STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155387	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLETON MANOR	2500 IOWA AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 4, 5, 6, 7 and 10, 2012 Facility number: 000318 Provider number: 155387 AIM number: 100266550 Survey team: Sharon Lasher RN, T/C Angel Tomlinson RN (September 4, 5, 7. and 10, 2012) Barbara Gray RN Leslie Parrett RN Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 4 Medicaid: 36 Other: 4 Total: 44 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/18/12 by Suzanne Williams, RN	F0000	Preparation and submission of this plan of correction by, **Caroleton Manor**, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F0221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.			
	Based on observation, interview and record review, the facility failed to ensure full side rails were not used for a resident that did not require full side rails for 1 of 1 resident randomly observed for side rail use. (Resident #46) Findings include: 1.) During observation on 9-4-12 at 2:08 p.m. Resident #46 had full side rails on both sides of her bed. The right side of the full side rails had a plastic zip tie around it and it could not be raised. The left side full side rails did not have a zip tie and could be raised. Interview with CNA #8 at this time indicated the resident had a full side rail up at night on the left side, because the resident tended to lay on her left side when she slept and this prevented her from falling out of the bed. At this time, Resident #46 indicated it was hard for her to get out of the bed with the side rails raised and it could cause her to fall, so she got out of the other side with the zip	F0221	1. Resident #46's was provided with bed that does not have side rails by maintenance director on 9-10-12. 2. An audit was completed by the maintenance director on 9/10/12 related to side rails with zip ties to ensure beds and side rails are provided per plan of care. 3. Staff were re-educated by Director of Nursing on or before 10-1-12 related to side rails and their function for residents that need rails.4. Maintenance/Department heads will complete an audit weekly for 4 weeks and monthly for 2 months to ensure residents' needs continue to be provided per plan of care related to side rails. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Administrator will be responsible for monitoring.**The Quaility Assurance Committee will re-evaluate the need for further monitoring after 3 months.	10/10/2012

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	ties because the side rails could not be raised on that side. During interview on 9-5-12 at 3:10 p.m. the Maintenance Supervisor indicated Resident #46 was not supposed to be using full side rails on her bed. The Maintenance Supervisor indicated the facility did not usually use full side rails unless a resident had an air mattress. The Maintenance Supervisor indicated the CNAs should have reported to him that Resident #46's full side rail straps had come undone. The Maintenance Supervisor indicated the straps were difficult to get off, and he was unsure how the resident's straps were taken off. Review of the record of Resident #46 on 9-7-12 at 3:15 p.m. indicated the resident's diagnoses included, but were not limited to, anemia, chronic kidney disease, Alzheimer's, dementia, depression, psychosis, and anorexia. The Minimum Data Set (MDS) assessment for Resident #46, dated 6-15-12, indicated bed rails were not used. The side rail assessment review for Resident #46, dated 6-15-12, indicated the resident was severely			

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	cognitively impaired and it was recommended and preferred by the resident that no side rails were used. The risk assessment totals for Resident #46, dated 6-15-12, indicated the resident was at high risk for entrapment. Interview with Resident #46's family on 9-7-12 at 3:45 p.m. indicated Resident #46 gets scared and hallucinates about falling out of bed. The family member indicated she had seen the facility staff put the resident's full side rails up because the resident was hallucinating there was a gigantic hole beside her bed. 3.1-3(w) 3.1-26(o)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to assist a resident to the restroom in timely manner resulting in the resident becoming incontinent of stool and failed to provide care in an manner that was not rushed for another resident, for 2 of 2 residents reviewed for dignity of 3 who met the criteria for dignity (Resident #13 and Resident #20). Findings include: 1.) During observation on 9-5-12 at 9:00 a.m. Resident #13 was in the hallway of the facility at shower room door knocking on it. The resident indicated she needed to use the bathroom. During observation on 9-5-12 at 9:05 a.m., Resident #13 requested CNA #6 to assist her to go to the bathroom. CNA#6 indicated the resident would have to wait because there was another resident in the bathroom.	F0241	1. Resident #13 was assisted to the bathroom immediately and incontinent care was provided by the CNA on 9/5/12. Resident # 20 was interviewed by social services on 9/19/12 related to her care needs and her psychosocial well-being. CNA # 6 was provided re-education by Director of Nursing on 9/11/12 related to assisting residents with toileting in a timely manner to avoid incontinent episodes. CNA # 7 was provided re-education by Director of Nursing on 9/11/12 related to assisting residents with toileting in a timely manner to avoid incontinent episodes. 2. An audit was completed by RN Supervisor on or before 10-1-12 related to residents requiring use of sit-to- stand lift for toileting needs to ensure assistance is provided as needed. An audit was completed by Social Services on 9-29-12 related to residents' care needs and psychosocial well being to ensure dignity and respect is provided during cares. 3. Nursing Staff were re-educated by RN Supervisor on or before 10/1/12 related to use of central shower and toileting needs per care plan and providing a bedside	10/10/2012

