

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2012
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NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 5, 7, 8, 9, 13, & 14, 2012</p> <p>Facility number :000316 Provider number: 155491 AIM number: 100286370</p> <p>Survey team: Angel Tomlinson, RN- TC Sharon Lasher, RN Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 107 Total: 107</p> <p>Census payor type: Medicare: 12 Medicaid: 86 Other: 9 Total: 107</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 19, 2012 by Bev Faulkner, RN</p>	F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of December 7, 2012.</p>	

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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F0159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide residents weekend access to their personal funds account, for 4 of 5 residents who met the criteria for personal funds. (Resident #3, #10, #118, #106)</p> <p>Findings include:</p> <p>An interview with Resident # 3 on 11/5/12 at 11:18 A.M., indicated she had no access to her personal fund account on the weekends.</p> <p>An interview with Resident #10 on 11/5/12 at 2:06 P.M., indicated she had no access to her personal fund account on the weekends.</p> <p>An interview with Resident #118 on 11/7/12 at 8:24 A.M., indicated he had no access to his personal fund account on the weekends.</p> <p>An interview with Resident #106 on 11/5/12 at 1:19 P.M., indicated she</p>	F0159	<p>F 159= B: Management of Personal Funds It is the practice of this facility to allow all residents access to their personal funds seven days week.</p> <p>1.For residents 3, 10, 118 and 106, and all other residents residing in the facility, personal funds will be made available in the business office seven days week.</p> <p>2.Resident banking hours posted in front lobby by business office seven days week.</p> <p>3.Resident banking hours discussed at Resident council meeting. Staff educated on extended banking hours 11.26.12.</p> <p>4.BOM and/or designee will check every Monday for disbursement of resident funds per request that occurred over the weekend for 9 months. Findings will be submitted to QA/QI committee.</p> <p>5. Compliance date: 12/7/12</p>	12/07/2012			

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	<p>did not know if she had access to her personal fund account on the weekends.</p> <p>An interview with the Human Resource Director on 11/14/12 at 10:32 A.M., indicated Resident #3, #10, #118, and #106, had a personal fund account with the facility. The Human Resources Director indicated personal funds were available to residents Monday through Friday, from the hours of 10:30 A.M., until 2:30 P.M. The Human Resources Director indicated the residents did not have access to their personal funds account money on the weekends.</p> <p>3.1-6(f)(1)</p>				

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS 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 observation, interview and record review, the facility failed to have a medical symptom or diagnosis for the use of a restraint for 2 of 2 residents that met the criteria for physical restraints (Resident #73 and Resident #112).</p> <p>Findings include:</p> <p>1). Observation on 11-8-12 at 9:05 a.m., Resident #73 was sitting in a wheelchair in the hallway wearing a seatbelt restraint with a metal buckle around his waist and attached to the wheelchair. CNA #2 attempted three times to have the resident release the seatbelt and the resident would not release it. The resident would reach for the CNA or pick at his pants, but would not attempt to undo the seatbelt. The Director Of Nursing (DON) attempted two times to have the resident undo the seatbelt and the resident did not attempt to remove it. CNA #2 indicated she had never seen Resident #73 undo his seatbelt.</p>	F0221	<p>F221= D: Free from physical restraints It is the practice of this facility to ensure residents are free from physical restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms</p> <p>1.A medical assessment and diagnoses obtained for residents #73 and #112.</p> <p>2.2. All residents with protective devices were reviewed for appropriate use and medical diagnoses</p> <p>3. Staff re-educated on identifying change of condition and need for reassessment of protective devices, such as self-releasing seatbelts, for appropriate use and medical diagnoses.</p> <p>4. DON or designee will randomly audit self-releasing devices daily five days a week x 4 weeks, weekly x 2 months and monthly thereafter for 9 months. Results from audits will be submitted to the QA/QI committee for review and recommendations</p> <p>1.Compliance date: 12/7/12</p>	12/07/2012	

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	<p>Observation on 11-8-12 at 9:53 a.m., RN #3, with the DON present attempted to get Resident #73 to take off his seatbelt. Resident #73 stated "why I don't know how." Resident #73 did not attempt to take the seatbelt off. The DON indicated the seatbelt had not been assessed as a restraint and Resident #73 had good and bad days.</p> <p>Interview with the DON on 11-8-12 at 9:53 a.m., indicated the nursing department had applied the seatbelt to Resident #73 and the therapy department had not assessed the resident's seatbelt. The DON indicated she did obtain a physician order on this day for Occupational Therapy to evaluate the resident's seatbelt.</p> <p>Observation on 11-8-12 at 11:20 a.m., Resident #73 was sitting in a wheelchair in the hallway with an alarming velcro seatbelt around his waist and attached to the wheelchair. RN #3 indicated the maintenance man had applied a different belt for Resident #73. RN #3 attempted to get Resident #73 to undo the alarming velcro belt and the resident did not attempt to take it off. RN #3 indicated she did not know who</p>				

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	<p>recommended the alarming velcro seatbelt for Resident #73.</p> <p>Review of the record of Resident #73 on 11-8-12 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, advanced dementia, hypertension, Congestive Heart Failure (CHF), insomnia, aggressive behaviors, dementia with behavioral disturbance with associated psychosis and acute small bowel obstruction secondary to an umbilical hernia.</p> <p>The physician progress note for Resident #73, dated 2-5-12, indicated the resident was conscious, alert but totally confused and disoriented to person, place and time.</p> <p>The physician progress note for Resident #73, dated 5-26-12, indicated the resident was conscious, alert but confused and disoriented to person, place and time. The resident was almost non verbal.</p> <p>The physician progress note for Resident #73, dated 7-21-12, indicated the resident was conscious and fairly alert but confused and disoriented to person, place and time.</p> <p>The physician progress note for</p>			

