STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155103	A. BUILDING 00 B. WING	12/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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F0000	This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaints #IN00118199 and #IN00116640. This visit was done in conjunction with the Investigation of Complaint #IN00120066 Complaint #IN00118199 - Substantiated/Federal Deficiency cited at F157 #IN00116640- Substantiated/Federal Deficiency cited at F203 Survey Date: December 4, 5, 6, 7, 10, 11, and 12, 2012 Facility number: 000042 Provider number: 155103 AIM number: 100291540 Survey Team: Julie Wagoner, RN, TC Shelly Miller-Vice , RN(12/5, 12/6, 12/7, 12/10, 2012) Deb Kammeyer, RN (12/4, 12/5, 12/6, 12/10, 12/11, 12/12, 2012) Lora Swanson, RN Shauna Carlson, RN	F0000	The creatin and submissin of this plan of correction does not constitute an admission by this provider of any conclusions set forth in the statement of deficiencies or any violation of regulations. This provider respectfuly requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit.	

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

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	Amber Bloss, Medical Surveyor (12/4, 12/5, 12/6, 12/7, 12/10, 2012) Census bed type: SNF/NF: 129 Total: 129 Census Payor type: Medicare: 11 Medicaid: 102 Other: 16 Total: 129 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review completed on 12/21/12, by Brenda Meredith, R.N.			

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to post a complete listing of contact information, including the complaint number for the Indiana State Department of Health. The facility also failed to display written information for the Elder Justice Act. This had the potential to affect 129 of 129 current residents. Finding includes: During a tour of the facility on 12/4/12 at 10:00 A.M., an observation made in the front lobby, indicated there was no written information posted for The Elder Justice Act or the complaint number for the Indiana State Department of Health. No posting was observed for 6 of 7 days (12/4,	F0156	**F 156:** It is the practice of this facility to post a complete listing of contact information, including the complaint number for the Indiana Dept of Helath. It is the practice of this facility to display written information for the Elder Justice Act. **Corrective Action:**Residents will be given notice of written description of pertinent State client advacacy groups at admission, periodically during resident coucil and upon postings in the front lobby of the facility. **How Others Identified:** All residents have the potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. **Preventative Measures:** All new residents will receive and admission policy reviewed with upon admit. Resident Council will	01/11/2013

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	12/5, 12/6, 12/7, 12/10 and 12/11/12) of the survey. The information was not noted to be posted at any other location in the facility. During an interview on 12/11/12 at 11:00 A.M., the Administrator indicated the Elder Justice Act and the complaint number for the Indiana State Department of Health were not posted in the facility and should have been. 3.1-4(j)(3) 3.1-4(j)(2)		review location of pertinent State client advocacy groups postings. Postings will be reviewed for any necessary changes. **Monitoring:** Admission team will ensure that residents and POA's are given admission paperwork, which informs of services, charges, legal rights, pertinent State advocacy numbers. Activity Director or designee will review location of State number postings monthly for three months, monthly for three months and then annually thereafter. Adminstrator or designee will ensure State advocacy numbers are appropriate monthly for three months and then monthly. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the	

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			administrator for review and presented to QA to determine further educational needs.	

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. A. Based on record review and interviews, the facility failed to notify the family of a medical change of condition that lead to an acute hospital admission. This affected 1 of	F0157	**F 157**: It is the practice of this facility that the resident, resident's physician and resident's family or legal representative will be informed when there is a change of	01/11/2013

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	3 residents sampled. (Resident D) B. Based on observation, interview and record review, the facility failed to notify 1 of 4 family members interviewed, of a change in a resident's condition. (Resident #57) Findings include: A. On 12/5/12 at 10:30 A.M., an interview was conducted with Resident D's family member by telephone. She indicated that the facility had not notified them, on 10/14/12, when Resident D's medical status had "...taken a turn for the worst..." She stated, "... my brother visited that afternoon and found our (parent) to be in distress... my brother had asked the facility if they had contacted the doctor, they said they had, but were awaiting a return phone call from his (the doctors) office... my brother waited and waited and our (family member) continued to get worse... (Resident D's) breathing was really bad... we were concerned (Resident D) may die... so, my brother picked up the phone and called 911... they (Emergency Medical Response) EMS responded and took our (family member) to the hospital... (Resident		condition. **Corrective Action:** Families have been notified of all residents who have had a recent change of condition. Nurses will be re-educated on family notification and then documentation of this notification. This notification will be placed on the SBAR, nursing notes, and 24 hour report.**How Others Identified:** All residents will have the above process completed with each change of condition. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees.**Preventative Measures:** The Unit Managers (UM), Assistant Director of Nursing (ADON) or designee will check the SBAR's, 24 hour report sheets and nursing notes. **Monitoring:** The UM or designee will check the SBAR's, 24 hour report sheets and nursing notes each morning during clinical review (Monday through Friday). UM or designee will monitor daily for two weeks, then three times a week for two weeks, and then weekly for two months and then monthly thereafter. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination.	

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	#D) was placed in the ICU (Intensive Care Unit) for one week... the hospital said (family member) was swollen and had CHF (Congestive Heart Failure) and that's why (Resident D) couldn't breath... when (family member) returned to the facility they put him on the (different resident unit identified) and things have been better...I just feel they could have let 'us' know that our (family member) wasn't doing well, and no one did... we had to find (Resident D) in that bad condition and then we had to contact emergency help just to get the facility to do something..." On 12/6/12 at 10:45 A.M. a record review was made of the clinical medical record for Resident D. It indicated that Resident D had been admitted to the facility in June of 2012. An entry, dated 10/14/12 at 1:20 P.M., noted, "...spent day in bed..." An entry, dated 10/14/12 at 5 pm, indicated an assessment by nursing staff was completed and noted a drop in (Resident D's) room air saturation to 84%. It also indicated an "updraft was given (breathing treatment) " with a "HOB (head of bed) elevated..." this was tolerated "well..." This same entry indicated that the resident,		Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.Addendum (1/18/13): Charts of residents with change of condition in the last 30 days are reviewed to ensure family notification of any change of condition. Corrections are made as needed.	

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	"...lungs exp (expiratory) wheezing but diminished in bases..." An entry dated, 10/14/12 at 7:45 P.M., noted,"... went in res (Resident D's) room. Res (resident) biox (lung air saturation) 90%- 91% r/a (room air)...resp (respirations) at 20 slightly labored... updrafts given as ordered. tolerated well. lungs diminished c(with) slight expiratory wheezing. Son came to visit resident. Requested res (Resident D) be sent out to hospital. This nurse went and called (Doctors name)." An entry, dated 10/14/12 at 8:00 P.M., noted, "...returned to resident room where another nurse was checking resident, son stated he had already called an ambulance. Canceled prompt ambulance. N.O (nurse order) received from Dr. (doctors name) to send resident to (hospitals name)." An entry, dated 10/14/12 at 8:15 P.M., noted, "...resident transported to (hospitals name) by stretcher by fire department paramedics." An entry, dated 10/15/12 at 2:10 A.M., noted, "... This nurse called (hospitals name) at this time to find out about resident's condition.			

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	Resident is being admitted for pneumonia and respiratory distress. (signature of nurse)." A record, titled, " SBAR Physician/NP(nurse practioner)/PA (physician's assistant) Communication and Progress Note," dated 10/14/12 at 8 P.M., with Resident D's name at the top of the page, indicated at the "A" for "Assessment (RN) or Appearance (LPN)" a template sentence stated, " I am not sure of what the problem is, but there had been an acute change in condition. In the space next to the Appearance (For LPN's)was documented: "The patient appears- typed and then handwritten "labored breathing, Biox 88%-91%". This form was signed by a Registered Nurse indicated by the "RN" at the end of the signature. A "Patient Transfer Order Form" from the hospital, dated 10/22/12, noted a primary diagnosis of "CHF (congestive heart failure)." There were no IDT (interdisciplinary team) progress notes found in the clinical medical chart from 9/28/12 to 10/24/12. An entry, in the nursing progress			

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	notes, dated,10/25/12 at 1:00 P.M., indicated "... Resident is readmitted to the facility from the hospital. Resident admitted to new room upon return. Resident and family like new room. No concerns or adjustment issues noted. Will continue to follow. (Social Workers signature)." An interview with the Unit Manger of Hall 100 was conducted on 12/7/12 at 2:00 P.M. She indicated that the procedure for notifying family members of a medical change was the same throughout the facility. She noted, "... If there is any kind of change, we are to call the doctor and the family right away...." An interview with the Unit Manager of Hall 300 was conducted on 12/7/12 at 4:30 P.M. She indicated that the procedure for notifying family members of a medical change was the same throughout the facility. She noted, "...we call the family and the doctor if we see any kind of change with the residents..." An interview was conducted with the Unit Manager of Hall 500 on 12/10/12 at 5:00 A.M. She indicated that the procedure for notifying family members of a medical change was the same throughout the facility. She			

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	noted, "...oh yeah... we'd call the family and doctor if their (residents) oxygen saturations seemed to be falling, even if we didn't see it as a 'real' concern... its our (the facility's) procedure to notify the family as situations develop... absolutely..." An interview was conducted with the ADON (Assistant Director of Nursing) on 12/10/12 at 9:30 A.M. She indicated that the facility and the nursing staff would and do notify the family of medical concerns and changes as the situations occur. She indicated it was not the policy of the facility to wait for a development of conditions to reveal a worsening condition but to notify the family and doctor immediately. A record review of the policy and procedure was requested of the ADON yet none was received. B. On 12-5-12 at 8:10 P.M., an interview with Resident #57's daughter indicated that she was the Power of Attorney (POA) and had not been notified of anything regarding her mother's care or concerns for the past four months. The daughter indicated she had not been notified of an arm bruise or of dentist exams. The clinical record of Resident # 57			

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	was reviewed on 12-12-12 at 10:15 A.M. The resident's diagnoses included, but were not limited to: dementia with behaviors, organic mental syndrome, anxiety, and depression. On 12-12-12 at 10:18 A.M., a clinical history note indicated the resident had dental exams from a dentist on 5-16-12 and 11-16-12. There was no notation in the nursing notes that the daughter had been notified about the dental exams. On 12-12-12 at 11:23 A.M., a review of the nursing notes indicated a bruise was documented on the left upper arm on 9-3-12 at 12 A.M. There was no indication of the possible cause of the bruise identified. The physician was notified on 9-3-12 at 3:00 A.M., but there is no record of the daughter being notified. A pain assessment was completed on 9-3-12, in relationship to the bruise. A social service progress note, dated 10-23-12, indicated the resident had a supportive family, that visited frequently. This Federal deficiency relates to Complaint #IN0018199.			

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IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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	3.1-5(a)(2)			

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F0203 SS=A	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone			

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	number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on record review and interview, the facility failed to provide residents rights information regarding readmission with a 30-day written notice for 1 of 3 residents sampled regarding discharge needs. (Resident E) Findings include: On 12/5/12 at 10:00 to 10:30 A.M., an interview was conducted with the family member of Resident E. She indicated that Resident E was transferred, from the facility, to a "..local hospital around labor Day..." She stated, "...we had a terrible time finding a place that would take her... the facility did not give us a 30-day written notice for discharging..." Resident E did not return to the facility.	F0203	**F 203:** It is the practice of this facility to provide residents rights information regarding readmission with 30-day written notice to all residents.Corrective Action: Residents are given resident rights information including 30-day written notice prior to discharge upon admission.How Others Identified All residents have the potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees.Preventive Measures: Licensed nurses will be re-educated regarding facility bed hold policy and procedure including family notification and documentation of such. Charts of discharged residents will be reviewed during Daily Clinical Review meeting to ensure bed hold policy has been given to resident and	01/11/2013

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	On 12/6/12 at 10:00 A.M., the closed clinical record for Resident E was reviewed. There was no documentation in the record that the facility had provided information regarding Resident's rights or a 30 day notice of discharge for Resident E. An entry, made on 9/1/12, indicated the resident had been transferred to a local hospital due to, ".. G-tube pulled out..." It was also noted, "... family and resident unhappy with medical director's care and refuses to follow his orders..." On 12/7/12 at 2:00 P.M.,. an interview was conducted with the Social Worker, the Admissions Coordinator, and the Administrator. It was noted, "... we do not have evidence that we provided a 30-day written notice upon discharge for this resident..." This Federal Tag relates to Complaint #IN00116640. 3.1-12(6)(A)(iii)		documented.Monitoring: DON/designee will monitor charts of discharged residents daily at Daily Clinical Review times 2 weeks; 3 times a week for two weeks; weekly for 1 month; monthly to assure policy and procedure are followed.	

