

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/05/2013
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NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
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F000000	<p>This visit was for a Recertification and State licensure survey. This visit was also for investigation of Complaint IN00134061. This visit resulted in an immediate jeopardy as past noncompliance. This visit resulted in an extended survey-substandard quality of care.</p> <p>Complaint IN00134061 - Substantiated. Federal/state deficiencies related to the allegation are cited at F-323</p> <p>Survey Dates: August 26, 27, 28, 29, 30, 2013 Extended Survey Dates: September 3, 4, 5, 2013</p> <p>Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400</p> <p>Survey Team: Mary Weyls RN TC Teresa Buske RN August 26, 27, 28, 29, 30, 2013 and September 4, 5, 2013 Laura Brashear RN Karen Hartman RN Joyce Hoffman RN</p> <p>Census Bed Type:</p>	F000000	F 000 Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Davis Gardens of the truth of the facts alleged in this statement of deficiency and plan of correction is submitted exclusively to comply with state and federal law. Davis Gardens reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Davis Gardens Quality Assurance Performance Improvement Committee.	

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

TITLE

(X6) DATE

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

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	<p>SNF/NF: 65 Residential 33 Total: 98</p> <p>Census By Payor Source: Medicare: 12 Medicaid: 25 Other: 61 Total: 98</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2</p> <p>Quality review completed on 09/11/2013 by Brenda Marshall Nunan, RN.</p>				

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure physical abuse did not occur for 1 of 3 residents reviewed for abuse (Resident #35).</p> <p>Findings include:</p> <p>Resident #35 was observed during resident interview, on 08/27/13 at 9:23 a.m., sitting on a special cushion in his recliner with his feet elevated on the recliner's foot rest. Interview with Resident #35, at this time, indicated he "had a guy try to fight me in here. He got laid off."</p> <p>Interview with Resident #35, on 08/30/13 at 11:00 a.m., indicated "The CNA (Certified Nurse Aide #12) grabbed my shoulder and got in my face." Resident #35 indicated the CNA didn't hurt him. Resident #35 indicated, "They (the facility) laid him off and fired him." Resident #35 indicated, CNA #12 was "not working</p>	F000223	F 223 Free From Abuse/Involuntary Seclusion What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? Resident 35 suffered no adverse effects as a result of this practice. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Interviews were conducted by Social Services Coordinator to assure that no other residents were affected. No other concerns were identified. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Education was conducted on Resident Rights/Abuse and Abuse Reporting for all health center staff. Davis Gardens health center has an employee assistance program for all employees to utilize. Staff will be	10/05/2013	

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	<p>here, they laid him off that morning, that day." Resident #35 indicated this incident "happened 7-8 weeks ago, it's been quit a while now." Resident #35 indicated he "thinks he told nurse, _____ (RN #11)." Resident #35 indicated he talked to "the main nurse man, the older guy (staff coordinator, RN #13)." Resident #35 indicated, "I told them all. I haven't seen him (CNA #12) since."</p> <p>Interview with the Administrator, on 08/30/13 at 11:11 a.m., indicated the incident happened on Jan. 12, 2013, at 12:15 p.m., in the shower room. The resident reported the incident to RN #11 and RN #11 told CNA #12 not to go back into Resident #35's room. RN #11 called the staff coordinator, RN #13, who was on call and he pulled CNA #12 off the floor, had him write out his statement, and sent him home. The Administrator indicated the police were called, but the resident did not want to file charges. The Administrator indicated RN #11 did an assessment of the resident and no injuries were found. The Administrator indicated the family was called, along with the physician, and Social Service Director. The Administrator indicated the incident was reported to the Indiana State Department of Health (ISDH) and the</p>		<p>monitored for any noticeable stressors they may be having and it will be recommended that they seek assistance and/or request time off. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?The Social Service Coordinator or designee will conduct Quality Assurance Performance Improvement audits by interview tools to ensure continued compliance. Audits will be 5 times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months and quarterly times six months. The Social Service Coordinator or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Administrator will oversee the process. Completion date: October 5, 2013</p>				

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	<p>CNA was turned into the CNA registry. The Administrator indicated the CNA denied the allegation, but indicated the CNA was terminated. The Administrator indicated, the facility had no other staff to resident alleged abuse.</p> <p>Interview with Administrator, on 08/30/13 at 11:55 a.m., indicated this incident was e-mailed to ISDH on 01/12/13, as the incident happened over the week-end. The Administrator indicated she followed up with a letter and spoke with ISDH via phone on the 01/14/13 as they had some questions in regards to the incident. A copy of letter to ISDH was presented.</p> <p>Interview with Administrator, on 08/30/13 at 12:40 p.m., indicated RN #13 the CNA was with RN #13 until he clocked out at 1:09 p.m. and left the building. RN #13 had CNA #12 write a statement before he left the building.</p> <p>Review of the Incident Report, dated 01/12/13 at 12:15 p.m., indicated, Resident #35 and CNA #12 had an altercation. "At 12:15 pm nurse, _____ (RN #11) entered room 121 to administer the noon med pass. At that time, _____ (name of Resident</p>			

