

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/28/2012
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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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F0000	<p>This visit was for the Investigation of Complaint IN00109740, and Complaint IN00110043, and Complaint IN00110366.</p> <p>Complaint IN00109740- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00110366- Substantiated. Deficiencies related to the allegations are cited at F253 and F469.</p> <p>Complaint IN00110043- Substantiated. Deficiencies related to the allegations are cited at F514.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey Date: 6/26/2012- 6/28/2012.</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN (6/26/2012 and 6/27/2012)</p> <p>Census Bed Type: SNF/NF: 35 Total: 35</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>Census Payor Type: Medicare: 1 Medicaid: 31 Other: 3 Total: 35</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/6/12 Cathy Emswiller RN</p>			

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interview the facility failed to ensure a resident was kept free from physical restraint for 1 of 1 residents reviewed for restraints in a total sample of 3. Resident #B.</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 6/27/2012 at 10:20 a.m. Diagnoses included but were not limited to; stroke, aphasia (difficulty speaking,) depression, contact dermatitis, hyponatremia, paranoid schizophrenia.</p> <p>During review of a facility incident self-reported to the state on 6/14/2012 at 2:08 p.m. indicated, "1. Brief description of incident: On 6/13/2012, CNA #5, came to Administrator and stated that CNA #4, had called him on the phone last evening, 6/12/2012 and reported that on 6/9/2012, resident #B had been restrained to his chair with a gait belt... 2. Type of Injury: None. 3. Immediate action taken: Staff were suspended pending investigation."</p> <p>Interview with LPN # 1 on 6/27/2012 at</p>	F0221	<p>(e) <b>Date of compliance:</b> 7/28/12</p> <p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</b></p> <p><b>F- 221 Physical Restraints</b></p> <p>(a) <b>What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>Resident B suffered no harm from use of improper restraint. Resident assessed and continued to have physically aggressive behaviors. MD came in to evaluate resident, and resident transferred to an inpatient psychiatric facility for medication assessment and adjustment of meds in a direct observational environment per MD order. He was transferred out of facility on 7/17/12.</p> <p>All residents at Meridian facility were</p>	07/28/2012			

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	<p>4:05 p.m. indicated she was the one who actually applied the gait belt. It went around his middle, through the arm rests and secured at the back of the wheelchair. She thought of the application of the gait belt as a way to try and keep him safe because she did this after the second time he had fallen that day. She thought they could use the gait belt as a restraint temporarily until they got a doctor's order for it, just to keep him safe in the meantime. They never did end up getting an MD order. She now knows after the educational inservice provided by the facility that restraints are not to be used ever, and gait belts cannot be used as restraints. The resident was able to remove the belt himself after a couple of minutes.</p> <p>Record review indicated there was no physician's order for a restraint, no restraint assessments and no care plan for a restraint.</p> <p>3.1-26(o)</p>		<p>assessed for use of restraints. Only one resident has a hand mitt to prevent him from hitting himself. Restraint assessment and documentation is in place and care planned per policy. Care plan was updated to reflect this review, and MDS reflects the use of hand mitt for the affected resident.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>Facility rounds were completed to ensure that any potential restraint was identified and assessed per Interdisciplinary Team.</p> <p>An audit of residents to identify residents with any type of potential restraint was completed to ensure that those residents have appropriate documentation in place. Any identified issues were immediately corrected.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>Facility nursing staff was educated regarding Standard and Guidelines</p>		

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			<p>for 'Restraints', 'Use of Restraints', and 'Unmanageable Residents'. These standards include pertinent guidelines for direct care staff, and includes information such as reason for restraint use. Education also focuses on restraint alternatives, doctors orders, regular assessment and release, observation guidelines, care planning, and all steps/information necessary for staff to utilize when needed. The policy entitled 'Unmanageable Residents' gives specific, immediate steps necessary should a situation arise when a resident has become unmanageable and threatens the safety of other residents, staff or him/herself. Emphasis was placed on mandatory steps such as MD/Director of Nursing notification and contact/consent from POA. Should a situation require even more immediate attention, local law enforcement could intervene to ensure safety.</p> <p>Nursing management staff will monitor/audit use of any potential restraints during daily nursing rounds to ensure that appropriate actions have been taken, including assessment and use of the least restrictive device, and that all policies are strictly adhered to. Nursing management will ensure that any restraints are only in place for the residents for whom it has been deemed appropriate.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the</b></p>		

