

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155145	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 603 E NATIONAL HWY WASHINGTON, IN 47501
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 6, 8, 9, 10, 13, 14, 2013</p> <p>Facility number: 000068 Provider number: 155145 AIM number: 100274980</p> <p>Survey Team: Dorothy Watts, RN TC Martha Saull, RN Terri Walters, RN 5/6, 5/8, 5/10, 5/13, 5/14, 2013 Carole Mc Daniel, RN 5/6, 5/8 5/9, 5/10, 5/14, 2013</p> <p>Census bed type: SNF: 8 SNF/NF: 70 Total : 78</p> <p>Census payor type: Medicare: 8 Medicaid: 60 Other: 10 Total: 78</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>F 000</p> <p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>	

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

TITLE

(X6) DATE

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

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	Quality review completed on May 20, 2013, by Jodi Meyer, RN				

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F000252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure a comfortable and homelike environment for 1 of 8 residents reviewed during environmental observations.</p> <p>Resident #91</p> <p>Findings include:</p> <p>On 5/8/13 at 10:24 A.M., Resident # 91's room was observed. Located on the wall next to the door was the resident's 1 inch by 3 inch institutional name plate. Resident # 91's room had the appearance of a vacant room. Upon entering Resident #91's room there was one 5 by 7 inch family photo on the table located in front of the window. The curtains were pulled open and the end of the curtain obscured seventy-five percent of the family photo. All the walls in the room were bare with numerous nail holes and unpainted plaster repairs in the drywall. The only furniture in the room was the table located under the</p>	F000252	F 252	06/13/2013			
			<p>This facility ensures a comfortable and homelike environment for residents by personalizing their rooms with familiar things from home.</p> <p>1. Resident #91 room was provided visual stimuli with pictures from the facility. The family, who is very supportive, was encouraged to bring familiar things of their choice from home to personalize the room. Maintenance had been preparing the walls with plaster to fill nail holes and marring in the walls, during survey, so that the room could be painted.</p> <p>2. All residents have the potential to be affected. Any other residents will be identified by housewide rounds conducted by administrative staff. Any concerns will be addressed and family contact will be made by Social Services. Those residents without family support will be provided with visual stimuli for a homelike environment by the facility. All maintenance needs identified will be processed to the maintenance department via</p>				

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	<p>window. The resident's mattress was covered by a bedspread, and the mattress was located on the floor. Another unoccupied bed without sheets or a bedspread on the mattress was located across the room.</p> <p>The clinical record for Resident #91 was reviewed on 5/13/13 at 1:30 P.M. Resident # 91's diagnoses included, but were not limited to, the following: "... Alzheimer's dementia with behavior disturbances, behaviors with delirium, prostate cancer, stroke, psychosis with mood disorder."</p> <p>The care plan addressing cognitive loss for Resident #91 was reviewed on 5/13/13 at 1:30 P.M. The care plan was initiated on 12/11/13 and last updated on 4/9/13. The problems identified were as follows: "... BIMS score of 1 as of 4/4/13, [score less than 15 indicated cognition deficits] Alzheimer's dementia, dementia with behavioral disturbances."</p> <p>Interventions included, but were not limited to, the following: "...Provide special environmental stimuli and directional markers as indicated. Encourage family and friends to bring in familiar items from home..."</p>		<p>Maintenance Request for repair.</p> <p>3. The facility has initiated a Customer Service Program and delegated each resident room to a member of our department head team. Included in the program duties are to ensure the environment of their assigned rooms are comfortable and have a homelike atmosphere. Any concerns will be brought to the daily morning meeting for corrections and initiation of plan of action.</p> <p>4. Residents/families are encouraged to bring familiar items from home to provide each resident a comfortable and homelike environment upon admission, during care plan meeting and throughout their stay. The findings of environmental comfort and homelike settings conducted by the assigned department head will be reviewed during the facility's Quality Assurance meeting and the plan of action will be revised accordingly, if indicated.</p> <p>5. Date of Completion: June 13, 2013</p>				

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	<p>During an interview with SS #1 in Resident #91's room on 5/13/14 at 12:31 P.M., SS#1 indicated that Resident #91's family visited often and that Resident #91 was frequently seated at the nurses ' station or participating in activities. SS #1 indicated that Resident #91 was not in his room very much. After walking around the room and surveying the walls, SS#1 said, "It ' s not very homey."</p> <p>3.1-19(f)(5)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a fall care plan had been revised to provide interventions to prevent falls for 1 of 3 residents who meet the criteria for falls.</p> <p>Resident # 106</p> <p>Findings include:</p> <p>On 5/10/13 at 12:38 P.M., Resident #106's clinical record was reviewed. His current care plan (received on 5/10/13 at 3:30 P.M.) with an initiation date of 2/28/13, included the problem of the resident being at risk for falls</p>	F000280	F 280 This facility provides comprehensive care plans and revisions in care plans according to assessments of its residents. 1. The care plan for Resident #106 was revised to reflect the immediate interventions placed for falls after 04/18/13, 04/25/13 and 05/5/13. 2. All residents have the potential to be affected. All fall care plans were reviewed to ensure interventions placed after the falls were addressed on the care plan, as appropriate. The	06/13/2013			

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	<p>related to decreased mobility, history of falls, pain, use of cardiac and narcotic medicines, poor balance, unsteady gait, decline in functional status and recent malleolar fracture.</p> <p>The goal was to reduce risk factors in an attempt to avoid significant injury related to falls.</p> <p>Interventions included: provide adequate lighting, clutter free pathways, non-skid footwear, monitor frequently when call lights not available (for example the dining room or activities), fall risk assessment on admission, quarterly, and with any significant change, monitor vital signs, neurological checks when indicated, notify responsible party and physician if a fall has occurred, keep frequently used items in resident's reach, and therapy services as indicated.</p> <p>Another intervention listed indicated, " Implement intervention to reduce risk for falls: (list interventions and date initiated)."</p> <p>An intervention dated 3/14/13 at 6:00 P.M., indicated, "Re education on call light for assistance. Resident sleeps in recliner."</p> <p>Nursing notes dated 3/14/13 at 6:00 A.M., indicated, " Pt. (patient) rolled</p>		<p>CNA assignment sheets have been reviewed to ensure all fall interventions are current to each revision.</p> <p>3. Incident and Accident reports will be reviewed during the daily morning meeting. The review will include the appropriate intervention is implemented, and the care plan is revised. The CNA assignment sheet will be reviewed for any necessary updates relative to the revised care plan. Staff were inserviced 03/23/2013 for Fall Policy and Procedures.</p> <p>4. The Quality Assurance program will include a Fall Intervention Audit. The DON or her designee will review 2 residents to ensure all current fall interventions are in place, the care plan revised and remain appropriate daily on scheduled days of work for 4 weeks; 3 times a week for 4 weeks then weekly until compliance is maintained for 6 consecutive months. The findings will be reviewed during the facility's Quality Assurance meetings and the plan of action revised accordingly, if indicated.</p> <p>5. Date of Completion: June 13, 2013</p>		

