

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00107716.</p> <p>Survey dates: May 9, 10, 11, 14, 15, 2012 Extended Survey dates: May 16, 17, 2012</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Survey team: Carole McDaniel RN TC Martha Saull RN Terri Walters RN Dorothy Watts RN (5/9, 5/10, 5/11, 2012)</p> <p>Census Bed Type: SNF/NF: 73 Total: 73</p> <p>Census Payer Type: Medicare: 12 Medicaid: 44</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: 17 Total: 73</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/25/12 by Suzanne Williams, RN</p>				

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F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to provide personal privacy for 3 of 3 residents observed receiving instillation of medication by 2 of 2 nurses observed administering medication in the dining room. (Resident #99 Resident # 17 Resident #65)</p>	F0164	<p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS</p>	06/11/2012	

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	<p>Findings include:</p> <p>On 5/15/12 at 7:45 A.M., the morning medication pass was observed taking place in the main dining room. Residents were seated at tables opposite each other in normal social dining fashion.</p> <p>During the observation of this meal at 7:58 A.M., LPN #1 was observed to approach the table of Resident #17 indicating, "I have spray for your nose." She tilted the resident's head back and sprayed each nostril twice with Fluticasone nasal spray and provided the resident a kleenex. This occurred in full view of table mates and surrounding dining room occupants.</p> <p>During the observation of the same meal, at 8:09 A.M., Resident #65 was seated at her place at table for breakfast. LPN #3 instilled 2 sprays of Fluticasone in each nostril and then sprayed the resident's mouth with Biotene indicating "Now your mouth, (name)." This resident was also seated in full view of other residents.</p> <p>LPN #3 the went on to Resident #99, and at 8:13 A.M., instilled a drop of Timolol 0.5% in each of the resident's</p>		<p>ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION AND SPECIFIC CORRECTIVE ACTIONS ARE PREPARED AND/OR EXECUTED IN COMPLIANCE WITH STATE AND FEDERAL LAWS.</p> <p>F 164D – PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>It is the intent of this facility to provide personal privacy for all residents during administration/instillation of medications.</p> <p>1. ACTIONS TAKEN:</p> <p>A. In regards to Resident # 99 and # 65: LPN # 3 was educated about not administering/instilling medication in the dining room and providing privacy for the resident.</p> <p>B. In regards to Resident 17: LPN # 1 was educated about not administering/instilling medication in the dining room and providing privacy for the resident.</p> <p>2. RESIDENTS IDENTIFIED:</p>		

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	<p>eyes. The nurse instructed the resident to tilt her head back and pulled the lower lid of each eye down for the instillations. She then handed the resident a kleenex. The resident's table mates watched the procedure.</p> <p>On 5/15/12 at 9:30 A.M., Resident # 99 was interviewed regarding her eye drops. She indicated it was usual practice for the nurses to administer her eye drops in the dining room.</p> <p>On 5/17/12 at 10:45 A.M., the Director of nursing was informed of the observations and indicated facility policy and procedure called for treatments to be performed in private, not public, areas.</p> <p>3.1-3(o)(2)</p>		<p>A. All residents would have the potential to be affected.</p> <p>3. MEASURES TAKEN:</p> <p>A. All nursing staff were in-serviced/educated in regards to the facility policy for providing privacy during instillation of medications</p> <p>4. HOW MONITORED:</p> <p>A. The Administrator/Designee will monitor daily to ensure privacy is provided for all residents during administration/instillation of any medication. This will be monitored during meal service twice daily, any discrepancies will be corrected immediately. This will be an on-going process.</p> <p>B. The Administrator/Designee will review a summary Of these daily audits in the Monthly QA meeting and quarterly In the QA meeting with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory</p>				

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			requirements. Our date of compliance is: June 11, 2012.	

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F0165 SS=D	<p>483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL</p> <p>A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.</p> <p>Based on interview and record review, the facility failed to ensure a resident felt free to voice concerns without worrying about reprisal for 1 of 1 resident council representative interview (resident council president).</p> <p>Findings include:</p> <p>On 5/16/12 at 8:37 A.M., the resident council president was interviewed. During the interview, she was asked if a resident at the facility or the resident council group complained about care if she or other residents were without worry about someone getting back at them. She indicated at this time she was worried if she voiced a complaint. She indicated as president of the resident council, she had frequent complaints voiced at the resident council meetings.</p> <p>On 5/16/12 at 8:37 A.M., the resident council president also indicated the facility had a form to complete regarding a concern or complaint about care. She indicated it had</p>	F0165	<p>F 165D – RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL.</p> <p>It is the intent of this facility for residents to feel free to voice concerns without worrying about reprisal.</p> <p>1. ACTIONS TAKEN:</p> <p>A. In regards to Resident D:</p> <p>2. RESIDENTS IDENTIFIED:</p> <p>A. All residents would have the potential to be affected.</p> <p>3. MEASURES TAKEN:</p> <p>A. All nursing staff were in-serviced/educated in regards to a Residents Right to voice grievances without fear of reprisal from the staff; which included instruction not to go back and discuss issues or concerns reported by a resident</p>	06/11/2012

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	<p>happened to her (voicing a resident complaint) the facility came and asked more questions. She also indicated the staff she had complained about came in and asked her the question, "What did I do that was so bad?"</p> <p>On 5/16/12 at 9:00 A.M., a facility reportable incident to the state agency was reviewed. This report dated 3/29/12, indicated the resident council president had voiced a concern regarding care provided by a CNA.</p> <p>On 5/17/12 at 1:25 P.M., the Social Service Director (SSD) was made aware of the resident council president worried about reprisal when reporting a complaint. The SSD indicated at this time she had been employed at this facility approximately 3 weeks.</p> <p>3.1-7(a)(1)</p>		<p>with the residents.</p> <p>4. HOW MONITORED:</p> <p>A. The Social Services Designee will meet weekly with the Resident Council President to ensure no employee has approached her in regards to reported events.</p> <p>B. The Social Service/Designee will meet weekly with the Resident Council to discuss any concerns they may have. SSD/Designee will report to the Administrator/Designee all identified concerns for follow-up and resolution.</p> <p>C. The Administrator/Designee will review a summary of these audits in the Monthly QA meeting and quarterly in the QA meeting with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: June 11, 2012.</p>		