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			<p><b>practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>An audit will be completed weekly by the Director of Nursing Services/designee to identify any residents with devices that restrict resident mobility and could be considered a restraint. Processes will be monitored to ensure facility compliance is maintained per policy.</p> <p>Findings will be reported at monthly Risk Management/QA meeting until such time as substantial compliance has been met.</p> <p>(e) <b>Date of compliance: 7/28/12</b></p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview the facility failed to ensure allegations of</p>	F0225	Preparation and/or execution of this plan does not constitute admission or agreement by the	07/28/2012			

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	<p>abuse were reported timely to the Administrator and documentation of criminal background checks were maintained. 1 of 9 employees reviewed for criminal background checks. RN #2.</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 6/27/2012 at 10:20 a.m. Diagnoses included but were not limited to; stroke, aphasia (difficulty speaking,) depression, contact dermatitis, hyponatremia, paranoid schizophrenia.</p> <p>During review of a facility incident self-reported to the state on 6/14/2012 at 2:08 p.m. indicated, " Alleged perpetrators: PT #7, LPN #1, CNA #4, RN #2, CNA #6. 1. Brief description of incident: On 6/13/2012, CNA #5, came to Administrator and stated that CNA #4, had called him on the phone last evening, 6/12/2012 and reported that on 6/9/2012, resident #B had been restrained to his chair with a gait belt... 2. Type of Injury: None. 3. Immediate action taken: Staff were suspended pending investigation."</p> <p>Interview with the Administrator on 6/27/2012 at 11:40 a.m. indicated RN #2's start date was 5/14/2005 and the documentation of her background check went missing. RN #2 has been in so many</p>		<p><b>provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-225 Investigate/Report Allegations/Individuals (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>Resident B was assessed and continued to have physically aggressive behaviors and was directly monitored on a 1:1 basis until MD evaluated resident at facility. Resident was then transferred to an inpatient psychiatric facility for medication assessment and adjustment of meds in a direct observational environment per MD order. He was transferred out of facility on 7/17/12. Reporting requirements review immediately with facility staff. . Background check for RN #2 was completed 6/27/12 and results returned and where placed in her employee file. .</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Business Office Manager/designee conducted audit of all current employee files to ensure that no other files were missing background checks and that files</p>				

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	<p>different positions over the years that the background check probably got lost. The Administrator indicated she would provide the new criminal background report when it came back, it usually takes 24 hours after the request is submitted.</p> <p>Interview and record review of an employee file with the Administrator on 6/28/2012 at 8:00 a.m. indicated RN #2's background check was completed on 6/27/2012 and it came back clear.</p> <p>A list provided by the Administrator on 6/28/2012 at 11:25 a.m. indicated the following employees were suspended on 6/13/2012; LPN #1, CNA #6. The following employees were suspended on 6/14/2012; CNA #4, RN #2.</p> <p>The Indiana Code (IC) 16-28-13-4 includes the following; "A person who operates or administers a health care facility shall apply within three business days from the date a person is employed as a nurse aide or other licensed employee...and a limited criminal history from the Indiana central repository for criminal history information..."</p> <p>3.1-14(a) 3.1-28(b)(1)(A)</p>		<p>were complete. No additional background checks were found to be incomplete. Resident interviews were conducted using the QIS Interview Process to determine if any allegations of abuse had not been reported according to facility, state, and federal requirements in a timely manner. Residents who are cognitively impaired had calls made to their responsibility party to identify if any allegation(s) of abuse. In addition, all cognitively intact residents were asked if they have ever witnessed abuse or neglect of <u>any</u> resident. No additional allegations were reported. <b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Facility Management and Direct Care Staff were re-educated on the facility policies for identification of potential Abuse/Neglect and immediate reporting of all potential Abuse/Neglect situations to the Administrator/designee. The Social Service Director/designee will meet weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator/ Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines weekly meetings are no longer necessary. In addition,</p>		

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			<p>"resident rights and responsibilities" was reviewed and discussed at next two subsequent resident Council Meetings. The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in a timely manner. Prior to hire all potential employees will have background check completed. The facility's Administrator /designee will audit any newly hired employee file for completion of background screens to determine that candidate is free from any disqualifying concerns in the screen. A copy of the background check will be filed in a confidential personnel file. (d) <b>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Administrator or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly. Administrator /designee will audit any newly hired employee file 2 X's month for completion of background screens to determine that candidate is free from any</p>	

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			disqualifying concerns in the screen. This will be an ongoing process for the next 3 months. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until compliance has been achieved and then quarterly monitoring by the RDCO is recommended to maintain compliance when completing system reviews which includes abuse/restraints and employee files. (e) <b>Date of compliance: 7/28/12</b>		