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	Interview with CNA #6 on 9-5-12 at 9-10 a.m. indicated the reason she did not take Resident #13 to her own bathroom connected to the resident's bedroom was because the resident had to use a stand up lift to go to the bathroom, and the resident's bathroom was too small to take her in there with a lift. CNA #6 indicated the resident had to wait on the shower room to go to the bathroom due to the size of the resident's bathroom. During observation on 9-5-12 at 9:15 a.m., CNA #6 indicated to Resident #13 that she was next for the bathroom. Resident #13 stated "don't let anyone else in; I have to go, I got to go. " During observation on 9-5-12 at 9:16 a.m., Resident #13 indicated to CNA #6 and CNA #7 that she was going to have an accident if they did not get her to the restroom, and this was happening everyday anymore. CNA #6 and CNA #7 assisted the resident to the restroom using a stand up lift. The resident had on a panty liner and had become incontinent of stool. Review of the record of Resident #13 on 9-7-12 at 2:38 p.m. indicated the resident's diagnoses included, but		commode as needed. Nursing Staff were re-educated by Director of Nursing/RN Supervisor on 9/21/12 related to slowing down when providing and rushed. 4. Director of Nursing/RN Supervisor will complete audits weekly for 4 weeks and monthly for 2 months to ensure assistance with toileting continues to be provided timely as needed and staff continue to respect residents during care by not rushing them. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow-up. **The Quaility Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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	were not limited to, stroke, anemia, hypertension, osteoarthritis, urinary incontinence, dermatitis and depression. The care plan for Resident #13, dated 3-31-11, indicated the resident required assistance with toileting due to functional limitations. The interventions included, but were not limited to, assist with toileting needs with transfer on/off the commode. The Minimum Data Set (MDS) assessment for Resident #13, dated 8-2-12 indicated the following: transfer- extensive assistance of two people, toilet use- extensive assistance of two people, urinary continence- frequently incontinent and bowel continence- always continent. The assessment for bowel and bladder retraining for Resident #13, dated 8-12-12, indicated the conclusion was the resident was a candidate for bowel and bladder training. The resident was frequently incontinent of her bowel and bladder and wore liners. The resident knew when she needed to void, but could not make it to the bathroom on time. The resident remained an extensive assist.			

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	Interview with the Director of Nursing on 9-10-12 at 2:07 p.m. indicated the stand up lifts could fit in the residents bathrooms, but it was a tight fit. The Director of Nursing indicated the central shower rooms provided the facility with more room. The Director of Nursing indicated there were two central shower rooms, one down each hall. The Director of Nursing indicated usually both shower rooms were not occupied at the same time and usually a there were not problems with residents having to wait to use the restroom. 2.) Interview with Resident # 20 on 9/4/12 at 11:09 a.m. indicated "about two months ago (CNA # 12) was rough with me, rushing me to get ready for bed. I don't know who I reported it to, but I did report it and I told my family about it. They(facility) don't have her care for me anymore but she is still here." On 9/4/12 at 12:05 p.m. interview with Resident # 20's husband and son indicated they were aware of their family member having problems with a CNA on evening shift. The son indicated they spoke with the DON (Director of Nursing) and the Social Services designee during a care plan meeting about the CNA rushing his			

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	mother during evening care. The husband and son indicated they did not feel the CNA had been "mean" to the resident. The son indicated "she's just in a hurry." Interview with Director of Nursing (DON) on 9/4/12 at 12:25 p.m. indicated on 6/28/12 the Social Services designee and herself attended a care plan meeting with the resident, her husband and son related to CNA # 12 rushing the Resident during her care. The DON indicated CNA # 12 was rotated to the other hall and does not provide care for the resident at this time. On 9/4/12 at 1:30 p.m. Resident # 20 indicated she did not feel CNA # 12 was trying to be "mean" to her. She indicated the CNA "just rushes you when your getting ready for bed; she tells me to bend my leg, several times, before I have time to do it. I don't think she's trying to be mean, just rushes me to do things so she can move on to other things, I guess." Review of a document titled "Resident's Rights" provided by the DON on 9/7/12 at 10:45 a.m., indicated, "This is to assure that (Resident name)... 9. Is treated with consideration,			

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	respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs...." 3.1-3(t)			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on observation, interview, and record review, the facility failed to provide a resident with her choice of when to get up in the mornings, for 1 of 4 residents reviewed for choices of 4 who met the criteria for choices. (Resident #48) Findings include: An interview with Resident #48 on 9/4/12 at 12:45 P.M., indicated staff get her up in the mornings for breakfast. Resident #48 indicated she would like to sleep in and get up "around 8:00 A.M., or 9:00 A.M.". An interview with Resident #48 on 9/6/12 at 2:11 P.M., indicated staff woke her up for breakfast. Resident #48 indicated she wanted to eat breakfast but did not want to eat that early. Resident #48 indicated she would like to get up for breakfast "around 8:00 A.M., to 8:30 A.M." Resident #48 indicated she would	F0242	1. Resident #48 was interviewed by Director of Nursing on 9/11/12 and the Activity Director on 9/17/12 related to when she would like to get up for breakfast. 2. An audit was completed by the Activity Director, Dietary Manager and Social Services on 9/29/12 to ensure residents preferences are updated and reflected in the plan of care. 3. Staff were re-educated on 10-9-2012 by the Administrator regarding residents having the right to make choices and staff will honor their choices. 4. The Director of Nursing/MDS Nurse will complete audits weekly for 4 weeks then monthly for 2 months to ensure residents choices continue to be honored. A report of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow-up. **The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	10/10/2012

