

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2012
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NAME OF PROVIDER OR SUPPLIER BREMEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 5, 6, 7, 8, 11, and 12, 2012</p> <p>Facility number: 000506 Provider number: 155474 AIM number: 100266530</p> <p>Survey Team: Sandra Haws, RN TC Shannon Pietraszewski, RN</p> <p>Census Bed Type: SNF/NF: 91 Total: 91</p> <p>Census by Payor Type: Medicare: 10 Medicaid: 62 Other: 19 Total: 91</p> <p>Sample: 19</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/18/12 Cathy Emswiller RN</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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F0241 SS=D	<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 observations, interview, and record review, the facility failed to ensure dignity was maintained related to exposure of the residents perineal areas (Resident # 53 and #56) and dignity related to soiled clothing and protective cover on the w/c (wheel chair) arm rest (Resident #72) for 3 of 19 sampled residents.</p> <p>Findings include:</p> <p>1. Resident # 53's record was reviewed on 6/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, depression, Lewy Body Dementia related psychosis.</p> <p>The resident's annual MDS (Minimum Data Set) assessment dated 3/19/12 indicated the resident had moderate cognitive impairment and was at risk for skin impairment.</p> <p>On 6/6/12 at 10:30 a.m., wound care to the coccyx was observed to Resident #53. The resident shared the bathroom with</p>	F0241	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident #53 was offered an apology about leaving the bathroom door open and the staff not pulling the curtain during care. Resident #56's covers were placed back over her by a staff member. The care plan was updated with interventions regarding moving of the covers. Resident #72's tray to her wheel chair was cleaned. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, therefore, this plan of correction applies to all residents. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>Nursing center staff has been in-serviced relative to dignity and respect of individuals, including but not limited to, privacy during provision of resident care and the</p>	07/12/2012			

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	<p>two other residents in the next room. LPN (Licensed Practical Nurse) # 3 and CNA (Certified Nursing Assistant) #12 turned the resident to her left side facing the bathroom door. The bathroom door was left open and the curtain was not pulled during the wound care. RN (Registered Nurse) #7 was observed walking to the door, touching it then turned around and walked back to the resident's foot of the bed.</p> <p>2. Resident #56's record was reviewed on 6/6/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, dementia, and rectal prolapsed.</p> <p>The resident's quarterly MDS assessment dated 3/2/12 indicated the resident had severe cognitive impairment and required extensive assistance with ADL's (Activity of Daily Living).</p> <p>On 6/8/12 at 2:30 p.m., the resident was observed in her bed with her head toward the wall and her feet facing the room mate/hallway. The resident did not have any covers over her lower half of the body, nor did she have any undergarments on, exposing her perineal area. The curtains were pulled back to the wall. There were visitors, staff and other resident observed in the hallway.</p>		<p>revised wheel chair cleaning schedule. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with privacy related to resident care and the new wheel chair cleaning schedule on all shifts. The Director of Nursing or designee will complete the indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>				

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	<p>CNA #12 was walking by the resident's room at this time and was interviewed at that time regarding the resident's exposure. She indicated the resident "does this often" and she will take care of it.</p> <p>Resident #56's care plan indicated the resident had a history of episodes of restlessness/fidgety with clothing, blankets which was initiated on 3/2/12. There were no interventions in place in regards to the resident when she removed her covers.</p> <p>3. Resident # 72's record was reviewed on 6/7/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia, manic depression and bipolar disorder.</p> <p>On 6/7/12 at 11:45 a.m., the resident was observed sitting in her room in her wheelchair. Her pants were soiled with several particles of food on it. Her tray attached to her wheel chair was also soiled.</p> <p>Resident #72's behavior sheet dated 6/7/12 indicated there were no behaviors by the resident in regards to being uncooperative/resistance with care.</p>			