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F0225	**F225** It is the practice of this	01/11/2013

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	interview, the facility failed to ensure 1 of 3 allegations of abuse were reported timely. This affected 1 of 3 residents who met the criteria for abuse investigations. Finding includes: During an interview with alert and oriented Resident #28, conducted on 12/05/12 at 9:38 A.M., she indicated some of the aides were really rude, had attitude issues, and were "short" (verbally) with her when she requested them to do thing for her. Interview with Resident #28, on 12/10/12 at 9:57 A.M., indicated she had not reported the rude attitude issues because the concerns seemed "petty." She indicated she saved the reporting for the "big" issues. She indicated in November 2012, she had reported a nursing staff member for a "bigger" issue and the staff member was not working at the facility anymore. Interview with SSD (Social Service Director) , Employee #5, on 12/10/12 at 10:15 A.M., indicated she did not recall any issue with Resident #28 regarding an allegation of abuse in the past few months.		facility that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including State Survey and certification agencies). **Corrective Action:** Resident #28 is stable with no signs or symptoms of psychosocial issues related to this incident. Incident was reported to State agencies as indicated. Facility will continue to follow Policy and Procedure related to Abuse Prohibition.**How others identified:** Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.**Preventative Measures:** Staff re-educated on reporting procedure related to Abuse Prohibition.**Monitoring:** Administrator and/or designee will continue to follow up on all allegation of abuse immediately. An accident and incident form will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All accident /incident forms are reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. All concern forms will continue to	

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	Interview with the Administrator, on 12/10/12 at 11:00 A.M., indicated she did find an "incident" involving Resident #28 and a former staff member. She indicated, after she reviewed the "incident" the facility was "reopening" the investigation and reporting the allegation to the State on 12/10/12. Review of the incident, submitted on 10/10/2012, indicated the following resident concern was documented: "One night, between the 1st and the 4th of October 2012, (the staff member's first name) was cleaning me up and she put her arm across my leg to reach across me. She leaned down with a lot of force. If I was a small person it would have snapped my leg in two. I told her it hurt but she just kept on cleaning without saying anything. On another occasion she has been very rough when she was cleaning me up. I would prefer that she wasn't my aide anymore. I'm sure other residents are having trouble with her also." There was investigative documentation, dated as being completed on 1019/12, which indicated the alleged staff member was not suspended pending the investigation but was instructed not to care for Resident #28. The staff member was also		be reviewed daily. All findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Addendum (1/18/13): Residents are informed upon admission of resident rights including reporting abuse. Resident rights including reporting abuse will be reviewed at least quarterly in resident council. Administrator/designee will review Resident council minutes monthly to ensure review of abuse reporting.	

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	instructed to provide care in pairs in the future. 3.1-28(c) 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their abuse policy and procedure. This affected 1 of 3 residents who met the criteria for abuse. (Resident #28) Finding includes: During an interview with alert and oriented Resident #28, conducted on 12/05/12 at 9:38 A.M., she indicated some of the aides were really rude, had attitude issues, and were short (verbally) with her when she requested them to do thing for her. Interview with Resident #28, on 12/10/12 at 9:57 A.M., indicated she had not reported the rude attitude issues because the concerns seemed "petty." She indicated she saved the reporting for the "big" issues. She indicated in November 2012, she had reported a nursing staff member for a "bigger" issue and the staff member was not working at the facility anymore.	F0226	**F226** It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents property. **Corrective Action:** Resident #28 is stable with no signs or symptoms of psychosocial issues related to this incident. Incident reported to State agencies as indicated. Facility will continue to follow policy and procedure related to Abuse Prohibition.**How Others Identified:** Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.**Preventative Measures:** Staff re-educated on implementing facility written policy and procedure related to Abuse Prohibition.**Monitoring:** Administrator and/or designee will continue to follow up on all allegation of abuse immediately. An accident and incident form will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All accident /incident forms are	01/11/2013

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	Interview with SSD (Social Service Director), Employee #5, on 12/10/12 at 10:15 A.M., indicated she did not recall any issue with Resident #28 regarding an allegation of abuse in the past few months. Interview with the Administrator, on 12/10/12 at 11:00 A.M., indicated she did find an "incident" involving Resident #28 and someone a former staff member. She indicated, after she reviewed the "incident" the facility was "reopening" the investigation and reporting the allegation to the State on 12/10/12. Review of the incident, submitted on 10/10/2012, indicated the following resident concern was documented: "One night, between the 1st and the 4th of October 2012, (the staff member's first name) was cleaning me up and she put her arm across my leg to reach across me. She leaned down with a lot of force. If I was a small person it would have snapped my leg in two. I told her it hurt but she just kept on cleaning without saying anything. On another occasion she has been very rough when she was cleaning me up. I would prefer that she wasn't my aide anymore. I'm sure other residents are		reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. All concern forms will continue to be reviewed daily. All findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Addendum (1/18/13): Residents are informed upon admission of resident rights including reporting abuse. Resident rights including reporting abuse will be reviewed at least quarterly in resident council. Administrator/desginee will review resident council minutes monthly to ensure review of abuse reporting.	

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	having trouble with her also." There was investigative documentation, dated as being completed on 1019/12, which indicated the alleged staff member was not suspended pending the investigation but was instructed not to care for Resident #28. The staff member was also instructed to provide care in pairs in the future. The facility policy,dated October 1999 and revised on 04/12, titled, "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" included the following: "...Protection. 1. Provide for the immediate safety of the resident upon identification of potential abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property....Suspend identified employee (s) immediately pending outcome of the investigation....Reporting...2. Report the incident immediately to the Administrator and DON/designee...4. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the			

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	results of the investigation...." 3.1-28(a)			

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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, record review, and interview, the facility failed to ensure 3 of 20 residents observed for care were dressed, covered, and/or assisted with personal hygiene to ensure their dignity was maintained. (Resident #139, 48, and 123) Findings include: 1. On 12/5/12 at 2:29 PM, Resident #139 was observed lying in bed awake, wearing a button down shirt with noticeable food residue on it. Resident #139 was wearing no pants had an adult brief on with his blanket down around his ankles. His brief was exposed as well as his bare legs. At 3:05 PM, Employee #28 walked into his room without knocking or announcing her name. Employee #28 indicated she was getting Resident #139 up out of bed so she could give him a snack. Employee #28 then pulled the privacy curtain partially closed around the resident. The door was closed for privacy. An employee from Housekeeping then	F0241	**F241:** It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity with respectful recognition of his or her individual self. **Corrective Action for Resident Affected:** Res #139 is receiving care to include clothing and Wheel Chair clean and free of food residue, proper clothing to provide dignity per their request while wearing adult brief. Employees are knocking and announcing their names before entering residents room. Resident's privacy curtain is completely pulled during care and door is closed. Activities are provided and resident is involved. Activities are explained to resident before starting. Oxygen tubing remains on resident as ordered by physician. Resident #48 and Resident #123 are dressed in appropriate clothes to promote dignity. **Other residents having the potential to be affected and corrective measures to ensure practice does not recur:**	01/11/2013

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	knocked on the door, announced "Housekeeping" and walked in to sweep leaving the door open. As the privacy curtain had not been completely drawn, Resident #139 could be observed from the hallway awake, lying in bed with his brief and bare legs exposed. On 12/06/12 at 9:15 AM, Resident #139 was observed sitting in his wheelchair at a table. Resident #139 was facing the exit door. The television was on, but Resident #139's back was toward it and he was unable to see it. Resident #139 had no objects or activities on the table where he was seated. At 9:21 AM, Resident #139 removed his oxygen tube off from his face and was noted to fidget with it. Resident #139's oxygen tubing later was noted to have fallen onto the floor. At 9:36 AM, an unidentified CNA moved Resident #139 into the hallway , by pulling his gerichair backward, without announcing her name or her intentions. Resident #139 remained between a cleaning closet and the housekeeping cart with his oxygen tubing off until Employee #26 obtained new tubing and placed the oxygen back onto the resident at 9:46 A.M.		Residents residing in the facility are being observed to ensure these alleged practices do not occur. Staff have been re-educated to promote dignity for all residents residing in facility. **This corrective action will be measured by:** Unit Manager or Designee will monitor resident care daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to ensure care is given per facility policy and procedure. All findings will be reviewed at monthly Quality Performance Indicator meeting Any identified non-compliance will be addressed through one to one education up to termination.	

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	On 12/6/12 at 9:31 AM, Resident #139 was observed wearing padded blue therapy boots with his full name written on a piece of tape in black marker on the outside of the right boot. On 12/7/12 at 9:30 AM, Resident #139 was in his wheelchair in the common TV area of the nursing unit at a table by himself. Resident #139 had his chin on his chest and was fidgeting with his oxygen tubing. His nose was noted to be continually dripping thin mucous onto his shirt leaving a large wet area. Resident #139 was observed to also have food residue and crumbs on the seat of his wheelchair. 2) On 12/5/12 at 10:22 AM, Resident #48 was observed lying in her bed wearing a hospital type of gown. On 12/5/12 at 3:00 PM, Resident #48 was observed still wearing the gown. Resident #48 was also observed to be wearing a hospital type gown on 12/6/12 at 2:40 PM, 12/7/12 at 9:30 AM, 12/7/12 at 1:51pm, and 12/10/12 at 11:23 AM. During an interview with Employee #26, an LPN, on 12/5/12 at 11:35 AM, she stated that Resident #48 is usually in the hospital gown unless			

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	they dress her for a shower. When asked whether there was a medical condition which would necessitate Resident #48 wearing a hospital gown, Employee # 26 stated "no". Employee #26 stated Resident #48 did not have many clothes. Upon inspection of Resident #48's closet, it was noted that she had a handful of sweatsuit items and a pink robe. Employee#26 then pulled out the pink robe and says this is the item the staff dress her in to take her to the shower. 3. On 12/7/12 at 7:30 PM, Resident #123 was observed sitting in the 200 hall dining room with 3 other residents with his pants down exposing his buttocks. On 12/7/12 at 7:36 PM, CNA #12 entered 200 hall dining room, addressed the table of residents sitting together and left the dining room. CNA #12 did not assist Resident #123 with his pants. On 12/7/12 at 7:37 PM, CNA #12 re-entered the dining room and washed her hands at the sink and left. On 12/7/12 at 7:47 PM, LPN #23 entered the dining room, noted the residents sitting in the dining room, did not perform any care, and left the room.			