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	<p>out of bed, abraised forehead..." "... Dr. called, incident filed, C.(care) plan updated. DON notified neuro ck's (neurochecks) cont. (continued). Pt. reaching for keys on the floor. Re-educated pt. to use call light for help."</p> <p>Nursing notes dated 4/18/13 at 3:40 P.M., indicated, " 0 (zero) nausea, pt. attempted to stand and pt stated, 'feet didn't slip just felt weak and weaker and didn't hit my head or anything.' ..."</p> <p>Another fall was documented in nursing notes of 4/25/13 at 2:00 P.M. The documentation indicated, " At 12 P.M. found res (resident) on floor in front of recliner which was in the up position. Res stated when he put the chair up the cushion began to slid et took res with it. No injuries..." "...Also order for gel cushion to w/c (wheelchair) chair (sic)..."</p> <p>Nursing notes dated 5/4/13 (no time) indicated, " Late entry: 9:30 P.M.. Resident found laying on the floor. Resident stated, ' I was getting up from my chair and lost my footing.' "...Pressure alarm placed in chair to alert when getting up. Redirected to use call light and ask staff for help. Will cont. to monitor."</p>			

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	<p>On 5/14/13 at 1:10 P.M., the DON was interviewed in regard to Resident #106's fall care plan. The DON was made aware of Resident #106's care plan lacking documentation of interventions initiated after the 4/18/13, 4/25/13, and 5/4/13 falls. She indicated the care plan needed to include interventions to prevent falls.</p> <p>3.1-35(d)(2)(B)</p>			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision, interventions and monitor devices to prevent falls and/or elopement for 3 of 3 residents reviewed for falls and 1 of 1 resident reviewed for elopement.</p> <p>Resident #49, Resident #106, Resident #86</p> <p>Findings include:</p> <p>1. On 5/13/13 at 10:45 A.M., Resident #49 was observed in the bathroom of her room. She was standing in front of the commode and was in the process of pulling up her depends. Her wheelchair was sitting in the doorway leading into the bathroom. Upon observing no one was assisting Resident #49, the call light was activated. Resident #49 turned and immediately sat down in her wheelchair. As Resident #49 descended into the wheelchair, the wheelchair started rolling backwards away from the resident. The brakes</p>	F000323	F 323 1. Resident #49: Has a history of removing and/or turning her alarms off or moving them. Her care plan and CNA assignment sheet has been revised to reflect her behavior and need for every shift monitoring to ensure interventions are placed appropriately. The resident has been reassessed to ensure interventions are appropriate to provide adequate supervision to prevent falls and/or elopement, as possible. Review of all interventions and proper placement have been provided by the DON. Staff have assessed resident's room to ensure items to remove her wanderguard are not in her possession. Nurses have been reeducated to monitor the presence of alarms and wanderguard during routine rounds, care per shift. Resident #86: The laser alarm was repositioned for staff access to efficiently use the alarm as intended. Anti-skid strips were placed on the bathroom floor as a fall intervention and the care plan revised. The resident has recently been moved from a	06/13/2013			

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	<p>on the wheelchair were not locked. The handle caught on the door frame and stopped the chair from rolling backwards away from the resident. Resident #49 narrowly missed sitting on the floor. As Resident #49 propelled herself out of the bathroom, her dycam was hanging over the left arm of the wheelchair and her pad alarm was hanging over the back of the wheelchair. No pressure reducing cushion was in her wheelchair. Resident #49's feet were bare and no non-skid socks were on her feet. The pad alarm was located in the seat of her recliner. No alarms had sounded.</p> <p>During an interview with CNA #6 on 5/13/12 at 10:50 A.M., CNA #6 indicated that Resident #49 was allowed to move about independently in her room. After checking her CNA assignment sheet, CNA #6 indicated no notes appeared on her CNA assignment sheet indicating Resident #49 was permitted to be up ad-lib. CNA #6 said she would check to see whether the ad-lib order had been changed. CNA #6 indicated she did not know why Resident #49's alarm did not go off. CNA # 6 said, "It should have sounded." CNA #6 turned the alarm box off and on and then placed the pad alarm in Resident #49's wheelchair seat under Resident</p>		<p>different room.</p> <p>Resident #106: A gel cushion was placed in recliner as assessed. The Care Plan and CNA assignment sheet were revised to reflect the alarm and gel cushion needed as interventions to prevent falls.</p> <p>2. All residents have the potential to be affected. All fall care plans were reviewed to ensure interventions implemented after the fall were revised on the care plan, as appropriate. The CNA assignment sheets have been reviewed to ensure all fall interventions are current to each revision.</p> <p>3. Incident and Accident reports will be reviewed every day during the morning meeting. The review will include the appropriate intervention is implemented, and the care plan is revised. The CNA assignment sheet will be reviewed for any updates to the care plan. Staff were inserviced 03/23/2013 for Fall Policy and Procedures.</p> <p>4. The Quality Assurance program will include a Fall Intervention Audit. The DON or her designee will review 2 residents to ensure all current fall interventions are in place, the care plan revised and remain appropriate daily on scheduled days of work for 4 weeks; 3 times a week for 4 weeks then weekly</p>		