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	<p>On 6/8/12 at 12:15 p.m., the resident was observed sitting in the dining room in her wheel chair. The tray attached to her wheel chair was soiled.</p> <p>On 6/11/12 at 10:00 a.m., the resident was observed sitting in her wheel chair. The tray attached to her wheel chair was soiled.</p> <p>On 6/11/12 at 12:20 p.m., the resident was observed sitting in her wheel chair. The tray attached to her wheel chair was soiled.</p> <p>The resident's quarterly minimum data set assessment dated 4/30/12 indicated the resident had severe cognitive impairment and required assistance with ADL's [activities of daily living].</p> <p>The resident's care plan initiated on 2/15/12 indicated the resident required extensive physical assist of staff for ADL's.</p> <p>The wheel chair cleaning schedule was provided on 6/12/12 at 1:50 p.m. by the Administrator. Resident #72's wheel chair was scheduled to be cleaned every Thursday on second shift. During interview at that time, the Administrator indicated the staff should have been cleaning any wheel chairs, including</p>						

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	<p>trays, anytime they became soiled.</p> <p>The facility's policy on Quality of Life was provided on 6/12/12 at 11:30 a.m. by RN #11. It indicated ..."1. The patient is treated with respect that assists the patient to maintain and enhance his/her self-esteem and self-worth...7. Patients' privacy of body is maintained including keeping patients sufficiently covered..."</p> <p>3.1-3(t)</p>				

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; 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; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure an assessment was completed for a physical restraint and ADL's (Activities of Daily Living) for 1 of 19 residents admission MDS (Minimum Data Set) assessments reviewed. (Resident #62).</p>	F0272	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p> <p><i>The corrective action taken for the residents found to have been affected by the deficient practice</i></p>	07/12/2012

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	<p>Findings include:</p> <p>Resident #62's record was reviewed on 6/7/12 at 9:50 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy, anoxic brain injury, autism, vaso-vagal episode, scoliosis, and seizure disorder.</p> <p>The resident was admitted to the facility on 5/3/12. An acknowledgment of a physical restraint use was signed by the POA (Power of Attorney) on 5/10/12.</p> <p>On 5/14/12 at 3:05 p.m., SSD (Social Service Director) had indicated in the progress notes the resident "...rarely/never expresses ideas/wants or understands what is said. Recvs [sic] (received) total care...Is fed meals by staff..."</p> <p>An admission MDS assessment date of 5/14/12 indicated the resident was intellectually disabled ('mental retardation' in federal regulation), severely impaired for daily decision making, totally dependent with personal hygiene, always incontinent of bowel and bladder, and indicated zero for no physical restraint. The Care Area Assessment (CAA) Summary indicated there were no triggers for ADL functional/rehabilitation potential or for physical restraints.</p>		<p><i>was:</i></p> <p>Resident #62 was reassessed for wearing the seat belt while up in geri chair. Resident #62's chart updated with current assessment. Care plan was reviewed and updated, as necessary.</p> <p><i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>The restraint use evaluations for all residents, that have restraints, have been reviewed with no concerns noted.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>Licensed nursing staff has been in-serviced relative to comprehensive assessments, including but not limited to, restraint assessment. Nursing center now has a full time MDS Coordinator which will help capture the resident information accurately on the MDS.</p> <p><i>To ensure the deficient practice does not recur, the monitoring system established is:</i></p> <p>A Performance Improvement indicator has been established which evaluates compliance with accurately capturing resident</p>				

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	<p>On 6/8/12 at 11:30 p.m., Resident #62 was observed sitting in her geri chair with a seat belt restraint secured around her waist.</p> <p>On 6/11/12 at 12:20 p.m., Resident #62 was observed sitting in her geri chair with a seat belt restraint secured around her waist.</p> <p>Resident #62's restraint record for May and June, 2012 indicated a restraint was used while the resident was up in her geri chair.</p> <p>During an interview on 6/12/12 at 11:05 a.m. with the Administrator, he indicated he did not have a MDS Coordinator at this time. He indicated a MDS Coordinator from another facility came in weekly to assist until his new MDS Coordinator starts and she did not know these residents. When inquired about where the information came from for the MDS Coordinator to answer the questions, he had indicated it should have come from the resident records/staff documentation.</p> <p>3.1-31(a) 3.1-31(c)(3) 3.1-31(d)(1)</p>		<p>information, including restraint use, on to the MDS. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>				