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	On 12/7/12 at 7:48 PM, LPN #23 and CNA #12 both re-entered the dining room. CNA #12 addressed Resident #123 and asked if he would like to return to his room for the night. Resident #123 did not respond to CNA #12. LPN #23 indicated "If he wants to just sit there, he can...." CNA #12 and LPN #23 then left the dining room and left Resident #123 sitting at the dining room table in the same condition. On 12/7/12 at 7:49 PM, CNA #24 entered the dining room and addressed Resident #123 asked if he wanted to return to his room since he was dozing off. LPN #23 entered the dining room and indicated "He's ignoring you. He'll go to his room when he's ready." On 12/7/12 at 7:52 PM, CNA #12 entered the dining room, and moved Resident #123's chair over so she can mop up a puddle of urine near the chair in which he was seated. CNA #12 left the dining room at 7:58 PM. On 12/7/12 at 9:10 PM, Resident #123 was still observed to be sitting in the same chair in the 200 hall dining room with his pants down exposing			

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	his buttocks. On 12/7/12 at 9:15 PM, the condition of Resident #123 was specifically brought to the attention of LPN #23. She indicated the following: "...I suppose I could cover him with a blanket..." The clinical record for Resident #123 was reviewed on 12/10/12 at 10:30 A.M. The resident had diagnoses, including but not limited to .Alzheimers with behavioral disturbance, anxiety, and depression. On 12/10/12 at 10:47 AM, review of Resident #123's annual MDS dated 9/27/12 indicated Resident #123 was an extensive assist of 1 person for dressing and an extensive assist of 1 person for personal hygiene. Review of Resident #123's quarterly MDS dated 8/13/12 indicated Resident #123 was an extensive assist of 1 person for dressing and an extensive assist of 1 person for personal hygiene. 3.1-3(t)			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure activity needs were thoroughly assessed and activities were provided for 3 of 8 residents who met the criteria for activities in a sample of 20. (Resident #186, 139, and 48) Findings include: 1. During an interview, with Resident #186, conducted on 12/05/12 at 1:47 P.M., she indicated she did not know if there were any evening activities because she could not read the posted activity calendar from her bed and she was never offered any evening activities. She indicated, "It would be nice to go (to evening activities) but I don't (go)." The resident was noted to be in her bed, which was placed near the window. The resident indicated she required a mechanical lift to get in and out of bed. Resident #186 was observed on	F0248	**F248:** It is the practice of this facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. **Corrective Action for Resident Affected:** Resident #186 has an activity calendar available which she can read. She is being offered evening activities. She has books, newspapers and magazines to read and music to listen to. Resident has a current activity care plan and is receiving one to one visits as needed. Attendance in activities are being documented. Resident #139 is being provided activities per his current care plan including wheelchair in hall and radio two to three times per week, Music 2-3 times per week and exercise. Resident #48 is participating in activities per her care plan including music 2-3 times weekly **Other Residents having the potential to be affected and corrective measures to ensure**	01/11/2013

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	12/04/12, 12/05/12, and 12/06/12 either in her bed, at therapy, or in the unit dining room during meal times. Review of the Activity Calendar for 12/04/12 indicated the following activities were scheduled: "9:15 Daily News , 9:30 Exercise, 10:00 T & A Unite, 1:30 T & A Unite, 3:00 P.M. - Movie and Popcorn." On 12/05/12 the following activities were scheduled: "9:15 Daily News, 9:30 Exercise, 1:30 WII games or Stories out of a Hat, 3:00 Table games" On 12/06/12 the following activities were scheduled "9:15 Daily News, 9:30 Exercise, 10:00 A.M. T and A Unite, 1:30 T & A Unite/church." Review of the activity assessment, "Life Enrichment Assessment - short stay" completed on 09/15/12, indicated the resident indicated it was very important for her to have books, newspapers, and magazines to read, to listen to music, to be around animals, to keep up with news, to do things with groups of people, to do favorite activities (activities unspecified), to go outside and get fresh air, to participate in religious services or practices. However, on the back of the form "yes" was marked next to the statement: "Resident states they do not want to		**practice does not recur:** Residents care plans have been reviewed and activities are being provided as care plans indicate. Activity staff has been educated regarding making activities calendars available to resident and following residents care plans **This Corrective action will be measured by**: Activities Director/Designee will monitor residents activities daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to ensure care is given per care plan. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	participate in group activities." The activities care plan, undated, initiated on 12/11/12, indicated the resident preferred large print books, soft music, cats and dogs, television, nail care, and reading, going outside, and religious activities. The goal was for the resident to participate in at least 1 -2 group activities per choice per week.- nail care, mass, and exercise were listed as activities of choice. Interventions included activity cart, provide newsletter/calendar, provide in room supplies, provide assistance to groups of interest, coordinate with therapy goals to assist with improvement and maintenance of physical skills and endurance, educate staff with resident preferences an choices, accept right to decline, provide resident items off the activity cart for in room use, follow resident diet orders, provide resident choices/preferences in areas somewhat or very important to them as indicated on plan of care, praise resident efforts, encourage participation in activity's of interest during stay. Interview with Activity Director, Employee #14, on 12/11/12 at 10:09 A.M., indicated there was no activity care plan documented so she initiated one for the resident.			

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Interview with Employee #14, the Activity Director, on 12/11/12 at 10:09 A.M. indicated the resident had been receiving 1:1 visits in October and November prior to the activity director starting to work at the facility. She indicated the resident was no longer receiving 1:1 visits from Activities.

The participation calendar for October 2012 indicated the resident did not participate in any group activities from 10/01/12 - 10/08/12. She participated in group activities at 11:30 A.M. on 10/09 and 10/10, called "Prepare to Dine/Music." On 10/11/12 at 2:30 P.M., she participated in balloon volleyball. On 10/16/12, she participated in "Preparing to dine/music" at 11:30 A.M., and Jeopardy at 2:00 P.M. On 10/18/12 at 11:30 A..M., she participated in "prepare to dine/music." On 10/24/12 at 9:30 A.M. and 10:30 A.M., she participated in exercise and music with (guest musician) name. On 10/31/12, she participated in jazz time.

Interview with the Activity Director, on 12/12/12 at 4:00 P.M., indicated "Preparing to Dine" was where the resident was transported to the dining room and if they ate in the Main

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	dining room or the Ridgedale Dining the activity staff provided 15 minutes of an activity. She indicated Resident #186 ate on the 100 unit and there was no activity staff in the dining room except to transport the resident to the dining room. The activity participation record for Resident #186 for December 2012, indicated she slept but was present at activities on 12/07/12 from 9:30 A.M. - 3:00 P.M. and on 12/10/12 at both 1:30 P.M. and 3:30 P.M. However, the resident was in an acute care facility from 12/06/12 at 3:00 P.M. until 12/10/12 at 5:45 P.M. Employee #14 indicated she did not know why the resident was documented as having attended activities when she was out of the building. 2. On 12/4/12 at 2:55 P.M., Resident #139 was observed sleeping in his bed. On 12/5/12 at 10:00 AM, Resident was observed sleeping in his bed. On 12/05/12 at 2:29 P.M. through 3:10 P.M., Resident #139 was observed awake in his bed fidgeting with this call light. There was no TV or Radio on or any other activity within reach of Resident #139. Employee			

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	#30, a CNA, entered Resident #139's room and stated she was getting him up to give him a snack because when he doesn't have anything in his hands, he "messes" with other things. On 12/06/12 at 9:15 A.M., Resident #139 was observed sitting in his wheelchair at a table. Resident #139 was facing the exit door. The television was on but Resident #139's back was toward it and he was unable to see it. Resident #139 had no objects or activities on the table where he was seated. At 9:21 A.M., Resident #139 took off the oxygen tubing from his face and was fidgeting with it and the oxygen tubing fell onto the floor. At 9:36 A.M., an employee moved Resident #139 into the hallway by pulling him backward without announcing her name or her intentions. Resident #139 remained between a cleaning closet and the housekeeping cart with his oxygen tubing off until Employee #31, an RN, placed new oxygen tubing back on the Resident at 9:46 A.M. Clinical record review on 12/7/12 at 10:45 A.M., indicated Resident 139's "Activity Pursuit Plan of Care" was originally signed on 3/30/12. The activity care plan stated that Resident #139 activity preference was to "keep			

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	up with the news". Resident #139's activity goals were to have his wheelchair in the halls, one to one visits, social gatherings. The activity plan also stated Resident #139 would participate in wheelchair in hall, TV, and radio 2-3 times per week. The activity plan also stated Resident #139 would participate in exercise and music 2-3 times per week. The activity plan of care listed interventions as one to one activities for socialization, support, and encouragement... During an interview with Activity Director, Employee #14, on 12/10/12 at 10:35 A.M., she stated they did not have documentation showing one to one activities with Resident #139. The Activity Director said she should change the goal of one to one activities because Resident #139 was around people while in the halls and she felt he no longer required it. ON 12/10/12 at 11:00 A. M., review of Resident #139's activity calendar, which was to be highlighted for those activities attended by Resident #139, indicated Resident #139 had not attended any group activities from December 1 through December 10, 2012.			

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	3. On 12/5/12 at 3:00 P.M., Resident #48 was observed sleeping on her back in bed. There was a radio playing in her room. On 12/6/12 at 9:10 A.M., Resident #48 was observed sleeping in bed. On 12/6/12 at 2:40 P.M., Resident #48 was observed sleeping in bed. Resident #48's roommate, Resident #41, was interviewed and stated Resident #48 sits up a little bit but does not get out of bed. On 12/7/12 at 9:30 A.M., Resident #48 was observed sleeping in her bed. On 12/7/12 at 1:55 P.M., a clinical record review was completed of Resident #48, whose diagnosis included but was not limited to head injury, dementia psychosis, and aphasia. The Activity Pursuit Plan of Care, dated 11/14/11, and revised on 11/25/12, indicated Resident #48 would independently participate in music 2-3 times a week. On 12/7/12 at 1:51 P.M., the Activity Director, Employee #14, was interviewed and stated that they did not document if Resident #48 participated in music activities 2-3			

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	times a week.(i.e. opportunities to listen to the radio.) When asked whether there was a medical indication for Resident #48 to remain in bed, the Activity Director responded not to her knowledge. 3.1-33(a)			

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F0272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, record review, and interview, the facility failed to comprehensively assess the bladder incontinence needs for 1 of 8 residents who met the criteria for a	F0272	**F272** It is the practice of this facility to ensure thorough follow-up assessments are completed on residents **Corrective Action:** Res #145, 139, 71, and 57 were reviewed	01/11/2013

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	decline in continence and 1 of 2 residents who met the criteria for observations of incontinence in a sample of 40. (Residents #145 and 139) In addition the facility failed to comprehensively assess the cognitive needs of 1 of 3 residents who met the criteria. (Resident #71) The facility also failed to comprehensively assess the oral care needs of 1 of 3 residents who met the criteria. (Resident #57) Finding includes: 1. Resident #139 was observed on 12/05/12 at 10:00 A.M., in his bed. The resident's room was noted to have a strong urine odor. On 12/12/12 at 8:57 A.M., Resident #139 was noted in 500 day room at dining room table, dressed, restrained with a seat belt in a gerichair. The resident had oxygen on, a soft neck brace and moon boots on his feet. A bowl of uneaten coagulated oatmeal and covered coffee cup with a straw was noted on the table in front of him. On 12/12/12 at 9:30 A.M., Resident #139 was pushed in his geri chair by activity staff from the day room directly to the large living room area by the facility's front office. The		for needed assessment and current documentation. Res #145, 139, 71 and 57 medical records were updated to reflect resident' current status and post acute charting started as needed.**How Others Identified:** Resident assessments will be reviewed/updated at their next comprehensive assessment. **Preventative Measures:** License nurses will be re-educated on assessment of conditions, communication of conditions and pertinent charting. Pertinent charting log to review need for change in condition/required post acute documentation will be kept in front of the post acute binders. Discontinuation of monitoring will only be completed by a nurse manager when all components met, including documentation that condition is stable and resident is taken through IDT. Nurse Manager will do the final assessment of resident's condition and document that the condition is resolved/stable.**Monitoring:**Nurse managers will review audit logs daily with each off going nurse for accuracy and changes. Nurse manager will determine during review of audits, 24 hr reports and physician orders of missing documentation and need for further follow-up. UM or designee will monitor daily for two weeks, then three times a week for two weeks, and then weekly for two months and then monthly	

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(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
	resident was observed in an exercise activity sleeping, and not actively participating. On 12/12/12/ at 10:15 A.M., Resident #139 was observed to still be in the large living room, now at a church activity, sleeping. On 12/12/12 at 11:05 A.M., Resident #139 was brought back from the large living room and placed in the 500 day room by the dining room table. On 12/12/12 at 11:32 A.M., Resident #139 remained in the 500 day room. 12/12/12/ at 11:45 A.M., CNA #22 placed Resident #139's tray in front of him and proceeded to feed him. On 12/12/12 at 1:20 P.M., Resident #139 was noted lying in his room in a low bed. CNA #22 was in the room. The CNA indicated he had put the resident to bed and changed him approximately 20 - 30 minutes ago. He also indicated he had gotten the resident up in the morning before breakfast, which was served on the 500 hall around 7:45 A.M. The Quarterly MDS (Minimum Data Set) assessment, completed on 10/04/12, indicated the resident was		thereafter. Identified trends will be reviewed in CQI monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Monitoring may be stopped when there are no identified trends consistent for 3 quarters. Any identified non-compliance will result in 1 on 1 re-education including progressive disciplinary action up to and including termination. Addendum (1/18/13): Assessments of all residents has been completed to ensure residents with similar issues have had their needs met	

