's chest. The report indicated the resident was on Coumadin (a blood thinner). The investigation indicated the area was probably the result of the Hoyer lift pad pinching the resident's left breast. Witnesses were identified as CNA #2 and CNA #3. The type of injury was described as "hematoma". The form indicated the resident's daughter and physician had been called.</p> <p>The nursing notes lacked any information related to a bruised area being noted on the resident's chest on 5/5/12. There were no nursing notes dated May 5, 6, 7, or 8, 2012. The clinical record lacked any follow up assessments or monitoring related to the area found on 5/5/12.</p> <p>A nursing note entry, dated 5/9/12 at 10:00 a.m., indicated the nursing staff had been called to the resident's room by "rehab". The note indicated the left side of the resident's chest area was swollen and hard to palpitation. The note indicated the physician was contacted and an order obtained for a PT/INR blood test.</p> <p>The PT/INR report, dated 5/9/12,</p>		<p>and/or designee, by 6/28/12, and ongoing, as needed. Licensed nurses, follow re-educated to follow up, with changes in status by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. Licensed nurses and Nursing Assistants were re-educated to the gait belt policy by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on the change of condition 24 hour report sheet by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed. The Director of Nursing Services is responsible to monitor for facility compliance in providing necessary care and services to the residents. Licensed nurses and Nursing Assistants were re-educated to the gait belt policy by the Director of Nursing Services, and/or designee, by 6/28/12, and ongoing, as needed.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice</p>		

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	<p>indicated the resident's INR level was 4.2. This indicated the resident's blood was too thin and above the therapeutic level. The physician was contacted and an order was obtained to hold the resident's Coumadin for 2 days and recheck the PT/INR blood test on 5/12/12.</p> <p>During an interview with the DoN on 6/14/12 at 10:39 a.m., additional information was requested related to the lack of documentation of the bruised area in the nursing notes when found on 5/5/12 and the lack of follow-up monitoring and assessment related to the injury.</p> <p>On 6/14/12 at 1:40 p.m., the DoN provided some 24 hour report sheets documenting some information related to Resident #F. These reports were not part of the clinical record. No information dated 5/5 (the date of the occurrence) or 5/6 was provided. A 24 hour report sheet, dated 5/7/12, indicated the area on the resident's left chest remained yellow in color. No vital signs were present. A 24 hour report sheet, dated 5/8/12, indicated the bruise on the resident's chest was fading and contained several sets of vitals signs. The size of the bruising and/or firmness of the area was never monitored in the</p>		<p>will not recur, i.e., what quality assurance program will be put into place?</p> <p>The physician orders and the 24 Hour Change of Condition Report sheets are reviewed by the Director of Nursing or designee, to ensure resident change of condition is reported to the physician.</p> <p>An ancillary service follow up log will be utilized by Social Services weekly X's 4, Monthly X's 2, and Quarterly thereafter to monitor for the need for ancillary services follow up.</p> <p>A "Changer of Condition" Audit tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor the Medication/Treatment Administration Records for compliance with administration, documentation, and physician notification, if applicable. The audits are reviewed by the IDT committee and action plans are developed, as needed, to improve performance.</p>				

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	<p>clinical record prior to the entry made on 5/9/12.</p> <p>During an observation and interview on 6/15/12 at 11:50 a.m., the resident's daughter indicated she had been notified of the resident's bruise prior to the area becoming swollen and hard to touch. The daughter opened the resident's blouse slightly and indicated the area was still hard to touch. A slight yellowish discoloration was still noticeable on the left side of the resident's chest.</p> <p>2.) The clinical record for Resident #C was reviewed on 6/13/12 at 9:44 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia with behaviors and neurodermatitis.</p> <p>A health care plan problem, last reviewed on 5/18/12, indicated Resident #C was at risk for skin breakdown due to incontinence, picking at his skin, and problems with improper body alignment. Approaches for this problem included, but were not limited to, "observe skin with daily activities of daily living care for signs of breakdown or irritation" and "record any finding in nursing notes, weekly skin log/ulcer report</p>			