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview, the facility failed to provide a resident a choice, regarding altering her treatment schedule, for 1 of 3 residents who met the criteria for limited choice in a sample of 30 residents interviewed. Resident # 99</p> <p>Findings include:</p> <p>On 5/11/12 at 2:05 P.M. Resident #99 was observed to be resting in her recliner in her room. The resident described herself as" completely exhausted." She indicated she had gone to another city (approximately and hour trip) for tests and had been "wore out" after the trip back. She indicated immediately upon arrival back at the Waters in Huntingburg, "Therapy wanted me to take my exercise. I said I was exhausted, and I asked couldn't I rest a bit. But, she said no, I had to do it then, so I did, but I am just exhausted.</p>	F0242	<p>F 242D – SELF-DETERMINTION – RIGHT TO MAKE CHOICES.</p> <p>It is the intent of this facility to provide every resident a choice regarding altering the treatment schedule.</p> <p>1. ACTIONS TAKEN:</p> <p>A. In regards to Resident # 99: PTA # 1 was educated/in-serviced To resident focused services.</p> <p>2. RESIDENTS IDENTIFIED:</p> <p>A. All residents would have the potential to be affected.</p> <p>3. MEASURES TAKEN:</p> <p>A. All therapy staff were in-serviced/educated in regards to resident focused services to include</p>	06/11/2012			

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	<p>The Minimum Data Set Assessment (MDS) of 4/11/12 was reviewed on 5/11/12 at 2:30 P.M. It indicated the resident had normal cognition, memory and mood.</p> <p>On 5/11/12 at 3:05 P.M., Physical Therapy Assistant (PTA) #1 was interviewed regarding the therapy session for Resident #99. She indicated she had found the resident returning to the facility. She stated "I got her (Resident #99) right as she got off the bus. She indicated her rationale for doing the therapy directly at that time was " I needed to get her (Resident # 99) right then because (Name Occupational Therapist # 1) had to see her right after lunch since it was her last patient and she had to go." PTA #1 indicated Occupational Therapist (OT) #1, " didn't have any other patients and she had nothing else to do that would be productive. (Name OT # 1) lives further away...and can't run home and come back." The PTA indicated the therapists stayed until "all the patients get their scheduled minutes then we can go." She indicated there were no set work hours but after assignments were completed they could leave.</p> <p>On 5/11/12 at 12:45 P.M., the new Therapy Director was informed of the</p>		<p>resident choice in regards to altering the treatment schedule.</p> <p>4. HOW MONITORED:</p> <p>A. The Therapy Director will audit weekly the Residents on caseload to ensure all therapy staff are honoring any request for altering their treatment schedule. The audits will be reviewed in the weekly QA stand-up meeting.</p> <p>B. The Administrator/Designee will review a summary of these audits in the Monthly QA meeting and quarterly in the QA meeting with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: June 11, 2012.</p>		

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	<p>problem. She indicated it was not consistent with resident focused services and would work with her staff to ensure flexibility for residents with a focus on their needs.</p> <p>3.1-3(u)(1)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident had a plan of care to address bathing and showering, refusals, and alternate measures attempted, for 1 of 3 residents reviewed for ADL (activities of daily living) care. Resident #A</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 5/16/12 at 2:00 p.m. The most recent MDS (Minimum Data Set assessment) dated 4/10/12, indicated</p>	F0279	<p>F-279D COMPREHENSIVE CARE PLANS</p> <p>The facility's intent is to develop an accurate care plan to ensure to address bathing/showering, refusals, and alternate measures attempted.</p> <p>A. ACTIONS TAKEN:</p> <p>1. In regards to Residents # A: the care plan was updated to include a bathing schedule per her choice, with alternatives of either a bath, shower, and/or bed bath; staff interventions for refusals, alternate measures attempted and notification of the DON if resident</p>	06/11/2012