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a care plan was initiated for a physical restraint, ADL's (Activities of Daily Living), contracture prevention and constipation for 2 of 19 sampled residents reviewed (Resident #62 and #72), and updating the care plans as indicated for 2 of 19 sampled residents reviewed. (Resident #56 and #70)</p> <p>Findings include:</p> <p>1. Resident #56's record was reviewed on</p>	F0279	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p> <p><i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i></p> <p>The care plans for residents #56, #62, #70 and #72 have been reviewed and amended to include the following:</p> <p>#56 – the need for the assistance of 3 for transfers. #62 – constipation, contracture</p>	07/12/2012			

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	<p>6/6/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression and dementia.</p> <p>A reportable event was reported to ISDH (Indiana State Department of Health) on 4/24/12 at 9:30 a.m. It indicated the resident was being transferred from the bed to the w/c (wheel chair) using a mechanical lift with the assistance of two CNA's (Certified Nursing Assistants) when the resident "suddenly lunged forward and before CNAs could catch her she fell forward out of lift." The preventive measures on the reportable report indicated "will utilize 3 assist to transfer resident in the future (w/ [with] one CNA in front)..."</p> <p>The resident's current care plan for 'fall risk' had not been updated to include the need for the assistance of 3 for transfers.</p> <p>2. Resident #62's record was reviewed on 6/7/12 at 9:50 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy, anoxic brain injury, autism, vaso-vagal episode, scoliosis, and seizure disorder.</p> <p>The resident was admitted to the facility on 5/3/12. An acknowledgment of a physical restraint use was signed by the POA (Power of Attorney) on 5/10/12.</p>		<p>prevention, restraints, and ADL's. #70 – interventional updates for appropriate treatments. #72 – refusal of wearing the hand splint.</p> <p><i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>The care plans for all residents were reviewed and updated, as necessary, to ensure they accurately reflect the resident's current status.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>Licensed nursing staff has been educated relative to developing comprehensive care plans, including but no limited to, ensuring care plans of each resident are updated to reflect current interventions, including assistive devices. DNS, ADNS, and designees shall be responsible for ensuring care plans of each resident are updated daily, during the Monday through Friday clinical meeting, ongoing, with receipt of new orders, diagnosis or assistive care device.</p> <p><i>To ensure the deficient practice does not recur, the monitoring system established is:</i></p>				

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	<p>On 5/14/12 at 3:05 p.m., the SSD (Social Service Director) indicated in the progress notes the resident "...rarely/never expresses ideas/wants or understands what is said. Recvcs [sic] (received) total care...Is fed meals by staff..."</p> <p>An admission MDS (Minimum Data Set) assessment date of 5/14/12 indicated the resident was intellectually disabled ('mental retardation' in federal regulation), severely impaired for daily decision making, totally dependent with personal hygiene, always incontinent of the bowel and bladder, and indicated a zero for no physical restraint. The Care Area Assessment (CAA) Summary indicated there were no triggers for ADL functional/rehabilitation potential or for physical restraints.</p> <p>The physician clinic note dated 6/4/12 indicated the resident had "some difficulty with constipation" and increased her medication and to "watch for signs of diarrhea." The note also indicated "flexion contractures of her hands and weakness of her arms and legs...flexion contractures of her legs and hands, feet, atrophy of the muscles in her arms, legs back, has a large incision, healed from previous rod placement..."</p>		<p>A performance improvement indicator has been established that evaluates the compliance with the presence of care plans accurately reflecting the care needs of the residents. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>On 6/7/12 at 10:30 a.m., the resident was observed in her bed with the head of the bed up high with the resident lying partially on her side/back in a fetal position low in the bed with the pad between back of her head and lower back.</p> <p>On 6/7/12 at 12:30 p.m., the resident was observed in bed with the head of bed up high, on her back, with her knees bent up towards her chest.</p> <p>On 6/8/12 at 12:00 p.m., the resident was observed up in her geri chair with the restraint belt secured around her waist and her legs had been partially bent.</p> <p>On 6/11/12 at 12:20 p.m. during a family interview, the resident was observed sitting in her geri chair with the restraint belt secured around her waist, and was being fed by her sister-in-law. She was also observed to have straightened out her legs upon excitement with the children in the room.</p> <p>Resident #62's restraint record and treatment record for May and June, 2012 indicated the restraint was used while the resident was up in her geri chair.</p> <p>Resident #62's record was reviewed on 6/7/12 at 9:50 a.m. and again on 6/11/12 at 4:00 p.m., there were no care plans</p>			

