

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy</p> <p>Survey dates: January 12, 2016</p> <p>Extended Survey dates: January 13, 14, 15, 18, 19, 20, and 21, 2016</p> <p>Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410</p> <p>Census bed type: SNF/NF: 43 Total: 43</p> <p>Census payor type: Medicare: 3 Medicaid: 37 Other: 3 Total: 43</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 1/25/16 by 29479.</p>	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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

TITLE

(X6) DATE

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

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F 0164 SS=D Bldg. 00	<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, interview, and record review, the facility failed to ensure visual privacy during a shower for 1 of 2 random observation. (Resident #7 and #26)</p>	F 0164	F164 requires the facility to provide personal privacy to the resident	02/20/2016

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	<p>Finding includes:</p> <p>1. During an interview on 1/13/16 at 10:42 a.m., Resident #7 indicated staff assisted her with showers and did not pull privacy curtains completely to prevent other staff who weren't providing care to her and entered the East hall women shower room from seeing her during showering.</p> <p>Resident #7's record was reviewed on 1/13/16 at 2:00 p.m. A Minimum Data Set (MDS) assessment, dated 10/1/15, indicated Resident #7 did not have a cognitive impairment, and did receive assistance with showers.</p> <p>On 1/15/16 at 11:30 a.m., Certified Nursing Assistants (CNAs) #7 and #13 were observed to transfer Resident #7 into the East hall Women's Shower Room. The resident was observed a few minutes after the resident was taken into the shower room. Upon entering the shower room, the resident was in the first of two shower stalls, on the shower chair, unclothed. The curtain provided to cover the front of the stall was pulled one-half way. The resident was in view of anyone who entered the shower room.</p> <p>2. On 1/13/16 at 10:58 a.m., Resident #26 was interviewed. The resident</p>		<p>1. No residents were harmed. All staff has been educated regarding ensuring resident privacy.</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, all staff was educated on Resident Rights related to personal privacy, specifically pulling privacy curtains prior to providing personal care, (See Attachment #1). Additionally, the facility will utilize department managers and a guardian angel program to monitor compliance and correct any concerns immediately.</p> <p>4. As a means of quality assurance, the Administrator or designee will complete privacy observations and interviews with 2 residents daily on varying shifts on scheduled days of work times 4 weeks, then 5 residents weekly on varying shifts time 4 weeks, then 5 residents monthly times 2 months, then 5 residents quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted, (See Attachment #2).</p>	

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F 0241 SS=E Bldg. 00	<p>indicated she was not always afforded privacy during showers, as the curtain was not pulled completely across the shower stall and staff not providing care to her came in the shower room.</p> <p>Resident #26's record was reviewed on 1/21/16 at 10:35 a.m. A Minimum Data Set (MDS) assessment dated 11/3/15, indicated Resident #26 had no cognitive impairment and required assistance with showers.</p> <p>A policy titled, "Resident Rights", dated 1/2015, provided by Administrator on 1/21/16 at 8:55 a.m., included by not limited to, "... (a) Dignity. A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>3.1-(p)(4)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his</p>		5. The above corrective actions will be completed on or before February 20, 2016.		

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	<p>or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to knock and wait for permission to enter resident rooms for 4 of 4 random observations and 6 of 30 census sample resident reviewed for dignity. (Residents # 5, 7, 14, 15, 43, and 48)</p> <p>Findings include:</p> <p>During observations staff entered resident rooms without knocking and gaining permission before entering rooms. The following was observed:</p> <p>1. On 1/12/16 at 2:12 p.m., during an interview with Resident # 48, Helping Hands Aide # 11, entered Resident # 48's room failing to knock or introduce herself prior to entry.</p> <p>On 1/12/16 at 1:41 p.m., review of Resident #48's quarterly Minimum Data Set (MDS) assessment dated 10/14/15, indicated the resident had no cognitive deficit.</p> <p>During an interview with Resident #48, on 1/21/16 at 11:25 a.m., he indicated nursing staff often entered his bathroom without knocking or introducing themselves prior to entering.</p>	F 0241	<p>F241 requires the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity.</p> <p>1. No residents were harmed. All staff has been educated regarding the maintenance of resident dignity.</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, all staff was educated on Resident Rights related to maintaining resident privacy and dignity, specifically knocking and introducing oneself prior to entering a resident room, (See Attachment #1). Additionally, the facility will utilize department managers and a guardian angel program to monitor compliance and correct any concerns immediately.</p> <p>4. As a means of quality assurance, the Administrator or designee will complete privacy observations and interviews with 2 residents daily on varying shifts on scheduled days of work times 4 weeks, then 5 residents weekly on</p>	02/20/2016