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	inform staff she wanted to sleep in but the staff would tell her she needed to get up for breakfast. Resident #48 indicated it did not make any difference to her if she ate breakfast with her peers or by herself. Resident #48's record was reviewed on 9/7/12 at 2:43 P.M. Diagnoses included, but were not limited to, acute kidney failure, muscle weakness, and abnormality of gait. A quarterly Minimum Data Set assessment for Resident #48, dated 7/22/12, indicated Resident #48's cognitive skills for daily decision making were moderately impaired. An Activity Assessment for Resident #48 dated 2/1/11, indicated the following: Resident #48 liked to get up for coffee in the morning, and her usual time was 8:30 A.M. An interview with the Activity Director on 9/7/12 at 3:06 P.M., indicated she tried to do an Activity Assessment yearly or if a resident had changes. The Activity Director indicated she had not completed an Activity assessment for Resident #48 since 2/1/11. The Activity Director indicated she did not usually address			

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	with the residents their preference for getting up in the mornings but she did try to ask residents what their normal routine was. A care plan for Resident #48 indicated the following: Onset 2/8/11. Problem-Resident #48 was a moderate nutritional risk, but was above her ideal body weight. Goal and Target Date-Resident #48 would maintain her current weight with less than 3 pounds of weight gain or loss through her next 90 day review on 10/19/12. Approaches-Added to the Care Plan on 8/27/12-Staff would encourage her to come to dining room for meals as she tolerated. Her family requested she be brought out of her bedroom for meals to promote meal intakes per her usual home routine. Staff would honor her right to choose where she preferred to consume her meals. An interview with the Director of Nursing (DoN) on 9/6/12 at 8:55 A.M., indicated the facility "gets residents up a lot by what the family tells us." The DoN indicated Resident #48 had two daughters who wanted their mother to eat in the dining room for all meals and sit with alert residents. The DoN indicated breakfast was served "around 7:30 A.M."			

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	On 9/6/12 at 12:11 P.M., Resident #48 was observed seated in the dining room eating lunch with her peers. An interview with CNA #2 on 9/7/12 at 10:01 A.M., indicated Resident #48 would often say she was tired and wanted to sleep in the mornings. CNA #2 indicated they started serving breakfast trays around 7:15 A.M., and then the dining room. CNA #2 indicated staff would go ahead and clean Resident #48 up if she got up to use the bathroom in the morning between 6:00 A.M., and 7:00 A.M. If Resident #48 did not get up to use the bathroom, then staff would get her up closer to 7:00 A.M. No further documentation was provided regarding Resident #47's preference on what time she wanted to get up for breakfast. A Meal Frequency Schedule provided by the Administrator on 9/4/12 at 10:50 A.M., indicated breakfast hall trays were served at 7:15 A.M., and the dining room was served at 7:30 A.M. 3.1-3(u)(1) 3.1-3(u)(3)			

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CAROLETON MANOR	2500 IOWA AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on observation, interview, and record review, the facility failed to plan pressure relieving interventions to assist in healing a Suspected Deep Tissue (SDT) injury and prevent further pressure injury for a resident when he was out of bed, for 1 of 28 residents reviewed for care plans. (Resident #47) Findings include: An interview with LPN #10 on 9/4/12 at 2:54 P.M., indicated Resident #47 had a Stage II purple area on his right	F0279	1. Resident #47 was re-assessed by the Director of Therapy on 9/7/12 and a non skid pressure relieving heel protector was applied to resident's affected heel. Resident #47 care plan was reviewed and updated by MDS Nurse on 9/10/12 to reflect resident's current condition and needs. 2. An audit was completed by Director of Nursing on 9/10/12 and 9/18/12 to ensure residents requiring assistive devices including pressure reducing devices, have a current care plan to reflect the resident's current needs. 3. Nursing Staff were re-educated by RN Supervisor on	10/10/2012