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	<p>initiated for constipation, contracture prevention, restraints and ADL's.</p> <p>Upon interviewing LPN (Licensed Practical Nurse) #2 on 6/12/12 at 11:15 a.m. regarding care plans, she indicated the nursing staff was never allowed to manage the care plans until the last few weeks.</p> <p>During interview on 6/12/12 at 11:05 a.m. with the Administrator, he indicated he did not have a MDS Coordinator at this time. He indicated a MDS Coordinator from another facility came weekly to this facility to assist until his new MDS Coordinator starts, and she did not know these residents. When inquired about where the information came from for the MDS Coordinator to answer the questions, he indicated it should have come from the resident records/staff documentation.</p> <p>3. Resident #70's record was reviewed on 6/7/12 at 3:45 p.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke) with hemiparesis, dementia with confusion, poor mobility, and bed fast.</p> <p>A progress note dated 5/16/12 at 4:05 p.m. indicated..."tx (treatment) conts (continues) to bottom..."</p>						

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	<p>Resident #70's MAR (medication administration record) for June, 2012, indicated on ...5/9/12 an order for "Mepilex border to bottom prophylactic every other day" and on 4/14/12 an order for "air boots on bilateral feet at all times..."</p> <p>A current care plan for "At risk for skin breakdown" was initiated on 11/28/11 and did not indicate interventional updates for the Mepilex border or the air boots to the bilateral feet. All interventions were dated 11/28/11.</p> <p>A care plan dated 3/1/12 for a stage II pressure area on the coccyx indicated it was healed on 4/4/12.</p> <p>Another care plan on 5/4/12 for a popped blister on the foot/heel indicated it was healed on 5/28/12.</p> <p>4. Resident #72's record was reviewed on 6/7/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia, manic depression, bipolar disorder and cerebral vascular accident (stroke).</p> <p>On 6/7/12 at 11:45 a.m., the resident was observed with no hand splint on the left hand. At 2:20 p.m., there wasn't a hand</p>						

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	<p>splint on the resident's left hand.</p> <p>On 6/8/12 at 10:20 a.m., the resident was observed with no hand splint on the left hand.</p> <p>On 6/11/12 at 10:00 a.m., the resident was observed not to have had a hand splint on the left hand. At 12:10 p.m., there wasn't a hand splint on the resident's left hand.</p> <p>Interviewed CNA # 8 and CNA #12 on 6/11/12 at 12:15 p.m. regarding the resident's left hand splint. Both indicated the resident refused to wear her splint and cried if it is attempted.</p> <p>Interviewed LPN #3 on 6/11/12 at 12:25 p.m. regarding the resident's left hand splint. Reviewed care plan at this time and inquired about the splint refusal and the care plan not being updated. LPN #3 had indicated they are waiting to see if the resident will respond to the seroquel. The seroquel had been discontinued on May 7, 2012 and it was recently restarted. Since May 7, 2012, the resident had refused to wear the splint.</p> <p>A company policy "Comprehensive Plan of Care" dated 5/28/08, was provided by RN #11 on 6/12/12 at 11:30 a.m. had indicated ..."25. Update the care plans during the course of care delivery to</p>				