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	<p>2. On 1/21/16 at 10:08 a.m., CNA # 2 failed to knock or introduce herself prior to entering Resident # 43's room.</p> <p>3. On 1/21/16 at 10:35 a.m., CNAs #13 and #14 failed to knock or introduce themselves prior to entering Resident # 7's room.</p> <p>4. On 1/21/16 at 11:15 a.m., CNA #13 failed to knock or introduce herself prior to entering Resident # 14's room.</p> <p>5. During an interview with Resident #5 on 1/21/16 at 10:42 a.m., he indicated there were times when staff entered his room and did not knock or introduce themselves prior to entering.</p> <p>On 1/21/16 at 11:00 a.m., review of Resident #5's quarterly MDS assessment dated 11/18/15, indicated the resident had no cognitive impairment.</p> <p>6. During an interview with Resident #15 on 1/21/16 at 10:49 a.m., she indicated nursing staff often had entered her room and did not knock or introduce themselves prior to entering.</p> <p>On 1/21/16 at 11:53 a.m., review of Resident #15's annual MDS assessment dated 10/30/15, indicated the resident had moderate cognitive deficit.</p>		<p>varying shifts times 4 weeks, then 5 residents monthly times 2 months, then 5 residents quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted, (See Attachment #2).</p> <p>5. The above corrective actions will be completed on or before February 20, 2016.</p>	

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F 0279 SS=D Bldg. 00	<p>During an interview on 1/21/16 at 11:32 a.m., QMA (Qualified Medication Aide) # 12 indicated staff should have knocked on the door and introduced themselves prior to entering a resident's room.</p> <p>During an interview on 1/21/16 at 1:48 p.m., RN #1 indicated staff should have knocked on the door and waited for a response before entering the resident's room.</p> <p>A policy titled, "Resident Rights", dated 1/2015, provided by Administrator on 1/21/16 at 8:55 a.m., included by not limited to, "... (a) Dignity. A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>3.1-3(t)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>			

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	<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 observation, interview, and record review, the facility failed to develop and implement a plan of care for 1 of 1 resident reviewed for dialysis care plan. (Resident #5)</p> <p>Finding includes:</p> <p>On 1/20/16 at 9:32 a.m., Registered Nurse (RN) #1 was interviewed regarding the type of dialysis access Resident #5 had. The nurse indicated she really didn't know. With the nurse, Resident #5 was observed. He indicated he had an intravenous port in the right upper chest utilized for hemodialysis. It was observed with a bandage over the site. The resident indicated he had no other access for hemodialysis.</p>	F 0279	<p>F279 requires the facility to develop, review and revise the resident's comprehensive plan of care.</p> <p>1. No residents were harmed. A dialysis communication book was developed to facilitate communication between the facility and the dialysis center, as well as to prompt the completion of the post-dialysis assessment of the resident upon return to the facility following dialysis. Additionally, an order was obtained and added to the treatment administration record to assess access ports each shift. Care plans for affected residents were updated, as warranted.</p>	02/20/2016

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	<p>On 1/22/16 at 12:00 p.m., the resident was observed in the dining room. He had a previous arteriovenous fistula, right wrist.</p> <p>On 1/20/16 at 11:41 a.m., the Director of Nursing (DON) was interviewed. She indicated she had called the dialysis center to find out what kind of access the resident had and was having hospital reports that addressed the access faxed to the facility. The DON indicated there was no other documentation in the facility regarding monitoring and care of the access sites.</p> <p>Resident #5's clinical record was reviewed on 1/20/16 at 11:00 a.m. A physician's order was noted for 8/28/15 for an AV (arteriovenous) fistula placement. A hospital operative report for 8/28/15 indicated an arteriovenous fistula was placed in the right wrist. Post discharge instructions included, but was not limited to, "...3. No blood pressures or blood sticks in the affected extremity unless approved by the doctor and drawn by a dialysis nurse....7. Make sure the blood is flowing through your access by feeling for a buzz or thrill each morning. If you do not feel a buzz, call the doctor immediately."</p>		<p>2. All residents receiving dialysis services have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, the facility policy and procedure for Dialysis Services, (See Attachment #3), was reviewed with no changes made. Additionally, all licensed nurses were educated on the aforementioned policy as well as the post dialysis assessment, (See Attachment #1).</p> <p>4. As a means of quality assurance, the Director of Nursing or designee will complete an audit of the post dialysis assessments and applicable charting for all residents receiving dialysis services daily on scheduled days of work times 4 weeks, then weekly times 4 weeks, the monthly times 2 month, then quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted, (See Attachment #4).</p> <p>5. The above corrective actions will be completed on or before February 20, 2016.</p>	