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	medial heel. Resident #47's record was reviewed on 9/6/12 at 3:23 P.M. Diagnoses included, but were not limited to, congestive heart failure, hypertension, chronic ischemic heart disease, anemia, chronic kidney disease stage III, cerebral vascular accident, diabetes mellitus, and right sided hemiplegia. A quarterly Minimum Data Set assessment for Resident #47, dated 7/2/12, indicated he had no pressure areas. A Weekly Pressure Ulcer Progress Report for Resident #47 indicated the following: Date of onset-8/26/12. Resident #47 had a new SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2 cm long and 2.5 cm wide. 8/30/12-Resident #47 had a SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2.5 cm long and 1.5 cm. wide. The area would be treated with skin barrier wipes. His heels would be kept up in a special device. A Patients at Risk (PAR) nurses note for Resident #47, dated 8/27/12 at		9/18/12 related to applying assistive devices per plan of care. 4. Audits will be completed by Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to ensure assistive devices continue to be applied per plan of care. A report of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow-up. **The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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	9:05 A.M., indicated the Interdisciplinary team had been informed Resident #47 had a reddish/purple area on his left heel. Resident #47 had problems with mushy heels in the past. Staff would plan to use a pressure relieving boot on Resident #47 when he was in bed. A Care Plan for Resident #47 indicated the following: Onset-9/7/10. Problem-Resident #47 was high risk for skin integrity related to decreased mobility, bowel incontinence, low albumin level, and an ankle foot orthosis brace. Added to the Care Plan 8/27/12-SDT injury to left foot. Goal and Target Date-Added to the Care Plan 8/27/12-Resident #47's SDT injury would resolve by 9/27/12. Approaches-Resident #47's heels would be kept up and other bony areas would be covered to reduce friction. Added to the Care Plan on 8/27/12- Resident #47 would have a pressure redistribution boot to his left heel. The Care Plan did not indicate when Resident #47 would wear the redistribution boot. On 9/6/12 at 9:34 A.M., Resident #47's left heel was observed with LPN #1. The area on the left inner heel			

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	was approximately the size of a nickel and reddish/purple in color. On 9/6/12 at 10:07 A.M., Resident #47 was observed being placed on the toilet with the assistance of CNA #2 and LPN #11. Resident #47 only had a sock on his left foot with no pressure relieving device. On 9/6/12 at 1:55 P.M., Resident #47 was observed seated in his wheelchair outside the facility on the porch. Resident #47 only had a non-skid sock on his left foot with no pressure relieving device. He had his left heel pressed to the pavement and was moving the top of his left foot in an up and down motion. On 9/6/12 at 1:59 P.M., LPN #1 indicated Resident #47 did not use a pressure relieving device on his left foot when he was up in his wheelchair because he used his left foot to propel his wheelchair. On 9/7/12 at 9:52 A.M., Resident #47 was observed seated in his wheelchair in the TV room. Resident #47 only had a non-skid sock on his left foot with no pressure relieving device. He had his left heel pressed to the floor and was moving the top of his left foot in an up and down			

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	motion. On 9/7/12 at 9:54 A.M., CNA #2 indicated Resident #47 did not wear a pressure boot on his left foot. CNA #2 indicated Resident #47's pressure boot was discontinued "a couple of months ago." On 9/7/12 at 10:50 A.M., the DoN indicated it was decided in the PAR meeting, Resident #47 would only wear a pressure boot when he was in bed, because he could not propel his wheelchair with a pressure boot on. 3.1-35(a) 3.1-35(b)(1)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview, and record review, the facility failed to follow pressure relieving care plan interventions, when a resident was in bed, to assist in healing a Suspected Deep Tissue (SDT) injury and prevent further pressure injury, for 1 of 28 residents reviewed for care plans. (Resident #47) Findings include: An interview with LPN #10 on 9/4/12 at 2:54 P.M., indicated Resident #47 had a Stage II purple area on his right medial heel. Resident #47's record was reviewed on 9/6/12 at 3:23 P.M. Diagnoses included, but were not limited to, congestive heart failure, hypertension, chronic ischemic heart disease, anemia, chronic kidney disease stage III, cerebral vascular accident, diabetes mellitus, and right sided hemiplegia. A quarterly Minimum Data Set assessment for Resident #47, dated	F0282	1. Resident #47 was re-assessed by the Director of Therapy on 9/7/12 and a non skid pressure relieving heel protector was applied to resident's affected heel. Resident #47 care plan was reviewed and updated by MDS Nurse on 9/10/12 to reflect resident's current condition and needs. 2. An audit was completed by Director of Nursing on 9/10/12 and 9/18/12 to ensure residents requiring assistive devices including pressure reducing devices, have a current care plan to reflect the resident's current needs. 3. Nursing Staff were re-educated by RN Supervisor on 9/18/12 related to applying assistive devices per plan of care. 4. Audits will be completed by Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to ensure assistive devices continue to be applied per plan of care. A report of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow-up. **The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	10/10/2012

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	7/2/12, indicated he had no pressure areas. A Weekly Pressure Ulcer Progress Report for Resident #47 indicated the following: Date of onset-8/26/12. Resident #47 had a new SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2 cm long and 2.5 cm wide. 8/30/12-Resident #47 had a SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2.5 cm long and 1.5 cm. wide. The area would be treated with skin barrier wipes. His heels would be kept up in a special device. A Patients at Risk (PAR) nurses note for Resident #47, dated 8/27/12 at 9:05 A.M., indicated the Interdisciplinary team had been informed Resident #47 had a reddish/purple area on his left heel. Resident #47 had problems with mushy heels in the past. Staff would plan to use a pressure relieving boot on Resident #47 when he was in bed. A physician's order for Resident #47, dated 8/27/12, indicated the following: Use a heels-up device in bed. A Care Plan for Resident #47			