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	<p>#35) stated, " _____ (name of RN #11) during my shower I told that CNA he did not rinse me good enough under my arms or bottom." The CNA and resident proceeded to argue. Resident #35 then reported that _____ (name of CNA #12) got very angry and grabbed him by the throat and said, "I don't have to put up with this." RN #11 told the resident that she would report this immediately and _____ (name of Resident #35) was relieved. No injuries. As soon as, _____ (name of RN #11), exited the room she immediately went to the CNA that was taking care of _____ (name of Resident #35), _____ (name of CNA #12), and informed him that he was not to go back into room __ (Resident #35's room) (name of RN #11) then called the on-call nurse, _____ (name of RN #13), to report the incident. _____ (name of RN #13) immediately called the associate administrator, _____ (name of associate Administrator), who notified the Administrator, _____ (name of Administrator). _____ (Name of associate Administrator) instructed to get Resident #35's statement and see if there was any injury. RN #11 contacted the POA (Power of Attorney) and advised her of the complaint and the steps that were being taken pending the</p>			
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	<p>investigation. RN #13 reported there were no signs of injury. Associate Administrator notified the Terre Haute Police Department who came to Davis Garden's to investigate and took a report. Preventive measures taken: RN #13 instructed the CNA, (CNA #12) , to leave the community immediately; he will be not be allowed back to work until the investigation is complete. Follow-up: Along with the above statement we contacted our Ombudsman, and Resident 35's family. Social services, _____ (name of social service person), also interviewed 3 alert and oriented residents that CNA #12 took care of and none of them had any complaints. Following the investigation we did terminate the employment between Westminster Village [Davis Gardens] and CNA #12. We also filed a report with Indiana State Department of Health against his CNA license. The family was updated on all of the above."</p> <p>Review of Interdisciplinary Progress Notes, dated 01/12/13 at 12:30 p.m., indicated, "Administrator notified this writer of possible alleged abuse to this pt (patient) from CNA. It was reported that CNA grabbed res. (resident) around the throat during shower. CNA placed immediate</p>						

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	<p>suspension. Checked res. for visual injuries, notified family per nursing staff that was on duty. An investigation initiated. TH (Terre Haute) police department notified per elder Justice Act Policy. SBOH (sic) notified".</p> <p>Notes, dated 01/14/13 at 10:00 a.m., indicated, "Res (Resident) without psychosocial distress. Does not mention previous incident et (and) does not voice concern or fear. SSD (Social Service Director) notified investigation continuing notified CNA registry and Ombudsman."</p> <p>Notes, dated 01/14/13 at 4:15 p.m., indicated, "Termed employee."</p> <p>Review of the facility's "Abuse Prevention Policy" , dated 11/03/11, indicated, "Policy Abuse Prevention Statement: It is the goal of this facility to establish a resident-sensitive and secure environment to assure proper and respectful treatment of all residents. The facility is obligated to insure (sic) that residents have the right to be free (sic) from verbal, mental, physical and sexual abuse, involuntary seclusion and neglect as defined in the attached addendum. The facility will not tolerate any abuse and will promptly and thoroughly</p>				

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	<p>investigate any allegation of abuse, neglect, misappropriation of resident property and all resident injuries of known and unknown origin. In addition, the facility will comply with the Elder Justice Act policy for reporting reasonable suspicion of a crime.... Physical, Sexual, Verbal and/or Mental (known and/or alleged) Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. this presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish....."</p> <p>3.1-27(a)(1)</p>				

