

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 10, 11,12, 13, 16, and 17, 2012</p> <p>Facility number: 010892 Provider number: 155661 AIM number: 200229560</p> <p>Survey team: Teresa Buske, RN -TC Mary Weyls, RN Laura Brashear, RN Debra Skinner, RN</p> <p>Census bed type: SNF: 6 SNF/NF: 93 Total: 99</p> <p>Census payor type: Medicare: 8 Medicaid: 71 Other: 20 Total: 99</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 20, 2012 by Bev Faulkner, RN</p>	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident had the right to make choices regarding her life in the facility for 1 of 20 residents interviewed regarding choices in that Resident #80 was not given her preferred choice of time when getting up in the morning.</p> <p>Findings include:</p> <p>1. During interview of Resident #80 on 7/11/12 at 11:20 a.m., the resident indicated the staff gets her up at 4 a.m., and she would like to get up at least a 1/2 hour later since she usually just sits in the hallway in her wheelchair. The resident stated she was "accustomed" to the time now. Upon interview of Resident #80 on 7/13/12 at 11:10 a.m., the resident indicated she got up at 4 a.m. that morning.</p> <p>On 7/13/12 at 11:20 a.m., the</p>	F0242	<p>F242 Resident #80 was interviewed to determine resident's current personal preference for wake times. The resident's assignment sheet and care tracker profile has been updated to ensure staff is aware of the resident's preference. All residents have the potential to be affected. DHS or designee will in-service nursing staff. Resident Profiles will be update and available on care tracker kiosk by Aug. 16, 2012. DHS/designee will ask 4 residents at least 3x a week for 8 weeks, then periodically, what time they are being got up in the morning and if they are satisfied with the time. The residents will be rotated as to which resident is asked. (Attachment B)An audit of resident preference sheets will be completed by August 16, 2012 and compared to the CRCA assignment sheets.DHS/designee will complete staff in servicing related to honoring resident choices and resident rights to be completed by August 16, 2012. DHS/designee</p>	08/16/2012			

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	<p>resident was observed to be transferred utilizing the Maximove mechanical lift by CNAs #10 and #11.</p> <p>Upon interview of CNA #10 on 7/13/12 at 11:20 a.m., the CNA indicated the resident was usually up before she gets here at 6 a.m. The CNA indicated the night shift gets the resident up "probably between 5 a.m. and 6 a.m." The CNA indicated the night shift had a "get up" list.</p> <p>Upon interview of CNA #13 on 7/16/12 at 2:43 p.m., the CNA indicated the resident was up when she came on this morning at 6 a.m. The CNA indicated the night shift gets the resident up "probably" around 5:30 a.m., but was unsure of exact time.</p> <p>Upon interview of LPN #12 on 7/13/12 at 1:40 p.m., the nurse indicated the night shift gets up some of the residents. The nurse indicated if the residents were wide awake at bed checks then they will go ahead and get the residents up.</p> <p>Through review of the CNA assignment for Resident #80, dated 7/16/12 on 7/16/12 at 3:30 p.m., indicated the resident was to be awakened at 8 a.m.</p>		<p>will ask 4 residents at least 3x a week for 8 weeks, then periodically, what time they are being got up in the morning and if they are satisfied with the time. The residents will be rotated as to which resident is asked. (Attachment B)These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until 100% substantial compliance is achieved x 6 mos. Results of audits will be discussed with QA team monthly for ongoing needs and action until 100 % compliance is achieved for 6 mos. DHS or designee will complete the audits August 16, 2012</p>		

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	<p>Upon interview of the Director of Health Services (DHS) on 7/17/12 at 12:08 p.m., the DHS indicated that the time on the assignment sheet was the time the resident was to be awakened. The DHS was unaware that the resident was getting up at 4 a.m. On 7/17/12 at 12:35 p.m., the DHS indicated the resident's preference to get up on admission (4/15/09) was 6 a.m. The DHS also indicated the resident's physician had ordered daily weights by 6 a.m. and the daily weights were discontinued on 6/24/12.</p> <p>Review of the clinical record on 7/16/12 at 2 p.m., indicated the most the recent Minimum Data Set (MDS) assessment was completed 5/13/12. The assessment identified the resident with moderate impairment of cognitive decision making skills, extensive assistance with bed mobility, transfers, and personal hygiene, and total dependence for bathing.</p> <p>During the interview of the Administrator on 7/17/12 at 1:07 p.m., the Administrator indicated it was the policy of the facility to allow each resident to get up at the time of their choice.</p>			