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	<p>and report to medical doctor for appropriate treatment."</p> <p>A nursing note, dated 5/28/12 at 10 a.m., indicated a "skin tear" had been noted on the resident's left forearm. The area was described as a 1 cm by 2 cm skin tear. The nursing note indicated the area was cleansed with normal saline and the physician had been "faxed" related to the skin tear being found.</p> <p>The next nursing note was dated 5/31/12 at 3:00 p.m. The note indicated new orders had been received for Resident #C.</p> <p>A physician's order, dated 5/31/12, indicated a treatment had been ordered for the skin tear on the resident's left forearm. The order was "cleanse with NS (normal saline), [apply] triple antibiotic ointment cream and cover with suresite [a clear thin dressing] - change every 3 days".</p> <p>The clinical record lacked any assessment and/or monitoring of the resident's skin tear from the time it was found on 5/31/12 and the date the order was obtained on 5/31/12. The clinical record lacked documentation of any other contact with the physician other than the fax</p>				

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	<p>sent on 5/28/12 prior to the order being obtained on 5/31/12.</p> <p>This indicated a time period of 3 days from the date the skin tear was noted and a treatment order was obtained.</p> <p>The May 2012 lacked any documentation of the treatment being completed on 5/31/12.</p> <p>The June 2012 treatment administration record (TAR) for Resident #C from 6/1/12 through 6/12/12 indicated the treatment was first completed on 6/2/12. This indicated a time period of two days from the day the order was obtained and a treatment done and a time period of 5 days from the date the skin tear was found and the first treatment was completed.</p> <p>The June TAR indicated the treatment was done on the following days: June 2, 2012 (the first treatment-two days after the order was obtained) June 5, 2012 June 10, 2012 (a time period of 5 days between treatments)</p> <p>The June TAR indicated the treatment was not done on 6/8/12 which would have been the three day</p>			

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	<p>time period from the June 5th treatment.</p> <p>During an interview with the Administrator and DoN on 6/13/12 at 10:30 a.m., additional information was requested related to the lack of assessment and follow up of the wound after the physician was faxed. Additional information was requested related to the delay in starting the treatment and the 5 day gap between the June 5th treatment and the June 10th treatment.</p> <p>During an interview on 6/15/12 at 1:45 p.m., the DoN indicated she had no information to provide related to monitoring of the skin tear after it was noted on 5/28/12 and a treatment was obtained on 5/31/12. She indicated no wound monitoring records had been developed related to the skin tear. She indicated she had no information to provide related to the delay in starting the treatments or the five day gap between treatments.</p> <p>3.) During an interview with resident #E on 6/12/12 at 1:05 p.m., with her family present, she indicated the staff frequently do not use a gait belt to transfer her. She said they go under her arms to transfer her and it hurts her. The family indicated they have</p>						

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	<p>observed the staff transferring her this manner as well. The family indicated the wheelchair is placed across from the chair Resident #E is being transferred from and is pivoted 180 degrees. The resident said she feels like she is plopped into the wheelchair when she is transferred in this manner and it hurts.</p> <p>During an interview with the Administrator and the Director of Nursing on 6/12/12 at 3:30 p.m. The Director of Nursing indicated the resident was interviewable and a gait belt was to be used when transferring the resident. She indicated some staff can transfer the resident with one assist and some staff requires two assist. She indicated it was up to the staff to decided how the resident is to be transferred.</p> <p>The CNA Assignment Sheet for Resident #E was provided on 6/12/12 at 3:30 p.m., by the Director of Nursing. The sheet indicated the resident had right sided weakness and was paralyzed on the left side. The sheet indicated the resident required one or two assists with a gait belt for transfers.</p> <p>Resident #E's clinical record was reviewed on 6/14/12 at 10:00 a.m.</p>			

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	<p>The resident had a 3/12/12, quarterly Minimum Data Set assessment. The resident scored 14 out of 15 on her Brief Interview for Mental Status. The score indicated the resident was interviewable. The assessment indicated the resident required extensive assistance of one transfers.</p> <p>Review of the 7/98, "Indiana State Department of Health Core Curriculum" for assist to chair indicated the chair is to be placed on the resident's unaffected side.</p> <p>4.) The clinical record for Resident #D was reviewed on 6/13/12 at 1:00 p.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, anxiety, depression, Alzheimer's dementia, and diabetes mellitus type 2.</p> <p>A Social Service progress note, dated 4/30/12, indicated resident had been seen by the in-house dentist and his dentures had been sent out for repair.</p> <p>A telephone order, dated 5/2/12, indicated the resident was to have a mechanical soft diet and ground meat until dentures repaired.</p> <p>The clinical record lacked any</p>			

