

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
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NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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F000000	<p>This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00145957.</p> <p>Complaint IN00145957- Substantiated - Federal/ State Deficiencies are cited at F241, F314, and F498.</p> <p>Survey Dates: May 12, 13, 14, 15, 16, 19, and 20,2014</p> <p>Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560</p> <p>Survey Team: Gloria J. Reisert, MSW/TC Gwen Pumphrey, RN (May 12, 13, 14, 15, 19 and 20, 2014) Chris Greeney (May 12, 13, 14, 15 and 16, 2014)</p> <p>Census Bed Type: SNF: 10 SNF/NF: 69 Total: 79</p> <p>Census Payor Type: Medicare: 7 Medicaid: 45 Other: 27 Total: 79</p>	F000000	Request face to face IDR for F314 because we disagree with the scope and severity	
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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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F000241 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 28, 2014, by Brenda Meredith, R.N.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure the dignity of residents with a Foley catheter was respected by covering the bags from public view. This deficient practice affected 2 of 5 residents observed with Foley catheters. (Residents #56 and #9)</p> <p>Findings included:</p> <p>1. During an observation of Resident #56 on 5/15/14 at 9:55 a.m., he was observed in bed asleep. His Foley catheter on the right side of bed was able to be seen from</p>	F000241	<p>1-Residents 9 and 56 did not have a negative outcome related to the alleged deficient practice and their catheter bags have been covered for dignity. 2-All residents have the potential to be affected by the alleged deficient practice. All residents with catheter bags will be identified and all will have appropriate covers for dignity on or before 6/13/14 Nursing staff in-serviced on catheter covers for dignity. All new hire nursing staff will be in-serviced on catheter covers for dignity. 3-Only catheter bags that simulate an opaque cover will be ordered for use with residents beginning on</p>	06/19/2014

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	<p>the door entrance. The catheter bag had no covering and urine was observed in the bag.</p> <p>During a second observation of Resident #56 again at 2:35 p.m., the resident was asleep in bed at this time, but his catheter bag remained uncovered and on the side of the bed able to be viewed from the doorway. The bag was half full of urine at this time.</p> <p>During an interview with the Administrator at 10:00 am and with the DON at 10:10 a.m. on 5/16/14, they indicated that all Foley catheter bags should be covered for dignity.</p> <p>2. During initial tour on 5/12/14 at 9:15 a.m., Resident #9 was observed in her room to have a Foley catheter without a dignity covering.</p> <p>On 5/12/14 at 2:48 p.m., 5/13/14 at 10:15 a.m., 5/15/14 at 2:49 p.m., and 5/20/14 at 1:04 p.m., Resident #9 was observed in her room to have a Foley catheter without a dignity covering.</p> <p>Resident #9 's clinical record was reviewed on 5/19/14 at 9:00 a.m. She was admitted to the facility on 1/10/13. She had diagnoses, including but not limited to, neurogenic bladder, renal</p>		<p>or before 6/13/14. Catheter covers will be stocked for nursing staff to use for allresidents with catheters on or before 6/13/14. Nursing staff in-serviced on catheter covers for dignity. All new hire nursing staff will bein-serviced on catheter covers for dignity. DNS/Designee will conduct rounds each shift to ensure catheter bags havebeen appropriately covered. 4-DNS/Designee will conduct rounds eachshift to ensure catheter bags have been appropriately covered.To ensure compliance, the DNS/Designeeis responsible for the completion of the catheter -CQI tool weekly times 4weeks, bi-monthly times 2 months, monthly times 6 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these audits will be reviewed by the CQI committee overseenby the ED. If threshold of 95% is notachieved an action plan will be developed to ensure compliance. Attachments A,B,C,D June 19, 2014</p>				