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F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on interview and observation, the facility failed to monitor for odors and provide an environment free of urine odor in 3 of 4 units (Halls B, C, and D).</p> <p>Findings include:</p> <p>1. On 7/10/12 at 2:15 p.m., a strong urine odor was noted on the C-wing hallway.</p> <p>On 7/11/12 at 10 a.m., there was a pervasive urine smell in the C-wing hallway which lessened as one moved down towards the end of the hall. Room 102 had a very strong urine smell, with bed A's sheets observed to have been removed. It was difficult to tell which part of the room in which the urine smell was worse. Bed B's closet door had a sign which indicated "Family will do laundry." Soiled clothes were visible in the plastic basket on the floor of the B-bed closet.</p> <p>07/12/12 at 11 a.m., there was a pervasive urine smell in the C-Wing hallway which lessened towards the</p>	F0253	F253 ED/.DHS or designee to perform at least one resident room audit daily x 5 days/week to monitor for odors and provide an environment free of urine odors. All residents on health center have the potential to be affected. Employees educated on general housekeeping/odor prevention/ laundry practices by August 16, 2012. Facility purchased new odor eliminating product. Facility currently undergoing renovations with installation of new flooring throughout the campus including resident rooms. One resident room daily to be audited for odors.. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until 100% substantial compliance is achieved for 6 mos. These audit will include checking odors from mattresses, wheelchairs, and other furnishings. Results of audits will be discussed with QA team monthly for ongoing needs and action x 6 mos. DHS or designee will complete the audits. Completion Date: August 16, 2012	08/16/2012			

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	<p>end of the hall.</p> <p>On 7/12/12 at 1 p.m., a strong urine odor was noted on the C-wing hallway.</p> <p>07/13/12 at 10 a.m., there was a pervasive urine smell in C-wing hallway which lessened towards the end of the hall.</p> <p>On 07/16/12 at 11:54 a.m., in the C-Wing hallway, the urine smell was not obvious until getting near Room 105. There were wet-looking spots noted on carpeting in the middle of floor.</p> <p>On 07/16/12 at 1:50 p.m., during the environmental tour with the Health Facilities Administrator (HFA) and Director of Environmental Services, there were strong urine odors in Room 105 C-Wing (soiled areas of carpeting in middle of floor) and in Room 115 C-Wing. The HFA indicated these two rooms would be receiving laminate flooring during the ongoing remodeling process to help combat the urine odors prevalent in these two rooms.</p> <p>2. On 7/16/12 at 11:42 a.m., a stale urine odor was noted in resident room D102.</p>			

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	<p>3. On 7/16/12 at 12 p.m., a heavy, stale urine odor was noted in resident room B110.</p> <p>3.1-19(f)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to be free of medication error rate of greater than 5% in that 6 medication errors were identified during 63 opportunities for error. This resulted in a medication error rate of 9.5%. The errors included administration of medications per physician ordered route, crushing of enteric coated tablets, ensuring exact amount of liquid medication, and flushing prior to administration of gastrostomy tube medications. The errors involved 3 residents (Resident #1, Resident # 84, and Resident # 2).</p> <p>Findings include:</p> <p>1. On 7/16/12 at 9:14 a.m., Resident # 84 was observed to receive enteric coated Ferrous Sulfate 325 milligram (mg) crushed, mixed with pudding, and by mouth. RN #4 was observed to administer the medication.</p> <p>Review of the resident's clinical record on 7/17/12 at 2:03 p.m., documentation indicated a physician's order, dated 1/2/12, of ferrous sulfate</p>	F0332	F 332 : On July 17, 2012 an order from attending physician was obtained stating approval to crush ferrous sulfate for #2 and #84. On July 16 & July 17, 2012 staff education was completed with RN #2 and all nurses/QMA on duty regarding the "Medication Crushing Guidelines". Coach and counseling completed with RN#2 regarding "Medication Crushing Guidelines."On July 17, 2012 orders were clarified and written for Resident #1 that medications are to be given per G-tube. On July 16 & 17, 2012 staff education was completed with LPN #7 and all nurses/QMA on duty regarding insuring orders are followed regarding the route of medication administration and proper techniques for measurement of medications.Coach and counseling with LPN #7 regarding the correct route of administration and proper techniques for measurement of medications.Residents found to have been affected by the alleged deficient practice will be included in the random audits.All residents have the potential to be affected by the same alleged deficient practice. All residents who receive medications via gtube chart's were audited to insure	08/16/2012			