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	<p>#49. CNA #6 then had Resident #49 stand, and the alarm sounded.</p> <p>CNA #6 was questioned regarding the wanderguard for Resident #49. CNA #6 indicated that there was an order for a wanderguard on Resident #49's assignment sheet. CNA #6 indicated she did not see a wanderguard on Resident #49 or on Resident #49's wheelchair. CNA #6 looked around the room and the floor but did not find the wandergaurd. CNA #6 put non-skid socks on Resident #49 and indicated she had not noticed whether Resident #49 had non-skid socks on earlier.</p> <p>During an interview with LPN #13 on 5/13/12 at 10:50 A.M., LPN #13 indicated she did not know whether Resident #49 had a wanderguard or not. LPN #13 indicated the wanderguard may have been discontinued by social services, but after checking the medication administration record she said, "Oh, I see we are checking it. It is marked checked but I haven't checked it yet." LPN #13 indicated that Resident #49 sometimes removed the wanderguard on her own.</p> <p>During an interview with Social Services (SS) #1 on 5/13/12 at 11:16</p>		<p>until compliance is maintained for 6 consecutive months. The findings will be reviewed during the facility's Quality Assurance meetings and the plan of action revised accordingly, if indicated.</p> <p>5. Date of Completion: June 13, 2013</p>		

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	<p>A.M., SS #1 indicated Resident #49 should be wearing a wanderguard. SS#1 indicated Resident #49 was going to have her wanderguard discontinued, but Resident #49 had started saying she wanted to go home again. Social Services staff assessed Resident #49 as an elopement risk and continued Resident 49's wanderguard order. SS #1 indicated she was not aware that Resident #49 was not wearing a wanderguard. SS #1 indicated the start date for the wanderguard order was 9/19/12.</p> <p>During an interview with LPN #13 at on 5/13/13 at 2:20 P.M., LPN #13 indicated she had placed a new wanderguard on Resident 49's left wrist. During observation no wanderguard was observed on Resident #49 on 5/13/13.</p> <p>Fall #1. Nurses progress notes dated 5/8/13 3:00 A.M., read as follows: "Resident sat down outside her room on a blanket. No injuries noted. She stated she did it because she wanted to."</p> <p>Fall #2. Nurses progress notes dated 5/8/13 at 10:45 A.M., read as follows: "Alerted by staff of resident sitting on the floor. Resident assessed and no</p>			

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	<p>injury noted....oxygen saturation 79% on room air. Moderate amount of loose stool noted on resident and floor. Resident is very confused and weak..."</p> <p>Fall #3. Nurses progress notes dated 5/8/13 at 7:00 P.M., read as follows: "Resident yelling for help. Staff immediately went to aid resident. Found resident on the floor in room 57. Resident was lying on her right side. Resident is confused, she states she was trying to "come up there," No injuries noted. Unknown whether resident fell in this position or curled up after falling. Resident had removed her socks and unplugged her safety alarm to recliner."</p> <p>The clinical record for Resident #49 was reviewed on 5/14/13 at 11:00 A.M. Diagnoses included, but were not limited to, the following: anxiety, depression, lung cancer, hypertension, gout, congestive heart failure, peripheral vascular disease. Review of the Elopement Risk Assessment Form completed on 5/1/13 read as follows: "...resident is a risk for elopement at this time. Interventions ...wanderguard." Physicians orders dated 1/29/13 were reviewed and the orders read as follows:</p>				

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	<p>"Wanderguard, check placement every shift." Physicians order dated 5/9/13 read as follows: "... up with assist of one. Discontinue up at lib. Pressure alarm to bed and chair to alert staff of patient attempting to get up unassisted." The last Minimum Data Set (MDS) assessment completed on 2/7/13 documented Resident #49 had moderate cognitive impairment as indicated by Brief Interview for Mental Status. (BIMS). MDS 2/7/13 documented that Resident #49 needed one person to physically assist with transfer from bed to chair or wheelchair. MDS 2/7/13 documented that Resident #49 need 1 person to physically assist with standing and walking.</p> <p>On 5/10/13 at 10:45 A.M., Resident #49's care plan for falls dated 12/11/12 was reviewed. The care plan for Resident #49 was last updated on 5/9/13. The care plan documented that Resident #49 had multiple risk factors for falls. Risks included, but were not limited to, the following: "...history of unsteady gait, diuretics, narcotics, pain, history of falls, antidepressant and antianxiety medication use, cancer and difficulty</p>			

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	<p>communicating needs." Interventions included, but were not limited to, the following: "... resident to utilize foot wear with non-skid soles, pressure alarm to mattress and chair, pressure alarm to wheelchair..."</p> <p>During an interview with Occupational Therapy (OT) in Resident #49's room on 5/10/13 at 10:55 A.M., OT indicated that, while looking at Resident #49's wheelchair, a pressure cushion should be placed with the dycam between the wheelchair seat and the cushion with an alarm on top of the cushion.</p> <p>During an interview with Physical Therapy (PT) on 5/14/13 at 2:00 P.M., PT indicated that Resident #49 had 3 falls on 5/8/13. PT indicated that Resident #49 should not to be up ad -lib, and, further, that Resident #49 should have the assistance of one person whenever Resident #4 was standing or transferring. PT also indicated that Resident #49 should have a wheelchair alarm, a bed alarm and an alarm in her recliner.</p> <p>2. The clinical record of Resident #86 was reviewed on 5/10/13 at 1 P.M. Diagnoses included, but were not limited to, the following: dementia and Parkinson's disease.</p>			

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	<p>A fall risk assessment dated 11/8/12 indicated the following: History of falls, weakness, use of assistive devices, confusion at times, unsteady gait at times due to Parkinson's.</p> <p>On 5/9/13 at 10:20 A.M. a copy of the current CNA assignment sheet was received from CNA #44. The form indicated the resident was to have a laser alarm to the bathroom.</p> <p>On 5/9/13 at 11 A.M. the resident was not in his room. The bathroom door was closed. When the door was opened and the area beneath the laser alarm was disrupted, no alarm sounded. The alarm did not function as it was intended.</p> <p>On 5/10/13 at 1:10 P.M., the DON was interviewed. She indicated the following for the resident: The resident had a fall in the bathroom on 3/21/13. She indicated at that time, non skid strips were placed in front of the toilet;</p> <p>4/6/13 was found on the floor by a CNA;</p> <p>4/9/13 was found on the floor in his room;</p>						