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F000282 SS=D	<p>failure, dementia, and diabetes. She had physicians order, dated 4/29/14, for a Foley catheter. Her care plan, dated 5/6/14, stated, "Store collection bag inside a protective dignity pouch."</p> <p>This federal tag relates to Complaint IN00145957.</p> <p>3.1-3(t)</p> <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 record review and interview, the facility failed to ensure physician's orders for vital signs monitoring were implemented as prescribed and failed to ensure staff reviewed communication from the dialysis center following treatment, for 1 of 1 residents reviewed for dialysis treatment. (Resident #20)</p> <p>The findings include:</p> <p>1. Resident #20's record was reviewed 5/14/2014 at 2:30 P.M. The resident's Physician's order Report, signed by the physician on 5/6/14, indicated Resident</p>	F000282	<p>1-Resident 20 did not have a negative outcome related to the alleged deficient practice. Vital signs are being obtained and recorded per Physicians orders and ensuring communication(information) is received and recorded from Dialysis with each visit and reviewed.</p> <p>2-All residents have the potential to be affected by the alleged deficient practice. All other residents receiving dialysis were reviewed by the DNS/Designee and their vital signs and communications(information) from dialysis are being recorded</p>	06/19/2014

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	<p>#20's diagnoses included, but were not limited to, congestive heart failure, peripheral vascular disease, hypertension, end stage renal disease and renal dialysis status. Resident #20's 12/27/2013 Minimum Data Set assessment indicated Resident #20 received dialysis both prior to admission and after admission to the facility.</p> <p>A physician's order, dated 4/14/2014, indicated vital signs were to be taken by the facility once daily. The April 2014 Documentation Flowsheet indicated the order had not been initialed as implemented on 4 of 16 days in the month since the order was implemented. Specifically the dates when vital signs were not recorded were 4/16, 4/17, 4/26 and 4/27/2014. Additionally, Resident #20's May 2014 Documentation Flowsheet indicated staff initials which were circled on 5/13/2014 at 9:00 A.M., but no blood pressure or heart rate was recorded.</p> <p>During an interview with Registered Nurse (RN) #1 on 5/14/2014 at 2:34 P.M., she indicated she was the nurse who documented the flowsheet on 5/13/2014. RN #1 indicated vitals were not taken on 5/13/14 because the resident was out of the facility receiving dialysis during that morning. The nurse indicated</p>		<p>per Physicians orders and policy and procedure. Nursing staff (as well all new hire nursing staff) in-serviced on dialysis care policy and procedure in particular physicians' orders for monitoring vital signs and reviewing communication from the dialysis center following treatment.</p> <p>3-Nursing staff (as well all new hire nursing staff) in-serviced on dialysis care policy and procedure in particular physicians' orders for monitoring vital signs and reviewing communication from the dialysis center following treatment. DNS/Designee will audit medical records to ensure vital signs and information communicated from the dialysis center recorded per policy and procedure</p> <p>4-To ensure compliance, the DNS/Designee is responsible for the completion of the dialysis-CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>Attachments E,F,G,H June 19, 2014</p>		

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	<p>the resident returned to the facility later that morning.</p> <p>Review of the facility's "Dialysis Care" policy and procedure, dated September 2012, indicated "Orders will be received at the time of admission specific to the Dialysis resident's specific care as ordered by the physician." The policy and procedure further indicated "An assessment of the resident will be completed upon return from each dialysis to include vital signs.... Documentation of the assessment will be recorded in the EMR (Electronic Medical Record) and dialysis flowsheet or MAR (Medication Administration Record)."</p> <p>Interview with the Director of Nursing (DON) on 5/14/14 at 2:40 PM, the DON indicated staff should have documented vital signs for Resident #20 in accordance with the physician's order when Resident #20 returned from dialysis. The DON confirmed there were no records of vital signs recorded for 4/16, 4/17, 4/26 and 4/27/2014.</p> <p>2. Review of the facility's "Dialysis Care" policy and procedure, dated September 2012, indicated that when dialysis patients returned from the dialysis unit "The nurse in charge at the time of return will review paperwork for new orders</p>			