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	<p>information related to the re-evaluation of the resident's diet after his dentures were repaired and returned to facility.</p> <p>During an interview with the Administrator, Director of Nursing and the RN Consultant on 6/13/12 at 3:55 p.m., information regarding resident's dentures was requested.</p> <p>During an interview with the Administrator on 6/14/12 at 9:05 a.m., she indicated the resident's dentures were repaired and returned to the facility on 5/8/12. She indicated speech therapy was supposed to evaluate the resident with dentures in place. A copy of the speech evaluation was requested.</p> <p>During an interview with the Administrator on 6/14/12 at 9:25 a.m., she indicated she could not find a speech evaluation for the resident. She indicated the physician had been contacted for an order for a speech evaluation for the resident today.</p> <p>A telephone order, dated 6/14/12, indicated the speech evaluation had been completed for Resident #D and his diet was to be modified to regular consistency.</p>						

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	<p>5.) Review of the current facility policy, dated 1/20/12, titled "CHANGE OF CONDITION", provided by the Director of Nursing on 6/14/12 at 1:40 p.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Ensure appropriate care and documentation occurs when residents experience a change of condition.</p> <p>Procedure:</p> <p>1. Assess resident's condition: change of movement or range of motion, level of consciousness, pain, swelling, bruising, discoloration, vital signs, respiratory status, neurological checks for injuries such as falls, etc....</p> <p>...3. Notify attending physician promptly of condition change....</p> <p>...5. Communicate condition change on the 24 hour report.</p> <p>6. Document symptoms, assessment, treatment, notifications, etc. in clinical record.</p> <p>7. Follow up nursing assessments and monitoring continue until condition has stabilized or at least 72</p>				

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	<p>hours. Assess signs and symptoms related to change in condition at least one time every 8 hours-12 hours and more often if symptomatic...</p> <p>...9. Examples of significant change include but are not limited to the following:...</p> <p>...B. Occurrence of:...</p> <p>...e). Bruises, laceration, blisters, rashes, or skin tears, swelling or discoloration...."</p> <p>This federal tag relates to Complaint IN00109756.</p> <p>3.1-37(a)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure fall risk assessments were completed accurately (Resident #D) and failed to ensure each resident received the proper assistance and supervision to complete a Hoyer lift transfer in a manner to ensure resident safety (Resident #F) for 2 of 6 resident's reviewed who met the criteria for falls.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #F was reviewed on 6/13/12 at 2:50 p.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, history of cerebral vascular accident with left sided weakness and hemiparesis, osteoarthritis, and diabetes mellitus.</p> <p>The April 2012 recapitulation of physician's orders for Resident #F indicated "May use Hoyer lift as needed for transfers for safety." The original date of this order was</p>	F0323	<p>It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # D was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents are assessed accurately for fall risk. Resident # F was not identified by the Indiana Department of Health survey team; however, the facility ensures that residents receive proper assistance and supervision to complete hoyer lift transfers.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents at risk to fall and residents requiring a hoyer lift for transfers have the potential to be affected by the alleged deficient practice.</p>	07/09/2012

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	<p>8/25/10.</p> <p>A health care plan problem, with a "team conference date" of 4/18/12, indicated the resident was a risk for falls related to "impaired mobility and cognition due to hemiparesis and dementia." One of the approaches for this problem was "Hoyer lift for transfers."</p> <p>During an interview with the DoN on 6/14/12 at 1:40 p.m., the DoN indicated it was facility policy for two nursing staff to be present during Hoyer lift transfers to provide proper positioning and ensure resident safety.</p> <p>A Investigation Report, dated 5/5/12, indicated an investigation has been initiated on 5/5/12 at 5:15 p.m. related to the staff noting a 9 cm by 8 cm yellow discolored area on the center of the Resident #F's chest. The report indicated the resident was on Coumadin (a blood thinner). The investigation indicated the area was probably the result of the Hoyer lift pad pinching the resident's left breast. Witnesses were identified as CNA #2 and CNA #3. The type of injury was described as "hematoma". The form indicated the resident's daughter and physician had been called.</p>		<p>Licensed nurses were re-educated on the fall risk assessments on 6/21/12 and 6/28/12 and ongoing. Certified nursing assistants were re-educated on transfer procedures on 6/21/12 and 6/28/12 and ongoing.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Residents are assessed for fall risk upon admission/re-admission and no less than quarterly. The charge nurse implements appropriate interventions to prevent falls. Those residents at high risk are reviewed by the Interdisciplinary Team for the least restrictive assistance device to prevent injury. The resident's plan of care and resident care sheets are revised, as needed. The Interdisciplinary Team reviewed residents fall risk score with each fall to ensure an appropriate change in the plan of care is initiated.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Residents with falls will be reviewed for accurate</p>		