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	155103	A. BUILDING 00 B. WING	12/12/2012

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	assessed to be moderately cognitively impaired, required total staff assistance for wheelchair locomotion needs, was nonambulatory, required extensive staff assistance for toileting needs, and was totally incontinent of his bladder. The most recent full MDS assessment, completed on 04/04/12 due to a Significant change in condition, indicated the resident was moderately, cognitively impaired, required extensive staff assistance for ambulation, required extensive staff assistance for wheelchair locomotion needs, required extensive staff assistance for toilet use, and was frequently incontinent of his bladder. The current bladder incontinence assessment, initiated on 10/27/11 and dated as reviewed as current on 09/24/12, indicated the resident was frequently incontinent of bladder, had Alzheimer's dementia, enuresis, and urge incontinence. There was no assessment of the resident's toileting and/or incontinence needs. The current health care plans for Resident #139, initiated on 04/04/12 and current through 12/24/12, included a plan for Urinary			

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	Incontinence. The goal was for the resident to be free from odors and bladder infections, and free from impaired skin. Interventions included Incontinent Care: Change soiled clothing, observe signs of UTI (urinary tract infection), labs, and check and change before arising, before and/or after meals, and at bedtime. Interview, on 12/12/12 at 2:45 P.M., with the MDS (Minimum Data Set assessment) nurse, Employee #19 indicated sometimes there was confusion because the MDS assessed episodes of incontinence and the bladder assessment assessed bladder control. The 04/04/12 resident bowel and bladder by shift indicated the resident had only one shift of continence so his bladder "control" had not declined much. She did not know if a bladder assessment should be completed when a resident declined from frequently to total incontinence. 2. During a clinical record review on 12/7/12 at 9:51 A.M., of Resident #71 whose current diagnosis include but is not limited to Depression, Dementia with psychosis, Vascular Dementia, Gerd, Mild Mental Retardation. The PASRR Level 1 (Identification Evaluation Criteria Certification by			

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	Physician for Long Term Care Services) stated that Resident #71 does not have a diagnosis of mental retardation (MR), developmental disability (DD) or other related condition. It also stated that Resident #71 had no history of MR/DD or related condition in his past nor did Resident #71 present with evidence that may indicate he has a diagnosis of MR/DD. During review of the "Cognitive Loss" assessment dated 6/15/2012, it states that Resident #71 has a diagnosis of mild MR. The Physician's Order dated 11/22/12, also states that Resident #71 has a diagnosis of mild MR. During an interview on 12/7/12 at 2:12 P.M., Employee #28 stated she called the organizations that would be involved with Resident #71's PASRR follow up including BDDS (Bureau of Developmental Disability Services) none of which had any record of Resident #71. Employee #28 stated they were researching whether the facility required a PASRR Level II instead of a PASRR Level I for Resident #71 and would call back. Employee #28 stated she would research where Resident #71's diagnosis of MR derived.			

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	During an interview on 12/7/12 at 2:45 P.M., Employee #28 stated Physician (name) had given Resident #71 the diagnosis just as an opinion without giving any testing. She stated that they were advised by BDDS to fill out an application for a PASRR Level II for Resident #71. When asked whether Employee #28 agreed there had been an oversight in Resident #71's PASRR and diagnosis of MR, Employee #28 responded, "Yes." 3. On 12/5/12 at 8:10 P.M., an interview with Resident # 57's daughter indicated that she doesn't believe her mother had received oral care. The daughter stated that the resident's teeth were" falling out." She was not aware if the staff brush the resident's teeth. The daughter had been told a dentist would examine the resident but she was not sure this exam had happened. On 12/11/12 at 2:35 P.M., an interview with the ADON indicated she could not get a report from the CareTracker (an electronic software program for charting) that indicated the resident's teeth are being cleanse daily. On 12-12-12 at 9:50 A.M., interview			

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	with CNA #4 indicated she did not brush the resident's teeth today because she didn't get her out of bed. The CNA #4 said the resident was usually up and dressed by the time she gets to the facility. The CNA #4 was unsure if the resident's teeth were brushed earlier this morning. A clinical chart review on 12/12/12 at 10:25 A.M., indicated a Comprehensive Assessment, dated 4/13/12, had no note regarding the resident's teeth, the area was left blank. A Quarterly Assessment, dated 10/23/12, did not assess oral status as this type of assessment is not included on the form. On 12/12/12 at 10:36 A.M., a review of the Care Plan indicated the resident had a potential or actual Activity of Daily Living (ADL)/Mobility deficit, poor oral hygiene, oral infection related to arthritis and dementia. The goal was to allow staff to care for residents ADL's and the resident will be neat, clean, and well groomed thru next review. The interventions included but are not limited to: dental services as needed, provide oral care daily and as needed. Staff to provide assistance with set up, physical assist and cue the resident with oral care.			

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	On 12/5/12 at 8:10 A.M., an interview with Resident # 57's daughter indicated that she doesn't believe her mother had received oral care. The daughter stated that the resident's teeth were" falling out." She was not aware if the staff brush the resident's teeth. The daughter had been told a dentist would examine the resident but she was not sure this exam had happened. On 12/12/12 at 9:50 A.M., interview with CNA #4 indicated she did not brush the resident's teeth today because she didn't get her up today. The CNA said the resident is usually up and dressed by the time she gets here. The CNA is unsure if the resident's teeth were brushed earlier this morning. On 12/12/12 at 10:18 A.M., a clinical history note from the dentist indicated the resident was seen on 11/16/12, his findings included but are not limited to: was fractured to cervical margin and #9 was unrestorable and had caries noted. An earlier dentist note, dated 6/3/10, indicated care is good, clean and healthy, good oral health. The number of remaining teeth was twelve.			

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A clinical chart review on 12/12/12 at 10:25 A.M., indicated a Comprehensive Assessment dated 4-13-12 had no note regarding the resident's teeth, the area was left blank. A Quarterly Assessment tool, dated 10/23/12, did not address oral care.

On 12/12/12 at 11:15 A.M., observation of teeth when resident smiled indicated the resident had some missing teeth.
4. The closed record for discharged Resident #145 was reviewed on 12/12/12 P.M., at 4:45 P.M. The admission Minimal Data Set (MDS) assessment for Resident # 145, completed on 6/23/12, indicated the resident was always continent of her bladder.

Review of the quarterly MDS assessment, completed on 9/23/12, indicated the resident had declined and was now occasionally incontinent of her bladder.

On 12/12/12 at 5:00 P.M., a review of the Bladder Data Collection Assessment for Resident #145, dated 10/12/12 indicated the assessment was incomplete. The Treatment Program and Interventions

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	that may benefit the resident were left blank. The only portion of the assessment completed was the first 2 questions which indicated if the resident had a history of bladder incontinence, had a catheter, and restated the MDS category for incontinence. The form indicated the resident did not have a history of bladder incontinence, did not have a catheter, and was occasionally incontinent. On 12/12/12 at 5:05 P.M., a review of the Care Plan initiated on 7/26/12 , indicated the resident was frequently incontinent of her bladder. The interventions included but were not limited to; Complete Bladder Data Collection and Assessment and Complete CareTracker 3-Day Elimination Tracking to determine incontinence pattern. There was no documentation provided to determine if the resident's new bladder incontinence had been thoroughly assessed and an individualized care plan established to attempt to restore as much bladder continency as was possible. 3.1-31(a) 3.1-31(b)(9)			

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	3.1-31(b)(3) 3.1-31(b)(12)			

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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, record review, and interview, the facility failed to ensure a care plan regarding activity needs was developed timely for 1 of 8 residents who met the criteria for activity reviews. (Resident #186) Finding includes: 1. During an interview, with Resident #186, conducted on 12/05/12 at 1:47 P.M., she indicated she did not know if there were any evening activities because she could not read the	F0279	**F279:** It is the practice of this facility to ensure a care plan regarding activity needs is developed for all residents **Corrective action for Resident affected:** Resident #186 care plan has been reviewed and resident is receiving activities per her current updated care plan. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** All residents are receiving activities per current updated care plan.	01/11/2013

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	posted activity calendar from her bed and she was never offered any evening activities. She indicated "It would be nice to go (to evening activities) but I don't (go)." The resident was noted to be in her bed. Resident #186 was observed on 12/04/12, 12/05/12, and 12/06/12, either in her bed, at therapy, or in the unit dining room during meal times. The clinical record for Resident #186 was reviewed on 12/06/12 at 2:00 P.M. Resident #186 was admitted to the facility on 09/15/12, with diagnoses, including but not limited to , status post cerebral vascular hemorrhage with hemiparesis. Review of the activity assessment, "Life Enrichment Assessment - short stay" completed on 09/15/12, indicated the resident had indicated it was very important for her to have books, newspapers, and magazines to read, to listen to music, to be around animals, to keep up with news, to do things with groups of people, to do favorite activities (activities unspecified), to go outside and get fresh air, to participate in religious services or practices. However, on the back of the form "yes" was marked next to the		100% audit has been completed with corrections as needed to assure all residents are receiving activities per care plan **This Corrective action will be measured by**: Activities Director/Designee will monitor residents activities daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure activities are provided per care plan. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	statement: "Resident states they do not want to participate in group activities." Interview with Activity Director, Employee #14, on 12/11/12 at 10:09 A.M., indicated there was no activity care plan documented so she initiated one, on 12/11/12, for the resident. 3.1-35(a)			

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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, record review, and interviews, the facility had failed to follow the care plan interventions for incontinence maintenance for 1 of 3 residents who met the criteria for incontinence. (Resident #139) Finding includes: Resident #139 was observed on 12/05/12 at 10:00 A.M., in his bed. The resident's room was noted to have a strong urine odor. On 12/12/12 at 8:57 A.M., Resident #139 was noted in unit day room at dining room table, dressed, restrained with a seat belt in a gerichair. A bowl of uneaten coagulated oatmeal and covered coffee cup with a straw was noted on the table in front of him. On 12/12/12 at 9:30 A.M., Resident #139 was pushed in his geri chair by activity staff from the day room directly to the large living room area by the facility's front office. The resident was observed in an exercise activity sleeping, and not actively	F0282	**F282:** It is the practice of this facility to follow the care plan interventions for incontinence maintenance of residents who meet the criteria for incontinence. **Corrective action for Resident affected:** Resident #186 care plan has been reviewed and resident is receiving incontinence care interventions per his current care plan . **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** Care plans of Residents identified as incontinent per the comprehensive assessment have had their care plans reviewed and corrections made as needed for incontinence maintenance. These residents are being provided incontinence care per care plan interventions. Nursing staff have been re-educated regarding following care plan of incontinent residents including interventions .**This Corrective action will be measured by:** Unit Manager/Designee will monitor residents incontinence maintenance daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure incontinence	01/11/2013

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	participating. On 12/12/12/ at 10:15 A.M., Resident #139 was observed to still be in the large living room, now at a church activity, sleeping. On 12/12/12 at 11:05 A.M., Resident #139 was brought back from the large living room and placed in the 500 day room by the dining room table. On 12/12/12 at 11:32 A.M., Resident #139 remained in the 500 day room. The meal trays were in a cart in the hallway. On 12/12/12/ at 11:45 A.M., CNA #22 placed Resident #139's tray in front of him and proceeded to feed him. On 12/12/12 at 1:20 P.M., Resident #139 was noted lying in his room in low bed. CNA #22 was in the room. CNA #22 indicated he had put the resident to bed and changed him approximately 20 - 30 minutes previous. He also indicated he had gotten the resident up in the morning before breakfast, which was served on the 500 hall around 7:45 A.M. The current health care plans for		interventions are provided per care plan. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	Resident #139, initiated on 04/04/12 and current through 12/24/12, included a plan for Urinary Incontinence The goal was for the resident to be free from odors and bladder infections, and free from impaired skin. Interventions included Incontinent Care: Change soiled clothing, observe signs of UTI, labs, and check and change before arising, before and/or after meals, and at bedtime. 3.1-35(g)(2)			