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	<p>reflect:...b. Improvement (interventions modified or deleted); c. New problems (resultant of change of condition or resident event); or d. Modified interventions (resultant of change of condition or resident event)..."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(d)(1) 3.1-35(e) 3.1-35(g)(1)</p>			
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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure showers were given, hair and nail care were cleaned for 2 of 19 reviewed. (Resident #5 and #62) and 1 of 19 resident reviewed for oral care. (Resident #56)</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 6/11/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), dementia, and hemiparesis.</p> <p>Resident #5's MDS (Minimum Data Set) assessment dated 4/30/12 indicated the resident was cognitively intact. The functional status indicated the resident needed extensive assistance with personal hygiene, and received physical help in part of the bathing activity.</p> <p>Resident #5's current care plan indicated "requires physical assist of staff for ADL's (Activities of Daily Living) and was initiated on 09/07/11. Interventions</p>	F0312	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's #5 and #62 received appropriate care at the time of discovery during the survey. Resident #56 received oral care at the time of discovery during the survey. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, thus, this plan of correction applies to all residents. Facility observed all other residents for nail, hair, and oral care needs and provided care as necessary. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been in-serviced relative to ADL care provision for the dependent resident, including but not limited to, ensuring resident's hair and nails are cleaned and oral hygiene is provided to the residents. <i>To ensure the deficient</i></p>	07/12/2012			

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	<p>indicated to assist to bathe as scheduled.</p> <p>The shower skin assessment form indicated the following; the resident had not taken a shower for the last 13 days (since 5/30/12) and there was no indication of a shower given for 10 days between 5/13/12 to 5/23/12.</p> <p>On 6/12/12 at 10:30 a.m. during a resident interview, Resident #5 indicated she had not received a shower in approximately four weeks. The resident indicated her shower days were Wednesday and Saturday on evening shift. Resident #5 indicated she had refused a few times when she had already gone to bed. When inquired about the past weekend shower schedule, Resident #5 indicated she had not received her shower on Saturday due to being short staffed. The resident indicated she was told by LPN (Licensed Practical Nurse) #14 and CNA (Certified Nursing Assistant) #15 they would try to get to her Sunday evening but "don't expect it." When inquired about offers for other days or times, the resident indicated she had not been offered another time and had to wait until the next scheduled shower day. Upon observation during this interview, the resident's hair appeared unclean.</p> <p>During interviewed with LPN #2 and RN</p>		<p><i>practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with grooming to include hair, nail, and oral care on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>(Registered Nurse) #7 on 6/12/12 at 11:15 a.m. regarding the resident's shower schedule, LPN #2 indicated the resident had periods of confusion and she was not made aware during report at change of shift of the resident's refusal of showers. LPN #2 indicated the resident liked to lie in bed with her hair in the towel after showers. RN #7 indicated she would look at the possibility of changing the resident's shower schedule from evening shift to day shift.</p> <p>2. Resident #56's record was reviewed on 6/6/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, and dementia.</p> <p>On 6/7/12 at 11:55 a.m., the resident was observed in the dining room with a beige colored substance at the gum line of the resident's teeth.</p> <p>On 6/8/12 at 10:30 a.m., the resident was observed in the dining room with a beige colored substance at the gum line of the resident's teeth.</p> <p>During interviewed with RN #7 on 6/11/12 at 11:50 a.m. regarding oral care for the resident, RN #7 indicated the resident needed oral care.</p> <p>3. Resident #62's record was reviewed on</p>						

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	<p>6/7/12 at 9:50 a.m. The resident's diagnoses included, but were not limited, to cerebral palsy, anoxic brain injury, autism, vaso-vagal episode, scoliosis, and seizure disorder.</p> <p>An admission MDS assessment date of 5/14/12 indicated the resident was intellectually disabled ('mental retardation' in federal regulation), severely impaired for daily decision making and was totally dependent with personal hygiene.</p> <p>On 6/11/12 at 12:20 p.m. during a family interview, the family member pointed out and it was observed a dark colored substance underneath the resident's nail beds.</p> <p>Shower skin assessment sheets for May and June, 2012 were provided by the Administrator on 6/12/12 at 12:30 p.m. The shower sheets indicated the resident had one shower between 5/4/12 and 5/17/12 and the resident did not have a shower between 5/19/12 to 6/1/12 and between 6/2/12 to 6/12/12.</p> <p>During interview with the Administrator on 6/12/12 on 12:30 p.m., the Administrator indicated a shower was not done between 6/1/12 and 6/12/12.</p>						

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	3.1-38(a)(2) 3.1-38(b)(1)				