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	indicated the following: Onset-9/7/10. Problem-Resident #47 was high risk for skin integrity related to decreased mobility, bowel incontinence, low albumin level, and an ankle foot orthosis brace. Added to the Care Plan 8/27/12-SDT injury to left foot. Goal and Target Date- Added to the Care Plan 8/27/12-Resident #47's SDT injury would resolve by 9/27/12. Approaches-Resident #47's heels would be kept up and other bony areas would be covered to reduce friction. Added to the Care Plan on 8/27/12-Resident #47 would have a pressure redistribution boot to his left heel. The Care Plan did not indicate when Resident #47 would wear the redistribution boot. On 9/6/12 at 9:15 A.M., Resident #47 was observed lying in bed on his back with two pillows under his head. His thighs were resting on a cushioned heels up device and his heels were resting on the bed mattress. An interview at that time with LPN #1, indicated the cushioned heels-up device was pushed up under Resident #47's legs too far to keep his heels off the bed mattress. LPN #1 moved the cushioned heels-up device under Resident #47's lower			

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	legs, so his heels were elevated off the bed mattress. On 9/6/12 at 9:34 A.M., Resident #47's left heel was observed with LPN #1. The area on the left inner heel was approximately the size of a nickel and reddish/purple in color. On 9/7/12 at 9:54 A.M., CNA #2 indicated Resident #47 did not wear a pressure boot on his left foot. CNA #2 indicated Resident #47's pressure boot was discontinued "a couple of months ago." On 9/7/12 at 10:50 A.M., the DoN indicated it was decided in the PAR meeting, Resident #47 would only wear a pressure boot when he was in bed, because he could not propel his wheelchair with a pressure boot on. On 9/7/12 at 11:15 A.M., LPN #1 indicated Resident #47 had worn a pressure boot in the past but did not currently wear one. On 9/7/12 at 11:17 A.M., Restorative Aide #3, indicated she could not locate a pressure boot in Resident #47's bedroom. 3.1-35(g)(2)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview, and record review, the facility failed to implement interventions to heal a Suspected Deep Tissue (SDT) injury for 1 of 4 residents reviewed for pressure ulcers of 16 who met the criteria for pressure ulcers. (Resident #47) Findings include: An interview with LPN #10 on 9/4/12 at 2:54 P.M., indicated Resident #47 had a Stage II purple area on his right medial heel. Resident #47's record was reviewed on 9/6/12 at 3:23 P.M. Diagnoses included, but were not limited to, congestive heart failure, hypertension, chronic ischemic heart disease, anemia, chronic kidney disease stage III, cerebral vascular	F0314	1. Resident #47 had pressure relieving boot re-applied after therapy customized it with non-skid material so that he is able to propel himself on 9-6-12 2. The Director of Nursing completed an audit on 9-6-12 to ensure residents' pressure relieving devises were applied per plan of care. 3. Licensed staff were re-educated by the Director of Nursing on 9-6-12 related to ensuring pressure relieving devises are applied, including heels up devises while in bed, and body audits are completed. 4. The Director of Nursing will complete an audit weekly for 4 weeks then monthly for 2 months to ensure pressure relieving devises continue to be applied per plan of care. A report of these finding will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. ** The Quaility Assurance	10/10/2012

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	accident, diabetes mellitus, and right sided hemiplegia. A quarterly Minimum Data Set assessment for Resident #47, dated 7/2/12, indicated he had no pressure areas. A Weekly Pressure Ulcer Progress Report for Resident #47 indicated the following: Date of onset-8/26/12. Resident #47 had a new SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2 cm long and 2.5 cm wide. 8/30/12-Resident #47 had a SDT injury to his left medial heel that was non-blanchable and red/purple in color. The area measured 2.5 cm long and 1.5 cm. wide. The area would be treated with skin barrier wipes. His heels would be kept up in a special device. A Patients at Risk (PAR) nurses note for Resident #47, dated 8/27/12 at 9:05 A.M., indicated the Interdisciplinary team had been informed Resident #47 had a reddish/purple area on his left heel. Resident #47 had problems with mushy heels in the past. Staff would plan to use a pressure relieving boot on Resident #47 when he was in bed.		Committee will re-evaluate the need for further monitoring after 3 months.	