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	<p>325 mg enteric coated, one tablet by mouth every day for supplement.</p> <p>Review of the facility's current policy and procedure for "Medication Crushing Guidelines," dated 2/1/10, on 7/17/12 at 10:20 a.m. indicated "...Medications that should not be crushed or chewed: The solid dosage forms of many medications should not be crushed or chewed for a variety of reasons. When a resident's condition prohibits the administration of solid dosage forms (tablets, capsules etc), the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form, if possible....The rationale for not crushing some medications includes: ...B. Enteric Coated Tablets are designed to pass through the stomach whole and then dissolve in the intestinal tract.</p> <p>2. On 7/16/12 at 9:35 a.m., Resident # 2 was observed to receive enteric coated Ferrous Sulfate 325 milligram (mg) crushed, mixed with pudding, and by mouth. RN #4 was observed to administer the medication.</p>		<p>correct route is documented. ADHS/designee will in-service all nursing staff by August 16, 2012. DHS/designee will conduct random medication pass audits to include all licensed nurses 3x wk for 4 wks then 2x wk for 4 wks then 1x wk for 4wks then periodically. Medication pass audits will be focused on insuring the 7Rs of medication of administration (route, dose, resident, time, medication, right to refuse and right documentation) are complied with. (Attachment A) Pharmacy consultant will completed medication pass audits monthly for a minimum of six months. Nursing management team will review all orders during clinical meeting to insure orders are written correctly. DHS/designee will complete staff in servicing related to "medication crushing guidelines" and 7Rs of medication administration to be completed by August 16, 2012. Medical records will audit monthly re-writes for all residents with G-tubes to insure the 7 Rs are followed. Medical records will report percentage of accuracy monthly in QA x 6months. Medical records will insure monthly that the list of medications to be crushed are in the front of all MARs. DHS/designee will conduct random medication pass audits for all licensed nurses 3x wk for 4 wks then 2x wk for 4 wks</p>				

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	<p>Review of the resident's clinical record on 7/17/12 at 2 p.m., documentation indicated a physician's order, dated 2/24/10, of ferrous sulfate 325 mg enteric coated, one tablet by mouth daily for anemia.</p> <p>Review of the facility's current policy and procedure for "Medication Crushing Guidelines," dated 2/1/10, on 7/17/12 at 10:20 a.m. indicated "...Medications that should not be crushed or chewed: The solid dosage forms of many medications should not be crushed or chewed for a variety of reasons. When a resident's condition prohibits the administration of solid dosage forms (tablets, capsules etc), the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form, if possible....The rationale for not crushing some medications includes: ...B. Enteric Coated Tablets are designed to pass through the stomach whole and then dissolve in the intestinal tract.</p> <p>3. On 7/16/12 at 11:57 a.m., LPN #7</p>		<p>then 1x wk for 4wks then periodically. Medication pass audits will be focused on insuring the 7Rs of medication of administration are complied with. (Attachment A)Pharmacy consultant will completed medication pass audits monthly for a minimum of six months.Nursing management team will review all orders during clinical meeting to insure orders are written correctly. Completed August 16, 2012</p>				