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	<p>A "Witness Statement" made by the DoN, dated 5/6/12 at 4:15 P.M., indicated she was notified of the bruising on Resident #F and it was on her left breast in the middle of the breast. "I instructed the staff working at that time to ensure the Hoyer pad was positioned correctly during transfers".</p> <p>During an interview on 6/14/12 at 10:39 a.m., the DoN indicated she had completed the investigation related to the bruising noted on 5/5/12 on Resident #F's chest. She indicated she had talked to all the staff members working who could possibly have used the lift on 5/5/12 to get Resident #F up that morning and back to bed prior to the bruising being noted on her chest. She indicated no staff members would identify themselves as the ones who had transferred the resident and/or assisted with the transfer on that date. She identified CNA #4 as the CNA she felt had gotten Resident #F up on that date. She indicated CNA #4 no longer worked at the facility. She indicated she did not know if the resident's transfers had been completed with one or two CNA's or if the lift pad had been properly placed to help prevent the resident from</p>		<p>assessments by the IDT with each event, to monitor compliance. The governing IDT committee will review the data. If the threshold for compliance is not met, an action plan will be developed.</p>	

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	<p>being pinched during a transfer.</p> <p>2.) The clinical record for Resident #D was reviewed on 6/13/12 at 1:00 p.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, anxiety, Alzheimer's dementia, diabetes mellitus type 2, stroke, and depression.</p> <p>The clinical record indicated Resident #D fell on 1/30/12, 2/9/12, 3/17/12, 4/7/12, 5/2/12, 5/5/12, and 6/4/12.</p> <p>The clinical record indicated the Fall Risk Assessments on 2/14/12, 3/4/12, and 4/30/12 were completed incorrectly. The "History of Falls" sections on the assessment form were scored incorrectly. The scoring on the form reflected no falls or a lesser amount of falls than actually occurred. The correct scoring would have represented "High Risk" for the resident for falls.</p> <p>Review of the current facility policy, dated 1/22/12, titled "FALL PREVENTION", provided by the Administrator on 6/14/12 at 3:435 p.m., included, but was not limited to, the following:</p>						

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	<p>"Purpose:</p> <p>Identify residents at risk for falls and reduce risk of falls and/or injury.</p> <p>Procedure:</p> <p>1. Each resident will have a fall risk assessment performed by a licensed nurse upon admission, quarterly, annually, and upon a significant change.</p> <p>2. Residents identified as a fall risk will be placed on a fall prevention program...."</p> <p>This federal tag relates to Complaint IN00109756.</p> <p>3.1-45(a)(2)</p>				

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F0353 SS=C	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>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 this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review and interview, the facility failed to ensure there was always sufficient staff on duty to ensure the needs of the residents were met in a timely manner for 6 of 6 residents (Resident #'s 27, 20, 93, 110, 1 and E) reviewed of the 16 who met the criteria for sufficient nursing staff review and for 2 of 4 family interviews (Resident # 9) related to sufficient staff.</p> <p>Findings include:</p> <p>During a review of the Resident</p>	F0353	<p>It is the practice of this facility to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Licensed Nurses will be utilized to work as C.N.A.'s when a C.N.A. is not available.</p> <p>Managers who hold a Certified Nursing Assistant certificate will</p>	07/09/2012