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	<p>and 4/18/13 was found on knees on the floor between the bed and wheelchair. The alarm was in place to his wheelchair and triggered.</p> <p>A doctor order dated 4/1/13 indicated a laser alarm was placed to the bathroom door. She indicated at that time, the laser alarm was to be on all the time, when the resident was not in the bathroom. The DON stated these were all his current interventions: up with assist, non skid strips in front of the toilet, bed and chair; dycem to wc, pressure alarm to bed and chair; laser alarm to the bathroom; non skid sox when not shoes on.</p> <p>On 5/10/13 at 2:45 P.M., the resident was observed in his room in bed. At that time, the resident's closed bathroom door was opened and an alarm sounded. CNA #44 came walking in the room to turn the alarm off. CNA #44 was not tall enough to reach the top of the door frame where the laser motion sensor was positioned. CNA #44 went over to the door of the room and said to another staff member in the hall, "Hey, I need someone tall, I'm not tall enough to turn the alarm off." CNA #45 came in and turned the alarm off over the door. At that time, there were no non skid strips observed on the floor in</p>			

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	<p>front of the toilet in the bathroom.</p> <p>On 5/13/13 at 12:25 P.M., the resident was observed in his room in bed. The door to the bathroom was closed and was then opened. An alarm box was noted above the door frame to the bathroom and no alarm sounded when the door was opened and someone passed through the door. At that time, CNA #44 was interviewed. She indicated she was working on this unit at that time. She indicated the resident was to have a laser alarm to the bathroom when he is not in the bathroom. At that time, she was asked her to see if the laser alarm over the bathroom door was on. She looked at it and stated "you know, it's not on now." She stated she needed to get a chair or something to use to be able to reach and turn on the laser alarm. The resident was in his room on his bed at that time. The CNA left the room to find a chair to stand on to turn the alarm on.</p> <p>On 5/14/13 at 11 A.M., the ADON toured the resident's room. At that time, there were no anti skid strips observed in front of the resident's toilet. The ADON indicated the resident had recently been moved to that room from a different room and</p>			
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	<p>the non skid strips wouldn't stick to that bathrooms floor surface. The ADON indicated they may need to revise the resident 's care plan to reflect the strips not sticking to his floor.</p> <p>3. On 5/10/13 at 12:38 P.M., Resident #106's clinical record was reviewed. He had been admitted to the facility on 2/17/13. Diagnoses included but were not limited to: diabetes mellitus, right bimalleolar ankle fracture, and hypertension. His Minimum Data Set Assessment dated 2/23/13, indicated cognition intact and extensive assistance of 1 person needed for transfers.</p> <p>His current care plan with an initiation date of 2/28/13, included the problem of the resident being at risk for falls related to decreased mobility, history of falls, pain, use of cardiac and narcotic medicines, poor balance, unsteady gait, decline in functional status and recent malleolar fracture.</p> <p>The goal was to reduce risk factors in an attempt to avoid significant injury related to falls.</p> <p>Interventions included: provide adequate lighting, clutter free pathways, non-skid footwear, monitor frequently when call lights not</p>			

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	<p>available (for example the dining room or activities), fall risk assessment on admission, quarterly, and with any significant change, monitor vital signs, neurological checks when indicated, notify responsible party and physician if a fall has occurred, keep frequently used items in resident's reach, and therapy services as indicated. Another intervention listed indicated, " Implement intervention to reduce risk for falls: (list interventions and date initiated)."</p> <p>" An intervention dated 3/14/13 at 6:00 P.M., indicated, "Re education on call light for assistance. Resident sleeps in recliner."</p> <p>On 5/10/13 at 2:15 P.M., evening CNA #15 was interviewed regarding Resident #106's care. She indicated Resident #106 had a pressure alarm on his recliner and if he gets in his wheelchair a pressure alarm was used there also. She indicated the resident sleeps in his recliner at present and not in his bed. Her CNA assignment sheet was reviewed at that time. The assignment sheet did not list any alarms for Resident #106.. Another resident listed on her assignment sheet did have the alarm listed.</p>				

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	<p>On 5/13/13 at 11:00 A.M., the Director of Nursing (DON) was interviewed regarding Resident #106's falls. Resident #106's clinical record was also reviewed at that time. The DON indicated on admission 2/17/13, Resident # 106 had been alert and oriented. She indicated over the past 2 months the resident had declined with some mental confusion noted. She indicated on admission the resident needed 1 person assist with non weight bearing of the right leg. She indicated falls were documented in the nursing progress notes and on a accident follow- up monitoring sheet.</p> <p>Nursing notes dated 3/14/13 at 6:00 A.M., indicated, " Pt. (patient) rolled out of bed, abraised forehead..." "... Dr. called, incident filed, C.(care) plan updated. DON notified neuro ck's (neurochecks) cont. (continued). Pt. reaching for keys on the floor. Re-educated pt. to use call light for help."</p> <p>Nursing notes dated 4/18/13 at 3:40 P.M., indicated, " 0 (zero) nausea, pt. attempted to stand and pt stated, 'feet didn't slip just felt weak and weaker and didn't hit my head or anything.' ..." The nursing note lacked</p>			
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	<p>documentation of an initiation of an intervention to prevent falls. The accident follow-up monitoring form dated 4/18/13 at 3:40 P.M., also lacked the initiation of an intervention to prevent further falls.</p> <p>The DON on interview 5/13/13 at 11:00 A.M., was made aware that documentation was lacking in the nursing notes, the follow-up accident monitoring, or the care plan of an intervention to prevent falls after the 4/18/13 fall. She indicated an extra skid strip had been added to the floor in front of his recliner.</p> <p>Another fall was documented in nursing notes of 4/25/13 at 2:00 P.M. The documentation indicated, " At 12 p.m. found res (resident) on floor in front of recliner which was in the up position. Res stated when he put the chair up the cushion began to slid et took res with it. No injuries..." "...Also order for gel cushion to w/c (wheelchair) chair (sic)..."</p> <p>Nursing notes dated 5/4/13 (no time) indicated, " Late entry: 9:30 P.M. Resident found laying on the floor. Resident stated, ' I was getting up from my chair and lost my footing.' "...Pressure alarm placed in chair to alert when getting up. Redirected to</p>			