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident safety by not having the sensor pad alarm plugged in alarm box for 4 out of 4 residents reviewed in a sample of 19. (Resident #10, #14, #45, #72)</p> <p>Findings include:</p> <p>1. Resident #10's record was reviewed on 6/8/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, aftercare of hip fracture, osteoarthritis, and dementia.</p> <p>A nursing note dated 5/9/12 at 12:39 p.m. indicated "...(arrow up) up (s with line over it-with) assistance 5/6/12 x2 (2 times) & (and) fell. Sensor mat on at all x's (times)..."</p> <p>A medication record for the month of June indicated a sensor mat to w/c (wheel chair) was initiated on 5/7/12 and was being initialed by staff as being monitored.</p>	F0323	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's #10, #14, #45, and #72 sensor pad alarm were plugged back into the alarm box at the time of discovery during the survey. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> The facility validated that all alarms are on appropriate per the resident's care plan. No other residents were found to be affected by these practices. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been in-serviced relative to accident hazards/supervision/devices, including but not limited to, the importance of ensuring resident's alarms are functional and operational. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance</p>	07/12/2012			

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	<p>On 6/8/12 at 3:20 p.m., the resident was observed lying in bed with sensor pad cord lying on the floor. The alarm box was hanging on the resident's w/c. The family member sitting at resident's bedside indicated the resident hadn't had an alarm on "all day". During this time, the Administrator was walking by the resident's room and entered the room and observed the alarm was not plugged in.</p> <p>A CAA (Care Area Assessment) summary dated 6/1/12 triggered the risk for falls. A "Review of Indicators of Fall Risk" was printed with the MDS assessment signed and dated for 6/1/12., and indicated the resident was "At risk for falls R/T (related to) hx (history) of falls w/fx (with fracture), confusion, hip fx."</p> <p>A Chair alarm and bed alarm monitoring tool was provided by RN #7 on 6/11/12 at 12:30 p.m. The tool indicated the use of both alarms for the month of June. RN # 7 indicated during interview at that time, a care plan was to be developed.</p> <p>A care plan for risk of falls was requested from RN # 7 on 6/11/12 at 12:30 p.m. but was not provided by the exit on 6/12/12.</p> <p>2. Resident #14's record was reviewed on 6/11/12 at 4:30 p.m. The resident's</p>		Improvement indicator has been established which evaluates compliance with resident safety regarding alarms on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.				

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	<p>diagnoses included, but were not limited to, cerebral vascular accident (stroke) with hemiparesis, mild intellect disability, encephalopathy and anoxic brain damage.</p> <p>On 6/8/12 at 3:25 p.m., the resident was observed lying in bed with a sensor pad cord lying on the floor. The alarm box was hanging on the resident's bed rail. During this time, RN (Registered Nurse) #7 was walking by the resident's room and entered the room to observe the alarm was not plugged in.</p> <p>The resident's care plan dated 1/27/12 indicated the resident was at "risk for falls" and "the sensormat" was to be on as ordered.</p> <p>The MDS (Minimum Data Set) assessment dated 4/12/12 indicated the resident had severe cognitive impairment.</p> <p>3. Resident #45's record was reviewed on 6/8/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, advanced dementia and hospice care.</p> <p>On 6/8/12 at 3:30 p.m., the resident was observed lying in bed with a sensor pad cord lying over the chair. The alarm box was hanging on the resident's bed rail. During an interview at that time, requested RN #7 came into the resident's</p>						