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F000282 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 and record review the facility failed to ensure physician orders were followed for 1 of 1 random observation of a resident with a gastrostomy tube [g-tube.] [Resident #69]</p> <p>Finding includes:</p> <p>On 8/27/12 at 1:00 p.m., LPN# 2 was observed to administer a medication to Resident #69 through a g-tube. The resident was in bed and a continuous tube feeding was infusing. The LPN stopped the feeding, disconnected the tubing, placed a piston syringe in the g-tube, instilled some air into the tube while auscultating abdomen to check for placement. After performing the check, the LPN continued with the administration of the medication but did not check for residual gastric content.</p> <p>Resident #69's clinical record was reviewed on 8/27/13 at 2:00 p.m. A physician's order on the most recent signed recapitulation for the month of</p>	F000282	<p>F 282 Services By Qualified Persons/Per Care Plan What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice?Resident 69 suffered no adverse effects as a result of this practice. Resident 69 was reassessed for g-tube administration and as a result no change in physician orders or careplan needed.How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents currently with gastrostomy tube have the potential to be affected. In house audit was completed to identify residents who have a gastrostomy tube all careplans were reviewed and no additional changes needed. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Education was provided on correct policy and procedure for g-tube administration and skills return demonstration for all health center licensed nurses was conducted. How will the corrective action(s) be monitored</p>	10/05/2013			

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	<p>August, 2013 was noted "Check residual before meds [medications] @ (and) document amount in cc's (cubic centimeters) report residual greater than 60 cc to MD (medical doctor.)" The order was dated 12/29/12.</p> <p>3.1-35(g)(2)</p>		<p>to ensure the deficient practice will not recur?DON or designee will monitor by observational audits by licensed nurses performing g-tube medication administration and care per physician orders 5 times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months and quarterly times six months. The DON or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Completion date: October 5, 2013</p>		

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview the facility failed to ensure pressure sores were unavoidable and/or that residents received services to promote healing of pressure sores for 2 of 3 residents reviewed with pressure sores, in that services to relieve pressure and/or to ensure skin inspections were completed as planned was lacking. (Resident #'s 16 and #55)</p> <p>Findings include:</p> <p>1. On 8/29/13 at 12:50 p.m. CNA's (Certified Nurse Aides) # 4 and 5 transferred Resident #16, utilizing a mechanical lift, from a wheelchair to the bed. The residents buttocks and upper thighs were observed to have deep indentations. A dressing was noted slightly across the middle of the resident's lower buttocks. Small</p>	F000314	F 314 Treatment/SVCS To Prevent/Heal Pressure Sores What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice?Resident 16 is currently on a ROHO cushion in wheelchair, air mattress on bed and following wound consult recommendations.Resident 55 with current treatment in place and following wound consult recommendations. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents with the potential to be affected were reviewed with corrections made as necessary to update the Norton Assessments. Residents at high risk have preventative measures in-place and careplans updated. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?	10/05/2013			

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	<p>pinpoint areas were noted on the skin surrounding the dressing. A darkened area was noted above the dressing on the left buttocks.</p> <p>On 8/29/13 at 2:35 p.m., RN #6 provided a treatment to the resident's buttocks and upper area on the left side of the buttocks. The resident was observed to have open areas on both buttocks and a discolored area on the left buttock.</p> <p>On 8/30/13 at 3:45 p.m., the ADON (Assistant Director of Nursing) observed Resident #16's buttocks.</p> <p>During interview of CNA #4 on 8/29/13 at 3 p.m., CNA #4 indicated on 8/29/13, Resident #16 had been transferred to the wheelchair at 6 a.m. and the resident had been up until 12:30 p.m., due to going to physical therapy right after lunch.</p> <p>During interview of the ADON (Assistant Director of Nursing) on 8/30/13 at 3:55 p.m., the ADON indicated the resident had just returned from dialysis. The ADON indicated the area to the left side of buttocks was a new area, and the right side area looked worse. The ADON indicated the resident went to dialysis three times a week, usually</p>		<p>Education was provided to health center staff on skin issues and pressure ulcer prevention procedures. Return skills demonstration will be conducted. All new admissions, readmissions or any resident with a change in condition will have the Norton score reviewed and careplan updated with appropriate interventions initiated. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? DON or designee will monitor pressure ulcer prevention/reduction per policy and procedure through observation five times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months and quarterly times 3 months. DON or designee will validate that the skin assessments are completed per policy and procedure. The DON or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Completion date: October 5, 2013</p>	

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	<p>left around 9 a.m. and returned around 2:30 p.m. or later. The ADON indicated the out patient dialysis units didn't have the ability to lay resident's down, "just have chairs." and indicated they sent a pressure relieving cushion with the resident. The ADON indicated the resident was readmitted to the facility from the hospital on 8/12/12, and was admitted with multiple small areas on both buttocks. The ADON indicated she measured the area around the multiple open areas on each buttocks and documented measurements.</p> <p>During interview of the PTA #20 (physical therapist assistant) on 09/03/13 at 11 a.m., the PTA indicated she provided services for Resident #16. The PTA indicated the resident was brought to therapy in a wheelchair and "... cannot reposition herself, and I don't try, I don't want to cause more problems by shearing. She is a total lift and requires a mechanical lift".</p> <p>Resident #16's clinical record was reviewed on 8/29/13 at 12:15 p.m. diagnoses were noted of, but not limited to, renal failure on hemodialysis.</p> <p>Documentation on a form titled</p>						