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	<p>Council minutes from January 2012 through June 2012, they included, but were not limited to, the following:</p> <p>1/10/12 meeting beds aren't being made waiting too long to get up and get them dressed/sitting too long in bathroom staff/CNA's - short</p> <p>2/8/12 meeting. not enough staff-CNA's bed's not being made until early afternoon call lights left unanswered 15-20 minutes</p> <p>3/13/12 meeting staff-short on weekends</p> <p>4/10/12 meeting. beds not made till end of day ice not passed until after 10 a.m.</p> <p>6/12/12 meeting ice passed untimely call lights taken 1 hour to be answered on second shift</p> <p>During resident interviews the following was noted:</p> <p>During an interview with Resident #J on 6/12/12 at 10:08 a.m., she</p>		<p>be utilized to work as C.N.A.'s when a C.N.A. is not available.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Charge Nurse has a list of employees who have the potential to work as a C.N.A., if coverage is not found Licensed Nurses will be scheduled as C.N.A.'s and will be added to the daily staffing sheets. When alternate coverage is needed managers that hold a C.N.A. license are called to work as a C.N.A. The facility continues recruitment efforts for Certified Nursing Assistants.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All staffing needs will be called in to the Director of Nursing to</p>		

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	<p>indicated that the facility did not have enough aides working on any of the shifts.</p> <p>During an interview with Resident #K on 6/11/12 at 11:45 a.m., he indicated the facility did not have enough staff, especially on the weekends. He indicated he has had to wait over an hour on the bed pan.</p> <p>During an interview with Resident #E on 6/12/12 at 1:29 p.m., she indicated there is a long call light wait. She also indicated that sometimes staff will come in and turn off call light and not come back.</p> <p>During an interview with the family of Resident #L on 6/11/12 at 2:39 p.m., she indicated she asked 30 minutes ago for someone to take her mother to the bathroom and they still have not because it takes two staff to assist her mother.</p> <p>During an interview with Resident #M on 6/11/12 at 12:21 p.m., she indicated the staff frequently complain about other staff not coming in and/or doing their jobs.</p> <p>During an interview with Resident #N on 6/11/12 at 3:18 p.m., she indicated the past Friday she had to wait over</p>		<p>ensure that appropriate staff can be identified.</p> <p>The governing IDT committee will review the data. If the threshold for compliance is not met, an action plan will be developed.</p>	

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	<p>30 minutes and Saturday over 1 hour for her call light to be answered. Her roommate went to get someone but was unable to find anyone to help.</p> <p>During an interview with Resident #G on 6/12/12 at 10:30 a.m., she indicated she did not think the facility had enough staff. She has to wait over half an hour for her call light to be answered once or twice a week. She also indicated staff will come in and turn off the call light and say they will be right back, but don't come back.</p> <p>During an interview with the Administrator on 6/13/12 at 10:00 a.m., information was requested related to the optimal level of staff the facility desired to provide resident care for each shift and unit.</p> <p>During a review of the facility optimal staffing levels on 6/13/12 at 1:00 p.m., provided by the Administrator at that time, the information indicated four CNAs were necessary to provide optimum CNA staffing on the 10 p.m. -6 a.m.</p> <p>During a review of the "as worked" CNA schedules for the time period of 5/1/12 through 6/11/12, conducted with the DoN on 6/15/12 at 1:00 p.m.,</p>			

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	<p>the following was noted:</p> <p>During the month of May 2012, the facility had only 3 CNA's on the 10 p.m. to 6 a.m. shift to provide care to approximately 70 residents for 20 of the 31 days of the month. This indicated they had one less CNA working than the identified optimal level of staff on 20 of 31 night (10 p.m.-6 a.m.) shifts.</p> <p>During the month of June 2012, the facility had only 3 CNA's on the 10 p.m. to 6 a.m. shift to provide care to approximately 70 residents for 5 of the 11 reviewed days of the month. This indicated they had one less CNA working than the identified optimal level of staff on 5 of 11 night (10 p.m.-6 a.m.) shifts.</p> <p>There had been other "call ins" during the months noted above, but the staff had usually been replaced by someone staying over from the previous shift to help for awhile.</p> <p>During an interview with the DoN on 6/15/12 at 1:00 p.m., she indicated it was difficult to replace staff at times. She indicated when a CNA was not replaced, the staff would have to go from one unit to another to help when a resident required care from 2 CNAs</p>				

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	<p>for a task to be completed. She indicated while the CNA was gone, the licensed staff on duty would be required to answer call lights and/or provide care.</p> <p>This federal tag relates to Complaint IN00109756.</p> <p>3.1-17(a)</p>			