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	<p>was observed to administer the following medications to Resident #1 per gastrostomy tube which included but were not limited to: Lortab 5/500, one tablet (crushed); phenobarbital 25 milliliters (ml) (100 mg) liquid; Dilantin 125 mg/ 5 ml liquid exact amount undetermined- less than 5 ml., and Seroquel 100 mg- one tablet (crushed). The nurse was observed to pour the Dilantin liquid into clear plastic measuring cup with the amount slightly below the 5 ml mark. The nurse was observed to crush the Seroquel and Lortab tablets and dissolve in the water. Prior to administration, the nurse was observed to auscultate placement of the gastrostomy tube by instilling air into the tube. The nurse then administered the liquid phenobarbital. The nurse did not flush the gastrostomy tube with water prior to administration of the first medication.</p> <p>Review of the clinical record of Resident #1 on 7/17/12 at 2 p.m., documentation indicated the following physician orders: Phenobarbital 20 mg/ 5 ml elixir- 25 ml (100 mg) by mouth at 12 noon for seizures dated 1/13/12; Dilantin 125 mg/ 5 ml suspension- give 4 ml (100 mg) by mouth twice a day for seizures dated 1/13/12; Seroquel 100 mg tablet- give</p>			

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	<p>one tablet orally every 12 p.m. and bedtime for agitation/behaviors dated 3/8/11; Lortab 5/500, give one tablet orally four times daily for pain dated 8/22/10.</p> <p>Review of the facility's current policy and procedure [no date] titled "Guidelines for Administering Gastric Tube Medications," on 7/17/12 at 9:57 a.m., indicated "...Procedure: 1. Verify the '5 Rights' before administering medications- the right medication; the right dose; the right resident; the right route, and the right time...25. For liquid medications...Place cup on a level surface and read the poured amount at eye level to check accuracy...34. Check placement in the stomach and residual gastric contents...35. Flush tubing with warm water as ordered..."</p> <p>During the interview of LPN #7 on 7/17/12 at 1:36 p.m., the LPN indicated Resident #1 does not like to take medications by mouth and that at one time they had tried to get him to do that.</p> <p>During the interview of the Director of Health Services (DHS) on 7/17/12 at 1:40 p.m., the DHS indicated the physician orders should have been by the gastrostomy tube route, and the</p>			

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	<p>exact amount of 4 ml should have been completed with measuring mark for that amount. The DHS also indicated that Resident #1 has not had any seizures in the last 6 months or longer.</p> <p>3.1-48(c)(1)</p>			

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F0371 SS=E	<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, interview and record review, the facility failed to serve food under sanitary conditions for 2 of 3 observations of 1 of 1 kitchen in that gloves in contact with contaminated surfaces were utilized handling food items and/or in contact with interiors of clean dishes during meal service. This had the potential to affect 47 of the 99 residents in the facility.</p> <p>Findings include:</p> <p>1. On 7/16/12 at 11:00 a.m., Dietary Aide #8 was observed wearing disposable gloves. The staff member was observed wearing the gloves and opening the walk-in refrigerator, entering and exiting the refrigerator, moving three rolling carts around in the kitchen and with the same gloves placed individual loaves of bread onto plates on serving trays located inside the food delivery carts.</p> <p>2. On 7/16/12 at 11:50 a.m., Dietary</p>	F0371	F371 All dining service employees where re-educated on hand washing policy and procedures as well as proper glove usage. All residents have the potential to be affected by this alleged deficient practice. sanitation audits to be completed monthly by RD or designee. Random audits to be completed by DFS or designee and Random checks will be completed for proper hand washing and glove usage. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly x 6 mos. for ongoing needs and action. DFS or designee will complete the audits. Completion Date: August 16, 2012	08/16/2012			

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	<p>Aide #9 was observed wearing disposable gloves at the steam table of the service line. The staff member was observed picking up clean dinner plates, touching the interiors of the plates, placing food on the plates, placing on metal trays and leaving service area, opening delivery carts opening and closing the carts and without changing gloves or washing hands returned to service area, picking up additional plates, and touching interiors of the plates and continued serving the food. The staff member continued the sequence of preparing two plates at a time and opening the delivery carts and placing plates inside. The staff member indicated the carts were utilized for food delivery to the closed unit and room trays.</p> <p>A facility policy titled "Hand Washing," dated 2009, provided by the Administrator on 7/17/12 at 9:50 a.m., included, but was not limited to: "Procedure: 1. All hands are washed: C. After handling soiled dishes and utensils. ...E. Before and after handling foods. ...K. Whenever soiled. "</p> <p>3.1-21(i)(3)</p>						