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	<p>room and observed the alarm was not plugged in.</p> <p>The resident's current care plan indicated the resident was at "risk for falls" and for the "sensor pad at all times."</p> <p>4. Resident #72's record was reviewed on 6/7/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia, manic depression, bipolar disorder and cerebral vascular accident (stroke).</p> <p>During observation on 6/8/12 at 10:20 a.m., the resident's sensor pad cord was lying on the floor with wires exposed. The alarm box was hanging on the resident side rail.</p> <p>During an interview at that time, LPN #1 indicated she was not made aware of the broken sensor wire/plug and did not know how long it has been broken.</p> <p>3.1-45(a)(2)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility had failed to ensure the meat slicer remained free from dirt and greasy build up, failed to ensure hand washing was completed upon contamination, and failed to ensure the kitchen environment was clean and sanitary from dirt and greasy debri on the floors, under the shelving units, serving area, and around the base boards. This deficient practice had the potential to affect 88 of 91 residents who resided in the facility and received meals from the kitchen.</p> <p>Findings include:</p> <p>Upon initial tour of the kitchen with the Dietary Manager on 6/5/12 at 10:50 a.m., the meat slicer was covered with a plastic bag. The Dietary Manager removed the bag for inspection. The meat slicer had dirt and greasy build up on the blades, around the screws and on the base.</p> <p>Dietary Aide # 1 was observed gloved, lifted up the trash can lid, then went back</p>	F0371	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i>The meat slicer was cleaned at the time of discovery. Dietary Aide #1 has been re-in-serviced on proper glove use while in the kitchen. Dietary Manager was re-in-serviced on proper hand washing. The whole kitchen floor power washed and cleaned during the survey process. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i>All residents have the potential to be affected, thus, this plan of correction applies to all residents. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Dietary staff has been re-in-serviced relative to sanitary food procurement, storing/preparing/serving, including but not limited to, kitchen sanitation, proper glove</p>	07/12/2012			

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	<p>to covering dishes with plastic wrap without washing her hands.</p> <p>The Dietary Manager did not wash her hands after touching the meat slicer. While looking through the clean dishes, both the Dietary Manager and Dietary Aide # 1 continued to pull out clean dishes during inspection. The Dietary Manager realized she hasn't washed her hands and informed the Dietary Aide # 1 she couldn't touch anything else without washing her hands.</p> <p>Thee floor under the shelving units and along the base boards had dark brown to black greasy debri/build up. This was also observed around the stove area and under the heated serving area.</p> <p>Upon interviewing the Dietary Manager during the tour, she indicated the kitchen was mopped nightly and power washed once a week.</p> <p>During observation on 6/11/12 at 11:50 a.m., the kitchen area continued to have dark brown to black greasy debri/build up on the floor along the base boards and under the shelving units and the heated serving area.</p> <p>Upon interviewing the Dietary Manager during this observation, she indicated the</p>		<p>use, and proper hand washing. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with kitchen sanitation, proper glove use, and proper hand washing on all shifts. The Nutritional Service Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Nutritional Service Director, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>power wash should be done every Saturday. She indicated it was a "rough weekend", it was "graduation weekend" and had a hard time getting the staff to work.</p> <p>The facility policy "Hand hygiene/handwashing" dated 8/31/11 was provided by RN (Registered Nurse) #11 on 6/12/12 at 11:50 a.m. indicated..."Hand hygiene is to be performed: ...Before and during food preparation; as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks..after handling soiled equipment or utensils..."</p> <p>During interview the policy on the kitchen environment/cleaning was requested from RN #11 and the cleaning schedule was requested from the Dietary Manager on 6/11/12 at 11:50 a.m.. As of exit on 6/12/12 neither was provided.</p> <p>3.1-19(f) 3.1-21(i)(2)</p>				

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F0514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident records were completed (Resident #45, #62 and #72) and accurately documented (Resident #45 and #53) for 4 of 9 residents in a sample of 19.</p> <p>Findings include:</p> <p>1. Resident #45's record was reviewed on 6/8/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, advanced dementia and hospice care.</p> <p>Nursing records on 5/7/12, 5/14/12, 5/21/12, 5/28/12 indicated the resident's wound measurements was 0.3 cm (centimeters) x (by) 0.3 cm. The nursing care plan on 5/15/12 indicated the resident's wound measured 3.0 cm x 1.0</p>	F0514	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p> <p><i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i></p> <p>Resident #45's wound was re-measured. Resident #45's chart updated with current measurement.</p> <p>Resident #53's wound was reassessed. Resident #53's chart updated with current assessment.</p> <p>Resident #62 was given a shower and repositioned at the time of during the survey.</p> <p>Resident #72 was re-evaluated</p>	07/12/2012			