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	<p>the following for the resident: total cognition summary score was a 13, which indicated the resident was cognitively intact; the resident required limited assistance to walk in her room, with transfers, personal hygiene and toileting; the resident required extensive assistance with dressing and for using the bathroom, the resident required one person physical assistance.</p> <p>On 5/16/12 at 10:25 A.M., CNA (certified nursing assistant) #10 was interviewed. She indicated each resident is to have two showers a week. She indicated if a resident refuses a shower, they approach them three separate times to try to get them to take a shower.</p> <p>On 5/16/12 at 11:50 A.M., CNA #12 was interviewed. She indicated they document showers in the ADL (activities of daily living) book. She indicated they also document showers on the CNA Bath Checklist. They document on the CNA Bath Checklist if the resident refuses a shower.</p> <p>On 5/16/12 at 12:00 P.M., the DON (Director of Nursing) was interviewed. The DON indicated if a resident is refusing, she will go talk to the</p>		<p>continues to refuse.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all resident care plans completed in regard to bathing schedules and refusals. No other residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. All Licensed Staff were in-serviced on Care Plan development/revision; which include a resident preferred bathing schedule; and alternative measures attempted if a resident refuses.</p> <p>D. HOW MONITORED:</p> <p>1. The IDT will audit/review and update all care plans quarterly and prn per the MDS schedule.</p> <p>2. The CEO/Designee will monitor for compliance in weekly QA stand-up meeting; will review audits in the monthly QA meeting with the IDT; and quarterly in QA meeting with the Medical Director.</p> <p>D. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of</p>	
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	<p>resident to see if they want a different time, day, etc., for their shower.</p> <p>On 5/16/12 at 1:00 P.M., the DON provided copies of Resident #A's CNA bath checklist for April (beginning the week of 4/8/12) and May 2012. She indicated this resident was offered showers on Tuesdays and Fridays. These checklists were for the following dates with the following information: 4/10: shower given; 4/13: refused shower; 4/17: shower given; 4/24: refused shower, "(employee name) notified and she still said no"; 4/27: refused; 5/1: shower given; 5/8: refused shower: needs to be talked to about refusing: 5/15: shower.</p> <p>On 5/16/12 at 1:52 p.m., the DON was interviewed. She indicated when residents refuse a shower, she would expect that they try again by another person and/or another day and/or another time. The DON indicated for Resident #A, she was unable to locate documentation of a plan of care for any other interventions/approaches being attempted or changes attempted due to Resident #A's refusal to take her showers.</p> <p>On 5/16/12 at 3:00 P.M., the DON</p>		<p>completion is: June 11, 2012.</p>	
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	<p>indicated she was unable to find documentation of the missing shower days for the resident on 4/20/12 and 5/4/12.</p> <p>On 5/16/12 at 3:45 P.M., the DON provided a current facility policy and procedure for "Bath/Shower-Dependent". This policy was dated 1/07. The policy indicated the following: "A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident."</p> <p>3.1-35(a)</p>			

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F0309 SS=D	<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 observation, interview and record review, the facility failed to ensure a resident's complaints of increasing pain were addressed in a timely manner and/or assessed in a timely manner, for 1 of 1 resident reviewed with a change in condition. Resident # 96</p> <p>Findings include:</p> <p>On 5/16/12 at 10:35 A.M., CNA (certified nursing assistant) #10 was at the 200 hall nursing station. A woman came up to the desk from Resident #96's room. She stated to CNA #10, "(name of Resident #96), he's hurting real bad. Can you get him something? His stomach hurts real bad." CNA #10 stated LPN #1 (the resident's nurse) was on break. CNA #10 indicated LPN #1 was aware of the resident's complaint but was on break and they "didn't have any antacid to give him." The woman stated to CNA #10 "he</p>	F0309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING.</p> <p>It is the intent of this facility for all residents who complain of pain to have the pain assessed and addressed in a timely manner.</p> <p>1. ACTION TAKEN: a. In regards to Resident # 96: CNA # 10 and LPN #1 were counseled for not intervening and assessing the residents' complaint of pain and notifying the physician of the residents complaint of pain.</p> <p>2. Others Identified: a. This could potentially affect all residents with complaints of any kind.</p> <p>3. Measures Taken: a. All Nursing staff was in-serviced on Intervening when a resident</p>	06/11/2012

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	<p>(Resident #96) thinks he can't wait no longer, don't they have anything they can give him?" CNA#10 indicated to the woman, they didn't have anything and the nurse would have to call the doctor. The woman looked perplexed and stated to CNA #10 "Can't they do that?" CNA #10 then indicated she would tell the nurse. The woman then returned to Resident #96's room. At this time, LPN #1 returned to the nursing station. CNA #10 informed LPN #1 of the above. LPN #1 stated "I told (Resident 96's name) Dr. (Resident #96's physician's name) was coming in today." CNA #10 suggested repositioning the resident to LPN #1. LPN #1 stated "OK try that." LPN #1 remained at the nursing station.</p> <p>At 10:41 A.M., CNA #10 and CNA #11 were observed going into Resident #96's room.</p> <p>At 11 A.M., LPN #1 was interviewed. She indicated Resident #96's physician "usually comes in on Wednesdays for employee physicals and things like that." LPN #1 indicated she was going to "notify him if the repositioning didn't help."</p> <p>At 11:12 A.M., the DON (Director of Nursing) was made aware of the</p>		<p>complains of pain; addressing and assessment of the pain; notifying the Physician of the residents' status; to include having nurses' covering for each other when on break to prevent prolonging attention to the resident.</p> <p>4. How Monitored:</p> <p>a. DON/Designee will review the 24 hour report daily In the QA stand-up meeting to ensure all Complaints are assessed and addressed in a timely manner</p> <p>b. CEO/Designee will ensure review daily in QA stand up meeting for compliance; results will be monitored monthly in QA meeting with the IDT team.</p> <p>c. CEO/Designee will review Results of audits with the Medical Director in the quarterly in QA meeting.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: June 11,</p>	

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	<p>observation at 10:35 A.M. on 5/16/12.</p> <p>Nurses notes, dated 5/16/12 at 11:20 A.M. documented by LPN #1 indicated the following: "Resident c/o (complained of) stomach hurting, burning it (sic) 'indigestion.' Told resident that he had no Mylanta but that (physician name) would be here anytime. Then understood that resident would wait and speak problems to (physician name) so left room. Left room then immediately a visitor came to nurses station to voice that resident c/o severe adb [sic] (abdominal) pain. CNA (certified nursing assistant) voiced to see if she could reposition him to see if helped any...."</p> <p>Nurses notes, dated 5/16/12 at 11:40 A.M., documented by LPN #1 indicated the following: "Visitor distressed that this nurse had no (sic) went back to room immediately but also unaware that this nurse had just previously spoke to resident and that res (resident) voiced that he would want to speak to (physician name). Bowel sounds active x 4 quads, abd (abdomen) firm but non tender phoned (physician name) to inform new order received and noted...informed Mylanta...and MOM (milk of magnesia) given at this time</p>		2012.		