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	<p>Resident #73, dated 9-3-12, indicated the resident was conscious, alert, but confused and disoriented to time, place and person. The resident "is in his own world."</p> <p>The history and physical examination for Resident #73 completed by the local hospital Medical Doctor, dated 10-12-12, indicated the resident was unable to answer any questions and unable to follow any commands. The resident's illness is severely limited secondary to the patient's clinical dementia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #73, dated 10-22-12, indicated the following: the resident had short and long term memory problems, cognitive skills for daily decision making- severely impaired, mobility devices- walker and wheelchair and physical restraints- not used.</p> <p>The careplan for Resident #73 with an original date of 12-13-11 and an review date of 10-24-12 indicated the resident was at risk for falls related to decreased safety awareness secondary to dementia. The interventions included, but were not limited to, self release alarming belt to the wheelchair.</p>			

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	<p>Review of Resident #73 record did not indicate a physician order for the seatbelt restraint, an assessment for the seatbelt restraint and there was no documentation of the resident being released from the seat belt restraint.</p> <p>Interview with Assistant Director Of Nursing (ADON) #1 on 11-8-12 at 1:30 p.m., indicated she had applied the metal seatbelt to Resident #73 about two to three weeks ago. ADON #1 indicated the reason she applied the metal seatbelt to the resident was because he had previously had on an alarming velcro seatbelt and it was becoming frayed. ADON #1 indicated there was no documentation that the resident could release either seatbelt or that the facility staff were releasing it for the resident because the facility did not feel it was a restraint. ADON #1 indicated there was no physician order for either seatbelt because the facility did not feel the seatbelts were a restraint. ADON #1 indicated the seatbelts were applied for positioning and safety by nursing. ADON #1 indicated she was attempting to reach Resident #73's family at this time to obtain consent for the use of resident's restraint. ADON #1 indicated she was unsure when the</p>						

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	<p>seatbelt was initially applied for Resident #73 and she would obtain it from the resident's old record.</p> <p>The fall action team: fall review dated, 11-28-11, provided by ADON #1 as the initial application of the seatbelt for Resident #73 indicated the resident had a change in mobility, standing or sitting balance. The resident had a decrease in ambulation and mobility and was using a wheelchair. The careplan interventions added were applied alarming self release belt.</p> <p>The nursing note for Resident #73, dated 11-29-11, indicated the Interdisciplinary Team (IDT) review was completed related to falls. The resident was unsteady. The resident was in the wheelchair for ambulation. Applied alarming self release belt to the resident's wheelchair.</p> <p>The Posey Airline Buckle Belt manufacturer's guidelines provided by ADON #1 on 11-8-12 at 3:15 p.m., indicated the "Posey self releasing belts help reduce the risk of forward sliding and act as a reminder for patients to ask for assistance with ambulation." "Posey self-releasing belts are not considered to be restraints as long as the individual is</p>				

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	<p>capable of releasing the closure themselves."</p> <p>2. Resident # 112 was observed on 11/9/12 at 11:30 a.m., sitting in the dining room at a table with coloring materials on the table in front of her. A lap buddy was observed extended across the front of the resident's wheelchair and attached snugly between the opening under the arm rests.</p> <p>Interview on 11/9/12 at 11:30 a.m., with QMA # 10 indicated that Resident # 112 could not remove the lap-buddy on command.</p> <p>Review on 11/9/12 at 11:40 a.m., of Resident # 112's record indicated a physician's order, dated 6/13/12: Apply Lap buddy while up in wheelchair related to Alzheimer's with dementia and decreased safety awareness. Per family request.</p> <p>Review on 11/9/12 at 11:30 a.m., of "Restraint Data Collection & Evaluation," dated 11/6/12, indicated "1. Condition/circumstances for Restraint considerations: to allow her to have a place to set items for tactile stimulation." "5. The interdisciplinary team has determined that the following device</p>			

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	<p>is necessary: Medical symptom: needs a place to set items for tactile stimulation R/T wandering. When to use: when in wheelchair. Plan for reduction: when needs change"</p> <p>A Care Plan with onset of 6/13/12 indicated the resident requires use of restraints,. "Problem: Requires use of Restraints (Lap buddy in w/c to provide a place to set items for tactile stimulation as she wanders throughout the facility R/T short attention span. She is unable to remove the lap buddy upon command) Goal & Target date Will have a place for items to provide tactile stimulation while wandering in w/c w/n (within) 3 mnths (months) Will be free of negative outcomes R/T (related to) Restraint use w/n 3 mnths Approaches: Assess for least restraint possible Period assessment for continued use & or change in Restraint type... Provide items for tactile stimulation such as stuffed animals, magazines, etc."</p> <p>Nurses notes, dated 6/13/12, indicated "Lap buddy placed on w/c per family request to provide a place</p>			
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	<p>for items that will provide tactile stimulation while she is in w/c R/T wandering & short attention span..."</p> <p>On 11/14/12/ at 5:00 p.m., interview with ADON # 1 during the exit conference indicated she had additional information to provide for the appropriate use of the lap buddy. She indicated Resident # 112 had a diagnosis of syncope (fainting) and collapse and presented a "Face Sheet," dated 6/7/10. The ADON indicated the resident has the lap buddy placed due to falls related to syncope. She presented nursing notes, dated 2010 and 2011, that indicated numerous falls in both years. A nursing note, dated 10/4/10, indicated Resident # 112 lost her balance and fell. No other documentation to indicate falls were related to syncopal episodes. There was no assessment for dizziness documented or no documentation from the resident that she had become dizzy during any falls. ADON # 1 presented a form titled ... "Rehab Services Interdisciplinary Therapy Screen Dated 3/8/12 and 6/1/12." This form indicated "Functional Areas: Balance seated/standing 3/8/12- impaired 6/1/12- unchanged History of falls 3/8/12- within</p>			