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	<p>cm.</p> <p>Bed and Chair alarm flow sheets did not indicated if the alarms were "on/off/sounded" during the day shift on 6/11/12.</p> <p>Interviewed LPN (Licensed Practical Nurse) #2 on 6/12/12 at 11:00 a.m., regarding the correct measurement, she indicated she didn't know and the nurse would be in tomorrow to measure the wound. She indicated everyone tends to measure differently.</p> <p>2. Resident #53's record was reviewed on 6/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes, Lewy Body Dementia related psychosis and history of a stroke.</p> <p>A physician order on 6/7/12 indicated a new treatment order for a debriding agent to be applied to the coccyx wound.</p> <p>Nursing documentation for daily monitoring for pressure ulcers indicated there had been no change in the wound appearance from June 2 to June 11, 2012. The wound nurse weekly pressure ulcer assessment indicated a deterioration in the wound appearance between June 1 to June 8, 2012. The resident's coccyx</p>		<p>on the application of the hand splint.</p> <p><i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>All residents have the potential to be affected, thus, this plan of correction applies to all residents.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>Nursing staff has been in-serviced relative to records complete/accurate/accessible, including but not limited to, the importance of ensuring documentation of care is complete and accurate.</p> <p><i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with accurate documentation of care provided to the resident. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. DNS, or designee, will review results during the monthly performance improvement committee meeting</p>		

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	<p>wound had went from a Stage III to a Stage IV with no granulation and 100% of the wound bed being necrotic tissue.</p> <p>3. Resident #62's record was reviewed on 6/7/12 at 9:50 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy, anoxic brain injury, autism, vaso-vagal episode, scoliosis, and seizure disorder.</p> <p>Shower skin assessment sheets for May and June, 2012 were received from the Administrator on 6/12/12 at 12:30 p.m. The shower sheets did not indicate the date the resident had a shower between 5/4/12 to 5/18/12 nor did it indicated if the resident had a shower between the dates of 6/1/12 to 6/12/12.</p> <p>The ADL (Activities of Daily Living) record for May 2012 had 17 areas were left blank between 5/4/12 to 5/15/12 between day and evening shift</p> <p>The Position Sheet for May 2012 had 18 days were left blank between 5/3/12 to 5/31/12 between day, evening, and night shifts.</p> <p>During record review on 6/7/12 at 9:50 a.m., the bowel retraining assessment and bladder status evaluation forms were found in the resident's clinical record and</p>		to determine the need for continued monitoring or resolution.				

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	<p>were found to be incomplete.</p> <p>The restraint record form for 6/2/12, 6/3/12, 6/4/12 and 6/6/12 were left blank for the entire shifts between days and night shift.</p> <p>4. Resident #72 record was reviewed on 6/7/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia, manic depression, bipolar disorder and cerebral vascular accident (stroke).</p> <p>During observation of the resident on 6/7/12 at 11:45 a.m., there was not a hand splint on the resident's left hand. At 2:20 p.m., there was not a hand splint on the resident's left hand.</p> <p>On 6/8/12 at 10:20 a.m., there was not a hand splint on the resident's left hand.</p> <p>On 6/11/12 at 10:00 a.m., there was not a hand splint on the resident's left hand. At 12:10 p.m., there was no hand splint on the resident's left hand.</p> <p>Treatment record for May and June, 2012 indicated the resident's hand splint was to be applied at 10:00 a.m. and removed at 12:00 p.m. The treatment order on the treatment record read "Left resting hand splint on 2 hours every a.m. and 2 hours</p>				

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	<p>every p.m." The record indicated by staff initials of the resident wearing the splint when she had not been wearing the splint.</p> <p>Interviewed CNA (Certified Nursing Assistant)# 8 and CNA #12 on 6/11/12 at 12:15 p.m. regarding the resident's left hand splint. Both indicated the resident refuse to wear her splint and cries if it is attempted.</p> <p>Interviewed LPN (Licensed Practical Nurse)#3 on 6/11/12 at 12:25 p.m. regarding the resident's left hand splint and the resident's refusal to wear the hand splint. LPN #3 indicated ever since the seroquel had been discontinued on 5/7/12 the resident had refused to wear the splint.</p> <p>3.1-50(a)(1)</p>				