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(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
F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to assist 1 of 3 residents who met the criteria for oral care assistance needs. (Resident #57) Findings include: On 12/5/12 at 8:10 A.M., an interview with Resident # 57's daughter indicated that she did not believe her mother had received oral care. The daughter stated that the resident's teeth were" falling out." She was not aware if the staff brushed the resident's teeth. The daughter had been told a dentist would examine the resident but she was not sure this exam had happened. On 12/11/12 at 2:35 P.M., an interview with the ADON (Assistant Director of Nursing) indicated she could not get a report from the CareTracker (an electronic software program for charting) that indicated the resident's teeth are being cleanse daily.	F0312	**F 312:** It is the practice of this facility to assure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. **Corrective action for Resident affected:** Resident #57 Oral care has been assessed using the facility assessment tool and resident is receiving oral care per her current care plan including brushing residents teeth. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** 100% audit has been completed with corrections as needed to assure all residents have current oral assessment using facility oral assessment tool. Nursing staff has been re-educated regarding following oral care plans. **This Corrective action will be measured by:** Unit Manager/Designee will monitor residents oral care daily times 2 weeks then, 3 times a week for	01/11/2013

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	On 12/12/12 at 9:50 A.M., interview with CNA #4 indicated she did not brush the resident's teeth today because she didn't get her up out of bed. The CNA #4 said the resident was usually up and dressed by the time she gets to the facility. The CNA #4 was unsure if the resident's teeth were brushed earlier this morning. The clinical record of Resident # 57 was reviewed on 12/12/12 at 10:15 A.M. The resident's diagnoses included, but were not limited to: dementia with behaviors, organic mental syndrome, anxiety, and depression. A clinical chart review, on 12/12/12 at 10:25 A.M., indicated a Comprehensive Assessment, dated 4/13/12, had no note regarding the resident's teeth, the area was left blank on the form. A Quarterly Assessment tool, dated 10/23/12, did not address oral care. Review of the Care Plan indicated the resident had a potential or actual Activity of Daily Living (ADL)/Mobility deficit, poor oral hygiene, oral infection related to arthritis and dementia. The goal was to allow staff to care for residents ADL's and the resident will be neat, clean, and well groomed thru next review. The interventions included but are not limited to: dental services		two weeks, weekly for 1 month, then monthly to assure oral care is provided per care plan. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	as needed, provide oral care daily and as needed. Staff to provide assistance with set up, physical assist and cue the resident with oral care. On 12/12/12 at 11:15 A.M., an observation of teeth when resident smiled indicated the resident has some missing teeth. On 12/12/12 at 3:30 P.M., an observation with the Nurse Manger # 3 indicated the Resident had three tooth brushes in a plastic bag that were completely dry. The nurse manager stated," these tooth brushes look like they haven't been used." 3.1-38(a)(C) 3.1-38(b)(1)			

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F0323 SS=E	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, record review, and interview, the facility failed to ensure the resident environment on 3 of 5 resident units was free from unsecured biohazardous waste. This potentially affected confused residents 4 of 5 units of the facility. Findings include: On 12/4/12 at 11:46 A.M., an observation of the soiled utility door on the 400 hallway indicated the door was unlocked. Residents were in the area in wheelchairs, and walking in the hallways. The door had a biohazard warning on it and the lock had a numbered pad lock. The area manager RN#26 was observed trying to shut and lock the door, however she was unable to get the lock the door to function. An interview with unit manager #13 on 12/4/12 at 11:50 A.M., indicated the lock had been broken and maintenance was aware of the problem. The unit manager #13	F0323	**F323:** It is the practice of this facility to ensure the resident environment is free from unsecured biohazard us waste. **Corrective Action:** Biohazard doors on 100 and 300 halls have been repaired and biohazard doors on 400 and 500 halls have been replace to assure resident environment is free of unsecured Biohazard us waste. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** All facility Biohazard doors have been inspected by Maintenance Director to ensure resident's area is free of unsecured biohazard waste. Facility Administrator re-educated Maintenance Director on the importance of secured Biohazard doors to ensure resident environment is free of unsecured biohazard waste. **This Corrective action will be measured by:** Maintenance Director/Designee will monitor biohazard doors	01/11/2013

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	indicated the lock had been broken for several days and maintenance had ordered a new one. On 12/10/12 at 9:05 A.M., an observation of a biohazard door indicated it was unlocked for the 300 hall. There was one confused resident in a wheelchair in the hallway across from the biohazard closet and some residents in their rooms. In the biohazard room there was a large box on the floor, with tied full red bags of biohazardous waste. Also, there was another red bag biohazard box with cardboard and other trash noted behind a housekeeping cart, which was also in the unlocked room. A maintenance worker, Employee #16 tried the door, found it unlocked, and then asked if the door should have been locked. The maintenance worker #16 tried the door a few more times and jiggled the door knob, he finally got the automatic lock to engage. On 12/11/12 at 9:30 A.M., an observation indicated the biohazard door on the 300 hall was again unlocked. The staff giggled the door knob and the door locked engaged to lock the door after several attempts. On 12/11/12 at 10:30 A.M., an		daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure Biohazard doors remain functional with any negative findings corrected immediately. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	observation indicated the biohazard door on 300 hall was again unlocked. There was no residents in the hallway. 3.1-45(a)(1)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interview, the facility failed to provide tracheal care and tracheal suctioning care for 1 of 1 residents who met the criteria for tracheostomy. (Resident #160) Finding includes: On 12/10/12 at 9:05 A.M., Resident #160 was observed in her room facing the window in bed. On 12/10/12 at 10:00 A.M., Resident #160 was observed in her room in bed. She was now facing the doorway and was noted to have a tracheostomy with oxygen tubing. On 12/10/12 at 10:50 A.M., the door to Resident #160 was noted to be partially closed. Nurse #15 was in the resident's room and indicated she was suctioning the resident because she needed it after a breathing	F0328	**F328:** It is the practice of this facility to provide tracheal care and tracheal suctioning care for resident who meet the criteria for tracheostomy care. **Corrective Action:** Resident #160 Licensed Nursing staff have been observed by nurse managers to give assure tracheal care and tracheal suctioning care is completed per facility policy including respiratory assessment and infection control measures. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** Facility residents who require tracheal care and tracheal suction care have been reviewed and are receiving this care per facility policy including respiratory assessment and infection control. Licensed Nursing staff have been re-educated regarding tracheal care and tracheal suctioning per facility policy including respiratory	01/11/2013

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	treatment. She indicated it was not a "scheduled suctioning." Interview with LPN #15, on 12/10/12 at 11:15 A.M.,indicated she had started her shift at 6:00 A.M. She indicated between 7:00 A.M. - 7:30 A.M., she had suctioned Resident #160. She indicated the resident was not scheduled to be suctioned again until 12:00 P.M. She indicated the resident's suction materials were kept in the resident's room because she was in isolation. On 12/10/12 at 12:00 P.M., LPN #15 was observed to perform tracheal suctioning for Resident #160. The resident had audible rattles upon entering the room. LPN #15, washed her hands, put on gloves, set up her supplies, put an oxygenation monitor of the resident's finger, and proceeded to performed the tracheal suctioning. The nurse was noted to be alternatingly pressing the suction valve as she was going into the resident's airway as well as when she was going out of the resident's airway. She went into the resident's airway three times, then placed the oxygen tubing back over the resident's trach for a minute then she went into the airway another two times using the same technique. She		assessment and infection control. **This Corrective action will be measured by:** Unit Manager/Designee will monitor Tracheal Care, Tracheal suctioning, respiratory assessment and infection control daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure Tracheal Care Tracheal suctioning procedures are followed. Any negative findings corrected immediately. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	did not assess the resident's breathsounds or respiratory rate prior to, during, or immediately after suctioning the resident. After LPN #15 had completed the suctioning process, as she was washing her hands prior to exiting Resident #160's room, she indicated she was going to assess the resident's respiratory status "in a few minutes" when she came back into the resident's room to administer her mediations. LPN #15 was noted to administer medications from 12:00 P.M. - 12:20 P.M. to other residents on the unit, but she did not reenter Resident #160's room to administer medications or perform a respiratory assessment. On 12/11/12 at 9:00 A.M., LPN, 22, the nurse on the unit, indicated she had started working at 6:00 A.M. and the resident was reported to have had very thin secretions during the night. She indicated went in a little before 8:00 A.M. and the resident seemed "dry" so she did not suction the resident. She indicated she would be periodically checking the resident to see if she needed "PRN (as needed) suctioning" but planned to suction her next around noon.			

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	On 12/11/12 at 9:25 A.M., LPN #22 was noted to be in Resident #160's room. The nurse indicated she was just checking the resident and would suction her soon. The nurse indicated the night shift had suctioned the resident close to 6:00 A.M., so she usually ended up suctioning the resident "about this time or a little later." The nurse indicated she would have the resident repositioned and then she would be suctioning the resident. On 12/11/12 between 9:40 - 9:55 A.M., tracheal suctioning for Resident #160 was observed. LPN #22 was noted to donned isolation wear but then while setting up her supplies, she removed her gloves several times and touched various items in the room, the resident's collection canister tubing, the resident's knee, and the resident's television with her bare hands. The nurse did donn the sterile gloves and performed suctioning of the resident's trach appropriately. The resident's sputum was noted to be bloody and thick. The nurse indicated at times the resident's drainage was bloody so she was not going to go in a third time (to suction). The resident's biox was assessed during the process and was			

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	noted to be in the 90's percentile throughout the process. The nurse did not assess the resident's respiratory status at all during the process. The resident's face and skin appeared flushed. Interview with LPN #22 indicated this was normal for the resident. The resident's oral cavity was also suctioned with a yanker catheter and again the bloody drainage was suctioned. The nurse indicated the facility policy was only to go into the resident's airway 3 times during suctioning. The resident was then repositioned by the nurse and a CNA During observation of a tracheal suction for Resident #22, on 12/11/12 at 12:00 P.M., which also included the administration of gastrostomy (gtube) medication, and sublingual narcotic medication, LPN #22 was observed to do the following: After gloving, gowning, she administered the gtube medication. She was noted to check for placement of the gastrostomy tube, then flush the tube with water, then she sprinkled the contents of the Loperamide capsule (a medication to treat loose stools) on top of the water in the ascepto, then continued her flush of the gtube. She then washed her hands and indicated she needed			

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	to suction the resident's mouth with a yanker catheter before she administered the sublingual medication. The nurse then removed her gloves again, and went into the bathroom, got a wet and soapy paper towel and a stack of dry paper towels, moved the suction tubing off the edge of a small bedside dresser, wiped the dresser with the soapy paper towel and then dried it with a paper towel and placed paper towels on the table, then moved the suction canister tubing, and a towel with her bare hands. Then she opened the sterile glove and suctioning packet, put a sterile glove on her right hand, however, while she arranged the items she needed and connecting the yanker to the suction tubing, she accidentally tipped the plastic cup in which she had placed the syringe with the liquid morphine. The syringe fell onto the floor. The nurse stated she would have to leave the room and go draw up more medicine for the resident. She gathered up paper towels and the plastic syringe which still contained the morphine, and the plastic cup and disposed of all of them in the biohazard red box in the			

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	resident's room. She then removed her isolation protection, washed her hands, and exited the room. She then was observed obtaining a second dose of the liquid narcotic medication from the medication cart. The nurse then donned her isolation protection, reentered the resident's room, washed her hands, donned gloves, and proceeded to place more paper towels onto the small dresser, connected the yanker catheter to the suctioning unit also on the dresser, and suctioned the resident's oral cavity. She then removed her gloves, washed her hands, put on another pair of gloves, and administered the liquid morphine. Next, the nurse removed her gloves, washed her hands, exited the bathroom without any gloves on, and prepared to set up her space to suction the resident. The nurse was noted to touch the suction tubing, the styrofoam cup she had used when flushing the resident's gtube with water, and a towel which was covering the suction machine. Then she opened a sterile package of suction materials and donned the right sterile glove. Then using her left bare hand, she positioned the			