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	<p>functional limits 6/1/12- within functional limits"</p> <p>Review of facility Policies and Procedures provided on 11/9/12 at 2:30 p.m., indicated "... Procedure: Physical Restraints:</p> <p>2. The resident/responsible party will sign permission of the use of a safety device...</p> <p>3. Permissible restraints used at ... will include but not limited to... Seat belt/ Skirt belt...</p> <p>4. The risk benefit to the resident or representative prior to initiating the restraint by copying the restraint authorization.</p> <p>5. The nurse will obtain the Physicians order for the restraint. This order will include the medical reason for the restraint.</p> <p>6. The staff will directly observe the restraints every 30 minutes. The staff will provide exercise every 2 hours and PRN. Release restraint for at least 10 minutes...."</p> <p>3.1-26(a) 3.1-26(b) 3.1-26(o)</p>				

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NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
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F0241 SS=B	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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 or her individuality.</p> <p>Based on observation and interview, the facility failed to provide meals in an environment that maintains the resident's dignity and individuality for 35 residents in a total sample of 54.</p> <p>Findings include:</p> <p>On 11/7/12 at 12:45 p.m., observation of the lunch meal in the West buildings main dining room, indicated 7 residents being served their lunch a on tray. Observation of 19 other residents, who's meals were removed from the tray and placed on the table.</p> <p>Interview on 11/7/12 at 12:55 p.m., with CNA # 8 indicated "leaving the meal on the tray is the residents preference."</p> <p>On 11/13/12 at 12:50 p.m., observation of the West buildings main dining room indicated 19 residents eating the lunch meal without a tray and 7 residents eating</p>	F0241	<p>F241=B: Dignity and Respect It is the practice of this facility to promote care for the 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>1.For the 12 residents cited and all other residents residing at the facility meals will be removed from the tray</p> <p>2.Meal Service discussed at Resident Council on 11.26.12</p> <p>3.Staff will be educated on proper meal service to promote dignity of residents</p> <p>4.Dietary Manager or designee will make random rounds in dining room daily five days a week to monitor at different meal times to capture all 3 meal times x 4 weeks, weekly x 2 months and monthly thereafter for 9 months to ensure established meal service is followed. Results of the audit will be made available to the QA/QI committee for recommendation and review</p> <p>1.Compliance date: 12/7/12</p>	12/07/2012			

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	<p>their meal on trays, while in the same dining room.</p> <p>Observation on 11/13/12 at 12:45 p.m., in the East building 300 hall dining room of 12 residents eating their lunch served on trays in the dining room.</p> <p>Interview on 11/13/12 at 12:55 p.m., with RN # 3 indicated that all residents are served their meals on trays in 300 hall dining room. She indicated she did not know why residents were served their meals on a tray. RN # 3 indicated she thought it was for consistency due to the residents being on an Alzheimer's unit.</p> <p>On 11/14/12 at 12:40 p.m., observation was made in the East buildings 100 hall rehabilitation unit dining room of 3 residents in the dining room eating their lunch meal from trays. There were no other residents observed in the dining room.</p> <p>Observation on 11/14/12 at 12: 45 p.m., was made of 8 residents in the 400 hall dining room in the East building eating the lunch meal served on trays. There were no other residents observed in the dining</p>						

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	<p>room.</p> <p>11/14/12 at 12:50 p.m., 5 residents were observed in the 200 hall dining room eating their lunch on trays.</p> <p>Interview with CNA # 9 on 11/14/12 at 12:55 p.m., in the East building indicated "If the resident asks me to, I take their food off of the tray."</p> <p>Interview on 11/14/12 at 1:00 p.m., with Resident # 116 indicated she has always been served her meals on a tray and has never been asked if she preferred her meal to be taken off of the tray.</p> <p>On 11/14/12 at 1:05 p.m., interview with Resident # 47 indicated "some of us are served our meals on a tray, but I don't know why. She indicated "no one has asked me if I preferred it on the table."</p> <p>Interview on 11/14/12 at 2:50 p.m., with the Dietary Manager indicated she has no resident preferences documented regarding residents preferring to have their meals taken off of the tray and placed on the table. She indicated the staff are to ask the resident if they want their meal placed on the table or left on the tray.</p>			

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F0279 SS=D	<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> <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 provide 1 resident with a plan of care for bladder incontinence of 5 residents who met the criteria for bladder incontinence. (Resident #132)</p> <p>Findings include:</p> <p>Resident #132 was observed sitting on the side of his bed on 11/7/12 at 3:52 P.M. Resident #132 indicated staff assisted him to the toilet.</p>	F0279	<p>F279=D Comprehensive Assessment</p> <p>It is the practice of this provider to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The facility makes a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at the least the following: Identification and demographic</p>	12/07/2012
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	<p>Resident #132's record was reviewed on 11/13/12 at 8:45 A.M. Resident #132 had a diagnosis of urinary incontinence.</p> <p>A significant change Minimum Data Set assessment for Resident #132, dated 7/17/12, indicated Resident #132 understood and was able to understand others, required limited assistance of 1 person to transfer and toilet, was occasionally incontinent of urine (less than 7 episodes of incontinence), and was not on a toileting program. The Participation in Assessment and Goal Setting indicated Resident #132 participated in his assessment. The Care Area Assessment Summary indicated Resident #132' urinary incontinence was addressed in his plan of care.</p> <p>A quarterly Minimum Data Set assessment for Resident #132, dated 10/1/12, indicated Resident #132 understood and was able to understand others, required limited assistance of 1 person to transfer, required extensive assistance of 1 person to toilet, was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence), and was not on a toileting program. The Participation in Assessment and goal</p>		<p>information; Customary routine; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; and Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. 1. Care plan for residents #132 has been reviewed and revised to reflect residents' current plan of care. 2. Residents with urinary incontinence will be reviewed during the Care Management Process and care plans revised as needed. 3. Staff will be re-educated in ensuring residents' plan of care is being followed and interventions are in place for residents with urinary incontinence. Nursing and MDS were re-educated to ensure care plans are accurate and correct and interventions are in place. 4. Director of Nursing or designee will monitor residents with urinary incontinence daily x4 weeks, weekly x2 months, and monthly thereafter for 9 months, and report results to the monthly QI/QA Committee for further review and recommendations. 5.</p>				