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	<p>A hospital operative report, with date of procedure of 12/4/15, indicated the resident's arteriovenous fistula, right wrist, was declotted and a Fistulogram performed. Documentation at the end of the procedure included, but was not limited to, multiple clots were obtained...the vein at time of procedure had a good thrill. The hospital reports were provided by the Director of Nursing (DON) on 1/20/16 at 11:41 a.m., after being sent from surgery center by facsimile, on 1/20/16.</p> <p>A hospital consultation report, dated 12/5/15 was noted for the resident was admitted for arteriovenous access declotting. The report indicated the access was not working again in spite of declotting efforts. He was taken to surgery and PermCath (intravenous access for dialysis) was placed.</p> <p>A "DIALYSIS COORDINATION/FACILITY SERVICES," dated 10/2014 and identified as current was provided by the Administrator on 1/21/16 at 8:35 a.m. The policy indicated, "...5. Any necessary intervention/recommendations will be addressed on resident's plan of care and communicated to necessary personnel...."</p>			

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F 0309 SS=D Bldg. 00	<p>3.1-35(a)</p> <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 interview and record review, the facility failed to ensure the assessment of a dialysis fistula (arteriovenous access) and intravenous dialysis port for 1 of 1 resident reviewed for dialysis. (Resident #5)</p> <p>Finding includes:</p> <p>On 1/20/16 at 9:32 a.m., Registered Nurse (RN) #1 was interviewed regarding the type of dialysis access Resident #5 had. The nurse indicated she really didn't know. With the nurse, Resident #5 was observed. He indicated he had an intravenous port in the right upper chest utilized for hemodialysis. It was observed with a bandage over the site. The resident indicated he had no other access for hemodialysis.</p>	F 0309	<p>F309 requires the facility to provide the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>1. No residents were harmed. A dialysis communication book was developed to facilitate communication between the facility and the dialysis center, as well as to prompt the completion of the post dialysis assessment of the resident upon return to the facility following dialysis. Additionally, an order was obtained and added to the treatment administration record to assess access ports each shift. Care plans for affected residents were updated, as warranted.</p>	02/20/2016

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	<p>Resident #5's clinical record was reviewed on 1/20/16 at 11:00 a.m. A physician's order was noted for 8/28/15 for an AV (arteriovenous) fistula placement. A hospital operative report for 8/28/15 indicated an arteriovenous fistula was placed in the right wrist. Post discharge instructions included, but was not limited to, "...3. No blood pressures or blood sticks in the affected extremity unless approved by the doctor and drawn by a dialysis nurse....7. Make sure the blood is flowing through your access by feeling for a buzz or thrill each morning. If you do not feel a buzz, call the doctor immediately." The record lacked indication assessments of the AV fistula had been completed prior to 11/25/15.</p> <p>A "POST DIALYSIS ASSESSMENT" form indicated the resident had dialysis on completed by facility staff, were noted for 11/25/15, 11/28/15, 12/3/15, 12/10/15, 12/15/15, 12/17/15, 12/19/15, 12/22/15, 12/27/15, 12/29/15, and 12/31/15 documented a thrill (pulsation) and bruit (audible blood flow) were present in the fistula. No other documentation of assessments of the fistula being done was noted and the form did not indicate the nurses who completed the assessments.</p>		<p>2. All residents receiving dialysis services have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, the facility policy and procedure for Dialysis Services, (See Attachment#3), was reviewed with no changes made. Additionally, all licensed nurses were educated on the aforementioned policy as well as the post dialysis assessment, (See Attachment #1).</p> <p>4. As a means of quality assurance, the Director of Nursing or designee will complete and audit of the post dialysis assessments and applicable charting for all residents receiving dialysis services daily on scheduled days of work times 4 weeks, then weekly times 4 weeks, then monthly times 2 months, then quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted, (See Attachment #4).</p> <p>5. The above corrective actions will be completed on or before February 20, 2016.</p>	

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	<p>A hospital operative report, with date of procedure of 12/4/15, indicated the resident's arteriovenous fistula, right wrist, was declotted and a Fistulogram performed. Documentation at the end of the procedure included, but was not limited to, multiple clots were obtained...the vein at time of procedure had a good thrill. The hospital reports were provided by the Director of Nursing (DON) on 1/20/16 at 11:41 a.m., after being sent from surgery center by facsimile, on 1/20/16.</p> <p>A hospital consultation report, dated 12/5/15 was noted for the resident was admitted for arteriovenous access declotting. The report indicated the access was not working again in spite of declotting efforts. He was taken to surgery and PermCath (intravenous access for dialysis) was placed.</p> <p>A facility policy, titled "Dialysis Coordination/Facility Services" dated 10/2014, provided by the Administrator on 1/21/16 at 8:55 a.m., included, but was not limited to, "Review physician's orders for the resident receiving dialysis to confirm: Type of access site and location. Orders for care or access site, if any specified....Procedure: 3. Upon return from dialysis, resident's access site and physical status shall be evaluated by</p>			