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	A physician's order for Resident #47, dated 8/27/12, indicated the following: Cleanse Resident #47's redness to his left heel with warm soapy water, rinse, and pat dry. Treat with skin barrier wipes and let dry 2 times a day until healed. Use a heels-up device in bed. A Care Plan for Resident #47 indicated the following: Onset-9/7/10. Problem-Resident #47 was high risk for skin integrity related to decreased mobility, bowel incontinence, low albumin level, and an ankle foot orthosis brace. Added to the Care Plan 8/27/12-SDT injury to left foot. Goal and Target Date-Added to the Care Plan 8/27/12-Resident #47's SDT injury would resolve by 9/27/12. Approaches- Resident #47's heels would be kept up and other bony areas would be covered to reduce friction. Added to the Care Plan on 8/27/12-Resident #47 would have a pressure redistribution boot to his left heel. The Care Plan did not indicate when Resident #47 should wear the redistribution boot. On 9/6/12 at 9:15 A.M., Resident #47 was observed lying in bed on his back with two pillows under his head. His			

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	thighs were resting on a cushioned heels up device and his heels were resting on the bed mattress. An interview at that time with LPN #1, indicated the cushioned heels up device was pushed up under Resident #47's legs too far to keep his heels off the bed mattress. LPN #1 moved the cushioned heels up device under Resident #47's lower legs, so his heels were elevated off the bed mattress. On 9/6/12 at 9:34 A.M., Resident #47's left heel was observed with LPN #1. The area on the left inner heel was approximately the size of a nickel and reddish/purple in color. On 9/6/12 at 10:07 A.M., Resident #47 was observed being placed on the toilet with the assistance of CNA #2 and LPN #11. Resident #47 only had a sock on his left foot with no pressure relieving device. On 9/6/12 at 1:55 P.M., Resident #47 was observed seated in his wheelchair outside the facility on the porch. Resident #47 only had a non-skid sock on his left foot with no pressure relieving device. He had his left heel pressed to the pavement and was moving the top of his left foot in an up and down motion.			

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	On 9/6/12 at 1:59 P.M., LPN #1 indicated Resident #47's did not use a pressure relieving device on his left foot when he was up in his wheelchair, because he used his left foot to propel his wheelchair. On 9/7/12 at 9:52 A.M., Resident #47 was observed seated in his wheelchair in the TV room. Resident #47 only had a non-skid sock on his left foot with no pressure relieving device. He had his left heel pressed to the floor and was moving the top of his left foot in an up and down motion. On 9/7/12 at 9:54 A.M., CNA #2 indicated Resident #47 did not wear a pressure boot on his left foot. CNA #2 indicated Resident #47's pressure boot was discontinued "a couple of months ago." CNA #2 indicated he usually wore a shoe, but it was left off since he developed a pressure area on his left heel. On 9/7/12 at 10:50 A.M., the DoN indicated it was decided in the PAR meeting, Resident #47 would only wear a pressure boot when he was in bed, because he could not propel his wheelchair with a pressure boot on.			

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	On 9/7/12 at 11:15 A.M., LPN #1 indicated Resident #47 had worn a pressure boot in the past but did not currently wear one. On 9/7/12 at 11:17 A.M., Restorative Aide #3 indicated she could not locate a pressure boot in Resident #47's bedroom. On 9/7/12 at 11:39 A.M., Resident #47 was observed seated in his wheelchair in the dining room. Resident #47 only had a non-skid sock on his left foot with no pressure relieving device. His left heel was pressed to the floor. On 9/7/12 at 1:38 P.M., Resident #47 was observed wearing a sock and pressure relieving boot on his left foot. He was propelling his wheelchair with the use of his left foot without difficulty. 3.1-40(a)(2)			

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NAME OF PROVIDER OR SUPPLIER CAROLETON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331	

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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.			
	Based on observation, interview and record review, the facility failed to assess and evaluate the need of a catheter for 1 of 2 residents reviewed for catheters of 2 who met the criteria for urinary catheters. (Resident #7) Findings include: Resident #7's record was reviewed on 9/6/12 at 10:00 a.m. Resident #7's diagnoses included, but were not limited to, diabetes and urinary tract infection. Resident #7's MDS (Minimum Data Set), assessment, dated 6/5/12, indicated the following: - BIMS (Brief Interview for Mental Status) 14, with a range of 13-15, cognitively intact - toilet use, extensive assistance - urine continence, frequently	F0315	1. Resident #7's physician was notified with new orders to discontinue the foley catheter as of 9-14-2012. 2. An audit of residents with foley catheters was completed by RN Supervisor on 9/12/12 to ensure required supporting diagnosis is available in the medical record. 3. Licensed staff re-educated by the Director of Nursing on 9/12/12 related to ensuring residents have required supporting diagnosis the use of a foley catheter. 4. RN supervisor/medical records will complete audits weekly for 4 weeks then monthly for 2 months to ensure residents continue to have required supporting diagnosis for foley catheters. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up **The Quaility Assurance Committee will re-evaluate the need for further monitoring after 3	10/10/2012

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	incontinent - bowel continence, always continent - UTI (Urinary Tract Infection), last 30 days Resident #7's care plan, dated 8/29/12, indicated "problem the catheter will be removed by next 30 days. 8/29/12, MRSA (Methicillin-resistant Staphyloccoccus aureus) to urine. Goal, The catheter will be removed by next 30 days, 9/29/12. 8/29/12, will be free from MRSA by next 30 days 9/29/12. Interventions, Foley care every shift, may change foley if leaking or non-patent, anchor foley per physician order, assess my urine volume, color clarity, odor per facility protocol, notify physician of the presence of fever, urine with dark color, odor, change in volume, or trauma related to foley catheter, change my urinary catheter and bag as ordered by physician or facility policy, keep my urinary catheter drainage bag off of floor and inside of privacy bag for resident dignity, document catheter potency, urine color-odor-volume, presence of dysuria, cloudy/dark urine, fever, changes in output, and communication with physician. 8/29/12, contact precautions, Bactrim DS (antibiotic), by mouth, times 10		months.	