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	<p>for complaints, will monitor."</p> <p>Nurses notes, dated 5/16/12 at 11:50 A.M., documented by LPN #1 indicated the following: "agreed to get up for in w/c (wheelchair) for lunch...will monitor no results from MOM yet, no c/o indigestion."</p> <p>On 5/16/12 at 12 P.M., the resident's clinical record was reviewed. Diagnoses included, but were not limited to, the following: quadriplegia, cancer. The MDS (Minimum Data Set assessment) dated 3/13/12, indicated the following: moderately impaired cognition; received prn (as needed) pain medication; resident frequently had pain, pain did interfere with sleeping at night; pain did affect day to day activities in limiting them; described pain as severe.</p> <p>On 5/16/12 1:45 P.M., Resident #96's physician was observed entering the building.</p> <p>A physician progress note, dated 5/16/12, indicated the following: "...was sent to the emergency room on the 14th of this month because of increasing abdominal pain and fever and chills...he was evaluated and was found to have...and constipation...He has had a small bowel movement</p>			

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	<p>earlier this morning but he has not had an enema. He was getting enemas every other day, and then he decided he did not want them any longer...Abdomen is somewhat distended. Few tinkling bowel sounds. Tender in the epigastric area...CT (computerized tomography) scan done on the 14th demonstrated no obstruction..."</p> <p>On 5/17/12 at 10 A.M., the DON provided copies of the resident's care plan which addressed the following problem: "Pain r/t (related to) cancer." This care plan was dated 3/13/12. Approaches included, but were not limited to, the following: "observe for s/s (signs and symptoms) of pain, pain assessment...prn (as needed); observe effectiveness medication/intervention; report MD of uncontrolled pain."</p> <p>On 5/17/12 at 10:30 A.M. the resident's MAR (medication administration record) was reviewed. This form indicated the resident was receiving the following medications: Lortab 10-325 mg four times a day; Lortab 10-325 mg every 4 hours as needed for pain; iron 325 mg twice a day; senna laxative 8.6 mg 2 tabs at bedtime; miralax 17 grams twice a</p>						

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	<p>day and colace 100 mg twice a day.</p> <p>At this time, the DON also provided a copy of the policy and procedure for "Physician notification of resident change of condition." This policy was dated 7/1/11. The guideline was as follows: "It is the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel as warranted." Procedure included, but was not limited to, the following: "Physician notification is to include but not limited to:...abnormal complaints of pain..."</p> <p>On 5/17/12 at 1:P.M., LPN #8 was interviewed. She indicated the nurses typically document bowel sounds assessment in the nurses notes. Resident returned to this facility this morning from the emergency room. LPN # 8 indicated the report she was given on this resident from the hospital staff indicated the resident had a BM while in the ER (emergency room). She indicated she was to start Relistor 12 mg subcutaneous x 3 days. The res was also ordered to receive "dulcolax po (by mouth) bid (twice a day) till BM. "</p> <p>Documentation was lacking of LPN</p>			

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	<p>#1 reassessing and/or addressing the resident in a timely manner after being made aware by CNA #10 of the resident's pain status.</p> <p>3.1-37(a)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to ensure a resident received the designated number of showers for 1 of 3 residents reviewed for ADL (activities of daily living) care. Resident #A</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 5/16/12 at 2:00 P.M. The most recent MDS (minimum data set assessment) dated 4/10/12 indicated the following for the resident: total cognition summary score was a 13, which indicated the resident was cognitively intact; the resident requited limited assistance to walk in her room, with transfers, personal hygiene and toileting; the resident required extensive assistance with dressing and for using the bathing, the resident required 1 person physical assistance.</p> <p>On 5/16/12 at 10:25 A.M., CNA (certified nursing assistant) #10 was interviewed. She indicated each</p>	F0312	<p>F-312D ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>The facility's intent is to ensure all residents receive the designated number of showers/baths.</p> <p>A. ACTIONS TAKEN:</p> <p>1. In regards to Residents # A: a meeting was held with the resident to determine a bathing schedule per her choice, with alternatives of either a bath, shower, and/or bed bath.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all resident completed in regard to bathing schedules and refusals. No other residents were identified.</p> <p>C. MEASURES TAKEN:</p> <p>1. All Licensed Staff were in-serviced on assisting/encouraging residents with preferred bathing schedule; and alternative choices.</p> <p>D. HOW MONITORED:</p> <p>1. The IDT will audit/review and update all care plans and CNA</p>	06/11/2012			

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	<p>resident is to have 2 showers a week. She indicated if a resident refuses a shower, they approach them 3 separate times to try to get them to take a shower.</p> <p>On 5/16/12 at 11:50 A.M., CNA #12 was interviewed. She indicated they document showers in the ADL (activities of daily living) book. She indicated they also document showers on the CNA Bath checklist. They document on the CNA Bath checklist if the resident refuses a shower. When this form (the CNA Bath checklist) is completed, the CNAs give it to the nurse so they can sign it . CNA #12 indicated they don't doc (document) on the ADL book if a resident refuses a shower. CNA #12 indicated the DON keeps sheets (the CNA Bath checklist).</p> <p>On 5/16/12 at 12 P.M., the DON (Director of nursing) was interviewed. The DON indicated if a resident is refusing, she will go talk to the resident to see if they want a different time, day, etc. for their shower.</p> <p>On 5/16/12 at 1:00 P.M.,the DON provided copies of resident #A's CNA bath checklist for April (beginning the week of 4/8/12) and May 2012. She indicated this resident was offered</p>		<p>pocket worksheets for resident preferred bathing schedule quarterly and prn per the MDS schedule.</p> <p>2. The CEO/Designee will monitor for compliance in weekly QA stand-up meeting; will review audits in the monthly QA meeting with the IDT; and quarterly in QA meeting with the Medical Director.</p> <p>D. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: June 11, 2012.</p>				