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	<p>Setting indicated Resident #132 participated in his assessment.</p> <p>A "Clinical Review" assessment for Resident #132, dated 11/12/12, indicated Resident #132 was incontinent of urine.</p> <p>An interview with the Assistant Director of Nursing #2 on 11/9/12 at 3:58 P.M., indicated Resident #132 did not have a plan of care for his bladder incontinence.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>		<p>Compliance date: 12/7/12</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the care plan for 1 resident with falls and to obtain a physician's order for 1 resident with a restraint for 2 of 26 residents reviewed for care plans. (Resident #110 and #73)</p> <p>Findings include:</p> <p>1.) The record of Resident #110 was reviewed on 11/8/12 at 10:00 a.m.</p> <p>Resident #110's MDS (Minimum Data Set), assessment, dated 10/20/12, indicated Resident #110's BIMS (Brief Interview for Mental Status) was 4 with a score of 0-7 indicating severe impairment of cognition, transfers-extensive assistance and ambulation, limited assistance and falls, 0.</p> <p>Resident #110's care plan, dated 10/16/12, indicated "Problem, potential for falls related to poor safety awareness/weakness/mobility deficit. Goal, will be free from injurious fall thru next review. Interventions, encourage to wear</p>	F0282	<p>F282=D: Services by qualified persons/per care plan</p> <p>It is the practice of this provider to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. 1. Medical Records were reviewed for residents #110 and #73 and care plans were updated to reflect current interventions for falls. 2. Residents at risk for falls have been reviewed thru the Care Management Process and interventions reviewed and ensure they were in place. 3. Staff was re-educated to ensure resident's interventions are in place per the residents' plan of care. 4. DON or designee will monitor residents at risk for falls and ensure interventions are in place daily x4 weeks, weekly x2 months, and monthly thereafter for 9 months. Results will be submitted to the monthly QI/QA</p>	12/07/2012
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	<p>proper footwear, assess gait for changes, refer to therapy PRN (as needed), assess need for assistive devices, assist with ambulation PRN, apply star symbol, encourage resident to keep scooted all the way back in his chair, not sitting on the edge of the wheelchair, 7/26/12 Dycem (non slip matting) in chair.</p> <p>Resident #110's physician's recapitulation orders, dated 11/1/12 to 11/30/12, indicated "activity level: up with assist."</p> <p>During observation on 11/9/12 at 11:20 a.m., was assisted from his wheelchair to be ambulated in the hall. When Resident #110 stood up behind his walker to walk, the seat of his wheelchair did not have a Dycem in it.</p> <p>During an interview on 11/9/12 at 11:25 a.m., CNA #5 indicated there was not a Dycem in Resident #110's wheelchair.</p> <p>Resident #110's nursing notes, dated 7/25/12 at 3:15 p.m., indicated "resident slid out of wheelchair falling to floor while playing bingo in dining room."</p> <p>A document titled "Fall Prevention</p>		<p>Committee for further review and recommendations. 5. Compliance date: 12/7/12</p>				

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	<p>Program At-A-Glance," undated, provided by the DON (Director of Nursing) on 11/13/12 at 12:30 p.m., and indicated by the DON to be the most current policy included: The Senior CNA, on all shifts, needs to be held accountable to ensure that the car plan to eliminate falls is being implemented.</p> <p>2.) Observation on 11-8-12 at 9:05 a.m., Resident #73 was sitting in a wheelchair in the hallway wearing a seatbelt restraint with a metal buckle around his waist and attached to the wheelchair. CNA #2 attempted three times to have the resident release the seatbelt and the resident would not release it. The resident would reach for the CNA or pick at his pants, but would not attempt to undo the seatbelt. The Director Of Nursing (DON) attempted two times to have the resident undo the seatbelt and the resident did not attempt to remove it. CNA #2 indicated she had never seen Resident #73 undo his seatbelt.</p> <p>Review of the record of Resident #73 on 11-8-12 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, advanced dementia, hypertension, Congestive Heart Failure (CHF), insomnia, aggressive behaviors, dementia with</p>			

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	<p>behavioral disturbance with associated psychosis and acute small bowel obstruction secondary to an umbilical hernia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #73, dated, 10-22-12, indicated the following: the resident had short and long term memory problems, cognitive skills for daily decision making- severely impaired, mobility devices- walker and wheelchair and physical restraints- not used.</p> <p>Review of Resident #73 record did not indicate a physician order for the seatbelt restraint.</p> <p>Interview with Assistant Director Of Nursing (ADON) #1 on 11-8-12 at 1:30 p.m., indicated there was no physician order for the seatbelts because the facility did not feel the seatbelts were a restraint.</p> <p>The fall action team: fall review, dated 11-28-11, provided by ADON #1 as the initial application of the seatbelt for Resident #73 indicated the resident had a change in mobility, standing or sitting balance. The resident had a decrease in ambulation and mobility and was using a wheelchair. The careplan</p>			