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	days, then repeat U/A (urinalysis) and C and S (culture and sensitivity) if indicated after antibiotic completed and encourage fluids." Resident #7's physician's order, dated 8/29/12, indicated "Bactrim DS, by mouth, BID (two times a day) times 10 days then repeat U/A and C and S if indicated. Anchor foley catheter and contact precautions related to MRSA in urine." On 9/9/12 at 9:00 a.m., Resident #7 was observed getting her slacks changed and she had an anchored foley catheter with a strap around her upper thigh holding the catheter tubing in place. An interview with the DON (Director of Nursing) on 9/10/12 at 2:42 p.m., indicated Resident #7 is incontinent of urine and she has a foley catheter to keep her urine contained because there is MRSA in her urine. Centers of Disease Control and Prevention indicated, "Precautions to Prevent the Spread of MRSA in Healthcare Setting" 2007, "These standard precautions (hand hygiene, gloving, mouth, nose, eye protection, gowning, appropriate device handling of patient care equipment and			

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	instruments/devices and appropriate handling of laundry) should control the spread of MRSA in most instances." 3.1-41(a)(1)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to transport a resident in a wheelchair safely, resulting in a fall, and failed to remain with a resident who required assistance during toileting resulting in a fall, for 2 of 3 residents reviewed for falls and accidents of 3 who met the criteria for falls and accidents. (Resident #50 and #42) Findings include: 1.) Interview with Resident #50 on 9-4-12 at 11:26 a.m. indicated he was experiencing pain in his back, because the other day when he was being weighed on the scales, the staff "dropped him." Review of the record of Resident #50 on 9-7-12 at 8:53 a.m. indicated the resident's diagnoses included, but were not limited to, diabetes mellitus, end stage renal disease, anemia, chronic kidney disease, status amputation above the knee (right), angina, congestive heart failure	F0323	1. Resident #50 was immediately placed in regular w/c by Charge Nurse and CNA on 8/27/12. Resident #50 was re-assessed by RN Supervisor on 8/28/12 related to fall risk and care plan was updated to reflect current condition and needs. Transport chair is no longer used to weigh residents. Resident #42 was re-assessed by MDS Nurse on 9/26/12 related to falls risk and the care plan was updated to reflect current condition and needs. 2. An audit was completed by Director of Nursing on 9/21/12 to ensure fall risk assessments are to date and care plans reflect the resident's current condition and needs. An audit was completed by the Director of Nursing on 9/12/12 related to residents requiring assistance with toileting to ensure safety needs are identified and care planned. 3. Nursing Staff were re-educated by Director of Nursing and RN Supervisor on 9/12/12 related to weighing amputees in a regular wheel chair to avoid tipping of the chair. Nursing Staff were re-educated by the Director of Nursing on 9/12/12 related to residents	10/10/2012

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	(CHF), hypertension, difficulty walking, muscle weakness, neuropathy, insomnia, anxiety and cellulitis. The fax sent to the physician for Resident #50, dated 8-27-12 indicated the resident was in the wheelchair being weighed by staff when the wheelchair rolled back off the the scale. The wheelchair tipped over with resident in it. The resident complained of back pain at that time. A one centimeter red area was to the left lower back. A neurological check was normal. The resident indicated he hit his head also. The x-ray for Resident #50 of the lumbar spine, dated 8-28-12, indicated there were no fractures. The physician order for Resident #50, dated 8-28-12, indicated the resident was to have neurological checks every 4 hours for 24 hours due to a fall on 8-27-12. The Fall assessment for Resident #50, dated 7-17-12, indicated the resident was at high risk for falls. The MDS assessment for Resident #50, dated 7-17-12, indicated the following: walk in room - did not		requiring assistance to the bathroom and not leaving them unsupervised. 4. Director of Nursing/RN Supervisor will complete audits weekly for 4 weeks and monthly for 2 months to ensure regular W/C's continue to be used when weighing residents with amputees. Director of Nursing will complete weekly audits for 4 weeks and monthly for 2 months to ensure residents requiring assistance to the bathroom continue to be supervised per plan of care. A report of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. ** The Quaility Assurance Committee will re-evauate the need for further monitoring after 3 months.	