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	<p>and/or paperwork accompanying the resident."</p> <p>During an interview with the Director of Nursing (DON) on 5/14/14 at 2:45 P.M., the DON indicated Resident #20 received dialysis services outside the facility on Tuesday, Thursday and Saturday mornings, usually returning to the facility about 11:30 A.M. According to Resident #20's May 2014 Documentation Flowsheet, the resident received services from the dialysis unit on 5/1, 5/3, 5/6, 5/8, 5/10 and 5/13/2014. However, review of May 2014 "(Dialysis Center's name) Transfer Summary" records contained in the client record indicated there was documentation present in the facility for the visits that occurred 5/1, 5/3, 5/6 and 5/13. These records included information relevant to that day's visit to the dialysis unit and included space for new orders. No documentation of the Transfer Summaries was present in the facility to be reviewed by the nurse for visits that occurred between 5/7 and 5/12/2014. Further interview with the Director of Nursing indicated it was likely there were no documents in the facility for those dates as at times the facility needs to contact the dialysis unit and have them fax over missing records when the Dietician is in the facility to review the chart.</p>			

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F000314 SS=D	<p>3.1-35(g)(2)</p> <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, interview and record review, the facility failed to ensure preventable measures were taken to prevent a pressure ulcer causing the resident harm. A resident admitted without impaired skin integrity acquired avoidable recurrent area to the coccyx, as well as multiple areas to the left and right heel while in the facility. This deficient practice affected 1 of 3 residents reviewed for pressure ulcers. (Resident #A).</p> <p>Findings include:</p> <p>On 5/15/14 at 2:51 p.m., Resident A was observed in his room in his wheelchair. He was observed to have a kerlix dressing to both his feet. He indicated he came to the nursing home after falling at</p>	F000314	<p>Request face to face IDR for F314 because we disagree with the scope and severity</p> <p>1-Resident A has preventable measures in place to prevent skin breakdown to include low air loss mattress, pressure relieving boots bilateral feet and pressure reducing cushion in wheel chair. An arterial doppler was obtained with positive results for severe peripheral vascular disease in the lower extremities. 2-All residents have the potential to be affected by the alleged deficient practice. Nursing staff (as well as all new hire nursing staff) in-serviced on preventative wound care per policy. Wound nurse/designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place daily. Wound team to make weekly rounds on residents identified with skin impairment to</p>	06/19/2014

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	<p>home. He indicated before he was able to take care of himself independently. He indicated now he needs assistance with most daily activities.</p> <p>On 5/19/14 at 2:47 p.m., RN #1 was observed providing wound care to Resident A's pressure ulcers. Resident A was observed to have an unstageable area(full thickness tissue loss in which the the base of the ulcer was covered and stage cannot be determined) to his left heel, two unstageable areas to his right heel, and a stage 3 (full thickness tissue loss) to his right heel.</p> <p>On 5/20/14 at 10:09 a.m., the Director of Nursing (DoN) indicated he discussed with the residents physician possible Doppler to determine alternative treatments for his pressure ulcer. He indicated the deterioration of Resident A's area was related to his arterial disease. The DoN indicated the resident is on a pressure relieving mattress as a preventative measure.</p> <p>On 5/20/14 at 11:00 a.m., Resident A's clinical record was reviewed. He was admitted to the facility on 12/13/13. He had diagnoses including but not limited to, hemorrhagic stroke, diabetes, neuropathy, high blood pressure, bladder cancer, and kidney disease. The record</p>		<p>ensure treatments continue to be completed per order, devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. 3-Nursing staff (as well as all new hire nursing staff) in-serviced on preventative wound care per policy. Wound nurse/designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place. Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. DNS/designee will conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of care. 4-To ensure compliance, the DNS/Designee is responsible for the completion of the skin management program CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the</p>	