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	<p>intervention added was "applied alarming self release belt."</p> <p>The policy for "physical restraint and reduction" provided by ADON #2 on 11-9-12 at 2:30 p.m., indicated the nurse will obtain the physician order for the restraint. This order will include the medical reason for the restraint.</p> <p>3.1-35(g)(1)</p>				

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to provide services to restore bladder function for 1 of 5 residents who met the criteria for continence decline (#132) and failed to have an appropriate diagnosis for 1 of 2 residents who met the criteria for unjustified catheter use (#10).</p> <p>Findings include:</p> <p>1.) Resident #132 was observed sitting on the side of his bed on 11/7/12 at 3:52 P.M. Resident #132 indicated staff assisted him to the toilet.</p> <p>Resident #132's record was reviewed on 11/13/12 at 8:45 A.M. Diagnoses included but were not limited to insulin dependent diabetes, hypertension, anemia, depression,</p>	F0315	<p>F315=D: Restore Bladder Function-Cathe ter It is the practice of this facility to provide services to restore bladder function to all residents</p>	12/07/2012

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NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331			
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	<p>cerebral vascular accident, coronary artery disease, benign prostate hypertrophy, chronic renal failure, and urinary incontinence.</p> <p>A significant change Minimum Data Set assessment for Resident #132, dated 7/17/12, indicated Resident #132 understood and was able to understand others, required limited assistance of 1 person to transfer and toilet, was occasionally incontinent of urine (less than 7 episodes of incontinence), and was not on a toileting program. The Participation in Assessment and Goal Setting indicated Resident #132 participated in his assessment. The Care Area Assessment Summary indicated Resident #132' urinary incontinence was addressed in his plan of care.</p> <p>A "Clinical Review" assessment for Resident #132, dated 9/12/12, indicated Resident #132 was incontinent of urine at times and was not on a toileting program.</p> <p>A quarterly Minimum Data Set assessment for Resident #132, dated 10/1/12, indicated Resident #132 understood and was able to understand others, required limited assistance of 1 person to transfer, required extensive assistance of 1</p>		<p>residing at the facility.</p> <p>1. Catheter assessment reviewed on resident #10 and all other residents with catheters. Reassessment completed on resident #132 and toileting program initiated. 2. Catheter assessments will be completed on all residents admitted to facility and all residents currently with catheters. Continence management programs will be initiated on any resident with decline incontinent status 3. Staff re-educated on programs to maintain continence management and appropriate diagnoses for catheter placement 4. Director of Nursing or designee will conduct daily rounds all shifts 5 days week to ensure residents with catheters have supported diagnoses and resident who are incontinent for restorative programs for a period of 9 months. Results will be brought to the monthly QI/QA Committee meeting for further review and recommendation.</p> <p>5. Compliance date: 12/7/12</p>				

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	<p>person to toilet, was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence), and was not on a toileting program. The Participation in Assessment and goal Setting indicated Resident #132 participated in his assessment.</p> <p>A Data Collection Form for Resident #132, dated 10/10/12, indicated Resident #132 scored 11 on his potential for bowel/bladder training. A score of 7 to 14 indicated Resident #132 was a "candidate for toileting schedule (timed voiding)."</p> <p>A Data Collection Form for Resident #132, dated 11/2/12, indicated Resident #132 scored 11 on his potential for bowel/bladder training. A score of 7 to 14 indicated Resident #132 was a "candidate for toileting schedule (timed voiding)".</p> <p>A "Clinical Review" assessment for Resident #132, dated 11/12/12, indicated Resident #132 was incontinent of urine and was not on a toileting program.</p> <p>An interview with the Director of Nursing on 11/13/12 at 8:50 A.M., indicated Resident #132 was not on a bladder restorative program.</p>			

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	<p>An interview with CNA #5 on 11/13/12 at 9:33 A.M., indicated Resident #132 was not on a bladder restorative program.</p> <p>The most current "Bladder Independence/Retraining" policy and procedure, provided on 11/14/12, by the Director of Nursing, indicated the following: "Policy: Residents will be assessed for bladder independence/retraining after determining the type of bladder incontinence. Those residents identified as potential candidates for bladder independence/retraining program will be evaluated by the interdisciplinary team to determine the implementation of a bladder independence-retraining program. Procedure: 1. A Potential for Bowel/Bladder Retraining form will be completed. A resident that receives a score of 0-6 is not a considered a candidate for retraining. But a scheduled toileting program may be needed. Residents that score 7-14 are to be considered candidates and residents that score 15-21 are considered good candidates for retraining"....</p> <p>2.) The record of Resident #10 was</p>			

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	<p>reviewed on 11/9/12 at 9:00 a.m. Resident #10's diagnoses included, but were not limited to diabetes, urinary incontinence and obesity.</p> <p>Resident #10's MDS (Minimum Data Set), assessment, dated 10/16/12, indicated Resident #10's BIMS (Brief Interview for Mental Status), 12, with a score of 8-12 indicating moderately impaired cognition, has catheter, always incontinent of bowel and no pressure areas.</p> <p>Resident #10's care plan, dated 11/13/12, indicated "Problem, potential for skin breakdown related to obesity, decreased mobility, dribbles urine at times-history or UTI (urinary tract infection), breasts/rash on back and buttocks/sometimes refuses care and showers/refuses to change clothes/refuses to get out of bed/incontinence/refuses uses restorative program for incontinence/refuses to get out of bed. Goal. will be free of skin breakdown within 3 months. Interventions included but were not limited to follow up with dermatologist as needed, Foley catheter as ordered and Foley catheter care every shift and as needed."</p> <p>Resident #10's physician's order,</p>			