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	<p>"Weekly Pressure Tracking Log" received on 8/28/13 at 3 p.m. from the ADON, indicated the resident was readmitted to the facility on 8/12/13, from the hospital with multiple open areas on the left buttock and right buttock. The documentation indicated the multiple areas on the resident's left buttocks measured 7.0 x 5.0 x 01 cm (centimeters), and the right buttock 7.0 x 4.5 x 0.1 cm.</p> <p>Documentation was received from the ADON on 9/4/13 at 3:17 p.m., indicating the resident had a yellow/black/ green area between the buttocks bilateral to the coccyx measuring 6.5 x 5.5 x 0.1 cm.</p> <p>A plan of care was noted, dated 8/12/13, identifying the resident with a stage 2 ulcer with an approach of, but not limited to, "Assist [resident] while turning and reposition a minimum of 2 hours."</p> <p>2. During interview of LPN #19 on 8/27/13 at 12:06 p.m., LPN #19 indicated Resident #55 had developed two Stage II pressure ulcers from an immobilizer utilized on the resident's right leg.</p> <p>During interview of the Assistant</p>						

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	<p>Director of Nursing (ADON) on 8/27/13 at 2 p.m., the ADON indicated the resident had returned from the hospital on 6/28/13 with a distal fractured femur. The ADON stated the resident had right leg immobilizer in place with orders to remove only for bathing and to check skin under the immobilizer each shift.</p> <p>The resident was observed on 8/29/13 at 11 a.m. to be positioned with a pillow under the right lower leg in a broda chair.</p> <p>On 8/30/13 at 10:42 a.m., dressings were in place and intact to the resident's right upper outer posterior thigh and right lower extremity.</p> <p>On 8/30/13 at 1:45 p.m., the right upper outer posterior thigh of Resident #55 was observed. The area was noted with pink granulation tissue and without drainage at that time. The resident was positioned with heels floated and right lower leg extremity supported with pillow.</p> <p>On 9/3/13 at 9:10 a.m., the right lower leg/ankle area treatment was observed to be completed. The area was noted to have yellow slough in the center and dark green area distal to the wound. Pink granulation tissue</p>						

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	<p>was noted around the edges.</p> <p>Upon review of Resident #55's clinical record on 8/30//13 at 3 p.m., documentation on a readmission note, dated 6/28/13, was noted with Stage II pressure ulcers to right buttocks and coccyx. The pressure ulcers to the right buttocks and coccyx were healed on 7/16/13 and 7/23/13 respectively.</p> <p>A physician's order was noted of immobilizer to right lower extremity at all times. An interagency discharge documentation dated 6/28/13 identified non-weight bearing to right lower extremity with immobilizer placed at all times to the right lower extremity and to inspect skin frequently.</p> <p>A visual skin evaluation dated 8/9/13 indicated skin intact and without concerns.</p> <p>A visual skin evaluation, dated 8/13/13, identified two Stage II pressure ulcers. A pressure ulcer on the right ankle measured 8 centimeters (cm) x 4.5 cm x 0.2 cm and a pressure ulcer on the right upper posterior thigh measured 2 cm x 1 cm x 0.1 cm.</p>						

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	<p>A wound review, dated 8/20/13, indicated the measurements on the right ankle of 7.5 cm x 3 cm x 0.1 cm with an additional assessment at the wound clinic on 8/2/13. Measurements of the right ankle wound on 8/27/13 were 7 cm x 2 cm x 0.1 cm. The measurements on 9/3/13 during wound treatment observation were 6.5 cm x 1.5 cm.</p> <p>A wound review dated 8/20/13 indicated measurements to right upper posterior thigh of 1.5 cm x 1 cm x 0.1 cm. Measurements of the right upper posterior thigh on 8/27/13 were 1 cm x 1 cm x 0.1 cm. The measurements on 9/3/13 of the area remained the same as 8/27/13.</p> <p>The Treatment Administration Record, dated August 2013, indicated the care plan dated 6/28//13 of "check RLE [right lower extremity] for pressure areas every shift." Documentation was lacking 8/9/13, 8/10/13, and 8/11/13 for 2 p.m. to 10 p.m. for the right lower extremity as checked for pressure areas.</p> <p>Upon interview of the Director of Nursing (DON) on 9/4/13 at 11:30 a.m., the DON indicated the facility did not follow the established plan to check for pressure areas to the right</p>			