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to ensure policy was followed in reporting an allegation of abuse for 1 of 3 residents reviewed for abuse. Resident #B.</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 6/27/2012 at 10:20 a.m. Diagnoses included but were not limited to; stroke, aphasia (difficulty speaking,) depression, contact dermatitis, hyponatremia, paranoid schizophrenia.</p> <p>During review of a facility incident self-reported to the state on 6/14/2012 at 2:08 p.m. indicated, " Alleged perpetrators: PT #7, LPN #1, CNA #4, RN #2, CNA #6. 1. Brief description of incident: On 6/13/2012, CNA #5, came to Administrator and stated that CNA #4, had called him on the phone last evening, 6/12/2012 and reported that on 6/9/2012, resident #B had been restrained to his chair with a gait belt... 2. Type of Injury: None. 3. Immediate action taken: Staff</p>	F0226	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</b></p> <p><b>F-226 Implement/Abuse/Neglect Policies</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> Resident B was assessed and continued to have physically aggressive behaviors and was directly monitored on a 1:1 basis until MD evaluated resident at facility. Resident was then transferred to an inpatient psychiatric facility for medication assessment and adjustment of meds in a direct observational environment per MD order. He was transferred out of facility on 7/17/12. Reporting requirements review immediately with facility staff. . Background check for RN #2 was completed 6/27/12 and results returned and where placed in her employee filed.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>Business Office Manager/designee</p>	07/28/2012			

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	<p>were suspended pending investigation."</p> <p>Interview with LPN # 1 on 6/27/2012 at 4:05 p.m. indicated she was the one who actually applied the gait belt. It went around his middle, through the arm rests and secured at the back of the wheelchair. She thought of the application of the gait belt as a way to try and keep him safe because she did this after the second time he had fallen that day. She thought they could use the gait belt as a restraint temporarily until they got a doctor's order for it, just to keep him safe in the meantime. They never did end up getting an MD order. She now knows after the educational inservice provided by the facility that restraints are not to be used ever, and gait belts cannot be used as restraints. The resident was able to remove the belt himself after a couple of minutes.</p> <p>Review of a policy titled, 'reporting resident abuse' on 6/27/2012 at 1 p.m. indicated, "4. Any employee who has knowledge or reason to believe that a resident has been a victim of abuse is under a duty to immediately report such incident or suspicion to the Nurse Supervisor."</p> <p>2. Interview with the Administrator on 6/27/2012 at 11:40 a.m. indicated RN #2's</p>		<p>conducted audit of all current employee files to ensure that no other files were missing background checks and that files were complete. No additional background checks were found to be incomplete. Resident interviews were conducted using the QIS Interview Process to determine if any allegations of abuse had not been reported according to facility, state, and federal requirements in a timely manner. Residents who are cognitively impaired had calls made to their responsibility party to identify if any allegation(s) of abuse. In addition, all cognitively intact residents were asked if they have ever witnessed abuse or neglect of <u>any</u> resident. No additional allegations were reported.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Facility Management and Direct Care Staff were re-educated on the facility policies for identification of potential Abuse/Neglect and immediate reporting of all potential Abuse/Neglect situations to the Administrator/designee. The Social Service Director/designee will meet weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator/ Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines weekly meetings are no longer necessary. In addition, "resident rights and responsibilities" was reviewed and discussed at next two subsequent resident Council Meetings. The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/28/2012	
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	<p>start date was 5/14/2005 and the documentation of her background check went missing. RN #2 has been in so many different positions over the years that the background check probably got lost. The Administrator indicated she would provide the new criminal background report when it came back, it usually takes 24 hours after the request is submitted.</p> <p>Interview and record review of an employee file with the Administrator on 6/28/2012 at 8:00 a.m. indicated RN #2's background check was completed on 6/27/2012 and it came back clear.</p> <p>A list provided by the Administrator on 6/28/2012 at 11:25 a.m. indicated the following employees were suspended on 6/13/2012; LPN #1, CNA #6. The following employees were suspended on 6/14/2012; CNA #4, RN #2.</p> <p>The Indiana Code (IC) 16-28-13-4 includes the following; "A person who operates or administers a health care facility shall apply within three business days from the date a person is employed as a nurse aide or other licensed employee...and a limited criminal history from the Indiana central repository for criminal history information..."</p> <p>3.1-14(a)</p>		<p>neglect or exploitation in a timely manner.</p> <p>Prior to hire all potential employees will have background check completed. The facility's Administrator /designee will audit any newly hired employee file for completion of background screens to determine that candidate is free from any disqualifying concerns in the screen. A copy of the background check will be filed in a confidential personnel file.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Administrator or designee will randomly interview 5 residents weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly. Administrator /designee will audit any newly hired employee file 2 X's month for completion of background screens to determine that candidate is free from any disqualifying concerns in the screen. This will be an ongoing process for the next 3 months. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until compliance has been achieved and then quarterly monitoring by the RDCO is recommended to maintain compliance when completing system reviews which includes abuse/restraints and employee files.</p> <p><b>(e) Date of compliance: 7/28/12</b></p>				