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	cardboard well and using the left hand to touch the suction tubing, connected the suction catheter to the end of the suction tubing. She then, using her gloved right hand, poured sterile water into the well. She then donned the other sterile glove. Next, she removed the suction catheter from the packaging and holding the patient end of the catheter with her right hand , after positioning her left hand on the suction valve, she moved the oxygen tubing out of the way with the side of her right hand. She then attempted to place the catheter into the resident's tracheal opening. The resident was facing away from the nurse which made visualization difficult. The end of the tracheal catheter touched 3 times the trach dressing/ties around the opening before LPN #22 actually got the tubing into the resident's trach opening. She then was noted to guide the catheter with the pointer finger of her right hand. She did not check the resident's oxygenation nor did she assess the resident's lungs prior to the suctioning. She was able to suction thick, slightly bloody drainage. The well holding sterile water had tipped on her paper towels so she rolled up			

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	the catheter, switched it to her left hand, and with her right hand reset the well and poured more sterile water into the well to clean out her tubing. She then suctioned the resident again utilizing the same technique. She then placed the catheter tubing onto the opened packaging, and checked the resident's breath sounds with a disposable stethoscope. She then without changing her gloves, suctioned the resident a third time. She then removed her gloves and washed her hands. She then returned to the bedside and indicated she was going to change the resident's inner cannula. She put a glove on her right hand but kept her left hand bare, removed the old trach from the resident and then touching the outer end of the inner cannula with her bare hands and guiding the cannula with her gloved right hand, she placed the new cannulal into the resident's tracheal opening and replaced the oxygen tubing . She then removed her right glove and gathered up all of her trash, placed the suction tubing back on top of the suction machine and covered the			

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	apparatus with a towel, Next, she wrapped up the trash with both bare hands, and placed it all in the biohazard box for trash located in the room. She then removed her isolation gown and mask, washed her hands, then went back into the resident's room to turn on the resident's television.. Interview with LPN #22, the first shift nurse on the unit and RN #28, the second shift nurse on the unit, on 12/11/12 at 2:50 P.M., indicated they did not think the suctioning was ordered every two hours. Neither nurse knew exactly what type of isolation they were to utilize for Resident #160. LPN #22 thought the isolation was due to VRE (Vancomyacin Resistant Entercoccus) infection of an unknown location and the other nurse thought Resident #160 was in isolation due to MRSA (Methacillin Resistant Staph Aureous) infection of the sputum. They indicated staff were to wear gowns and masks because the resident sometimes coughed and body fluids could come out of her trach. The clinical record for Resident #160 was reviewed on 12/07/12 at 2:00 P.M. Resident #160 was admitted to the facility on 05/30/12. The			

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	resident's diagnoses, included but were not limited to: hypoxic encephelopathy due to drug overdose or alcohol overdose, hx of cardiopulmonary arrest, hypertension, vegetative state, hx mrsa sputum positive, anoxic brain injury, hx sepsis. The physician's orders regarding the tracheal care included the following orders: 11/05/12 - humidity set at 28%, duoneb .5 mg - 3 mg / 3 ml via nebulizer q 4 hours, oxygen to trach at 3 liters to keep oxygen sats (saturation) above 90 %, suction q (every) 2 hours, empty suction canister every shift, trach care every shift and prn (as needed), biox (oxygen saturation) every shift, change trach ties daily,change inner canula #6 daily, change oxygen tubing q week on Sundays, change nebulizer tubing q week on Sundays. 3.1-47(a)(5) 3.1-47(a)(6)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview and record review, the facility failed to adequately monitor the blood pressure per physician order before giving a blood pressure medicine for 1 of 1 residents in a sample of 10 who fit the criteria for unnecessary medications. (Resident #98) Findings include: Record review on 12/10/12 at 11:12 A.M., indicated Resident #98's	F0329	**F329:** It is the practice of this facility to adequately monitor and record the blood pressure per physician order before giving a blood pressure medicine. **Corrective Action:** Resident #98's Blood Pressure is being taken before giving blood pressure medication and recorded on Vital Sign flowsheet. **Other Residents having the potential to be affected and corrective measures to ensure**	01/11/2013

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	diagnosis included but were not limited to "...hypertension, syncope, peripheral vascular disease...." Physician order written 11/18/11, indicated "Do BP (Blood pressure) prior to giving BP med (medicine) and record on VS (Vital Signs) flowsheet, Call if SBP (Systolic blood pressure) <100, or HR (Heart rate) <50." Physician medication order written 8/3/09, indicated Metoprolol (medicine for blood pressure) 25 mg BID (twice a day), hold if SBP <100 or HR <50". Review of Resident #98's Medication Administration Record- Vital Signs Flowsheet indicated on the days of 12/5/12 at 4 P.M., 12/7/12 at 4 P.M., 12/8/12 at 4 P.M., and 12/9/12 at 4 P.M., the blood pressure was not recorded before giving the prescribed Metoprolol. Interview the LPN #2 on 12/10/12 at 11:25 A.M., indicated there should be a blood pressure recorded on the Vital Signs Flowsheet for Resident #98 on the days specified above because the Metoprolol was charted as given. 3.1-48(a)(3)		**practice does not recur:** 100% audit of residents with orders to monitor and record blood pressure before giving blood pressure medications has been completed with corrections made as needed. Licensed nursing staff have been re-educated to monitor and record blood pressures prior to giving blood pressure medications. **This Corrective action will be measured by:** Unit Manager/Designee will monitor blood pressure monitoring and recording daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure blood pressures are monitored and recorded per physician order. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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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, record review and interview, the facility failed to post the total hours of licensed and unlicensed nursing staff that worked daily on the Daily Staffing Report for 7	F0356	**F356:** It is the practice of this facility to have nurse staffing data available to the public for review. **Corrective Action:** Staffing Coordinator/Designee has been	01/11/2013

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	of the 7 days the posting was observed (12/4, 12/5, 12/6, 12/7, 12/10, 12/11, and 12/12/12). Finding includes: The "Daily Staffing Report" was observed and reviewed during the 7 days of survey, from 12/4/12 through 12/12/12. The posting indicated the total number of Registered Nurse's (RN's), Licensed Practical Nurse's (LPN's) and Certified Nurse Aides (C.N.A.'s) working each day. The posting did not include the actual hours worked by each direct care staff for each shift. Interview with the Administrator, on 12/12/12 at 4:00 P.M., indicated there was no other location of the staff daily posting other than the posting at the front of the building. 3.1-13(a)		re-educated by DON of the requirements to post staffing daily using the Daily Staffing Report sheet and make available to the public for review. **This Corrective action will be measured by:** Administrator/Designee will monitor Daily Staffing Report Posting daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure Daily Staffing Report Posting is posted. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to serve food at the proper temperature at point of service. This had the potential to affect 51 of 51 resident's that received hall trays on the 100, 300, 400 and 500 halls. Findings include: During an observation on 12/7/12 at 10:56 A.M., the meal trays were to be delivered at 11:15 A.M. on the 300 hall The trays arrived at 11:25 A.M. The last tray was passed at 11:38 A.M. The pineapple was at 63 degrees Fahrenheit (F), the wing sauce was at 49 degrees F, the milk was 49 degrees F, french fries was 90 degrees F, and the chicken wings was at 102 degrees F. The 500 hall meal trays arrived at 11:25 A.M. The temperatures for pureed meal was 126 degrees F, the potatoes was 114 degrees F, the applesauce was at 60 degrees, the apple juice was at 54 degrees F, the	F0364	**F364:** It is the practice of this facility to serve food at the proper temperature at point of service to conserve nutritive value, flavor, appearance and is palatable and attractive. **Corrective Action:** Resident #5, Resident #191n and Resident #186 are receiving food trays timely and at the proper food temp. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** Resident hall trays on all halls have been monitored for proper food temps and residents are receiving food trays at proper temperatures per facility policy. Dietary staff has been re-educated on proper food temp at point of service. **This Corrective action will be measured by:** Dietary Manager/Designee will monitor food temperature daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month,	01/11/2013

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	tomato juice was at 57 degrees F, and the milk temperature was at 57 degrees F. During an observation on 12/7/12 at 11:34 A.M., the meal trays arrived on the 100 hall at 11:34 A.M. The last tray was served at 11:40 A.M. The Dietary Manager dropped the thermometer on the floor while attempting to temp the test tray. The Dietary Manager went to the kitchen to obtain another thermometer. The temperature of test tray taken at 11:43 A.M., indicated the following: the chicken wings was at 92 degrees F, the french fries was at 94 degrees F, the milk was at 60 degrees F and the pineapple was 58 degrees F. During an observation on 12/7/12 at 11:50 A.M., the meal trays arrived on the 400 hall at 11:50 A.M., the last tray was served at 12:10 P.M. The milk temperature was 55 degrees F, the pineapple was at 64 degrees F, water was 63 degrees F, the chicken wings was 96 degrees F, and the french fries temperature was 100 degrees F. On 12-5-12 at 9:20 A.M., an interview with Resident # 5 indicated his meals are cold half the time.		then monthly to assure food is the proper temperature. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	During an interview with Resident #191 on 12/5/12 at 8:52 A.M., the resident indicated food is usually cooled down by the time it gets served. Room trays for breakfast and supper are sometimes cold. During an interview with Resident # 186 on 12/5/12 at 1:54 P.M., the resident indicated she eats in the 100 hall dining room, the food is cold by the time it gets there. On 12/7/12 at 11:44 A.M., an interview with the Dietary Manager indicated if a resident complained of the food being cold she would look at temp log in the kitchen, and see when the hall trays went out to the floor and how long the trays had sat. The current facility policy entitled, "Serving Procedure" effective date November 2000, revised July 2011, and received from the Dietary Manager was reviewed on 12/12/12 at 11:10 A.M. This policy indicated "...Serve hot foods above 135 degrees F and cold foods at or below 41 degrees F for service." 3.1-21(a)(2)			

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing and handling of unpackaged food. This deficiency affected 21 of 21 residents who received meals in the 200 hall dining room. Finding includes: On 12/4/12, the following were observed during the lunch meal in 200 hall dining room: CNA #9 was observed to serve 5 meal trays to residents seated in the 200 hall dining room including assisting residents to open food without washing her hands between trays. CNA #10 was observed to serve 4 meal trays to residents seated in the 200 hall dining room including opening food and handling dishes without washing hands.	F0371	**F371:** It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions. **Corrective Action:** Food is being monitored to assure it is distributed and served under sanitary condition per facility policy in regards to hand washing and handling of unpackaged food on the 200 hall. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** For all residents of the facility food is being distributed and served under sanitary conditions per facility policy. Staff have been re-educated regarding facility policy for hand washing and handling of unpackaged food. **This Corrective action will be measured by:** Dietary Manager/Designee will monitor hand washing and handling of unpackaged food per facility policy daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure hand washing and	01/11/2013

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	At 11:36 A.M., CNA #8 was observed to serve a meal tray to a resident seated in the 200 hall dining room and open and butter the roll with her bare hands. At 11:38 A.M., QMA #7 was noted to serve her second meal tray to a resident seated in the 200 hall dining room and open the roll and butter it with bare hands. At 11:40 A.M., QMA #7, was noted to serve her third meal tray to a resident seated in the 200 hall dining room and open the roll and butter it with bare hands. At 11:40 A.M., LPN #2 was observed to serve a meal tray to a resident seated in the 200 hall dining room and open and butter the roll with bare hands. At 11:41 A.M., QMA #7 was observed after serving 3 meal trays to wash hands for 10 seconds. QMA #7 was observed to serve 3 more resident meal trays, including opening and buttering rolls without washing hands. At 11:45 A.M., CNA #9 was observed to wash her hands for 8 seconds.		handling of unpackaged food per facility policy. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	At 11:47 A.M., CNA #9 was observed to serve a meal tray to a resident seated in the 200 hall dining room. CNA #9 was noted to open and butter the resident's roll with bare hands. CNA #8 was observed to serve 6 more resident meal trays before washing her hands at 11:47 AM for 6 seconds. At 11:48 A.M., LPN #2 was observed to wash her hands for 3 seconds without adding soap. At 11:50 A.M., QMA #7 was observed to wash her hands for 6 seconds. At 11:53 A.M., CNA #9 was observed to mop the floor of urine noted under a resident seated in the 200 hall dining room, wash her hands for 8 seconds, and then continue to assist moving dishes in the dining room. At 11:56 A.M., CNA #10 was observed to wash her hands for 10 seconds after serving 4 meal trays. On 12/10/12, the following were observed during the lunch meal in 200 hall dining room: At 11:41 A.M., CNA #9 was observed to wash her hands for 10 seconds.			