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	occur, and device for mobility was a wheelchair. A fall risk care plan for Resident #50, dated 3-19-12, indicated the resident was at high risk for falls related to decreased mobility and right above the knee amputation. The interventions included, but were not limited to, use standard wheelchair with left foot pedal (added 8-28-12). Observation and interview with CNA #5 on 9-7-12 at 2:10 p.m. indicated she was the CNA weighing Resident #50 on 8-27-12 when the resident fell. CNA #5 provided the wheelchair she was using when the resident fell. The wheelchair was observed to have four small wheels on it. CNA #5 indicated she weighed Resident #50 in the wheelchair on the scales. CNA #5 indicated when she was done weighing the resident, she got in front of him and began pulling on the wheelchair arms to get him off the scale. CNA #5 indicated the scale had a small incline so she lifted the front of the wheelchair wheels slightly off the ground and that was when the resident's weight shifted and the wheelchair tipped backwards onto the scale with the resident in it. Interview with the Director of Nursing at this time indicated the facility put the			

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	wheelchair with the small wheels in the garage so it could not be used. The Director of Nursing indicated Resident #50 had been using the transport wheelchair to go to dialysis, and now the resident would only use a regular wheelchair with the large wheels on it. 2.) Interview with RN #9 on 9-5-12 at 9:51 a.m. indicated Resident #42 had a fall in the last 30 days. RN #9 indicated the resident was on the toilet and his legs gave out and he slid off the toilet. RN #9 indicated there were no staff present when the resident fell off the toilet. Review of the record of Resident #42 on 9-10-12 at 2:30 p.m. indicated the resident's diagnoses included, but were not limited to, Parkinson disease, Alzheimer disease related to dementia, lung disease and hypothyroidism. The risk assessment totals for Resident #42, dated 7-27-12 indicated the resident was at medium risk for falls. The MDS assessment for Resident #42, dated 8-1-12, indicated the following: transfer- extensive assistance of one person, toilet use-			

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	extensive assistance of one person, moving from a seated position to a standing position- not steady only able to stabilize with human assistance and moving on and off the toilet- not steady only able to stabilize with human assistance. The fall care plan for Resident #42, dated 8-14-12, indicated the resident was at moderate risk for falls related to Parkinson disease and poor safety awareness. The interventions included, but were not limited to, do not leave unattended when in the bathroom. The fax sent to the Physician for Resident #42 on 8-14-12 indicated the resident slid from toilet to floor with no evident of injury or complaint of pain. The nurses note for Resident #42, dated 8-14-12, indicated the resident fell off the toilet. The resident was found sitting on the floor on his buttocks. The resident indicated he slid off the toilet. The resident had a history of Parkinson's disease and tremors. The resident had no complaints of pain, but indicated "hurt my pride." The investigation report for Resident			

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	#42, dated 8-14-12, indicated the resident was sitting on the floor in front of toilet disoriented as usual. The resident slide off the toilet and there were no injuries. The resident was taken to the bathroom by a CNA and CNA then left the resident and he had a spasm of the legs due to Parkinson and slid off commode. Staff was immediately reminded to stay with the resident when in the bathroom. Interview with CNA #4 on 9-10-12 at 3:47 p.m. indicated one way she knew which residents not to leave in the bathroom alone was if the resident had alarms on their wheelchair or bed and any residents that required the use of a mechanical lift for transfers. CNA #4 indicated she did not leave Resident #42 alone in bathroom because he was so unsteady and shaky. CNA #4 indicated the CNA assignment sheet did not indicate not to leave Resident #42 alone; it indicated he required one assist to the bathroom. Interview with the Director of Nursing on 9-10-12 at 5:03 p.m. indicated, for any resident who was assisted to the bathroom, the CNA was supposed to stay with the resident. The Director of Nursing indicated residents with			

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	dementia really need staff to stay with them when using the restroom. The fall potential and risk reduction protocol provided by the Director of Nursing on 9-10-12 at 4:55 p.m. indicated it was the policy of the facility to assess residents for the potential for falls and identify factors that might contribute to falls. The facility will address those factors identified in order to reduce the risk for falls. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post Nurse Staffing information on a daily basis for 1 of 5 days during the survey process. This potentially affected 44 of 44 residents.	F0356	1. Nursing hours were posted immediately by Director of Nursing the day of survey entrance on 9-4-12. 2. An audit was completed by Administrator on 9/12/12 to ensure staffing is completed and posted as	10/10/2012

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	Findings include: On 9/4/12 at 9 a.m. during a tour of the facility, staff posting was observed for day shift, evening shift and night shift that was not visible to the public or the residents. Posting indicated 2 nurses listed for day shift and evening shift and 1 nurse listed for night shift. No CNAs were listed on the posting. The posting indicated "hours varies." On 9/4/12 at 9:10 a.m., interview with Director of Nursing indicated "the hours for the nurses varies by census so we don't put those on the posting." The Director of Nursing did not indicate a reason the CNAs and their hours were not listed on the posting. 3.1-13(a)		required. 3. Director of Nursing was re-educated by Administrator on 9/11/12 regarding positing of nursing hours daily as required. 4. Administrator will complete audits weekly for 4 weeks then monthly for 2 months to ensure staffing continues to be posted as required. Results of these audits will be presented to the Quality Assurance Committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up. ** The Quaility Assurance Committee will re-evauluate the need for further monitoring after 3 months.	