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	<p>a licensed nurse with evaluation documented....5. Any necessary intervention/recommendations will be addressed on resident's plan of care and communicated to necessary personnel....7. Licensed nursing personnel will monitor the resident with a shunt/access or central line utilized for dialysis every shift. Notation shall be made on the medication administration record to denote bruit (heard) and thrill (palpated) each shift. If a central line is in place, presence of closed clamps in place shall be denoted. Abnormal findings will be reported to the dialysis center or designated dialysis nurse and/or physician upon discovery. The following should be addressed on the Treatment Administration Record every shift of the resident on dialysis who has a shunt in place: Bruit (heard), Thrill (palpated, Site observed for bleeding, edema, warmth, redness The following should be addressed on the Treatment Administration Record every shift of the Dressing dry and intact. Clamps present/closed."</p> <p>3.1-37(a)</p>			

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F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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 maintain water temperatures less than 120 degrees F (Fahrenheit) to prevent burns to skin in contact with the hot water from sinks in 3 of 11 resident bathrooms on the 100 and 200 hall. This deficient practice had the potential to affect 2 of 2 cognitively impaired residents who independently accessed water from a shared bathroom with a water temperature of 137 degrees F (Residents #15 and #44). (B) In addition to the residents in the Immediate Jeopardy, the facility failed to ensure oxygen and harmful chemicals were safely stored resulting in harm or potential harm that is not Immediate Jeopardy for 3 of 5 residents (Residents #26, #54, and #55) reviewed for oxygen storage and 3 of 3 hallways observed for chemical storage.</p> <p>The Immediate Jeopardy was identified on 1/13/2016 and began on 1/13/16 when sinks in bathrooms shared by resident room #s 218, 216, 217, 212, 121 and 119 had water temperatures that exceeded</p>	F 0323	<p>Please note that the facility respectfully requests an IDR for this deficiency. Please see attached request rationale.</p> <p>F323 requires the facility to 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>1. A. No residents were harmed. A new mixing valve was placed on the sink between rooms 216 & 218. Additionally, a larger mixing valve was placed on the water lines coming from the main hot water source. Water temperatures were obtained hourly until repairs could be made. Water temperatures have been maintained between 100F and 120F since repairs were completed with no concerns noted.</p> <p>B. No residents were harmed. The liquid oxygen tanks for Resident #26, Resident 55 and Resident #54 were moved to be at least 5 feet from the heat source. All</p>	02/20/2016

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	<p>maximum temperatures to prevent burns. The Administrator, Regional Director and Corporate Compliance nurse were informed of the Immediate Jeopardy on 1/13/2016 at 4:40 p.m.</p> <p>Findings include:</p> <p>A1. During an observation on 1/13/16 at 10:00 a.m. Resident #44 entered the bathroom between resident rooms #218 and #216. The water from the sink faucet was too hot to hold hands under the water for more than a few seconds without burning the skin. The Maintenance Supervisor checked the water temperature at 10:08 a.m. and indicated the temperature was 124 degrees F per the facility's thermometer.</p> <p>During an observation on 1/13/16 at 11:15 a.m., Residents #44 and #15's shared bathroom had a water temperature of 134 degrees F and was too hot to hold hands under the water for more than a few seconds without burning the skin.</p> <p>During an observation with Maintenance Supervisor on 1/13/16 at 11:30 a.m., the Maintenance Supervisor checked the water temperature of the shared bathroom for Residents #44 and #15 and indicated the temperature was 137 degrees F per the facility's thermometer.</p>		<p>housekeeping closets and soiled utility rooms were locked and staff was educated to ensure they remained locked at all times.</p> <p>2. A. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. A. As a means to ensure ongoing compliance, all staff was educated on the facility policy and procedure related to Excessive Water Temperatures, (See Attachment #5).</p> <p>B. As a means to ensure ongoing compliance, all staff was educated on the facility policy and procedure related to Oxygen Safety Standards, (See Attachments #1 and #6). Additionally, staff received education regarding proper storage of hazardous materials.</p> <p>4. A. As a means of quality assurance, the Administrator or designee will complete water temperature audits every shift times one week, then daily times one week, then weekly times 4 weeks, then monthly times 3 months, then per the Preventative Maintenance Schedule ongoing. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted,</p>	