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	<p>dated 9/20/12, indicated "18 french (scale of the size of a catheter), 30 cc (cubic centimeters) balloon Foley catheter, change monthly and as needed, Foley catheter care every shift."</p> <p>Resident #10's nursing notes, dated 9/20/12 at 2:30 p.m., "received new order from physician to insert Foley related to rash on bottom and resident is incontinent of urine, Foley to be placed to attempt to keep resident dry until rash is resolved."</p> <p>On 11/9/12 at 1:00 p.m., Resident #10 was observed in bed and her Foley catheter was patent with medium yellow urine draining in the tubing.</p> <p>During an interview on 11/13/12 at 12:33 p.m., the DON (Director of Nursing), indicated Resident #10 had a rash on her buttocks and was sent to the wound center, but the wound center did not treat her and referred her to a dermatologist. The dermatologist ordered a Foley catheter for Resident #10. The DON also indicated there was no open areas on Resident #10's buttocks, but the resident will not get up or tell the staff when she has to go to the bathroom and "her buttocks is wet a</p>			

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	<p>lot."</p> <p>Resident #10's "Non-Decubitus Skin Condition Record," dated 9/13/12, indicated "description, rash bilateral buttocks and ischium (the curved bones that constitute each half of the pelvis), continues breakdown of existing rash."</p> <p>The weekly evaluation indicated the following:</p> <ul style="list-style-type: none"> - 9/20/12, progress, improving, site, bilateral buttocks and ischium, size, unmeasurable, color, red raised, other, resident complains of discomfort - 9/27/12, progress, no change, site bilateral buttocks and ischium, size, unmeasurable, color, red - 10/4/12, progress, improving, site, bilateral buttocks and ischium, size, unmeasurable, color, red - 10/11/12, progress, no change, site, bilateral buttocks and ischium, size, unmeasurable, color, red - 10/17/12, progress, no change, site, bilateral buttocks and ischium, size, unmeasurable, color, red - 10/24/12, progress, improved, site, bilateral buttocks and ischium, size, unmeasurable, color, red - 10/31/12, progress, improving, site, bilateral buttocks and ischium, size, unmeasurable, color, deep red - 11/7/12, progress, significantly 			

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	<p>improved, site, bilateral buttocks and ischium, size, unmeasurable, color, red to pink, other, reevaluate next week to remove catheter</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement fall prevention interventions for residents with a history of falls for 2 of 3 residents that met the criteria for accidents (Resident #45 and Resident #110).</p> <p>Findings include:</p> <p>1.) Interview with RN #3 on 11-7-12 at 10:19 a.m., indicated Resident #45 had sustained a fall from her wheelchair.</p> <p>Observation on 11-8-12 at 9:03 a.m., Resident #45 was sitting in the dining room in her wheelchair, there was no Dycem (non slip pad used to prevent sliding) in the resident's wheelchair.</p> <p>Review of the record of Resident #45 on 11-8-12 at 10:57 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, Cerebral Vascular Accident (CVA) (stroke), seizure disorder, depression and</p>	F0323	<p>F323 Accidents and Supervision</p> <p>It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible. 1. Medical Records for resident's #45 and #110 have been reviewed, the care plans have been updated to include the appropriate interventions for falls, and ensure appropriate interventions are in place. 2. Resident with falls has been reviewed to ensure interventions are in place and being followed. 3. Staff have been re-educated on ensuring residents at risk for and with multiple falls have interventions in place and will report to their supervisor when they remove or refuse interventions. 4. Director of Nursing or designee will monitor daily five days a week x4 weeks and then weekly x2 months, and monthly thereafter for 9 months. Results will be reported to the monthly QI/QA Committee for further review and</p>	12/07/2012

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	<p>dementia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #45, dated 9-6-12, indicated the resident's BIMS (Brief Interview for Mental Status) score was 15, with a range of 13-15, indicating the resident is cognitively intact and mobility devices were walker and wheelchair.</p> <p>The care plan for Resident #45 with a original date of 11-18-11 and review date of 10-29-12 indicated the resident was at risk for falls. The interventions included, but were not limited to, Dycem in the wheelchair.</p> <p>The nursing note for Resident #45, dated 10-25-12 at 1:30 p.m., indicated the resident was found on the floor in her room. The resident stated she was trying to reach a box and scooted out of her wheelchair. The resident indicated she fell on her right side. There was no injuries noted, the resident complained of some discomfort in her right hip and right arm. The resident had previously had chronic pain in those areas.</p> <p>Interview with Resident #45 on 11-13-12 at 10:03 a.m., indicated when she fell on 10-25-12 she was sitting in her wheelchair and</p>		<p>recommendations. 5. Compliance date: 12/7/12</p>				

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	<p>attempted to pick up something on the floor. The resident indicated she slid out of her wheelchair. Resident #45 was observed to have a bath towel on the seat of her wheelchair and did not have a Dycem in the seat of the wheelchair. Resident #45 indicated she had never had any kind of pad in her wheelchair to prevent her from sliding.</p> <p>Interview with RN #3 on 11-13-12 at 10:11 a.m., indicated she did not know Resident #45 was supposed to have a Dycem in her wheelchair. CNA #4 indicated at this time that she did not remember Resident #45 ever having a Dycem in her wheelchair.</p> <p>Interview with RN #3 on 11-13-12 at 10:15 a.m., indicated it was the responsibility of the Assistant Director Of Nursing (ADON) to ensure residents fall interventions were in place.</p> <p>Interview with the Administrator on 11-14-12 at 3:07 p.m., indicated the ADON was responsible to ensure fall interventions were implemented for residents.</p> <p>2.) The record of Resident #110 was reviewed on 11/8/12 at 10:00 a.m.</p>				