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	<p>showers on Tuesdays and Fridays. These checklists were for the following dates with the following info: 4/10: shower given; 4/13: refused shower; 4/17: shower given; 4/24: refused shower," (employee name) notified and she still said no"; 4/27: refused; 5/1 : shower given; 5/8: refused shower: needs to be talked to about refusing: 5/15: shower.</p> <p>On 5/16/12 at 1:52 p.m. the DON was interviewed. She indicated when residents refuse a shower, she would expect that they are tried again by another person and/or another day and/or another time.</p> <p>On 5/16/12 at 3:00 P.M., the DON indicated she was unable to find documentation of the missing shower days for the resident on 4/20/12 and 5/4/12.</p> <p>On 5/16/12 at 3:45 P.M., the DON provided a current facility policy and procedure for "Bath/Shower-Dependent". This policy was dated 1/07. The policy indicated the following: "A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident."</p> <p>3.1-38(a)(3)</p>			

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F0323 SS=K	<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>A. Based on observation, interview, and record review, the facility failed to ensure water temperatures in resident care areas were at a safe range for 4 of 6 randomly checked bathrooms in use by 4 residents capable of independent sink use on 2 of 3 units. This had the potential to affect 30 residents, capable of independently utilizing sinks, on the 100 and 300 units from a total census of 73. Residents #91, #30, # 86, #97</p> <p>The Immediate Jeopardy began on 5/10/12, at 3:10 P.M., when the facility failed to ensure water temperatures in resident care areas were in a safe range. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 5/10/12 at 6:05 P.M. The Immediate Jeopardy was removed on 5/11/12 at 5:15 P.M., but the facility remained out of compliance at a level of a pattern, no actual harm with potential for more than minimal harm that was not Immediate Jeopardy.</p>	F0323	<p>F-323K FREE OF ACCIDENTS/HAZARDS/SUPERVISION/DEVICES</p> <p>The facility's intent is for water temperatures in resident care areas were at a safe range.</p> <p>WE RESPECTFULLY REQUEST AND IDR FOR TAG F323 IN REGARDS TO WATER TEMPERATURES FOR DECREASE IN SCOPE AND SEVERITY.</p> <p>The intent of the facility is to ensure side rail gaps between the headboard and the top of the side rail and/or enabler are measured and assessed and are safe.</p> <p>A. ACTIONS TAKEN:</p> <p>1. In regards to Resident #91, #30, #86, and #97: The water temperature on the 300 Unit was adjusted to an appropriate temperature. The water heater on the 100 Unit had a faulty valve and was replaced; during this process the bathroom doors on this unit were locked so no resident had access to the water until the repair was completed. The Maintenance Director was re-educated and</p>	06/11/2012

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	<p>B. Based on observation, interview and record review, the facility failed to ensure side rail gaps between the headboard and the top of the side rail and/or enabler were measured and assessed, and were safe, for 1 of 1 specialty bed and 1 of 1 enabler in use on a bed for 2 residents' beds randomly observed. Resident #79, Resident #57</p> <p>Findings include:</p> <p>A 1. On 5/10/12 at 3:10 P.M., the Administrator was made aware the hot water at the sink in the bathroom used by Resident #97 felt extremely hot when tested by placing your hand under the running hot water. The Administrator placed his hand under the running hot water. He indicated the water temperature was hot and close to the highest range of safe temperatures. The Administrator then at 3:15 P.M., went to the dietary department and brought back a dial thermometer to check the hot water temperatures. The thermometer dial went slowly to the 90 degree Fahrenheit (F) range but the water continued to feel extremely hot when checked by holding a hand under the running water. The Administrator agreed the dial thermometer was not</p>		<p>counseled in regards to monitoring water temperatures and the appropriate range for resident safety.</p> <p>2. In regards to Resident #79: the specialty bed and mattress were replaced by a bed appropriately assessed for mattress placement and the safety of the side rails.</p> <p>3. In regards to Resident #57: the enabler bar was adjusted to ensure resident safety and a side rail assessment was completed and documented.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all resident care areas was completed after the repairs were made. No others identified.</p> <p>2. 100% audit of all resident beds, mattresses, and side rails was completed to ensure resident safety. All identified with issues/concerns were corrected.</p> <p>C. MEASURES TAKEN:</p> <p>1. All Maintenance Staff were in-serviced on appropriate water temperatures for resident safety and daily monitoring of the water temperatures; an appropriate Water Temperature Log has been initiated with the parameters for water</p>				

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	<p>working correctly.</p> <p>On 5/10/12 at 3:24 P.M., the Administrator returned with a digital thermometer and rechecked the hot water of the bathroom sink used by Resident #97. The temperature registered 128 degrees Fahrenheit. The Administrator indicated the facility's water temperatures would have to be adjusted.</p> <p>On 5/14/12 at 8:45 A.M., Resident # 97's clinical record was reviewed. Her current Minimum Data Set Assessment (MDS) dated 4/9/12, indicated diagnoses which included, but were not limited to, anxiety and depression. An occupational therapy assessment for visit date of 4/13/12, included, "...continues to require stand by assistance... due to...concerns with safety/judgement during ADL (activities of daily living)...."</p> <p>On 5/10/12 at 3:25 P.M., the Administrator checked the bathroom sink hot water of room 132 which was 128 degrees F. On 5/10/12 at 3:26 P.M., the Administrator indicated at this time he wanted the facility's water temperatures to be 120 degrees F or less. Then, at 3:27 P.M., the hot water at the sink in the bathroom</p>		<p>temperatures identified on the form.</p> <p>2. All Nursing Staff and Maintenance Staff were in-serviced on proper completion of the Side Rail Assessment Tool, proper measurement of side rails/enablers for safety, and proper placement of the mattress for resident safety. The side rail assessment will be completed quarterly with the MDS schedule.</p> <p>D. HOW MONITORED:</p> <p>1. The Maintenance Director /Designee will monitor for compliance of waters temperatures with of six rooms on each unit completed daily and reviewed with the Administrator/Designee in daily QA stand-up meeting. Any room with a temperature above 120 degrees will be immediately adjusted and reported to the Administrator.</p> <p>2. The Maintenance Director /Designee will reassess/review all beds, mattresses, and side rails quarterly to ensure resident safety. All assessments/audits will be reviewed by the Administrator/Designee in the weekly QA meeting as completed.</p> <p>3. The Adm. /Designee will review results of audits at the monthly QA meeting with the IDT;</p>		