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F0441	F 441 On July 16 and 17, 2012 staff education was completed	08/16/2012			

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	<p>ensure staff changed gloves when contaminated according to facility policy and procedure for 1 of 3 licensed staff (LPN #7) providing care and 1 of 4 CNAs (CNA #1) observed providing care.</p> <p>Findings include:</p> <p>1. On 7/16/12 at 11:57 a.m., LPN # 7 was observed to auscultate and administer medications through Resident # 1's gastrostomy tube. The LPN was observed to wear gloves during the procedure. After completing the procedure, the LPN was observed to open the bathroom door wearing the contaminated gloves. The LPN rinsed the syringe utilized during the procedure. The LPN then removed her gloves and washed her hands.</p> <p>2. During observation on 07/16/12 at 12 p.m., Resident #62 was transferred from the wheelchair to the bed to be changed and peri-care provided. CNA #1 and CNA #2 transferred the resident from the wheelchair to bed with the Hoyer lift. The resident was observed to be totally dependent for all movements. As soon as the resident was laying on the bed, both CNA's placed a reusable lift sheet under the resident. This shiny-looking sheet was placed</p>		<p>with LPN #7 and CNA #1 and CNA #2 and all nursing staff on duty on infection control related to hand washing, and glove removal. Residents found to have been affected by the alleged deficient practice will be included in the random audits. All residents have the potential to be affected by the same alleged deficient practice. DHS/designee will complete staff in servicing related to infection control by August 16, 2012. DHS/designee will conduct random audits 3x wk for 8 weeks then monthly specifically observing resident care and g tube medication administration until substantial compliance is achieved. Results of audits will be discussed with QA team monthly x 6 mos. for ongoing needs and action. Completed August 16, 2012</p>		

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	<p>on top of the Hoyer lift sling. CNA #1 removed the resident's soiled and wet incontinence brief and provided peri-care to the front and rectal/buttock areas. The resident had been incontinent of both bowel and bladder. A new brief was applied without gloves being changed or hands being washed by CNA #1. CNA #1 had then assisted CNA #2 to put clean pants on the resident with the same soiled gloves. The reusable lift cloth was then removed from underneath the resident by both CNA's. CNA #1 had then been observed to touch her own hair with the same soiled gloves. CNA #1 then touched the Hoyer lift sling (on her side) underneath the resident in order to reposition it. CNA #1 had then been observed to remove her gloves before assisting CNA #2 to transfer the resident by the lift back to the wheelchair. No handwashing had been observed during or after the entire process.</p> <p>The MDS (Minimum Data Set) assessment information included: Quarterly 04/24/12: The resident required total assist of 2 for all ADL's (activities of daily living) except eating (assist of 1 required); was non-ambulatory; was incontinent of bowel/bladder; had a BIMS (Brief</p>						

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	<p>Interview for Mental Status) score of 11 out of 15; had no skin problems; received no psychotropic's nor diuretics; had no UTI's (urinary tract infections).</p> <p>Review of the facility's current policy and procedure, dated 12/2010, titled "Guidelines Standard Precautions" on 7/17/12 at 1:05 p.m., indicated "...c. Gloves and Handwashing,...2. Gloves should be changed after having contact with infective material that may contain high concentrations of microorganisms (fecal material, wound drainage.) 3. Remove and discard gloves within the room and wash hands immediately. 4. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room..." Review of the facility's current policy and procedure dated 10/2004 titled "Guidelines for Handwashing" on 7/17/12 at 9:57 a.m., documentation indicated "...Health care workers shall wash hands at times such as:...d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen etc...."</p> <p>3.1-18(l)</p>				