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	<p>use call light and ask staff for help. Will cont. to monitor."</p> <p>On 5/13/13 at 12:35 P.M., Resident #106 was observed sitting in his room in his recliner. The resident was asked if he had a cushion in his chair besides the recliner cushion. He indicated he did not and raised the sheet covering his lap to provide a view of no gel cushion in his chair. A pressure alarm was observed in use on the recliner. Also his wheelchair was observed in his room with no gel cushion in place. Two skid strips were observed on the floor in front of his recliner and 3 skid strips were observed on the floor on the side of the bed.</p> <p>On 5/13/13 at 12:40 P.M., during interview with CNA #10 she indicated they don't use a gel cushion in his recliner. She indicated that a gel cushion was used in his wheelchair if he was in his wheelchair.</p> <p>On 5/14/13 at 10:15 A.M., Resident # 106 was observed sitting in his recliner. Pressure pad alarm intact in recliner. No gel cushion was observed in use in recliner. A gel cushion was observed in the wheelchair sitting in his room. CNA #10 indicated at that time that Resident # 106 did not have</p>			

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	<p>a gel cushion in his recliner at present because she was waiting for dycem to use with the gel cushion. CNA #10 provided a copy of her CNA assignment sheet at that time. Documentation was lacking for the use of a pressure alarm or gel cushion for the resident.</p> <p>On 5/14/13 at 1:10 P.M., the DON was interviewed in regard to Resident #106's falls. The DON was made aware of Resident #106 had been observed on 5/13/13 and 5/14/13, without a gel cushion in his recliner. She was also made aware of CNA assignment sheets lacking documentation of a gel cushion and pressure alarm to be used. She was also made aware of the lack of documentation of an intervention after the 4/18/13 fall and the care plan lacking documentation of interventions initiated after the 4/18/13, 4/25/13, and 5/4/13 falls. She indicated at that time Resident #106 should be using a gel cushion in his recliner and wheelchair. She also indicated the care plan and CNA assignment sheets needed to include safety devices and interventions to prevent falls.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure alternate interventions were attempted prior to as need administration of a hypnotic and/or a gradual dose reduction was considered and/or attempted per facility policy for 2 of 9 residents reviewed for psychoactive medications.</p> <p>Resident #57, Resident #87</p>	F000329	<p>F 329</p> <p>This facility provides alternate interventions and/or gradual dose reductions prior to as needed administration of hypnotic and/or psychoactive medications.</p> <ol style="list-style-type: none"> Gradual Dose Reductions were initiated for Residents #57 and #87. All residents with ordered psychoactive medications have the potential to be affected. An audit was completed on all 	06/13/2013

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	<p>Findings include:</p> <p>1. On 5/13/13 at 10 A.M., the clinical record of Resident #57 was reviewed. Diagnoses included but were not limited to, the following: insomnia, Parkinson, Dementia, behaviors, mental retardation, anxiety, psychosis, .</p> <p>A care plan, dated initially 11/16/12, indicated the following: "...requires use of a sedative/hypnotic medication: Ambien." Interventions included but were not limited to, the following: Administer medication as ordered;.. Attempt GDR (gradual dose reduction) per policy; ...Provide environmental sleep aids such as a quiet environment, soft music, massage..."</p> <p>On 5/13/13 at 9 A.M., the DON (Director of Nursing) was interviewed. She indicated the resident had been admitted to the facility from the behavior unit on 11/8/12. She indicated upon return to the facility the resident had the following order written "Ambien (sedative-hypnotic medication) 5mg po (by mouth) O/ (a zero with a hash mark through the zero symbol) prn (as needed) @ (at) hs (bedtime) for insomnia." The DON indicated she was not able to clarify</p>		<p>residents receiving psychoactive to ensure all GDR's were considered and/or attempted per facility policy. Additionally, those residents with PRN psychoactive medications were reviewed in an effort to identify further potential concerns with PRN administration lacking alternate interventions attempted prior to PRN administration. Corrective action/re-education was taken accordingly.</p> <p>3. A calendar has been initiated to ensure ongoing view of the GDR due dates for each applicable resident. Administrative nursing shall be responsible to review with the physician in an effort GDR's be considered and/or attempted as per facility policy. Licensed nurses shall be re-educated as to the need to attempt and document alternate interventions prior to PRN psychoactive medication administration.</p> <p>4. The GDR process and PRN psychoactive medication administration will be reviewed weekly in combination with the Behavior meeting. The Quality Assurance program will include a GDR Audit. Social Services will review 2 residents to ensure residents on hypnotic and/or antipsychotic medications receive timely GDR's for 4 weeks; 3 times a week for 4 weeks then weekly until compliance is</p>				

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	<p>the above hand written order, as the nurse who wrote the order was no longer employed at the facility. At that time, the form "Fax to {name of behavior unit}" was dated 11/14/12 and was reviewed. That form indicated the " recent medical changes " to include but was not limited to, the following: "...Ambien 5mg q hs prn."</p> <p>On 5/13/13 at 9:10 A.M., the November 2012 MAR (medication administration record) was reviewed. The form listed "Ambien 5 mg po prn @ hs for insomnia." That form indicated the resident had been administered on the following dates: 11/13 (two separate initials documented on this date); 11/15; 11/27 and 11/31. Nurses notes for the November 2012 were reviewed at that time and indicated the following on 11/13/12 at 2 A.M. "yelling cont {continued} - disturbing other res {residents} 1 Ambien po given..." Documentation was lacking in the clinical record of alternative interventions attempted prior to administration of the prn Ambien.</p> <p>The December 2012 MAR was also reviewed at that time and indicated the following: "Ambien 5mg...give 1 tablet by mouth at bedtime for</p>		<p>maintained for 6 consecutive months. Administrative nursing will review 2 residents daily (if applicable) who received PRN medication to ensure alternate interventions were attempted prior to administration for 4 weeks; 3 times a week for 4 weeks then weekly until compliance is maintained for 6 consecutive months. The findings will be reviewed during the facility's Quality Assurance meetings and the plan of action revised accordingly, if indicated.</p> <p>5. Date of Completion: June 13, 2013</p>		