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	<p>used by Resident #91 was checked and was 122 degrees Fahrenheit.</p> <p>On 5/14/12 at 8:45 A.M., Resident's #91's clinical record was reviewed. Her current Minimum Data Set Assessment (MDS) dated 2/9/12, indicated diagnoses which included, but were not limited to, hypertension and depression. The MDS cognition score was an 8 (8-12 moderate impairment). This MDS indicated Resident #91 was independent in transfers and toilet use.</p> <p>The clinical record included a plan of care dated 2/8/12, which addressed the following problem: Stroke with hemiparesis. Approaches included, but were not limited to, the following: severely impaired cognition with name on door to find room; and remind resident of what she is doing when she forgets.</p> <p>On 5/10/12 at 3:28 P.M., the Administrator checked the temperature of the hot water in the bathroom shared by Resident #30 and Resident #86. The temperature registered 122.8 degrees F. Earlier in an interview on 5/10/12 at 11:36 A.M., Resident #30 indicated, "... my hands are numb; I have carpal tunnel...."</p>		<p>and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: June 11, 2012.</p>				

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	<p>On 5/14/12 at 8:45 A.M., Resident #30's current Minimum Data Set Assessment (MDS) dated 4/19/12, was reviewed. His total cognition score was 14 (cognition intact). This MDS indicated a functional range of motion (ROM) of the upper extremities as impairment of both sides. This MDS indicated independence in toileting, bed mobility and transfers.</p> <p>On 5/14/12 at 8:45 A.M., the clinical record of Resident #86 was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease.</p> <p>A care plan, dated 3/12, addressed the following problem: "My cognition is moderately impaired." Approaches included, but were not limited to, the following: "When speaking to me, speak slow using short direct questions or statements; give me verbal cues/reminders when I appear to not be able to remember."</p> <p>On 5/10/12 at 3:45 P.M., the Administrator provided the facility's water temperature log for May 2012. The log indicated the following locations and water temperatures:</p> <p>5/1/12: Unit 1 shower room --- 126 F</p>						

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	<p>Resident Room 310 --- 123F</p> <p>5/3/12: Park Place Shower Room--- 123 F.</p> <p>5/4/12: Resident Room 320 was 122 F</p> <p>5/7/12: Park Place Unit Room 305 -- --123 F</p> <p>5/8/12: Park Place Resident Room 308 --- 122 F</p> <p>5/9/12: Unit 1 Shower Room ---- 123 F Resident Room 315 --- 122 F</p> <p>5/10/12: Park Place Unit Restroom--- 123 F</p> <p>On 5/10/12 at 3:55 P.M., the Administrator was interviewed regarding the elevated water temperatures logged on the May 2012 facility water temperature log. The Administrator indicated the maintenance staff member had been told by the facility's Property Director (corporate staff) that water temperatures around 123 degrees F or 125 degrees F were okay.</p> <p>On 5/10/12 at 6:05 P.M., during interview, the Administrator indicated</p>			

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	<p>a cracked mixing valve on the boiler was the causative factor affecting elevated water temperatures.</p> <p>On 5/11/12 at 10:35 A.M., during interview LPN #1, identified 15 residents in the unit 100 population who were capable of independently capable of utilizing bathroom sinks.</p> <p>On 5/11/12 at 10:45 A.M., during interview, QMA #1, identified 15 residents in the 300 unit who were capable of independently utilizing bathroom sinks.</p> <p>On 5/14/12 at 10:15 A.M., the DON (Director of Nursing) was interviewed. She provided inservices provided to the CNAs (certified nursing assistants) on 1/10/12. The inservice included, but was not limited to, the following showering procedures with the following direction: "...turn on water and have resident check water temperature. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature." Documentation was lacking to indicate staff were informed of safe water temperature ranges for residents. The DON indicated staff were provided requisitions for maintenance to be submitted when</p>			

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	<p>there were problems requiring maintenance intervention. Documentation was lacking to indicate staff (using water for their handwashing and resident care) were alert to and/or perceived water temperatures were too hot at times and reported it to maintenance.</p> <p>The State Operational Manuel (SOM) was reviewed on 5/14/12 at 11:22 A.M., regarding water temperatures. This interpretative guideline indicated the following: For a water temperature of 127 degrees Fahrenheit (F) the time required for a third degree burn to occur would be 1 minute. With a water temperature of 120 degrees F the time required for a third degree burn would be 5 minutes.</p> <p>The Immediate Jeopardy that began on 5/10/12 at 3:10 P.M., was removed on 5/11/12 at 5:15 P.M., when the facility implemented a system to ensure safe water temperatures by replacing a water valve and continued monitoring of water temperatures. Facility staff were also inserviced on the safe range of water temperatures and immediate notification of administrative and maintenance staff if unsafe water temperatures occur. The noncompliance remained at the</p>						