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	<p>During an observation with Maintenance Supervisor on 1/13/16 at 3:25 p.m., the water temperature in Resident #44 and #15's shared bathroom was 131 degrees F per the facility's thermometer.</p> <p>The Medicare State Operation Manual, Rev. 133, (02-06-15) was referenced on 1/13/16 at 1:41 p.m. for safe water temperatures for bathing and indicated 100 degrees F was a safe temperature. Page 338 of the manual indicated the time required for 3rd degree burns from water temperatures of 124 degrees F was 3 minutes, 127 degrees F was 1 minute, 133 degrees F was 15 seconds, and 140 degrees F was 5 seconds.</p> <p>During an interview on 1/13/16 at 2:00 p.m., CNA #10 indicated Resident #15 accessed the bathroom independently to brush her own teeth and performed activities of daily living (ADLs) including washing her face independently.</p> <p>During an interview on 1/14/16 at 9:46 a.m., Resident #15 indicated sometimes the water from the sink faucet had been too hot to keep her hands under and indicated she turned cold water on to adjust the temperature..</p>		<p>(See Attachment #7).</p> <p>B. As a means of quality assurance, the Administrator or designee will complete audits to ensure that oxygen tanks are appropriately placed and that housekeeping closets and soiled utility rooms are locked at all times daily on scheduled days of work times 4 weeks, then weekly times 4 weeks, then monthly times 2 months, then quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted, (See Attachment #8).</p> <p>5. The above corrective actions will be completed on or before February 20, 2016.</p>		

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	<p>Resident #44's record was reviewed on 1/13/16 at 2:33 p.m.. Diagnoses included, but were not limited to, Alzheimer's, dementia with psychosis, and behavior problems due to dementia.</p> <p>A Minimum Data Set (MDS) assessment, dated 11/19/15, indicated Resident #44 had severe cognitive impairment and required assistance of one person for transfers and required supervision for bathing/showering.</p> <p>Resident #15's record was reviewed on 1/13/16 at 2:28 p.m. Diagnoses included, but were not limited to cognitive impairment, cerebrovascular accident with right sided paralysis, and insulin dependent diabetes.</p> <p>A quarterly MDS, dated 11/13/15, indicated Resident #15 had a Brief Interview for Mental Status (BIMS) score of 8, indicating cognitive impairment. The assessment indicated mobility impairment of the right upper and lower extremities and indicated the resident utilized a wheelchair for mobility. The resident required 2 person assistance for toileting and one person physical assistance for personal hygiene.</p> <p>A document, titled "WEEKLY RANDOM RESIDENT ROOM TEMPS</p>			

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	<p>" was provided by the Administrator on 1/13/16 at 4:00 p.m. The record did not indicate any rooms with temperatures outside parameters of 100-120 degrees F and indicated the last time the temperature was monitored in the shared bathroom between resident rooms #218 and #216 was 12/1/15 and the water temperature was 110 degrees F.</p> <p>A2. During an observation on 1/13/16 at 10:10 a.m., the shared bathroom between resident room #121 and #119 had a skink faucet with a water temperature of 123 degrees F. The residents who resided in the rooms did not independently access the bathroom.</p> <p>A3. During an observation on 1/13/16 at 11:55 a.m., the bathroom utilized by room #212 had a sink faucet with a water temperature of 122 degrees F. The resident residing in room #212 was assisted by staff to access the bathroom and did not turn on the faucet independently.</p> <p>A4. During an observation on 1/13/16 at 11:57 a.m., the bathroom for room #217 had a sink faucet with a water temperature of 127 degrees F. The resident residing in room #217 was totally dependent on staff for care and did not utilize the bathroom.</p>			

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	<p>During an interview on 1/13/16 at 11:30 a.m., the Maintenance Supervisor indicated the water temperature should have been less than 120 degrees F and indicated he adjusted the water heater after he became aware of the water temperature in the shared bathroom for resident rooms # 218 and #216. The Maintenance Supervisor indicated he checked 3 random rooms per week on each resident hall for water temperatures.</p> <p>During an interview with Administrator on 1/13/16 at 11:50 a.m., she indicated there had been no reported burns or scalding's as a result of water temperatures.</p> <p>During an interview with the Administrator on 1/13/16 at 1:25 p.m., she indicated maintenance staff had not reported hot water temperatures exceeding allowable parameters prior to today.</p> <p>A "Preventative Maintenance Program," dated April 2012, and identified by the Administrator as current on 1/13/16 at 12:11 p.m., indicated, "...Water Temps [temperatures] (Shower Rooms/Beauty Shop/Random Rooms: In that resident room water temps are assessed on at least a quarterly basis with resident room</p>			

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	<p>observations, the water temps of all shower rooms (both shower and sink temperature, beauty shop, and at least 3 random rooms from each hall shall be taken and logged on a weekly basis...Temperatures outside the parameters of 100-120 [degrees] F must be reported to the Administrator immediately and corrective action initiated....."</p> <p>The Immediate Jeopardy that began on 1/13/16 was removed on 1/15/16, after the facility maintenance supervisor adjusted the water temperature, added a mixing valve and a contracted vendor (plumber) confirmed the modifications resulted in safe water temperatures. In addition to the environmental modifications, all facility staff received in-service training on the facility ' s policy for "Excessive Water Temperature," and need monitor and immediately report concerns of excessive hot water temperatures to the Administrator. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring to ensure safe hot water temperatures.</p> <p>B1. On 1/13/16 at 10:43 a.m., Resident</p>			