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	CNA #9 was then observed to serve 5 meal trays for residents sitting in the 200 hall dining room, including opening and buttering pieces of bread with her bare hands without washing her hands between trays. At 11:48 A.M., QMA #7 was observed to wash her hands for 5 seconds. At 11:50 A.M., LPN #2 was observed to wash her hands for 4 seconds. At 11:51 A.M., LPN #2 was observed to serve a meal tray to a resident seated in the 200 hall dining room She opened and handled butter and a piece of bread with her bare hands. At 11:55 A.M., QMA #7 was observed serving a meal tray to a resident seated in the 200 hall dining room. The QMA was noted to handle a piece of bread with her bare hands. At 11:57 A.M., LPN #2 was observed to wash her hands for 6 seconds. At 12:02 P.M., QMA #7 was observed to serve a meal tray to a resident seated in the 200 hall dining room and handle a piece of bread with bare hands. At 12:03 P.M., LPN #2 was observed			

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	to wash her hands for 7 seconds. The current Food Serving Procedure policy with effective date of 11/2000 and revised 7/2011, was received on 12/12/12 at 11:03 A.M., from Employee #18 (Dietary Manager). Review of this policy indicated "...Never touch cooked or ready-to-eat...foods with bare hands...." The current Personal Hygiene Procedure policy with effective date 11/2000 and revised 7/2011, was received on 12/12/12 at 11:45 A.M., from Employee #1 (Assistant Director of Nursing). Review of this policy indicated "...to ensure proper personal hygiene practices to prevent contamination of food...thoroughly distribute soap over the entire area of hands and wrists...rub hands together vigorously for 15-20 seconds...." 3.1-21(i)(3)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure there was an accurate system for liquid narcotic reconciliation and a	F0431	**F 431:** It is the practice of this facility to ensure there is an accurate system for liquid narcotic reconciliation and the Schedule IV controlled Substance	01/11/2013

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	Schedule IV Controlled Substance was properly secured. This deficient practice affected 4 of 5 halls in the facility. Findings include: 1. On 12/11/12 at 3:00 P.M., LPN #25 and RN # 29 were asked to examine a bottle of liquid Morphine medication for Resident #160. There were graduated measurements for 28 ml (milliliters) and 24 ml on the side of the bottle Interview with RN #29 indicated she estimated approximately 27 ml were left in the bottle. LPN #25 indicated she knew how many milliliters were supposed to be in the bottle as she had administered the medication during her shift. She indicated she did not every "go by the amount in the bottle, but by the documentation on the narcotic form." LPN #25 was asked to look at the bottle and compare it to the narcotic form. She did agree it looked like more in the bottle when visualizing the medication than what was charted as left in the bottle on the narcotic form. Both nurses indicated the pharmacy sent the bottles often overfilled to start with more than the amount indicated on the delivery form. This was the only liquid narcotic on the 300 hall medication		are properly secured. **Corrective Action:** Resident #160, resident #203 and resident #138 receive liquid narcotic which are measured using a marked syringe, provided by the pharmacy. These residents have shown no harm related to this practice. Resident #54's Ativan was destroyed. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** No residents were harmed by this practice. Pharmacy has been notified of inconsistency related to liquid narcotic delivered to facility. Pharmacy is now sending liquid narcotic in clear measured bottles which assure correct amount is delivered. Discontinued Narco are being destroyed per facility policy. Licensed Nursing staff have been re-educated to notify Director of Nursing/Assistant Director of Nursing of any liquid narcotic delivered which have not been measured properly. This will then be handled by the pharmacy. Licensed Nursing staff have also been re educated regarding safe handling for drug destruction. **This Corrective action will be measured by:** Director of Nursing/Designee will monitor Delivery of liquid Narco and safe handling of drug destruction daily	

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	cart. On 12/12/12 on 10:25 AM, 4 bottles of Roxanol liquid pain medicine was observed for 3 residents in the 300 hall medication carts. Dosage label on the bottle for Resident #201 indicated strength was 20mg/ml, residents prescribed dose was ml every 2-4 hours. The narcotic count log for resident indicated there was 22 ml's left in bottle. Observation of the Roxanol bottle showed there was more than 22 ml's left. Interview with LPN #25 indicated the actual count in bottle was "over 24 ml's." Dosage label on the sealed new bottle of Roxanol liquid pain medicine for Resident #138 indicated strength was 20 mg/ml, residents prescribed dose was 5 mg or 0.25ml. The narcotic count log for resident indicated this was a new bottle and the count was 30ml's. Observation of the Roxanol bottle showed there was more than 30ml's in bottle. Interview with LPN #25 indicated actual bottle "looked to have 32ml's". Resident #180 had 2 bottles of Roxanol liquid pain medicine with his prescription label affixed. Resident #180's prescribed dose was 1ml		times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure delivery of Liquid Narcotic and safe handling of drug destruction are complete. All findings will be reviewed at monthly Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	every 1 hour. The first bottle had a small amount of clear liquid in it. Interview with LPN #25 indicated this was his Roxanol that was almost finished and he had a new bottle when this one was gone. The narcotic log book for this bottle indicated there was 2ml's left in the bottle. Interview with LPN #25 indicated this bottle was very hard to determine how much was in there because "the liquid was clear but there was at least 4ml's" in bottle. Observation of Resident #180's second bottle of Roxanol liquid pain medicine was a sealed new bottle. Prescribed dose for this resident was 1ml every hour. Narcotic log book indicated this was a new bottle and the count was 30ml's. Interview with LPN #25 indicated this new bottle had an actual filling of "32ml's". On 12/12/12 at 10:55 A.M., Roxanol liquid pain medicine was observed in the 500 hall med cart. Dosage label on a sealed new bottle for Resident #190 indicated the strength of this medicine was 20mg/ml, prescribed dose for this resident was 0.5ml-1mL prior to dressing change. Interview with LPN #26 as she pulled the bottle out of the med cart indicated "the count says 30ml's but there's more than that in there...." The narcotic			

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	count log for resident indicated this was a new bottle and the count was 30ml's. Interview with LPN #26 indicated the actual count was "filled to 35ml's." 2. On 12/12/12 at 11:20 A.M., 2 plastic medication bags of liquid Ativan vials were observed on the top shelf in the refrigerator in the 400 hall medication room. One bag for Resident #54 was observed to have 7 total vials of unopened liquid Ativan 2mg/ml. One bag for Resident #39 was observed to have 5 total vials of liquid Ativan 2mg/ml with 2 vials being opened and partially used. During an interview on 12/12/12 at 11:25 A.M., LPN #27 indicated "...this isn't where they are supposed to be...." Interview on 12/12/12 at 11:30 A.M., with Employee #1 (Assistant Director of Nursing) indicated "...facility policy is to keep discontinued narcotics in the locked drawer so we can make sure they are all still there. Then within 7 days to draw them up with 2 nurses and flush med's (medications) down the toilet...." 3. On 12/12/12 at 11:45 AM, review of the current "Destruction of			

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	Medications" policy dated, 7/2010 and revised on 7/2011, received from Employee #1 indicated "...destroy all controlled substances in the presence of two licensed nurse [sic]...destroy drugs when discontinued, daily or at a minimum or weekly....If the controlled drugs must be stored awaiting destruction, the drugs must be kept in a secure double locked area..." 3.1-25(e)(2) 3.1-25(e)(3)			

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F0441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interviews, the facility failed to	F0441	**F441:** It is the practice of this facility to establish and maintain	01/11/2013

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	ensure staff followed infection control procedures regarding handwashing, use of disposable gloves during nursing care and during food service, and failed to ensure biohazardous waste was properly stored and secured . This was noted on 5 of 5 units in the facility and potentially affected 129 of 129 residents. Finding includes: 1. On 12/11/12 between 9:40 - 9:55 A.M., tracheal suctioning for Resident #160 was observed. LPN #22 was noted to appropriately donned isolation precautions but then while setting up her supplies, she removed her gloves several times and touched various items in the room, the resident's collection canister tubing, the resident's knee, and the resident's television with her bare hands. During observation of a tracheal suction for Resident #22, on 12/11/12 at 12:00 P.M., which also included the administration of gastrostomy medication, and sublingual narcotic medication, LPN #22 was observed to do the following: After gloving, gowning, she administered the gastrostomy tube (gtube) medication. She was noted to check for placement of the gtube, then flush the		an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action:** Resident #23 is observed receiving tracheal care following current facility policy and procedure including infection control. Staff are washing hands per facility policy to include hygiene precautions to prevent contamination of foods and to help prevent the development and transmission of disease and infection. All Biohazard containers have been observed with lids in place and trash bags securely closed. **Other Residents having the potential to be affected and corrective measures to ensure practice does not recur:** Resident receiving tracheal care have been reviewed and are receiving care per facilty policy and procedure including infection control. Nursing staff are washing hands per facility policy including hygiene practices to prevent contamination of food and to prevent the development and transmission of disease and infection. Biohazard containers have been observed and have lids in place with trash bags securely closed.	

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	tube with water, then she sprinkled the contents of the Loperamide (a medication to treat loose stools) capsule on top of the water in the ascepto, then continued her flush of the gtube. She then washed her hands and indicated she needed to suction the resident's mouth with a yanker catheter before she administered the sublingual medication. The nurse then removed her gloves again, and went into the bathroom, got a wet and soapy paper towel and a stack of dry paper towels, moved the suction tubing off the edge of a small bedside dresser, wiped the dresser with the soapy paper towel and then dried it with a paper towel and placed paper towels on the table, then moved the suction canister tubing, and a towel with her bare hands. Then she opened the sterile glove and suctioning packet, put a sterile glove on her right hand, however while she arranged the items she needed and connecting the yanker to the suction tubing, she accidentally tipped the plastic cup in which she had placed the syringe with the liquid morphine. The syringe fell onto the floor. The nurse stated she would		Licensed nursing staff have been in serviced Regarding tracheal care following current facility policy and procedure including infection control. Nursing staff have been in serviced regarding hand washing per facility policy including hygiene practices to prevent contamination of food and to prevent the development and transmission of disease and infection. Staff has been in serviced regarding Placement of lids on biohazard containers and the need to securely close trash bags in an effort to prevent transmission of disease and infection. **This Corrective action will be measured by:** Unit managers/Designee will monitor Tracheal Care, Hand washing Biohazard containers daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure residents receiving tracheal care, hand washing done per policy and Biohazard containers have lids and securely closed bags. All findings will be reviewed at monthly Quality Performance	

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	have to leave the room and go draw up more medicine for the resident. She gathered up paper towels and the plastic syringe which still contained the morphine, and the plastic cup and disposed of all of them in the biohazard red box in the resident's room. She then removed her isolation protection, washed her hands, and exited the room. She then was observed obtaining a second dose of the liquid narcotic medication from the medication cart. The nurse then donned her isolation protection, reentered the resident's room, washed her hands, donned gloves, and proceeded to place more paper towels onto the small dresser, connected the yanker catheter to the suctioning unit also on the dresser, and suctioned the resident's oral cavity. She then removed her gloves, washed her hands, put on another pair of gloves, and administered the liquid morphine. Next, the nurse removed her gloves, washed her hands, exited the bathroom without any gloves on, and prepared to set up her space to suction the resident. The nurse was noted to touch the suction tubing, the styrofoam cup she had used when flushing the resident's gtube with		Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	water, and a towel which was covering the suction machine. Then she opened a sterile package of suction materials and donned the right sterile glove. Then using her left bare hand, she positioned the cardboard well and using the left hand to touch the suction tubing, connected the suction catheter to the end of the suction tubing. She then, using her gloved right hand, poured sterile water into the well. Thus contaminating her right hand. She then donned the other sterile glove. Next, she removed the suction catheter from the packaging and holding the patient end of the catheter with her right hand, after positioning her left hand on the suction valve, she moved the oxygen tubing out of the way with the side of her right hand. She then attempted to place the catheter into the resident's tracheal opening. The resident was facing away from the nurse which made visualization difficult. The end of the tracheal catheter touched 3 times the trach dressing/ties around the opening before LPN #22 actually got the tubing into the resident's trach opening. She then was noted to guide the catheter with the pointer finger of her right, contaminated			

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	gloved hand. The well holding sterile water had tipped on her paper towels, while she was suctioning the resident, so she rolled up the catheter, switched it to her left non-sterile hand, and with her right hand , reset the well and poured more sterile water into the well to clean out her tubing. She then suctioned the resident again utilizing the same technique. She then placed the catheter tubing onto the opened packaging, and checked the resident's breath sounds with a disposable stethoscope. She then without changing her gloves, suctioned the resident a third time. She then removed her gloves and washed her hands. She then returned to the bedside and indicated she was going to change the resident's inner cannula. She put a glove on her right hand but kept her left hand bare, removed the old trach from the resident and then touching the outer end of the inner cannula with her bare hands and guiding the cannula with her gloved right hand, she placed the new cannulal into the resident's tracheal opening and replaced the oxygen tubing .			