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	<p>lower scope of severity level of a pattern of no actual harm with the potential for more than minimal harm which was not immediate jeopardy, because monitoring of water temperatures was still being done to ensure a consistent safe range.</p> <p>B 1. On 5/9/12 at 12:45 P.M., Resident # 79's bed was observed. Both upper side rails were in the up position. When looking at the bed, from the foot of the bed, only the right lower side rail was up. Both the upper and lower side rails were perpendicular to the foot board and the head boards on the bed. The resident was not in the bed at the time. The HOB (head of bed) was in the down position and flat. The gap area between the edge of the top headboard and the top of the siderail on the side of the bed measured 7 inches with a standard ruler. The gap area between the edge of the foot board and the edge of the lower side rail was 11 inches, also measured with a standard ruler.</p> <p>On 5/9/12 at 2:20 P.M., the Administrator was interviewed and made aware of the gap measurements. He indicated the facility only had one of these types of beds. He indicated this was a speciality type bed. At 2:35 P.M. the</p>			

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	<p>lower siderail was observed to be lowered.</p> <p>On 5/9/12 at 2:30 P.M., Resident #79's clinical record was reviewed. Diagnoses included but were not limited to, the following: paralysis of bilateral lower extremities. Documentation was lacking of a side rail assessment.</p> <p>On 5 /9/12 at 3 P.M., the DON (Director of Nursing) was interviewed. She indicated the resident had been using this current speciality bed since August of 2011 and had not had any problems with it regarding the side rails.</p> <p>On 5/10/12 at 10 A.M. the clinical record was again reviewed. At this time a side rail assessment screen was dated 5/9/12. This form indicated the following: "The side rail has been measured and the gaps between the rail(s) themselves and the gaps between the side-rail and the mattress are conducive to resident safety as based on this individual resident." This comment was checked "Yes." The following comment was also checked "yes": "Head of the bed was elevated to conduct a visual review to assess that the mattress and the side rail did not</p>			

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	<p>have a gap large enough to impose a resident safety issue/concern based on this individual resident."</p> <p>B.2. On 5/11/12 at 11 A.M. the Administrator was made aware of the gap measurement between the headboard and the "enabler" bolted to the each side of the bed, near the head of the bed. This bed was in Resident #57's room. The "enablers" are observed to be in an inverted "U" shape and are bolted to each side of the bed, near the head of the bed. When measured with a standard ruler, the gap between the headboard and the edge of the enabler closest to the headboard, measured 9 inches. The head of the bed was flat when this measurement was obtained. The resident was not in the bed at the time the measurement was obtained.</p> <p>On 5/11/12 at 11:30 A.M. the clinical record of Resident #57 was reviewed. A Side Rail Assessment Screen, was dated 4/17/12. This form was partially completed; documentation was incomplete: The "Side-Rail Safety" portion has the following choices: "side rail has been measured and the gaps between the rails themselves and the mattress are conducive to resident safety as based on this individual resident" and/or</p>			

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	<p>"head of the bed was elevated to conduct a visual review to assess the mattress and the siderail did not have a gap large enough to impose a safety issue/concern based on this resident" and /or "visual review has been performed to assess the mattress does not shift/slide allowing for an increased gap between the bed and the side rail." This review resulted: "No safety issues/concerns." This entire area was blank in addition to the lower section of the form, which indicated the following: "Based upon the above assessment findings, the resident will not utilize side rails at this time" or "Based upon the above assessment findings, the side-rail(s) is not a restraint and will be utilized to enable the resident to attain or maintain his/her highest practicable level and/or based upon the above assessment findings, the resident will utilize side rails and they will be considered a restraint."</p> <p>On 5/11/12 at 4:11 P.M., the Maintenance Man was interviewed. He indicated he is taking all the side rails off of all the beds. He is now working in the 200 hall.</p> <p>On 5/16/12 at 3:15 P.M., the bilateral enablers remained on the resident's</p>			

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	<p>bed. Documentation remained incomplete for assessment of the enablers on the clinical record.</p> <p>On 5/16/12 at 9:55 A.M., the DON provided a current copy of the facility policy and procedure for "Side Rails." This policy was dated 7/1/11. The guideline included, but was not limited to, the following: "It is the intent of this facility to provide the licensed nurse with a process for the evaluation, documentation needs...relating to side rails evaluation and utilization..."</p> <p>On 5/17/12 at 4:15 P.M. the Facility Consultant was interviewed. She indicated the facility views enablers as side rails and the guidelines apply for both.</p> <p>The Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The</p>			

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	<p>"Hospital Bed Safety WorkGroup (HBSW)" and the "International Electrotechnical Commission (IEC)" along with the FDA recommend the space be less than 4 3/4 inches.</p> <p>The FDA recommends the space under the rail - at the ends of the rail be small enough to prevent neck entrapment. The HBSW and the IEC along with the FDA recommend this space be less that 2 3/8 inches and greater than a 60 degree angle.</p> <p>3.1-19(a) 3.1-19(r)(5) 3.1-45(a)(1)</p>			

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F0353 SS=E	<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 observation, interview and record review, the facility failed to ensure adequate staffing for prompt call light response for 13 of 30 residents interviewed confidentially. Residents V, Q, L, U, M, G, B</p> <p>Findings include:</p> <p>Interviews were conducted with cognitively screened residents on 5/09, 10, 2012 day shifts. During interview of 30 residents regarding sufficient staffing there were 13 residents who indicated there were</p>	F0353	<p>F-353E SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLANS It is the facility's intent to ensure adequate staffing for prompt call light response. A. ACTIONS TAKEN: 1. In regards to Residents # V, Q, L, U, M, G, B: The Park Place Unit rooms 301-311 will be closed, placing all residents in these rooms on Unit 1 and Unit 2. Residents/Families will be given prior notice and transfer papers signed. B. OTHERS IDENTIFIED: 1. All residents would have the potential to be affected. C. MEASURES TAKEN: 1. All Nursing Staff was in-serviced on answering call</p>	06/11/2012			