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	<p>lower extremity according to the documentation. The DON indicated the right lower leg immobilizer was ordered on 6/28/13 and discontinued on 8/14/13.</p> <p>3.1-40(a)(2)</p>				

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F000315 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 and record review the facility failed to ensure services to prevent urinary tract infections for 1 of 1 random observation of a resident with an indwelling catheter. [Resident C]</p> <p>Findings include:</p> <p>1. On 8/ 27/13 at 2:00 p.m., Resident B was observed to receive a dressing treatment to the coccyx area. LPN #17 and CNA #18 positioned the resident on the left side. The resident had an indwelling Foley urinary catheter. The drainage bag and tubing were on top of the mattress throughout the treatment and was not positioned below the level of the bladder.</p> <p>2. On 9/3/13 at 9:20 a.m. Resident B was observed in a low bed. The</p>	F000315	F 315 No Catheter, Prevent UTI, Restore Bladder What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice?No corrective actions could be made for Resident D since the resident was discharged from the facility. However, the resident's foley catheter tubing did have an anti-reflex valve present to prevent the backflow of urine. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken?All residents in the facility whom have catheters have the potential to be affected by this practice. All residents in the facility with foley catheters have an anti-reflex valve preventing backflow of urine. A house audit was completed and all residents with foley catheters will be assessed every shift for proper foley catheter placement. Residents	10/05/2013			

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	<p>Foley catheter drainage bag was in contact with a blue floor mat positioned next to resident's bed.</p> <p>A physician's order was noted dated 7/14/13 to reinsert a catheter. A plan of care to address catheter positioning was not found.</p> <p>A facility policy titled "Catheter Care, Urinary" dated 2010, provided by the Assistant Director of Nursing on 9/4/13 at 3:44 p.m., included, but was not limited to "Maintaining Unobstructed Urine Flow 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. ...Infection Control 2. b. Be sure the catheter tubing and drainage bag are kept off the floor."</p> <p>3.1-41(a)(2)</p>		<p>who have a catheter in a low bed position will have a storage barrier between the catheter and the floor. Nursing staff education will be conducted on proper foley catheter placement. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Education was provided to health center staff on proper foley catheter placement. All admissions, readmissions and new foley catheter placement orders will be assessed for proper handling techniques and careplans. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?DON or designee will monitor foley catheter placement per policy and procedure through observation five times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months and quarterly times 3 months. The DON or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Completion date: October 5, 2013</p>		

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F000323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>a. Based on interview and record review the facility failed to provide supervision of a cognitively impaired individual with known elopement risk for 1 of 3 residents reviewed for elopement risk. This deficient practice resulted in a past non-compliance immediate jeopardy (Resident A).</p> <p>The Immediate Jeopardy began on July 26, 2013 when a newly admitted resident had been assessed as high risk for elopement and the facility failed to implement procedures to monitor/prevent elopement. The resident was discovered missing from the facility on July 29, 2013. The Administrator, Associate Administrator, Executive Director, and Director of Nursing were notified of the immediate jeopardy at 5:00 on 9/4/13. The immediate jeopardy was removed on July 29, 2013, and the deficient practice corrected, on August 2, 2013, prior to the start of the survey, and was therefore Past Noncompliance.</p>	F000323	Past non compliance. No POC required.	08/02/2013			

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	<p>Findings include:</p> <p>On 8/26/13 at 10:45 a.m., LPN #19 was interviewed. The LPN indicated Resident A was the only resident on the second floor unit who had eloped from the facility. Resident A was not wearing a Wander Guard when he eloped from the facility on 7/26/13. LPN #19 indicated the resident currently utilized a wander guard.</p> <p>Resident A's clinical record was reviewed on 9/3/13. The pre-admission assessment completed on 7/23/13, by the Assistant Director of Nursing (ADON) indicated the resident was alert and oriented with intermittent confusion at times. The resident's wife indicated the resident was confused while living at home.</p> <p>The initial nursing assessment, completed on 7/26/13, coded the resident with long and short term memory impairment, impaired decision making, and indicated cues/supervision was required. The assessment indicated Resident A required assistance of one for transfers and ambulation, was confused, and no safety devices or special equipment were utilized.</p> <p>A nursing note dated 7/26/13 at 10:50</p>				