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a sanitary environment for 1 of 1 kitchen in that a one-half inch gap was observed at the bottom of the kitchen exit door to the outside of the building on 2 of 3 kitchen observations.</p> <p>Finding includes:</p> <p>During initial observation of the kitchen on 7/10/12 at 11:15 a.m., with the Dietary Manager, a 1/2 inch gap was observed at the bottom of the exit door of the kitchen to the outside of the building. The gap was observed again during observation of meal preparation and meal service on 7/17/12 at 11:00 a.m. and 11:50 a.m.</p> <p>On 7/17/12 at 2:50 p.m., in interview, the Administrator indicated weather stripping had been replaced on the bottom of the door.</p> <p>3.1-19(f)</p>	F0465	F 465 Weather stripping on exterior exit kitchen door was replaced prior to completion of survey exit. All residents have the potential to be affected. Weather stripping will be added to sanitation audits to be completed monthly by DFS or designee. Plant Operations will also include weather stripping on their preventive maintenance rounds monthly for 100 % substantial compliance. Results will be discussed in QA monthly for 6 mos. or until committee determines compliance. August 16, 2012	08/16/2012	

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F0469 SS=D	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview and record review, the facility failed to maintain an effective pest control program for 1 of 1 resident room observed with live activity of ants in that ants were observed to be present on and in the room of Resident #21.</p> <p>Findings include:</p> <p>1. On 7/11/12 at 10:52 a.m., Resident #21 was observed to have live ants crawling on a lap blanket during an interview. The resident was unaware of the ants on the blanket. Live ants were also noted on the resident's mattress and privacy curtain. The bed linens had been removed from the mattress prior to entering the resident's room. The staff were immediately informed of the ants and acted upon notification.</p> <p>On 7/11/12 at 10:52 a.m., the resident indicated she had not had any concerns with ants prior to today.</p> <p>Upon review of the resident's clinical record on 7/11/12 at 11:30 a.m., indicated the most recent Minimum</p>	F0469	<p>F469 As indicated, staff immediately acted upon notification of incident with Resident #21 who indicated no prior concerns with ants prior to this date. All residents have the potential to be affected. Plant Operations or designee will review and continue with Quality Assessment & Assurance Committee Action Plan. Contracted Pest Control will continue to work with campus until desired level of compliance is achieved. HFA has contacted contracted Pest Control Company to request any additional services that are available. Exterior Treatments to be completed twice per year added to contract. QA will continue to monitor each month for at least 6 months and then quarterly to assure compliance. Completed 8/16/12</p>	08/16/2012			

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	<p>Data Set (MDS) assessment was completed 4/3/12. The assessment identified the resident as cognitively intact.</p> <p>Upon interview of CNA #2 (staff person notified of ants) on 7/11/12 at 10:54 a.m., the CNA indicated ants "having kinda been coming and going."</p> <p>Upon interview of QMA #14 on 7/11/12 at 10:55 a.m., QMA indicated ants had been found on another wing and that they had been spraying around the facility.</p> <p>The pest control program customer service invoices were observed on 7/12/12 at 9:25 a.m. Visits were noted as follows: 7/11/12- retreatment, 90 % of all resident rooms were sprayed as well as hallways, dining areas, kitchen, lobby, and activity areas. Ants were found in 4 or 5 rooms. Ants worse due to current construction and dry summer; 6/26/12- call back/reservice - targeted ants serviced rooms and areas- D115, D113, D111, nurses station D hall, Cafe and Lobby; 5/27/12- no live pest activity noted, all areas inspected and serviced; visits were noted on 2/26/12, 3/25/12, and 4/23/12 without live pest activity.</p>			

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	<p>The Administrator provided a Quality Assessment and Assurance Committee Action Plan on 7/12/12 at 3:50 p.m. Documentation indicated the following interventions, but were not limited to pest control to be called immediately for service call as necessary, pest control to visit more often than monthly as needed, explore any possible alternative options to make sure campus is exhausting all efforts of prevention, care tracker message to re-educate and re-enforce the importance of keeping resident rooms and common areas as clean as possible, and leadership team to complete coffee breaks [mini inservices] and do routine rounds to inspect areas of concern.</p> <p>Upon interview of Administrator on 7/12/12 at 3:50 p.m., the Administrator indicated resident rooms and areas were being inspected daily by staff.</p> <p>The facility's current policy and procedure [no date] titled "pest control" on 7/17/12 at 2:25 p.m., indicated "...1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents..."</p>			

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