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	3.1-28(b)(1)(A)			

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, interview, and record review the facility failed to maintain a clean environment in which to live for 4 of 4 resident rooms.</p> <p>Findings include:</p> <p>During an environmental tour and interview with the Environmental Director on 6/27/2012 at 2:20 p.m. visible dirt was observed on the floor in each doorway corner in the facility. When pointed out to the Environmental Director, he agreed that dirt was visible in each doorway corner. Additionally, resident rooms #9, #12, #1, and #17 all had multiple small streaks of what looked like dried dirty mop water on the floor. The Environmental Director indicated he felt that housekeeping hadn't been keeping up with their duties because they've only had a manager to keep on top of them once a week on Fridays since he primarily works at other buildings and is only temporary until the new Director starts tomorrow.</p> <p>Interview with the Administrator on 6/28/2012 at 7:55 a.m. indicated she has</p>	F0253	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</b></p> <p><b>F 253 - Housekeeping and Maintenance Services</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>The corners of each doorway throughout the facility were cleaned of dirt. Resident Rooms #9, #12, #1, and #17 were completely cleaned to remove the streaks on the floors</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>A facility wide audit was completed to ensure that no other areas needed additional cleaning.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>Housekeeping Director has been in-serviced as to the required components of this tag. The Housekeeping Cleaning Checklist</p>	07/28/2012

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	<p>noticed the floors are dirty, especially the corners. She agreed that the streak spots on the floors was most likely dried dirty mop water. She indicated her plan is to have housekeeping work on all the corners with scrub brushes to get the dirty floor corners cleaned. She thinks this has been a problem of getting housekeeping to get and implement a system such as they should mop in the morning, then spot mop throughout the day and then mop again in the early evening.</p> <p>Review of a document titled, daily cleaning resident room, provided by the Administrator on 6/28/2012 at 9 a.m. indicated, "4. Dust mop: The entire floor must be dust mopped-especially behind dressers and beds. Employees should never damp mop a floor before it has been dust mopped. Corners and along baseboards must be dust mopped to prevent buildup. 5. Damp mop: Remember this is damp mop not wet mop. The most important part of cleaning a resident's room is to disinfect the floor. This is where most of the air borne bacteria will settle and so it has to be sanitized every day. Start in the far corner of the room and run the mop along the edges first. Never push the mop into a corner to avoid build up. Using a figure 8 motion, work your way out the door."</p>		<p>was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Housekeeping Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months as they review the proper cleaning of the facility. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended.</p> <p><b>(e) Date of compliance: 7/28/12</b></p>				

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	This federal tag relates to Complaint # IN00110366.  3.1-19(f)			

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F0469 SS=F	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review the facility failed to maintain adequate pest control for the building for 1 of 4 resident bathrooms and 1 of 4 resident rooms. This deficient practice had the potential to affect all 35 residents who reside in the facility.</p> <p>Findings include:</p> <p>Observation of Bathroom #1 on 6/26/2012 at 11:15 a.m., and on 6/27/2012 at 12:05 p.m. indicated several ants crawling around the commode.</p> <p>During an environmental tour with the Environmental Director on 6/27/2012 at 2:20 p.m. several small live ants were observed in Bathroom #1. The ants were located on the floor in the far right corner in the shower and also on the floor surrounding the toilet. In resident room #9, 4 mouse droppings were observed on the wall shelf on located on the far wall of the room.</p> <p>Review of a policy titled, Pest control, provided by the Administrator on 6/28/2012 at 9 a.m. indicated, "Policy</p>	F0469	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</b></p> <p>F 469 Maintains Effective Pest Control Program</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>Bathroom #1 was treated for ants and Resident Room #9 was treated for rodents, as was the entire facility by contracted Pest Control Service.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>A facility wide audit was completed to ensure that no additional resident rooms or areas had evidence of insects or rodent infestation, none was identified.</p>	07/28/2012