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	<p>#26 was interviewed. The resident was observed to utilize liquid oxygen. A small e-cylinder of oxygen was observed next to the room's heating source. A large 41 liter liquid oxygen tank was next to that. The heating source was on and running.</p> <p>With the Maintenance Supervisor on 1/13/16 at 12:15 p.m., the external surface temperature of the heating unit was tested and was 77 degrees Fahrenheit. At the same time the Respiratory Therapist was interviewed. She indicated the large cylinder was half full and the small one, one-quarter full. She indicated she filled the large tank herself. The therapist indicated the e-cylinder was only utilized by the resident when out of the facility. She indicated it could be stored in the facility oxygen storage area. The therapist indicated the resident wanted the large cylinder on the right side of the bed which was why it was close to the heating unit.</p> <p>On 1/14/16 at 3:15 p.m. with the Maintenance Supervisor the distance from the heat source and the 41 liter liquid oxygen tank was measured at 14 inches.</p> <p>B2. On 1/14/16 at 3:18 p.m. with the</p>				

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	<p>Maintenance Supervisor Resident #55's room was observed with a large 41 liter liquid oxygen tank. The oxygen tank was in use. The distance between the rooms's heating source, which was on, and the cylinder was measured at 25 inches.</p> <p>B3. On 1/14/16 at 3:20 p.m., with the Maintenance Supervisor, Resident #54's room was observed. A large 41 cylinder liquid oxygen tank was observed in the room 30 inches from the room's heat source. The resident was observed on 1/13/16 at 10:14a.m., utilizing the oxygen tank.</p> <p>On 1/14/16 at 3:10 p.m. the Respiratory Therapist provided a policy, dated 10/2015, and identified as current, titled "Oxygen Safety Standards". The policy included, but was not limited to, "...General Oxygen Safety: 1. Keep oxygen equipment and oxygen tubing at least five (5) feet away from any heat source....4. Do not place any oxygen device near electrical heaters...."</p> <p>B4. During initial tour on 1/12/16 at 10:15 a.m., a housekeeping closet on the main hallway leading to the 3 resident units and across from the main dining room, was observed to be unlocked. The closet contained 2 gallon jugs of a chemical called Vertex, and 2 containers</p>			

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	<p>of Glance NA.</p> <p>On 1/13/16 at 9:35 a.m., the housekeeping closet on the main hallway, leading to the 3 resident units and across from the main dining room, was unlocked. The closet contained 2 gallon jugs of a chemical called Vertex, 2 containers of Glance NA, 2 boxes of Vectra, and 2 bottles of Virex TB.</p> <p>On 1/13/16 at 12:05 p.m., the housekeeping closet, on the main hallway leading to the 3 resident units and across from the main dining room, was observed to be unlocked. The closet contained 2 gallon jugs of a chemical called Vertex, 2 containers of Glance NA, 2 boxes of Vectra, and 2 bottles of Virex TB.</p> <p>On 1/14/16 at 9:25 a.m., the housekeeping closet, on the main hallway, leading to the 3 resident units and across from the main dining room, was unlocked. The closet contained 2 gallon jugs of a chemical called Vertex, 2 containers of Glance NA, 2 boxes of Vectra, and 2 bottles of Virex TB.</p> <p>B5. On 1/21/16 at 11:30 a.m., The soiled utility room door on the 100 hall was unlocked and contained a bottle of Virex, bottle of biological liquid odor control, and a spray bottle of blue liquid</p>			

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	<p>(identified as glass cleaner).</p> <p>On 1/21/16 at 11:30 a.m. the 100 hallway soiled utility room was observed unlocked with three bottles of cleaning chemicals in spray bottles on the hopper. With the Maintenance Supervisor the chemicals were identified as "Virex," "Biological Liquid Odor Control/Cleaner," and an unlabeled bottle of blue liquid, later identified by the Administrator as glass cleaner.</p> <p>B6. On 1/21/16 at 11:55 a.m., the door to the 300 hall housekeeping closet was observed to be unlocked. Several chemicals were observed sitting in the unlocked closet. The chemicals present in the closet included, but were not limited to, Lemon Furniture Polish, Virex, Tackle Rust, Calcium and Lime Deposit Remover, Good Sense Odor Counteractant, Snapback and Vertex. Residents were observed participating in a supervised activity near the area.</p> <p>On 1/21/16 at 3:00 p.m., during an environmental tour of the 300 hall, with the Administrator and the Maintenance Supervisor present, the housekeeping closet was observed to be unlocked. Several chemicals were observed sitting in the unlocked closet. The chemicals present in the closet included, but were</p>				