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	She then removed her right glove and gathered up all of her trash, placed the suction tubing back on top of the suction machine and covered the apparatus with a towel, Next, she wrapped up the trash with both bare hands, and placed it all in the biohazard box for trash located in the room. She then removed her isolation gown and mask, washed her hands, then went back into the resident's room to turn on the resident's television. Review of the a procedure for "Sterile Tracheobronchial Suction by Way of Tracheostomy or Endotracheal Tube" from a 2006 nursing manual book, presented as the current policy and procedure, by Employee #1, on 12/11/12 at 2:25 P.M., indicated the following instructions: "...8. Put on sterile gloves. Designate one hand as contaminated for disconnecting, bagging, and working with the suction control...The hand designated as sterile must remain uncontaminated so organisms are not introduced into the lunches. The contaminated hand must also be gloved to prevent sputum from contacting the nurse's hand, possible resulting in an infection of the			

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	nurse...." 2.(a) On 12/6/12 at 10:15 A.M., an observation of CNA # 20 was made assisting a resident to the restroom. After assisting the resident the CNA #20 took her gloves off and washed her hands for 3 seconds. An interview with CNA #20 indicated the hand washing policy stated she was to wash hands for 15 seconds. The CNA #20 indicated she did not wash her hands for the entire 15 seconds. On 12/10/12 at 11:53 A.M., an observation of CNA #21 indicated she washed her hands for 8 seconds prior to serving lunch to resident's in the main dining room. An interview with CNA #21 regarding the hand washing policy indicated she was to wash her hands for 30 seconds per the policy. 3. (a) On 12/4/12 at 11:36 A.M., during lunch service, CNA #8 was observed to wash her hands for 6 seconds. On 12/4/12 on 11:41 A.M., during lunch service, QMA #7 was observed to wash hands for 10 seconds. On 12/4/12 at 11:45 A.M., during lunch service, CNA #9 was observed			

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	to wash her hands for 8 seconds. On 12/4/12 at 11:48 A.M., during lunch service, LPN #2 was observed to wash her hands for 3 seconds without adding soap. On 12/4/12 at 11:50 A.M., during lunch service, QMA #7 was observed to wash hands for 6 seconds. On 12/4/12 at 11:53 A.M., during lunch service, CNA #9 was observed to mop the floor of urine noted under a resident seated in the 200 hall dining room, wash hands for 8 seconds, and continue to assist moving dishes in the dining room. On 12/10/12 at 11:41 A.M., during lunch service, CNA #9 was observed to wash hands for 10 seconds. On 12/10/12 at 11:48 A.M., during lunch service, QMA #7 was observed to wash hands for 5 seconds. On 12/10/12 at 11:50 A.M., during lunch service, LPN #2 was observed to wash hands for 4 seconds. On 12/10/12 at 11:56 A.M., during lunch service, CNA #10 was observed to wash hands for 10 seconds.			

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	On 12/10/12 at 11:57 A.M., during lunch service, LPN #2 was observed to wash hands for 6 seconds. On 12/10/12 at 12:03 P.M., during lunch service, LPN #2 was observed to wash hands for 7 seconds. The current Food Serving Procedure policy, effective date 11/2000 and revised 7/2011, was received on 12/12/12 at 11:03 A.M., from Employee #18 (Dietary Manager). Review of this policy indicated, "...Never touch cooked or ready-to-eat...foods with bare hands...." The current Personal Hygiene Procedure policy, effective date 11/2000 and revised 7/2011, was received on 12/12/12 at 11:45 A.M., from Employee #1 (Assistant Director of Nursing). Review of this policy indicated, "...to ensure proper personal hygiene practices to prevent contamination of food...thoroughly distribute soap over the entire area of hands and wrists...rub hands together vigorously for 15-20 seconds...." 3. (b) On 12/10/12 at 7:46 AM LPN #11 was observed to wash her hands for 7 seconds, answer and talk on phone, help the unit CNA put			

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	Resident #185 back in bed with the hoyer lift, and took Resident #185's shoes off before putting disposable gloves on. LPN #11 then applied Lidocaine patch (medication patch for pain) on Resident #185's left shoulder and removed disposable gloves. After removing gloves, LPN #11 set the dirty gloves on top of Resident #185's dresser, prepared medications, and put same dirty gloves back on before giving Resident #185 his scheduled pills. LPN #11 was then observed to wash her hands for 8 seconds. On 12/10/12 at 8:21 AM, after preparing and before giving med's (medications) LPN #11 was observed to wash her hands for 4 seconds. Review of the current Hand Hygiene policy effective date 4/1999 and revised 11/2011 received on 12/12/12 at 11:45 AM from Employee #1 (Assistant Director of Nursing) indicated to wash hands "...before having direct contact with residents...after contact with a resident's intact skin (e.g...lifting a resident)...after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident)...thoroughly distribute soap....rub hands together vigorously for 15-20 seconds..."			

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	3. (c) On 12/7/12 on 7:52 PM, CNA #12 was observed to bring the housekeeping cart from the biohazard room and a clean towel from the linen cart into the dining room on the 200 hall. CNA #12 donned clean gloves and obtained a plastic trash bag before mopping up a puddle of urine on the floor. After placing the dirty towel in the plastic trash bag, CNA #12 opened the door to the biohazard room with the dirty gloves on. CNA #12 returned to the dining room with dirty gloves on, removes them, and washes hands before pushing housekeeping cart back to biohazard room and opening door with bare hands. After leaving biohazard room for the second time, CNA #12 obtains clean linens from the linen cart and enters a resident room to provide care. On 12/10/12 at 8:00 PM, CNA #19 entered the biohazard room using bare hands to open door. Review of the current Personal Hygiene Procedure policy effective date 11/2000 and revised 7/2011 received on 12/12/12 at 11:45 AM from Employee #1 (Assistant Director of Nursing) indicated "...wash hands after the following activities...after			

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	using a cleaning, polishing, or sanitizing chemical...after touching anything that may contaminate hands..." 4. On 12/7/12 at 1:55 P.M., during an environmental tour with the Maintenance Supervisor and the Administrator it was observed the biohazard room on the 500 hall had 2 red plastic containers. No lids were observed on either container. Also in the same 500 hall biohazard room observed a bag of trash with disposable wipes were floating in the water in the hopper. On 12/7/12 at 2:00 P.M., during interview with the Maintenance Supervisor regarding proper disposal of waste, the Maintenance Supervisor indicated he is not sure why lids were not on the biohazard containers, and the trash bag floating in the hopper water was not proper disposal of waste. 3.1-18(l)			

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record reviews and interviews, the facility failed to ensure the quality assessment and assurance committee included a physician in attendance on a quarterly basis and failed to ensure a plan of action to address unlocked biohazard doors was implemented effectively. Finding includes: Interview with the Administrator, on	F0520	**F520:** It is the practice of this facility to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. **Corrective Action:** The facility Medical Director has been informed via mail of the requirement to attend a Quality Performance Indicator meeting at least on a quarterly basis. **This Corrective action will be**	01/11/2013

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	12/12/12 at 2:00 P.M., regarding the facility's quality assessment and assurance committee indicated committe met monthly but the Medical Director was supposed to attend the meetings at least quarterly. Review of the attendance records for quality assessment and assurance meetings for the past year indicated facility's medical director had not attended any quarterly meetings since 03/03/12. The Administrator indicated the unlocked biohazard doors had been noted at the previous QA and A meetings and the "door locks were now all fixed." There was no response when asked why the doors were noted to still not be locking appropriately on all days of the survey except 12/12/12. There was no response. A work order, regarding the ordering of locking mecanisms indicated they were not ordered until 12/04/12. No specific information was provided regarding when the QA and A (Quality Assurance and Action) committee had first noted the issue and no action plan regarding the issue was presented. 3.1-52(a)(2)		**measured by:** Administrator/designee will review Quality Performance Indicator meeting attendance record to assure Medical Director in attendance at least quarterly. Any negative findings will be addressed immediately.Addendum (1/18/13): Quality performance indicator committee, plans of action will be monitored by the Administrator/designee to ensure effective outcome. This monitoring will be completed monthly times three months. Then quarterly times six months.	

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F9999	State Findings: 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course or instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induction with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facility shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (23) months, the baseline tuberculin	F9999	**F9999:** It is the practice of this facility to maintain personnel files which include current Mantoux tests and in-service documentation. **Corrective Action:** Employee #50, Employee #51 and Employee #32 have received the Mantoux test including second step. This is recorded in their personnel file. Employee #50 has job specific orientation documentation signed and in their personnel file. Employee #33 has current fire, safety and Hazardous in-service documentation signed and in their personnel file. 100% audit of personnel files has been completed with corrections of any negative findings. Business office has been re-educated to monitor personnel files to assure compliance with State and Federal regulations **This Corrective action will be measured by:** Administrator/Designee will monitor Personnel files for Mantoux test, job specific orientation and Fire safety and Hazardous in-service documentation daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly to assure Personnel files are complete. All findings will be reviewed at monthly	01/11/2013

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	skin testing should employee the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 9 Employee files reviewed contained documentation of a two step tuberculin skin testing. (Employee #50, 51, and 52) Finding includes: During review of personnel files, conducted on 12/12/12 at 4:00 P.M., the following was noted: 1. There was no tuberculin skin testing documentation for Employee #50, a CNA with a start date of 11/19/12. Interview with Employee #32, the Human Resources Coordinator, on 12/12/12 at 4:05 P.M., confirmed there was no Mantoux testing documentation available for Employee #50.		Quality Performance Indicator meeting. Any identified non-compliance will be addressed through one to one education up to termination.	

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	2. The tuberculin skin testing documentation for Employee #51, a Dietary employee with a start date of 06/13/12, indicated the employee had a negative Mantoux test documented on 06/15/12, but had not had a second step Mantoux testing documented until 08/20/12. Interview on 12/12/12/ at 4:00 P.M., with the Human Resources Coordinator, Employee #32 indicated the employee must have "missed" their second step and had been caught up in August 2012. 3. The tuberculin skin testing documentation for Employee #52, a Registered nurse, with a start date of 07/19/12, indicated she had a first step Mantoux test documented as having been given on 07/17/12. The second step Mantoux testing had not been administered until 08/12/12. This was 4 weeks after the first step testing. 3.1-14(t)(1) 3.1-14 PERSONNEL (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations			

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	served in the facility for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; (E) care of cognitively impaired; residents (2) A review of resident's rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment an procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. This state rule was not met as evidenced by: Based on review of record review and interview, the facility failed to ensure 1 of 9 personal files reviewed had documentation the employee was oriented in the facility's emergency procedures including fire procedure			

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	and evacuation plans. (Employee #53) In addition, there was no documentation of job specific orientation for 1 of 9 employees. (Employee #50) Findings include: 1. The personnel files were reviewed on 12/12/12/ at 4:00 P.M. This review indicated there was no job specific orientation documentation available for Employee #50, a CNA with a start dated of 11/19/12. Interview with Employee #32, the Human Resources Coordinator, on 12/12/12/ at 4:05 P.M., indicated there was no documentation available regarding a job specific orientation for Employee #50. The employee file for a laundry staff member, Employee #53, with a start date of 08/03/12, indicated the fire safety and hazardous inservice documentation, completed on 08/03/12, was from an outside contracted agency and was not specific to the facility. 3.1-14(p)			

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