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	<p>a.m., indicated the resident was noticed to be missing from the unit. The note indicated Resident A was last seen on second floor at 10:30 a.m. A Code yellow (missing resident) was announced. All available staff began looking for the resident inside and outside of the facility. The police were also notified. At 12:25 p.m. the facility security staff found the resident ambulating down the street , two miles from the facility. The resident ambulated in an area of his community that has a large volume of vehicular traffic. All roads were 2 lanes and had a speed limit of 30 miles per hour. The area was mostly residential, had four traffic lights and some businesses located in a small strip mall. The resident was returned to the facility at 1:00 p.m. The resident indicated he had fallen while out of the facility due to the sidewalk being broken. The resident had an abrasion to his left cheek measuring 0.8 X 1 x 0.1 centimeters (cm) with a 2 x 1.5 reddened area. He also had an abrasion to left knee measuring 1 X 0.4 0.2 X 0.5 cm and a bruise to the left shoulder measuring 2 X 1.5 cm.</p> <p>Upon return to the facility a Wander Guard bracelet was applied to the resident. The device was checked for</p>				

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	<p>functioning by verifying the alarm sounded when the resident was in close proximity to the elevator doors on the second and first floors. The resident was also placed on every 15 minute checks.</p> <p>The Director of Nursing (DON) was interviewed on 9/3/13 at 1:50 p.m. The DON indicated nothing had been put in place to address the possibility of an elopement prior to the resident exiting the facility. The DON indicated, after the resident was returned to the facility and an investigation was initiated, a housekeeper indicated Resident A attempted to get his keys and said "I'm going to find my wife." The employee indicated the resident was very coherent and aware of surroundings. The DON indicated the resident attempted to get on the elevator with a maintenance staff person, who redirected the resident away from the elevator. The DON indicated she did not know if the maintenance staff notified other staff of the incident.</p> <p>The DON provided a policy on 9/3/13 at 2:50 p.m. titled "Eloperments," (no date). The policy indicated, "...1. Staff shall promptly report any resident who tries to leave the</p>				

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	<p>premises or is suspected of being missing to the Charge Nurse or Director of Nursing ...."</p> <p>During interview of the DON on 9/3/13 at 1:50 p.m., the DON provided the old policy titled "Eloperments," (no date) addressed procedures to follow after any resident is suspected of leaving the facility. The DON indicated prior to the resident's elopement, there was no formal plan to apply Wander Guards to residents deemed as at high risk. It would be up to the nurse.</p> <p>On 9/3/313 at 1:50 p.m. the DON indicated a care plan to address the resident's high elopement risk had not been developed.</p> <p>The past noncompliance immediate jeopardy began on July 26, 2013. The immediate jeopardy was removed on July 29, 2013, and the deficient practice corrected on August 2, 2013 after the safe return of the resident. The facility implemented a systemic plan that included the following actions: Resident A was re-assessed and assigned a safety alert device; all other residents were assessed for elopement risk and no additional residents were identified as needing a safety alert device; the</p>						

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	<p>facility implemented a new elopement assessment tool; the facility developed and implemented a new procedure which required the application of a safety alert device to any resident who was assessed as a high risk for elopement; and the facility ensured all staff on all shifts were inserviced on the new policy and procedures for residents who are at risk for elopement, including the application of the safety alert device and the timely communication of information regarding any resident exhibiting exit seeking behaviors.</p> <p>b. Based on observation, interview, and record review the facility failed to maintain a safe environment for 3 or 3 random observations of residents utilizing mobility devices "bed canes," and lacked a required covering to ensure safety as interior, open spaces within the rail exceeded the FDA (Federal Drug Administration) recommendation of 4 and 3/4 inches. (Resident C, Resident F and Resident E)</p> <p>1. On 8/27/13 at 11:45 a.m. Resident C was observed in bed with two assistive devices "bed canes" in the raised position. The spaces within the rails were measured at 12 inches by 9 inches.</p>				

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	<p>A Side Rail Assessment, dated 6/7/12, provided by the Assistant Director of Nursing (ADON) identified as the most recent assessment until August of 2013, scored the resident with a 4 for bilateral enable siderail plan. The assessment tool indicated a score of 10 or below should have an Interdisciplinary team review notify DON. A safety device and side rail use risk completed in August, 2013 scored the resident as a 0 with the same notation on the tool.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated, 8/2/13, coded the resident with severe cognitive impairment, has hallucinations, delusions physical behaviors. Bed mobility was extensive assistance of two total assistance of two for transfers, and non-ambulatory.</p> <p>2. On 8/27/13 at 10 a.m., a rectangular assistive device was noted attached to the left side of Resident F's bed. The space within the assistive device measured 15 inches wide by 10 inches height between top of mattress to top of rail.</p> <p>Upon interview of RN #11 on 8/27/13 at 10:33 a.m., the RN indicated the</p>			
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	<p>assistive device was supplied by the resident's husband after her admission.</p> <p>On 8/27/13 at 12 p.m., the rectangular assistive device was removed from Resident F's bed, and a new assistive device "bed cane" with cover was observed applied to the resident's bed.</p> <p>Upon interview of Resident F on 8/28/13 at 11:07 a.m., the resident indicated she "really doesn't use the assistive device too much."</p> <p>Upon review of Resident F's clinical record on 8/30/13 at 3:11 p.m., the most recent Minimum Data Set (MDS) assessment was completed dated 7/25/13. The assessment identified the resident as moderately impaired in cognitive decision making skills, extensive assist of one for bed mobility, and extensive assist of two for transfers.</p> <p>A Safety Device and Siderail Use assessment dated 8/28/13 indicated the resident was able to get in and out of bed safely with siderail and the resident expressed the desire to use siderail.</p> <p>3. On 8/27/13 at 10:55 a.m., Resident</p>				