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	<p>not limited to, furniture polish, Virex, Tackle, Good Sense, Snapback and Vertex.</p> <p>During an interview on 1/13/16 at 12:18 p.m., the Administrator indicated the housekeeping closet doors should have been locked at all times.</p> <p>During an interview on 1/21/16 at 11:30 a.m., QMA (Qualified Medication Aide) #12 indicated the soiled utility door on the 100 hall had a keypad to unlock it, but the door was not shut all the way which allowed the door to open without using the keypad.</p> <p>On 1/21/16 at 11:20 a.m., copies of the warning labels for the chemicals located in the 300 hall housekeeping closet were provided by the Administrator. The current warning labels indicated the potential hazards of the chemicals included, but were not limited to:</p> <p>a. Lemon Furniture Polish: Hazard identification included, but were not limited to, inhalation and eye contact hazards.</p> <p>b. Virex: Hazard identification included, but were not limited to, skin and eye contact hazards.</p> <p>c. Tackle. Rust, Calcium and Lime Deposit Remover: Hazard identification included, but were not limited to, Skin</p>			

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	<p>irritant and swallow hazard.</p> <p>d. Good Senses Odor Counteractant: Hazard identification included, but were not limited to, explosion and fire hazard.</p> <p>e. Snapback: Hazard identification included, but were not limited to, skin and eye irritant.</p> <p>f. Vertex: Hazard identification included, but were not limited to, eye irritant, inhalation and swallowing hazard.</p> <p>g. Vectra: Hazard identification included, but were not limited to, skin and eye irritant.</p> <p>h. Glance NA: Hazard identification included, but were not limited to, skin and eye irritant.</p> <p>i. DfE B.L.O.C.: Hazard identification included, but were not limited to, eye and skin irritant, inhalation and swallowing hazard.</p> <p>j. Glass Cleaner: Hazard identification included, but were not limited to, eye and skin irritant.</p> <p>On 1/21/16 at 4:20 p.m., the Administrator provided a current policy titled, Storage and Security of Items Potentially Hazardous to Residents," dated 1/2016. The policy indicated, "Policy: This facility shall provide each resident an environment that is as free as possible from hazards over which the facility has control,...safe storage of toxic chemicals...Procedure: 2. Chemicals must</p>			

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F 0465 SS=E Bldg. 00	<p>be secured when not in use..."</p> <p>3.1-45 (a)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure living environments were functional and comfortable for 3 of 3 nursing units reviewed for comfortable living environments (Hallways 100, 200, an 300).</p> <p>Findings include:</p> <p>On 1/21/15 at 3:00 p.m., during environmental rounds with the Administrator and Maintenance Supervisor, the following issues were observed:</p> <p>100 hall:</p> <p>a. In Room #102, missing veneer was observed on top of the footboard of the resident's bed and had a rough edge. Five</p>	F 0465	<p>F465 requires the facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.</p> <p>1. No residents were harmed.</p> <p>100 hall</p> <p>a. In room 102 the footboard on the resident's bed was removed. The floor was stripped and waxed</p> <p>b. The floor in the 100 hall lounge area was stripped and waxed</p> <p>c. In room 107 the floor in the bathroom was replaced.</p> <p>d. The floor in room 108 was stripped and waxed</p>	02/20/2016

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	<p>floor tiles were observed with black residue in center of the floor (appear to have been from non skid strips).</p> <p>b. In the 100 hall lounge area, the floor was observed to be scuffed and marred.</p> <p>c. In room #107, torn non-skid strips were observed in front of the shared bathroom stool, and the floor covering was stained around stool.</p> <p>d. In room #108, the floor was observed with scuff marks.</p> <p>e. In room #118, the caulking around the bathroom was observed stool rough and the interior of bathroom door edges were observed to be chipped and marred.</p> <p>f. In room #121, a strong urine odor was observed in the hall way.</p> <p>g. The exterior of kitchen door was observed to be heavily marred and black scuff marks were observed on the floor in hallway outside of the kitchen door.</p> <p>200 Hall:</p> <p>a. 9 out of 22 overhead lights on the 200 hall ceiling contained heavy accumulation of dead bugs.</p>		<p>e. In room 118 the caulking around the toiled was replaced. The bathroom door was repaired and painted.</p> <p>f. Room 121 was deep cleaned.</p> <p>g. The kitchen door was repaired and painted.</p> <p>200 hall</p> <p>a. The overhead lights were cleaned</p> <p>b. The vent at the end of the 200 hall was properly secured</p> <p>c. The 200 hall floor was cleaned, stripped and waxed.</p> <p>d. The men's shower room door was repaired and painted.</p> <p>300 hall</p> <p>a. In room 300 the entry door and wall next to the bathroom door were painted.</p> <p>b. In room 303 the wall was painted, the entry door was repaired, The plaster was finished and painted, lightbulbs in the bathroom were replaced and the sink was replaced.</p> <p>c. In room 307 the cracked floor tiles were repaired and the plaster along the baseboard was</p>	