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	<p>lacked documentation of any discussion with the physician regarding alternative treatments. The record also lacked documentation of Resident A 's arterial disease.</p> <p>Resident A's initial nursing admission assessment, dated 12/17/13, indicated he did not have any pressure ulcers.</p> <p>Resident A's care plan, dated 12/18/13, indicated, "Resident is at risk for skin breakdown due to: urostomy, impaired mobility, DM [diabetes], bladder cancer, CKD[chronic kidney disease], osteoarthritis, lymphedema, chronic back pain, dermatitis, anemia, obesity, and CVA [stroke]."</p> <p>Resident A's care plan, updated on 4/10/14, indicated, "Resident has impaired skin integrity: unstageable wound R [right] heel, unstageable wound to ball of right foot."</p> <p>The Weekly Skin Assessment, dated 2/23/14, indicated the resident did not have any pressure areas.</p> <p>The Shower Report, dated 3/1/14, indicated redness to the resident ' s buttocks.</p> <p>The Weekly Skin Assessment, dated</p>		ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Attachments I,J,K,L June 19, 2014	

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	<p>3/4/14, indicated the resident had a Stage 2 (a shallow open ulcer with a red-pink wound bed and no slough) area to his coccyx.</p> <p>A physician order, dated 3/4/14 at 2:30 p.m., indicated, "cleanse area to coccyx with wound cleanser apply bacitracin and cover with dry dressing daily and as needed. dry, apply bacitracin dry dressing, change daily and as needed. Cleanse open area to right buttock with wound cleanser, pat dry, apply bacitracin and dry dressing. Change daily and as needed."</p> <p>A physician order, dated 3/19/14, indicated, "discontinue bacitracin and dry dressing to left buttock related to healed."</p> <p>A physician order, dated 3/26/14, indicated, "Discontinue bacitracin and dry dressing to right buttock related to healed. "</p> <p>The Weekly Skin Assessment, dated 4/2/14, indicated the resident's buttock was reddened and (Name) barrier cream was applied every shift and as needed.</p> <p>The Weekly Skin Assessment, dated 4/9/14, indicated the resident's buttock was reddened.</p>						

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	<p>The Weekly Skin Assessment, dated 4/16/14, indicated the resident had an open area to his buttocks and an open area to his left heel.</p> <p>A physician order, dated 4/8/14 at 10:00 a.m., indicated, " cleanse area to left outer heel with wound cleanser, apply bacitracin and cover with dry dressing. Change daily and as needed. "</p> <p>A physician order, dated 4/10/14 and untimed, indicated, "Resident to wear pressure relief boot to left heel at all times. "</p> <p>A physician order, dated 4/15/14 and untimed, indicated, "Cleanse right and left inner buttock with wound cleanser, apply bacitracin, and cover with dry dressing daily and as needed."</p> <p>The Weekly Skin Assessment, dated 4/23/14, indicated, "Stage 2 to right buttock, stage 2 to left heel and suspected deep tissue injury to right heel."</p> <p>A physician order, dated 4/21/14, indicated, "Resident to wear pressure relief boots to bilateral feet at all times. Skin prep to right heel every shift."</p> <p>On 5/20/14 at 2:10 p.m., the Assistant Director of Nursing (ADON), "After the</p>			

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	<p>area on his right heel was discovered. The next week [4/24/14] we found the area had a purple bruise and a small fluid filled blister. Then we decided to send the resident to the wound center [for evaluation]."</p> <p>The Outpatient Wound Center notes, dated 5/1/14, indicated the resident has no pressure relief boot on either foot. The measurement for the right heel area was 4.5 x 5.5 centimeters. The left proximal heel had necrotic tissue with measurements of 1 x 1.5 centimeters. The left distal heel had a Stage 2 area with measurements of 0.5 x 1 x 0.1 centimeters. The notes indicated there was no dressing to the left distal heel.</p> <p>The Outpatient Wound Center notes, dated 5/15/14, indicated the right heel was deteriorating, Stage 3 with measurements of 3.8 x 10 x 0.1 centimeters. The notes indicated the physician performed full thickness selective debridement. The Resident did arrive with pressure relief boots on both feet. The left distal heel area was resolved. The area to the resident's right buttock was resolved.</p> <p>On 5/20/14 at 2:00 p.m., the DoN indicated the preventative measures used for Resident A was a pressure relieving</p>			