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	<p>statement: Our facility shall maintain an effective pest control program. Policy interpretation and implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Pest control services are provided by (name of pest control company.) 6. Maintenance services assist, when appropriate and necessary, in providing pest control services."</p> <p>Interview with the Administrator on 6/28/2012 at 1:48 p.m. indicated the (name of pest control company) worker is here to treat the facility for the mice and the ants.</p> <p>Interview with the Administrator on 6/28/2012 at 4:50 p.m. during the exit conference indicated the pest control company had been regularly coming twice a month to the facility and checking the log book where sightings of pests were documented. These sightings were then treated. The pest control company did not perform regular assessments for the presence of pests.</p> <p>This federal tag relates to Complaint # IN00110366.</p> <p>3.1-19(f)(4)</p>		<p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Maintenance and Housekeeping Directors have been in-serviced as to the required components of this tag. The Facility Maintenance Rounds Checklist will be modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p>In addition, contracted Pest Control Services will make weekly facility visits to assess and provide any necessary treatment as needed.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance and Housekeeping Directors as they will make weekly walking rounds for the next four weeks and bi-monthly for 2 months as they look for evidence of insects or rodents. Any issues identified will be immediately addressed for correction. Contracted Pest Control Service will continue to make weekly facility visits to assess and treat as needed until such time that no activity has been observed for 6 months, visits by Pest Control Service</p>				

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			<p>will then decrease in frequency per their recommendations to maintain compliance. A report of their findings then will be discussed at the monthly Risk Management/QA meeting to monitor. Monthly monitoring by the NHA and Maintenance Director will continue in addition to quarterly monitoring by the Assistant Director of Plant Operations/Designee.</p> <p>(e) Date of compliance: 7/28/12</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure there was complete and accurate documentation for application of a condom catheter for 1 of 3 resident reviewed for catheters, in a sample of 5. (Resident C)</p> <p>Findings include:</p> <p>The clinical record of Resident C was reviewed on 6/26/12 at 11:35 a.m. The diagnoses for Resident C included, but were not limited to: spinal stenosis, degenerative joint disease, chronic kidney disease, and urinary incontinence.</p> <p>A review of the Admission Orders and Plan of Care, dated 6/1/12, indicated there was an order for a condom catheter, with catheter care to be provided each shift.</p>	F0514	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p><b>F- 514- Medical Records/Complete/Accurate/Access sible:</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>Residents C was reviewed with MD immediately for order clarification and care planning. At that time, condom catheter was discontinued and Foley catheter was inserted per MD order with diagnosis of urinary retention and neurogenic bladder. Orders were written/received from MD (including date and time received). They were also correctly transcribed onto TAR and care plan,</p>	07/28/2012			

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	<p>On 6/4/12, no time indicated, there was a Physician's Order to discontinue the condom catheter.</p> <p>A Physician's Order written, on 6/6/12, indicated that condom catheter care is to be provided each shift.</p> <p>On 6/26/12, there was a clarification order indicating that the condom catheter is to be changed every 48 hours and as needed for soilage, skin prep should be used when applying the catheter, and the leg bag and drainage bag should be changed every week and as needed.</p> <p>An order to reapply the condom catheter, after 6/4/12, was not located when the clinical record was reviewed, which included the Nurse's Notes and Physician's Orders.</p> <p>During an interview with the DoN (Director of Nursing), on 6/27/12 at 11:58 p.m., she indicated that she was unable to find an order to reapply the condom catheter after 6/4/12.</p> <p>On 6/27/12 at 12:45 p.m., the DoN indicated that when the 6/6/12 catheter care order was written, the Nurse that wrote the order, forgot to write that the condom catheter should be reapplied on the 6/6/12 order.</p>		<p>as well as CNA sheets per policy.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>A facility wide review was conducted on all residents with catheters to ensure MD orders complete (including date and time) and transcribed correctly to TAR, care plan and CNA sheets per policy. This also included review of daily catheter care. No new errors were found.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>Education was provided to the licensed nurses regarding correct transcription of MD orders (including date and time), and to nurses and CNAs to include specific care of catheters in TAR and on CNA sheets per facility policy. New orders will be reviewed at the next morning meeting by DNS /MDS/designate on new orders (including catheters) to make sure orders meet the documentation requirements for any type of catheter/condom catheters..</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The facility DNS/designee will conduct a random weekly audit of orders of at least 5 residents weekly</p>				

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	An MD order dated 6/27/12, with no specified time ordered, indicated, "Resident to wear condom cath."  This federal tag relates to Complaint #IN00109740.  3.1-50(a)(1) 3.1-50(a)(2)		x 4 weeks and then every 2 weeks X 4 months to ensure MD orders transcribed accurately onto TAR, care planned, and noted on CNA sheets per policy.  The RDCO will continue quarterly monitoring to ensure compliance. Findings will be reported and monitored and addressed at the monthly QA/Risk Management meeting thereafter per facility policy.  (e) <b>Date of compliance:</b> 7/28/12		