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	<p>b. The vent at the end of the 200 hall adjacent to room #222 had screws missing and was partly detached from the ceiling.</p> <p>c. The 200 hall floor was observed to be dirty with food debris, dirt, and heavy amount of black scratches.</p> <p>d. The men's shower room exterior door on the 200 hall was observed to be heavily scarred with chipped paint and wood.</p> <p>300 Hall:</p> <p>a. In room #300, a black scuff was observed on the entry door and on the wall next to bathroom door.</p> <p>b. In room #303, scuff marks were observed on the wall at foot of the resident's bed. Missing veneer was observed on the bottom of entry door. Unfinished plaster was observed on bottom left wall next to the head of the bed. 2 of 4 light bulbs were observed to be out in bathroom light above the sink. The porcelain was observed to be cracked around overflow drain of bathroom sink (sharp edges). Rooms #303 and #305 shared a bathroom.</p>		<p>repaired and painted.</p> <p>d. In room 311 the plaster along the baseboard and in the bathroom above the sink was repaired and painted.</p> <p>e. In room 313 the molding around the bathroom door was repaired and the bathroom door was repaired.</p> <p>f. In room 315 the bathroom lightbulbs were replaced, the plaster in the bathroom was repaired and painted</p> <p>g. In room 317 the laminate on the window sill was repaired.</p> <p>h. In room 318 the bathroom wall was painted, the unfinished plaster was repaired and painted.</p> <p>i. In room 312 the floor tile was repaired, the sink was recaulked, the plaster above the bathroom sink was repaired and painted, and the vent cover above the toilet was secured.</p> <p>j. In room 314 the bathroom door was repaired and painted.</p> <p>k. In room 310 the floor tile was repaired in the closet, the plaster in the bathroom was repaired and painted.</p> <p>l. The crack in the hallway wall and ceiling outside room 315 was repaired.</p>	

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	<p>c. In room #307, cracked floor tiles were observed next to wall under the heating unit. Plaster on the wall along side of the bed was observed with a bubbled area above the baseboard.</p> <p>d. In room #311, the plaster behind the resident's bed was observed with a bubbled area above the baseboard. Unfinished plaster was observed above the bathroom sink at the left of the mirror.</p> <p>e. In room #313, scuff marks were observed on the molding around bathroom door and the veneer was missing from the inside bottom of the bathroom door. Rooms #311 and #313 shared a bathroom.</p> <p>f. In room #315, 3 of 4 light bulbs were observed to be burned out above the bathroom sink. Unfinished plaster was observed on the wall left of the bathroom sink. A hole was observed in left wall above the backsplash of the bathroom sink and 4 areas of cracked and peeling paint were observed on the wall right of the bathroom sink.</p> <p>g. In room #317, cracked laminate was observed on the window sill next to resident's bed with sharp edges.</p>		<p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, Maintenance and Housekeeping schedules have been created for the following: painting, daily room cleaning and floor care. Schedules will be followed with any exceptions prior approved by the Administrator. Additionally, the maintenance supervisor has been educated on the facility Preventative Maintenance program, (See Attachment #9). Resident room repair needs will be identified during scheduled inspections per the Preventative Maintenance program, reviewed by the Administrator, and repairs completed within one week, as warranted.</p> <p>4. As a means of quality assurance, the Administrator or designee will complete Maintenance and Housekeeping rounds with the applicable department manager weekly, ongoing, to ensure concerns are addressed timely. The audits and any corrective actions will be reviewed at the monthly Quality Assurance Meeting with the plan of action adjusted accordingly, if</p>	

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	<p>Rooms #315 and #317 shared a bathroom.</p> <p>h. In room #318, a yellow stained area was observed on the wall behind the water line into the toilet and unfinished plaster was observed on the wall left of the bathroom sink. Rooms #316 and #318 shared a bathroom.</p> <p>i. In room #312, broken floor tile was observed against the wall under the heating unit and on the corner of the floor behind head of the resident's bed. The bathroom sink was observed to be pulled away from the wall with broken caulking and unfinished plaster was observed above the bathroom sink. The vent cover above the toilet was loose from the ceiling.</p> <p>j. In room #314, scuff marks were observed on the outside of the bathroom door. Rooms #312 and #314 shared a bathroom.</p> <p>k. In room #310, broken floor tile was observed in the closet and unfinished plaster was observed on the wall left of the bathroom sink. Rooms #308 and #310 share a bathroom.</p>		<p>warranted, (See Attachment).</p> <p>5. The above corrective actions will be completed on or before February 20, 2016.</p>		

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	<p>1. A crack was observed in the hallway wall above the entry door to room #315 that continued across the hallway ceiling to the hallway wall above the entry door to room #316.</p> <p>On 1/21/16 at 3:30 p.m., the Maintenance Supervisor indicated when he received a maintenance request form from staff with identified maintenance needs, he took the request to the Administrator for review and approval.</p> <p>3.1-19 (f) 3.1-19 (aa) (3) (D)</p>			