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	<p>insomnia." That portion of the order was preprinted. The following directive was hand written: "and 1 pill 1 hr {hour} later if needed prn." Under the heading "hour" of the MAR was written "prn." Also under this heading, the "9 P.M." had been scratched out. Ambien was documented as administer on the following dates for December 2012: 12/1, 12/3, 12/5, 12/6, 12/9, 12/22-12/27.</p> <p>Documentation was lacking in the clinical record of alternated interventions attempted prior to medication with Ambien. The DON indicated at that time, she was unable to find a physician order for the hand written portion of the above order " and 1 pill 1 hr {hour} later if needed prn."</p> <p>The January, February, March, April and May 2013 MAR was also reviewed at that time. The form indicated the following: "Ambien 5mg...give 1 tablet by mouth at bedtime for insomnia." Under the heading "hour", 9 P.M. was listed. The medication was documented as administer routinely. These MAR indicated a start date of the medication of 11/8/12.</p>						

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	<p>On 5/13/13 at 3:12 P.M., the DON was interviewed. At that time, she provided the current facility Psychotropic drug log indicated that the current Ambien dose is 5mg every hs prn. On the form, the initiation date of the medication is 11/8/12. At that time, the DON the SSD (Social Service Director) reviewed the form and indicated the Ambien is actually administered routinely at hs and not prn. The SSD indicated when the resident returned to the facility on 11/8/12, the medication was to be prn.</p> <p>On 5/14/13 at 8:28 A.M., the ADON (Assistant Director of Nursing) provided a current copy of the facility policy and procedure for "Sedative/Hypnotic Drug Use Policy." The policy was dated 3/07. The purpose included but was not limited to, the following: "...Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to, medication. Gradual dose reductions will be attempted, unless clinically contraindicated, in an effort to discontinue these drugs...For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for</p>			

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	<p>duration of use, the facility will attempt to taper the medication quarterly unless clinically contraindicated. Clinically contraindicated means: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why an attempted dose reduction would likely impair the resident's function or cause psychiatric instability..."</p> <p>On 5/14/13 at 9:07 A.M., the DON was interviewed. At that time, she was made aware of the concerns with documentation and tracking of the resident ' s medication orders for Ambien. She indicated about 2 months ago, the facility instituted a tracking system. The DON indicated this new system includes, but is not limited to, staff initiating a form when they give a prn medication to determine if the medication was effective and also to document any alternate interventions that were attempted prior to the prn administration. The DON indicated the facility attempts GDRs quarterly, per policy, and the DON was made aware that documentation was lacking of an attempted GDR in the clinical record and /or pharmacy notes.</p>			

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	<p>On 5/14/13 at 1:14 P.M., the DON was interviewed. She indicated in January, February, March and April 2013 there were no pharmacy recommendations noted for changes related to a GDR attempt and/or denial for Ambien. At that time, the DON was made aware of the facility policy and procedure which indicated a GDR be addressed at least quarterly. No additional information was provided at this time.</p> <p>2. On 5/13/13 at 2 P.M., the clinical record of Resident # 87 was reviewed. Diagnosis included but was not limited to, the following: insomnia.</p> <p>A physician order dated 8/10/12 indicated the following: D/C (discontinue) Ambien 10mg q (every) hs (bedtime). Start Ambien 5 mg po (by mouth) q hs, insomnia."</p> <p>The current MAR for May 2013 documented the following: "Ambien 5 mg..give 1 tablet at bedtime." Documentation on the current MAR indicated the Ambien had been given nightly at 9 P.M.</p> <p>A "Note to the Attending Prescriber" dated 11/16/12, indicated the</p>			

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	<p>following: "...resident receives Ambien 5 mg q hs...started Aug {August} 2012, possible dose reduction: change to PRN..." The physician had checked the box indicating the following: "Disagree: cannot reduce dose because resident's symptoms have worsened in past attempts and so medically contraindicated to try a GDR."</p> <p>On 5/14/13 at 10 A.M., the DON was interviewed. She indicated she was unable to provide documentation of the resident having previous unsuccessful attempts at reduction of the Ambien. At that time, the Psychotropic Drug Log was reviewed. That form indicated the resident had Ambien started at 10 mg q hs on 12/15/11 and was reduced to 5 mg q hs on 8/10/12.</p> <p>On 5/14/13 at 2 P.M., the ADON provided documentation from the Corporate Nurse, which included but was not limited to, the following: "...direct copy from the Federal Interpretative Guidance of F329: Tapering considerations specific to sedatives/hypnotics: for as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for</p>			

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	<p>duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. Clinically contraindicated means: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder: or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. At that time, the ADON indicated the pharmacy had informed her "there were no manufacturer recommendations for duration of use in the elderly." The ADON indicated at that time, the pharmacy "feels this 5mg is the lowest dose."</p> <p>On 5/14/13 at 2:28 P.M. the ADON provided a copy of the following she</p>				

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	<p>received from the pharmacy: "Ambien." That information had the following address noted at the bottom of the page: mhtml:file://C:\Documents and Settings\Admin\Local Settings\Temporary..." That information included but was not limited to, the following information: "...Indications and Usages: Ambien is indicated for the short-term treatment of insomnia..."</p> <p>3.1-48(a)(6)</p>			
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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure practices to prevent food contamination and refrigeration temperature control, provide clean sanitized dinner and cookware, and adequate sanitizing solution during 3 of 3 kitchen tours. This had the potential to impact 75 residents.</p> <p>Findings include: On 5/6/13 at 10:30 A.M., during the first kitchen tour, the following observations were made:</p> <p>1. The hand wash sink area had a jagged caulk line across the back which had accumulated gray soil, dirt and food matter. The sink back splash wall was unsmooth with deteriorated surface painted over. The soap dispenser was caked with pasty brown/gray soap accumulated under the handle and soap finger touch dispenser handle.</p>	F000371	<p>F 371</p> <p>The facility procures food from sources approved by Federal, State or local authorities and stores, prepares, distributes and serves food under sanitary conditions. However, as noted by survey the facility will ensure this requirement is met through the following corrective measures.</p> <p>1. -The caulking around the hand sink was replaced. Both the sink, soap dispenser and the back splash were deep cleaned, sanitized and placed on a daily cleaning schedule. -The trash can was cleaned and sanitized. -Staff beverages were discarded and staff were reeducated regarding the prohibition of storing their items with facility food. -All interior and exterior surfaces on the appliances, doors, cupboards and counters were cleaned and sanitized. -Items (peanut butter tubs, cd player) on the food prep counter were cleaned.</p>	06/13/2013	