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	<p>Resident #110's MDS (Minimum Data Set), assessment, dated 10/20/12, indicated Resident #110's BIMS (Brief Interview for Mental Status score was 4 with a score of 0-7 indicating severe impairment of cognition, transfers-extensive assistance and ambulation, limited assistance and falls, 0.</p> <p>Resident #110's care plan, dated 10/16/12, indicated "Problem, potential for falls related to poor safety awareness/weakness/mobility deficit. Goal, will be free from injurious fall thru next review. Interventions, encourage to wear proper footwear, assess gait for changes, refer to therapy PRN (as needed), assess need for assistive devices, assist with ambulation PRN, apply star symbol, encourage resident to keep scooted all the way back in his chair, not sitting on the edge of the wheelchair, 7/26/12 Dycem (non slip matting) in chair.</p> <p>Resident #110's physician's recapitulation orders, dated 11/1/12 to 11/30/12, indicated "activity level: up with assist."</p> <p>Resident #110's "Risk for Falls," assessment, dated 10/9/12, indicated a total score of 12. The "Risk for</p>			

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	<p>Falls," also indicated "if the score is 10 or above deems resident at risk for falls.</p> <p>During observation on 11/9/12 at 11:20 a.m., Resident #110, was assisted from his wheelchair to be ambulated in the hall. When Resident #110 stood up behind his walker to walk, the seat of his wheelchair did not have a Dycem in it.</p> <p>During an interview on 11/9/12 at 11:25 a.m., CNA #5, indicated there was not a Dycem in Resident #110's wheelchair.</p> <p>Resident #110's nursing notes, dated 7/25/12 at 3:15 p.m., indicated "resident slid out of wheelchair falling to floor while playing bingo in dining room."</p> <p>Resident #110's nursing notes, dated 10/27/12 at 5:45 p.m., indicated "while out on outing the resident was being escorted across a wooden bridge. The end of the bridge was not level with the ground and when the wheelchair reached the end of bridge the wheel got stuck and the wheelchair tipped forward and resident fell out."</p> <p>During an interview on 11/13/12 at</p>			

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	<p>9:45 a.m., ADON #2, indicated there was not an intervention put in place after Resident #110's fall on 10/27/12.</p> <p>3.1-45(a)(2)</p>			

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F0356 SS=B	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to provide nurse staff posting information in the East building 6 of 6 days of survey, and failed to provide nurse staff posting information that was visible in the</p>	F0356	<p>F 356 Posted Nurse Staffing Information It is the practice of the provider to post the following information on a daily basis: *Facility name *The current date *The total number and the actual hours worked by the following</p>	12/07/2012

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	<p>West building for 1 of 6 days of survey.</p> <p>Findings include:</p> <p>During initial tour of the facility on 11/5/12 at 9:00 A.M., the nurse staff posting information in the West building was correct, but not all of the information was visible. The information was on a clip board in a wooden box holder, high on the wall. The facility's name, date and census could be viewed. The remainder of the information on the clip board was down in the wooden box holder and out of sight.</p> <p>No nurse staff posting was visible in the East building. An interview with the Assistant Director of Nursing (ADON) #1, on 11/5/12 at 9:29 A.M., indicated the facility just posted nurse staffing in the West building.</p> <p>On 11/14/12 at 12:00 P.M., the ADON #1 indicated nurse staffing had not been posted in the East building for the 6 days of survey.</p> <p>3.1-13(a)</p>		<p>categories of licensed and unlicensed nursing staff directly responsible for resident care per shift in both building 1. Posting of staffing information corrected. 2. Facility nursing staffing information will be posted in both buildings by copy room. 3. The administrator has re-educated the DON related to the facility policy and procedure on staff posting. The Director of Nursing or designee will post the staffing patterns for the following day each weekday evening and for the weekend on Friday. 4. The administrator or designee will verify that the staffing pattern is posted for the day by visualizing presents of posting daily five days a week for 4 weeks then weekly x 2 months and monthly thereafter for 9 months. Results of these visual rounding will be submitted to the facility QI/QA for further review and recommendations. 5. Compliance date: 12/7/12</p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to</p>	F0441	F441=D	12/07/2012

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	<p>follow standard infection control practices, in that the nurse failed to wash her hands and don gloves, prior to insulin and eye drop administration for 2 of 2 residents observed for insulin administration and 1 resident of 2 residents observed for eye drop administration. (Resident #47 and #69)</p> <p>Findings include:</p> <p>1.) On 11/8/12 at 9:37 A.M., Resident #47 was observed for medication administration by LPN #7. Medications set up for Resident #47 included oral medications, insulin, and eye drops. LPN #7 entered Resident #47's bedroom and announced her procedure. LPN #7 provided Resident #47 her oral medications. LPN #7 administered 12 units of Novolog 70/30 subcutaneous in Resident #47's left lower abdomen. LPN #7 administered Alphagan 0.1% eye drops in each of Resident #47's eyes. LPN #7 then washed her hands. LPN #7 was not observed washing her hands or donning gloves prior to the insulin and eye drop administration.</p> <p>LPN #7 was queried at that time if she normally washed her hands and donned gloves prior to insulin and eye</p>		<p>Infection Control It is the practice of the facility to follow all infection control procedures.</p> <p>1. Assessment completed on resident #47 and #69 to ensure no adverse reactions were evident. 2. All residents receiving eye drops or injections were evaluated for signs and symptoms related to possible infections 3. Staff reeducated on infection control program. 4. DON or designee will monitor nursing procedures for infection control policy daily five days a week x 4 weeks, weekly x 2 months and then monthly thereafter for 9 months. Results of the audit will be reported to QI/QA committee for review and recommendation. 1.Compliance Date 12/7/12</p>	
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	<p>drop administration. LPN #7 replied "I don't; no."</p> <p>The most recent Eye Drop Administration policy provided by the Assistant Director of Nursing #2 on 11/9/12 at 2:30 P.M., indicated the following: "Policy: Medications are to be instilled in the eye in a consistent manner to minimize discomfort and ensure effectiveness. Installations [sic] are to be performed by a Clinical Nurse as ordered. Procedure: 5.) Wash hands and apply gloves"....</p> <p>2.) Resident #69's record was reviewed on 11/08/12 at 11:00 a.m. Resident #69's diagnoses included, but were not limited to sepsis, osteomyelitis (bone injection), stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure area with MRSA (Methicillin-Resistant Staphylococcus Aureus).</p> <p>Resident #69's MDS (Minimum Data Set), assessment, dated 10/24/12, indicated the following:</p> <ul style="list-style-type: none"> - could not name correct year, month or day - wound infection, yes - stage 4 pressure ulcer, 1 			