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F000356 SS=B	<p>mattress and barrier cream.</p> <p>In an interview on 5/20/14 at 2:00 p.m., when asked why the residents right heel did not receive preventative measures the DoN indicated, " It was evaluated, but no open area noted. "</p> <p>A copy of the policy titled, "Skin Management Program," was provided by the DoN on 5/20/14 at 2:00 p.m. The policy indicated, "...assess each resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually, and with significant change."</p> <p>This federal tag relates to Complaint IN00145957.</p> <p>3.1-40 (a)(1) 3/1-40 (a)(2)</p> <p>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</p>			

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	<p>vocational nurses (as defined under State law).</p> <ul style="list-style-type: none"> - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the daily staff posting of the number of Nurses and Certified Nursing Assistants (CNA's) per shift was current 4 out of 7 survey days. (May 12, 13, 14 and 15, 2014)</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During an observation on 5/12/14 at 10:45 a.m., the daily posting in lobby of the number of nurses and CNA's for the day, did not reflect today's date. The date posted was Friday 5/9/14. 2. During observations on 5/13/14 at 9:45 	F000356	<p>1-Residents did not have a negative outcome related to the alleged deficient practice. The nurse staffing data is posted daily.</p> <p>2-All residents have the potential to be affected by the alleged deficient practice. Nurse managers (including the Scheduler) demonstrated to ED/Designee competency with the posting of nurse staffing data on or before 6/13/14 in the absence of the Scheduler. 1:1 In-service on posting of nurse staffing data conducted with all Nurse Managers and Scheduler. All new hire nurse managers and schedulers will be in-serviced on posting of nurse staffing data.</p>	06/19/2014

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F000498 SS=D	<p>a.m., 5/14/14 at 12:42 p.m., and on 5/15/14 at 8:45 a.m. and again at 2:15 p.m., the daily posting in the lobby of the number of nurses and CNA's for the day reflected Monday 5/12/14.</p> <p>During an interview with the Staff Development Coordinator and the Director of Nursing (DoN) on 5/15/14 at 2:40 p.m., the DoN indicated that the Staff Development Coordinator was responsible for ensuring the correct staffing ratio form was posted for the day. The Staff Development Coordinator indicated that because she did not come into work Monday 5/12/14, until noon and that she was working different shifts and tasks, she had not be able to keep it posted daily with the correct form. The DoN indicated that in her absence, he would have been the one responsible for making sure it was correct every day.</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are</p>		<p>3-Nurse managers (including the scheduler) demonstrated to ED/Designee competency with the posting of nurse staffing data on or before 6/13/14 in the absence of the Scheduler. 1:1 In-service on posting of nurse staffing data conducted with all NurseManagers and Scheduler. All new hire nurse managers and schedulers will be in-serviced on posting of nurse staffing data ED/Designee will conduct daily observations of posted staffing data to ensure it is posted per regulations.</p> <p>4-To ensure compliance, the ED/Designee is responsible for the completion of the Administration -CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Ed/Designee will conduct daily observations of posted staffing data to ensure it is posted per regulations.</p> <p>Attachments M,N,O,P June 19, 2014</p>				