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	<p>2. There was a large trash barrel next to the sink which was coated on the outside with wet and dried food matter.</p> <p>3. In the refrigerator there were 3 opened bottles (2 water and 1 soda) which the Certified Dietary Manager (CDM) identified as belonging to staff. The bottles were not labeled or dated and 2 had fingerprints from food on the outside and were touching clean stored food containers inside the refrigerator. The refrigerator handles were visibly heavily soiled and tacky to the touch as were all handles and hand touch surfaces on appliances, doors, cupboards and edges of counters.</p> <p>4. On one side of the kitchen there was a 3 compartment sink for washing pots and pans. It had a food prep counter to the left which had 2 tubs of peanut butter. The exterior lids and exterior surfaces had accumulated peanut butter on them and unidentifiable food matter and crumbs imbedded in the peanut butter. There was also peanut butter and a layers of greasy matter lodged in the buttons of a boom box on the window sill above the counter. There was a heavy layer of greasy dust obscuring</p>		<p>-The wall was cleaned, resurfaced and repainted.</p> <p>-The ceiling was repaired.</p> <p>-The knives and utensil holder were cleaned and sanitized.</p> <p>-New spatulas were purchased. All affected utensils were cleaned and sanitized.</p> <p>-The garbage disposal was repaired during survey and is in good working order.</p> <p>-New thermometers were placed in the dual temperature unit.</p> <p>-The caddies, silverware and lids were cleaned and sanitized.</p> <p>-Table service, coffee mugs, glasses and dinner plates identified as dirty were not used and re-washed/dried.</p> <p>-New Coffee carafes were purchased.</p> <p>-The steam table and wells were cleaned. The dials were cleaned and are easy to read.</p> <p>-The CDM was re-educated on personal hygiene by the RD Consultant.</p> <p>-No identified dishes, glasses or plates were used. The items were re-washed.</p> <p>-All items were sanitized by running them through the dish machine. A representative from State Cleaning Solutions was contacted and made the necessary adjustments.</p> <p>-The utensils and wire whip were run through the dish machine. The rubber spatula was discarded.</p> <p>-The garbage disposal was repaired during survey.</p>		

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	<p>the mesh over the boom box speakers. The wall behind the 3 compartment sink was deteriorated with dried food matter adhering.</p> <p>5. The ceiling over the 3 compartment sink had a circular area of chipped and peeling bubbles, approximately 16 inches in diameter.</p> <p>6. There were 5 of 5 knives stored for use which had tacky handles and dried food on blades from prior use and the slots that held the blades also had food matter in them.</p> <p>7. On the clean side of the 3 compartment sink there was a tall plastic caddy of utensils drying for storage. Four of 4 utensils had food still lodged in crevices and all were standing in an inch of water in which food particles were floating. Two of 2 spatulas had torn, ripped and degraded rubber paddles.</p> <p>8. Beneath the 3 compartment sink there was a disposable rectangular aluminum pan on the floor. It had 2 inches depth of tan, thick, milky, and malodorous matter in the bottom which drained from the leaking garbage disposal.</p> <p>9. The beverage refrigerator</p>		<p>-The CDM was re-educated on proper handwashing techniques by the RD Consultant. -Both caddies were discarded. The grill bricks are now stored in the utility closet. -The bottle containing the sanitation solution was cleaned. Proper sanitizing procedures were reviewed with the employee. -The garbage disposal was placed on the preventative maintenance program to be serviced weekly.</p> <p>2. All residents have the potential to be affected. A dietary designee will be appointed by the CDM to complete the Daily Dietary Monitoring form to ensure corrective actions have been performed.</p> <p>3. An inservice was conducted immediately on 05/06/13 by the CDM to review kitchen sanitation, warewashing and dishwashing, proper labeling and dating of food, proper procedure if refrigerator/freezer is not functioning properly, equipment cleaning and sanitation, handwashing, proper use of sanitation buckets, proper use of 3 compartment sink and personal hygiene. The attendance sheet is listed as "Attachment A". Bi-monthly inservices will be conducted to review kitchen operations in an effort to ensure that food is stored, prepared and distributed</p>		

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	<p>thermometer read 56F (Fahrenheit degrees). The CDM indicated it was too warm and needed to be 40F or below. On the freezer side of the same unit, the CDM looked deeply into the freezer and indicated "...this one is OK it's zero"(the thermometer was observed to be broken). The thermometer was frozen over with food matter (which was no longer stored in the refrigerator) and food was lodged in the broken edge.</p> <p>10. There were 2 of 2 silverware caddy ' s covered with white plastic lids. The lids were medium gray colored with hand soil on the corners and edges where the lids were being touched during removal. There were 8 of 10 pieces of silverware removed from the caddys which had food dried on them.</p> <p>11. There was table service dinnerware stored as clean which was markedly wet with trapped water and had not been adequately air dried or cleaned of food debris and oil. They numbered 10 of 10 plastic glasses, 15 of 15 plastic coffee mugs, 5 of 5 dinner plates.</p> <p>12. There were 4 of 4 coffee carafes heavily stained with rough battered surfaces coated with tacky residue.</p>		<p>under sanitary conditions. All inservice materials and a monitoring sheet are listed as "Attachment B".</p> <p>4. A dietary designee will be assigned by the CDM for completing the audit sheet daily (Monday through Friday) for 4 weeks then twice daily for 4 weeks then weekly for 2 months then monthly ongoing to ensure compliance is maintained. The findings of the above audits will be reviewed during the facility's Quality Assurance meetings and the plan of action adjusted accordingly. Corrective action will be taken against dietary employees that fail to comply with the above practices.</p> <p>5. Date of Completion: June 13, 2013</p>				