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	<p>not adequate numbers of staff to respond to call lights in a reasonable length of time. Some comments related by seven of those residents included:</p> <p>1. a. Resident V "Sometimes have waited an hour and a half...usually I call to go to the bathroom. I told them and they kind of pushed it off. I was told I went too much so I timed it and I don't think twice all day is unreasonable."</p> <p>b. Resident Q "If I put my call light on they do not come promptly...have to wait at least a half hour...it's that way all the time...I need help to go to the bathroom so that makes it hard." On 5/09/12 from 11:55 A.M. until 12:10 P.M. this resident's call light was observed to be on. After it was answered, the resident remarked, "That was much better than usual. They are really on it today."</p> <p>c. Resident L "It takes awhile for them to answer my call light, 20 to 25 minutes." "Thirty minutes or longer if they are busy with showers." "It gets on your nerves."</p> <p>2. A confidential interview with Resident U, indicated a problem with prompt answering of her call light.</p>		<p>lights promptly and assisting residents with their needs. D. HOW MONITORED: 1. The Staffing Coordinator will schedule adequate staff on each unit. The DON/Designee will monitor for compliance by auditing the staffing sheet daily in the daily QA stand-up meeting. 2. The Administrator /Designee will review all audits as completed. 3. The Adm. /Designee will review all audits daily to ensure compliance; will review weekly in QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: June 11, 2012.</p>		

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	<p>She indicated during interview it sometimes takes a hour or longer for her call light to be answered. She indicated she thought it should only take 15 minutes. She indicated a delay in answering her call light did not occur on any specific shift, but on all shifts. She indicated she doesn't think the facility has enough staff.</p> <p>3. A confidential interview with Resident M, indicated a problem with not enough staff to care for residents promptly. She indicated on her unit, there was a large number of residents who can't do a lot of their own care. She indicated her unit had only 1 CNA on each shift. She indicated on her unit, there was one resident who needed the assistance of 2 staff members to toilet. She indicated that takes 2 staff members away from the other residents on her unit who also need care. She also indicated her unit frequently had new staff that "don't know what they are doing."</p> <p>4. On 5/17/12, during interview with the LPN Staffing Schedule Manager, she indicated the facility master plan for scheduling included staffing hours required based primarily on census. She indicated if the work load or resident care needs dramatically changed, the facility could submit a</p>						

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	<p>request for approval of an increase in staffing. She indicated there had not been staffing changes in the past few months. On day shift on the Park Place unit, 1 nurse and one CNA were scheduled. On the night shift on Unit 2, 1 nurse and 1 CNA were scheduled. On the night shift from 11:00 P.M. to 3:00 A.M., there was 1 CNA alone on Park Place who was to call the unit 2 nurse if assistance was required, and from 3:00 AM until 7:00 A.M. there was one nurse and 1 CNA scheduled.</p> <p>5. On 5/14/12 at 1:40 P.M., a confidential family member of Resident G was interviewed. This family member stated "they need more workers here. It's not right when they have two workers in the hall helping to put someone back to bed and then there is no one else to help other residents. I have gone to the front office and told them. I don't want to get the girls in trouble but they really need more help here."</p> <p>6. On 5/10/12 at 2:20 P.M. confidential interview was conducted with Resident B. She stated regarding the facility and staffing, "they could use more help; people keep quitting."</p>						

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	<p>7. On 5/17/12 at 2:20 P.M. the resident council meeting minutes were reviewed. The meeting minutes dated 3/2/12, indicated the following as new concerns: "Several residents from all units were c/o (complaining of) waiting for very long periods to go to the bathroom."</p> <p>3.1-17(a)</p>			

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F0431 SS=A	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to provide security from unauthorized access to the medication room for 2 of 4 units in the</p>	F0431	F 431A – DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	06/11/2012

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	<p>facility (Unit 1, Unit 2), during one random observation.</p> <p>Findings include:</p> <p>On 5/15/12 at 9:30 A.M., the Human Resource Coordinator(HRC) was observed in the medication room with LPN #1. The LPN left the medication room, saying "Close the door when you leave." LPN # 1 then left the area. The HRC was observed to continue to stay alone and unsupervised in the medication room for another 4.5 minutes.</p> <p>On 5/17/12 at 10:00 A.M., the HRC was interviewed regarding the observation. She indicated she was aware she was not to be in the drug room alone but had not heard what the nurse said and did not realize the nurse had left until she was done and turned around to leave. She indicated there were forms she needed which were stored in the drug room.</p> <p>3.1-25(m)</p>		<p>It is the intent of this facility to provide security from unauthorized access to the medication room.</p> <p>1. ACTIONS TAKEN:</p> <p>A. In regards to the Human Resource Coordinator all forms required by Her were removed from the medication room.</p> <p>B. In regards to LPN #1: she was educated to not leave anyone unattended in the medication room.</p> <p>2. RESIDENTS IDENTIFIED:</p> <p>A. No residents were affected.</p> <p>3. MEASURES TAKEN:</p> <p>A. All nursing staff were in-serviced/educated in regards to the facility policy for providing security from unauthorized access to the medication room. No person is to be left unattended in the medication for any reason.</p> <p>4. HOW MONITORED:</p> <p>A. The IDT/QA Team will monitor daily during</p>	

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			<p>rounds to ensure security is provided for the medication room at all times. The door will remain locked unless a Nurse is present. This will be an on-going process and will be included on the QA rounds tools.</p> <p>B. The Administrator/Designee will review/audit all Rounds tools daily in the daily QA stand-up meeting for compliance.</p> <p>C. The Administrator/Designee will review a summary of these audits in the Monthly QA meeting and quarterly In the QA meeting with the Medical Director.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: June 11, 2012.</p>		