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	<p>able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure nurse aides were able to demonstrate competency training with incontinence care and hoyer lift transfers. This deficient practice affected 3 of 3 residents observed for incontinence care and 2 of 2 residents observed for hoyer lift transfers. (Resident B, C, D, and E).</p> <p>Finding include:</p> <p>1. On 5/14/14 at 1:05 p.m., CNA #1 and CNA #2 were observed using a hoyer lift to transfer Resident B from the chair to the bed. CNA #1 was observed to began the transfer without locking the hoyer lift or the chair before lifting the resident out of the chair. CNA#2 was observed to not be close to the resident to guide her as she was transferred from the chair to the bed.</p> <p>On 5/15/14 at 2:22 p.m., CNA #3 and CNA #4 were observed using a hoyer lift to transfer Resident E from the wheel chair to the bed. The lift nor the chair were locked before lifting the resident out of the bed.</p>	F000498	<p>1-Residents B and E did not have a negative outcome related to the allegeddeficient practice and their wheel chairs and hoyer lifts are locked with eachtransfer. Residents B, C, and E did not have a negative outcome related to thealleged deficient practice referring to incontinence care Incontinent care and hoyer transfers are being provided to residents perpolicy. 2-All residents have the potential to be affected by the alleged deficientpractice. Incontinent care and hoyer lift transfers are being provided to residentsper policy. In-services on incontinent care and hoyer lift transfers conducted forall nursing staff and all new hire nursing staff. 3-In-services on incontinent care and hoyer lift transfers conducted forall nursing staff and all new hire nursing staff. Nurse Managers/Designee will conduct rounds each shift to ensure properincontinent care and hoyer lift transfers are completed. 4-To ensure compliance, the DNS/Designee is responsible for thecompletion of the mechanical lift -CQI tool weekly times 4 weeks, bi-monthlytimes 2 months, monthly times 6 and then quarterly to encompass all shiftsuntil continued compliance</p>	06/19/2014

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	<p>In an interview with the DoN (Director of Nursing) on 5/14/14 at 3:15 p.m., he indicated the CNA's did not use proper technique with the transfer and would receive education.</p> <p>The orientation checklist was reviewed for CNA#1, CNA#2, CNA#3, and CNA#4. The orientation checklist indicated each CNA received training on using the hoyer lift.</p> <p>A copy of the policy titled, " Mechanical Lift," was provided by the Director of Nursing on 5/14/14 at 3:56 p.m. The policy indicated to refer to the manufacturer guidelines related to locking of lift/or chair during transfer.</p> <p>2. On 5/14/14 at 1:15 p.m., CNA #1 was observed for incontinent care on Resident B. CNA#1 was observed to rewipe Resident B 's labia in a back to front direction.</p> <p>On 5/14/14 at 1:59 p.m., CNA #1 was observed for incontinent care on Resident C. CNA#1 was observed to wiping the resident in a back to front direction.</p> <p>On 5/20/14 at 9:10 a.m., CNA #5 and CNA #6 on Resident E. CNA #5 was observed rewiping Resident E 's labia in a back to front direction.</p>		<p>is maintained for 2 consecutive quarters. Therresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance. Transfer technique and incontinence careskills validation check will be completed on all shifts daily for one week, biweekly for 1 week, weekly times 2 week, and monthly for six months byDNS/Designee . Results of the skills validation will be reviewed by the CQIcommittee overseen by the ED. If 95% compliance is not achieved an action planwill be developed to ensure compliance. Nurse Managers/Designee will conductrounds each shift to ensure proper incontinent care and hoyer lift transfersare completed. Attachments Q,R,S,T,U,V June 19, 2014</p>		

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	<p>The orientation checklist was reviewed for CNA #1, CNA#5, and CNA#6. The orientation checklists indicated each CNA received training on incontinence care. The checklist indicated each CNA was able to perform the skill independently.</p> <p>On 5/20/14 at 10:41 a.m., the DoN provided a copy of the policy titled, "Perineal Care." The policy indicated the staff should wipe from front to back direction. The policy also indicated, "Do not rewipe area, unless using a clean area of the wash cloth. "</p> <p>This federal tag relates to Complaint IN00145957. 3.1-14(i)</p>			