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	<p>Resident #69's "culture of left heel wound," dated 9/26/12," indicated "many staph aureus MRSA."</p> <p>On 11/8/12 at 7:50 a.m., LPN #6 was observed administering a SQ (subcutaneous, just under the skin) injection of insulin into Resident #69's right lower quadrant of her abdomen. LPN #6 did not wear gloves while administering the insulin.</p> <p>During an interview on 11/8/12 at 7:55 a.m. LPN #6 indicated she did not wear gloves to give insulin injections. LPN #6 also indicated Resident #69 was in contact isolation due to MRSA in her left heel.</p> <p>A document titled, "Subcutaneous Injection," dated 3/12, provided by the ADON on 11/13/12 at 2:00 p.m., and indicated by the ADON to be the most current policy indicated, "Policy, The Clinical Nurse will administer subcutaneous injections per physician's order, and will vary subcutaneous injection sites to minimize tissue damage, aid absorption and avoid discomfort. Procedure: included but were not limited to, identify resident, explain procedure to resident, provide privacy, wash hands and put on gloves."</p>			

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	3.1-18(l)			

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 bathrooms were free of odor and/or toilets were clean and sanitary for 9 of 40 rooms observed, the facility failed to maintain a wall in good repair of 1 of 40 rooms observed in 2 of 2 buildings (East and West), the facility failed to ensure call lights were maintained in working order in 3 of 40 resident rooms or bathrooms for call light function.</p> <p>Findings include:</p> <p>1. On 11/5/12 at 1:17 P.M., the wall in Room 313 was observed to have numerous gouge marks on the wall near the recliner and at the end of the bed.</p> <p>An interview with Resident #45 in Room #306, on 11/5/12 at 1:45 P.M., indicated the toilet was very dirty and it had been 3 to 4 weeks since the toilet had been cleaned. Observation at that time, the toilet was extremely dirty black in the toilet bowl. The toilet seat was also soiled.</p>	F0465	<p>F465=E: Safe/Functional/Sanitary/Comfortable Environment It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the community.1. Toilets in resident bathrooms #102, 209, 306, 313, 403, 409, 812, 903 and 910 were scrubbed and cleaned with no hard water stains visible.</p> <p>Floor in resident rooms #102, 313, and 903 stripped and waxed to alleviate odor in room and hallway.</p> <p>Wall repaired in resident room 313</p> <p>Call light in rooms 306 and 812 repaired and in good working order.</p> <p>2. Toilets were checked in all shower rooms and resident bathrooms for cleanliness .</p> <p>All other resident rooms and hallways checked for urine odor.</p>	12/07/2012

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	<p>On 11/7/12 at 9:22 A.M., the 900 hall in the West building smelled strong of urine throughout the entire hallway.</p> <p>On 11/7/12 at 9:52 A.M., the bathroom in Room #102 was observed to have a dirty toilet and floor.</p> <p>On 11/7/12 at 3:46 P.M., Room # 903 smelled strong of urine. There was a large area of a brown, sticky substance on the floor near the bed. The bathroom smelled strongly of urine. The toilet seat had a dark smeared substance on it. There was a yellowish and brown substance on the floor. There were gnats observed flying around in the bathroom. LPN #7 indicated the room smelled like urine and Resident #74 must have spilled something by his bed.</p> <p>2. An environmental tour was conducted in the East and West building on 11/14/12 at 1:21 P.M., with the Maintenance Supervisor. The toilets in Room #s 910, 812, 209, 313, 306, 403 and 409 had a dark yellowish and brown substance visible in the toilet bowls. The bathroom for Room # 313 smelled strong of urine. An interview at that time with the Maintenance Supervisor indicated the toilets had water stains and the</p>		<p>All resident rooms with recliners checked for gouge marks and repaired.</p> <p>3. Staff have been re-educated on sanitation practices including odor free environment.</p> <p>Staff re-educated on updating Maintenance when repairs needed.</p> <p>Maintenance and Housekeeping Supervisor will make daily rounds to ensure areas of concern are addressed.</p> <p>1.Administrator or designee will conduct random rounds to ensure areas of concern are in compliance daily x4 weeks then weekly x 2 months and monthly thereafter. Results of these visual rounding's will be submitted to the QI/QA Committee for further review and recommendations.</p> <p>1.Compliance Date 12/7/12</p>				

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	<p>bathroom for Room #313 smelled like urine.</p> <p>3. On 11/5/12 at 11:20 A.M., Room #812's light above the bedroom door in the hallway was observed not to light up to summon help when the bathroom call light was tested.</p> <p>On 11/5/12 at 2:15 P.M., Room #306's light above the bedroom door in the hallway was observed not to light up to summon help, when the bathroom call light and bedroom call light were tested. An interview with the Maintenance Supervisor at that time indicated the bulb needed replaced. Maintenance replaced the light bulb and the call light was observed to light up outside the bedroom door when the bathroom and bedroom call light were tested on 11/5/12 at 2:20 P.M.</p> <p>3.1-19(f)</p>				

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

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FORM APPROVED

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