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	<p>E's bed was noted to have assistive devices of "bed cane" on each side. The "bed canes" were noted to have a space within the assistive devices that measured 12 inches x 9 inches. A cover over the "bed canes" was lacking. On 8/27/13 at 12 p.m., coverings were noted to be on the "bed canes" bilaterally.</p> <p>Upon interview of RN #11 on 8/27/13 at 10:58 a.m., the RN indicated she was unaware as to why coverings were missing from the "bed canes." The RN also identified the resident as alert/oriented and transfers self in bed.</p> <p>Upon interview of Resident E on 8/3/13 at 10:18 a.m., the resident indicated she did not like the coverings on the "bed canes." She stated that once in bed she does not use the assistive devices. The resident also indicated the facility offered a different type of assistive device, but she chose to keep the "bed canes."</p> <p>Upon review of the clinical record of Resident E on 8/30/13 at 3:30 p.m., the most recent Minimum Data Set (MDS) was completed on 6/29/13. The assessment identified the resident without cognitive impairment,</p>			

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	<p>and extensive assistance of two for transfers and bed mobility.</p> <p>A Safety Device and Siderail Use assessment dated 8/27/13 identified the resident with ability to get in/out of bed safely with siderails.</p> <p>Upon review of the manufacturer's assembly instructions for the "bed cane" on 9/5/13 at 2:05 p.m., documentation indicated the coverings were required for appropriate assembly.</p> <p>Upon interview of the Administrator on 8/27/13 at 10:58 a.m., the Administrator indicated the coverings came with the "bed canes" and that they should have been in place.</p> <p>This federal tag relates to Complaint IN00134061.</p> <p>3.1-45(a)(2)</p>				

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F000371 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 Based on observation and interview, the facility failed to ensure food was stored and prepared food under sanitary conditions for 2 of 4 dietary observations.</p> <p>Findings include:</p> <p>The initial dietary tour on 8/26/13 at 10:15 a.m., with the Registered Dietician (RD) and Food Service Supervisor (FSS) the following were observed:</p> <ol style="list-style-type: none"> <li>Dietary staff #21, #22, #23, and #24 were observed in the food preparations areas without hair coverings.</li> <li>Range hoods over cooking services had rusted areas on the interiors.</li> <li>Two 2 foot by 4 foot vent panels in the ceiling over the bake and salad prep areas had a heavy accumulation of dust.</li> </ol>	F000371	<p>F 371 Food Procedure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice?No residents suffered adverse effects as a result of this practice. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken?All residents in the facility have the potential to be affected by this practice. Food and Beverage Director or Designee will perform hair net observations in the main kitchen five times a week for one month. Any staff member found to be noncompliant with facility policy and procedure for hair nets will be re-educated upon discovery. Maintenance or designee will refinish the rusted areas on the interiors of the range hoods.Maintenance has deep cleaned the vent panels in the ceiling.Maintenance or designee will repair and refinish the lower shelf of the stainless steel counter.Maintenance or designee will repair and refinish bottom</p>	10/05/2013	

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	<p>4. In the bakery prep area the lower shelf of the stainless steel counter had chipped paint with clean plastic tubs utilized for food contact placed inverted on the shelf</p> <p>5. The bottom shelf of the stainless steel counter in the salad prep area with clean cooking utensils stored had peeling paint.</p> <p>6. The Hot Box utilized to keep food warm had a white substance on the interior of glass door (maybe in between double paned glass)</p> <p>7. The exterior of the toaster had heavy accumulation of crumbs and spillage.</p> <p>8. The exterior of Vulcan oven had a heavy accumulation of grease.</p> <p>9. Metal strips holding up ceiling tiles in dish area including above clean dishes, were heavily rusted.</p> <p>10. On 9/5/13 at 9 a.m., the dishmachine temperature was checked with Dietary Aide #25. The staff member did not have a hair covering on until surveyor entered kitchen, and she obtained one from the container next to entrance door</p>		<p>shelf of the stainless steel counter in the salad prep area. Food and Beverage Director or designee will purchase a new hot box door. Toaster in question has been removed and new toaster has been purchased and implemented in kitchen. The exterior of Vulcan oven has been deep cleaned by kitchen staff. Maintenance or designee will repair and refinish the rusted metal strips holding up ceiling tiles in dish area. New hair net receptacles have been added to all entrances into the kitchen in order to ensure accessibility. Food and beverage department staff have been re-educated on facility policy and procedure for hair nets. Food and Beverage Director or designee will continue to monitor daily cleaning schedule for accuracy. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Food and Beverage staff have been re-educated on facilities policy and procedure for hair nets. Food and Beverage Director or Designee will perform hair net observations in the main kitchen five times a week for a month. Additional hair receptacles have been added at kitchen entrances. Food and Beverage Director or designee will perform a monthly inspection of range hoods for any rust or degradation. The range hoods will be professionally</p>		

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	and put on.  11. On 9/5/13 at 10:44 a.m., cleaning schedules were provided by the RD (registered dietician). The cleaning schedules indicated the above areas were on a daily cleaning schedule.  3.1-21(i)(3)		cleaned bi-annually. Maintenance will be removing and cleaning the vent panels on a monthly basis. Food and Beverage Director or designee will perform a monthly inspection of shelves in the bakery prep area for any signs of chipping paint or degradation. Food and Beverage Director or designee will perform a monthly inspection of shelves in the salad prep area for any signs of chipping paint or degradation. Food and Beverage Director or designee will perform a monthly inspection on the new hot box doors for any deterioration. The Food and Beverage Director or designee will perform a monthly inspection on the new toaster for cleanliness or any sign of deterioration. The Food and Beverage department will perform a monthly deep clean of the Vulcan oven. The food and beverage director or designee will monitor the completion. The Food and Beverage director or designee will perform a monthly inspection of the metal strips for any signs of rust or deterioration. Food and Beverage staff have been re-educated on facilities policy and procedure for hair nets. Food and Beverage Director or Designee will perform hair net observations in the main kitchen five times a week for a month. Additional hair receptacles have been added at kitchen entrances. Food and Beverage Director or designee will continue		

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			to monitor daily cleaning schedule for accuracy. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?Food and Beverage Director or designee will create an audit tool and will monitor sanitation in the kitchen through observations five times a week times one month, weekly times one month, bi-weekly times one month, monthly times nine months. The Food and Beverage Director or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Administrator will oversee the process. Completion date: October 5, 2013	

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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.</p> <p>Based on observation and record review, the facility failed to ensure</p>	F000441	F 441 Infection Control, Prevent Spread, Linens What corrective	10/05/2013			

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	<p>hand hygiene for 1 of 1 random observation of a resident with a gastrostomy tube (g-tube.) Resident #69</p> <p>Finding includes:</p> <p>On 8/27/13 at 12:20 p.m., LPN #2 was observed to administer a medication to Resident #69 through a g-tube. While wearing gloves, the nurse handled the g-tube, checked placement, flushed the tube with water, administered the medication, had to milk the tubing to assist with infusion, flushed the tube after the medication. The nurse, while wearing the same gloves, reattached the feeding tubing, returned the syringe to a plastic bag and hung it on the pole utilized for the feeding pump. She adjusted the resident's covers, picked up the call light and positioned it for the resident, picked up the stethoscope and utilized it to check placement, hung it around her neck and then removed the gloves.</p> <p>A facility policy titled "Handwashing/Hand Hygiene," dated April 2012, provided by the Assistant Director of Nursing (ADON) on 9/5/13 at 2:05 p.m. included, but was not limited to, "When to Wash Hands 5. Employees must wash their hands for</p>		<p>action(s) will be accomplished for those residents to have been found affected by the deficient practice? Resident 69 suffered no adverse effects as a result of this practice. LPN #2 received written education on importance of infection control. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected. Education was provided to all health center staff with a return skill demonstration on hand washing along with recommendations on when to change gloves. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Education was provided to all health center staff with a return skill demonstration on hand washing along with recommendations on when to change gloves. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? DON or designee will monitor hand washing five times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months and quarterly times 3 months. The DON or designee will report the results of the audits to the Quality Assurance Performance Improvement Committee who will</p>				

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	<p>at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice).</p> <p>3.1-18(l)</p>		<p>determine the need for further monitoring. Completion date: October 5, 2013</p>		