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	<p>13. The steam table and food steamer units were heavily soiled with accumulated dirt, dust and oil which obscured markings on dials.</p> <p>14. Throughout the tour the CDM wore 4 rings, 3 of which were ornate and a bracelet to handle and touch items in the food preparation area.</p> <p>15. On 5/06/13 at 4:00 P.M., a second kitchen tour was made. The broken thermometer in the freezer had not been replaced. Upon request the CDM removed the thermometer to read it and indicated "I don't know what I was looking at before, I see now it's broken."</p> <p>There were dishes used at lunch and now on the line for supper use. There were 12 of 12 mugs and 12 of 12 glasses stored with trapped water inside and 6 of 6 dinner plates with food on them.</p> <p>16. On 5/10/13 at 10:30 A.M. a third tour began. The dietary aid (DA) #1 had been washing articles in the 3 compartment sink and dipping putting them in the sanitizing rinse solution. When asked to test the solution, it registered as having no chemical sanitizer. DA #1 indicated she</p>						

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	<p>believed the test tape should be held in the solution until it turned the desired color. The manufacturer's label on the test tape indicated read after 5 seconds. After remixing solution twice in an attempt to get the desired strength she was informed there was air in the chemical feed line which being used to deliver the chemical. She indicated there had been trouble with that before and would have to call the chemical supplier.</p> <p>17. She was then observed to dry utensils, which had been washed in that manner, with a rag. She intended to store them for reuse, including a shredded rubber spatula and a wire whip with food lodged in the wires.</p> <p>18. DA#1 was interviewed regarding the garbage disposal leaking. It had been repaired she thought since first observed. She indicated it happened "from time to time and then we collect it (the leaked garbage disposal water) for a week or so and then we dump it in the sink" gesturing to the first of the 3 compartment sink. She indicated the maintenance man fixes it when he can.</p> <p>19. The CDM was then observed to</p>			

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	<p>enter the kitchen, wearing her rings and wrist bracelet and wash her hands. She took paper towels, turned off the faucets and then used the paper towel to dry her hands.</p> <p>20. In the 3 compartment dish sink area there were 2 caddies stored which had plastic lids. One contained 2 unused clean grill bricks sprinkled with food and what appeared to be crushed taco chips. The other caddy had a rancid odor when the lid was removed and contained about an inch depth of blackened grease and food debris appearing to be bits of egg and meat. DA #2 was interviewed regarding the soiled grill brick storage and she indicated "Oh, that's the one we are using now and the others are stored for when this one gets bad."</p> <p>21. At the same time DA #2 was preparing desserts on a food preparation counter. She wiped the counter with a wet rag of soapy dish detergent. While the counter was wet, she lightly sprayed it with a solution of Quat sanitizer from a bottle with a trigger spray handle imbedded with hand soil and oily matter. That action diluted the strength of the sanitizing solution. She then directly wiped the sanitizing solution off with the same soapy dish detergent rag</p>			

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	<p>and left the counter to air dry.</p> <p>22. The maintenance director was interviewed on 5/10/13 at 10:45 A.M., regarding the garbage disposal leaking. He indicated he had fixed it the first day of survey but had known about it for a week. He indicated he gets to it as fast as he can. He attributed the problem to vibration of the garbage disposal during operation which loosens a nut which has to be tightened from time to time. He indicated there was no preventive maintenance plan in place whereby the nut was tightened periodically on a schedule.</p> <p>23. The CDM was interviewed on 5/10/13 at 1:20 P.M. regarding the concerns noted above. She indicated staff were not performing at her desired level and knew better and the kitchen had just been deep cleaned in April. She indicated she reviewed cleaning and temperature logs daily and provided them for review for the last quarter. All were complete.</p> <p>24. The 10/02/2008 Policy and Procedure for sanitizing worktables and counters directed counters be cleansed with sanitizing solution and air dried afterward.</p>			

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	<p>The 10/02/2008 Policy and procedure for personal hygiene of dietary employees referenced the hand washing policy which directed cleansed hands to be dried with paper towel which are then used to turn off the water faucets. It further directed prohibition of any hand or arm jewelry except a simple wedding band.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to properly label and store a multi-dose vial of intravenous medication</p>	F000431	F 431 The facility labels and stores multi-dose vials from the EDK kit. However, as noted by survey the	06/13/2013			

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	<p>obtained from the emergency drug kit on North 1 Hall.</p> <p>Findings include:</p> <p>During an inspection of the medication storage room located on North 1 Hall on 5/10/13 at 1:35 P.M., a vial of vancomycin HCL1gm that had been reconstituted was observed lying on its side on the bottom shelf in the refrigerator. Next to the vial, but not attached to it, was a post-it-note with the following hand written information: "Resident #34, 50 mg/ml 2.5 mg for 125 mg dose, vial good for 24 hours." There was no name inscribed on the vial itself or any label attached to the vial in which identified the resident to whom the medication belonged. Nor was any date inscribed on or attached to the vial to identify when the medication was used for the first time or the last time.</p> <p>Review of the physician's order dated 5/8/13 for Resident #34 read as follows: "... vancomycin 125 mg every 6 hours by mouth two times. May use IV powder/30 ml."</p> <p>During an interview with LPN #12 on 5/10/13 at 1:35 P.M., LPN #12 indicated that the vial of vancomycin had been taken from the Emergency</p>		<p>facility will ensure this requirement is met through the following corrective measures.</p> <ol style="list-style-type: none"> The one multi-dose identified during survey was discarded immediately. All residents have the potential to be affected. Multi-dose medication from the EDK kit will be provided a separate label that indicates: <ul style="list-style-type: none"> Medication Name; Resident Name; Date Opened & Time; Date Expired & Time. An inservice was held 03/23/2013 to educate nurses regarding the proper procedures for use/labeling of multi-dose medications from the EDK kit. The Quality Assurance program will include a Multi-Dose Proper Label and Storage Audit for medication used from the EDK kit. The DON or her designee will review 2 medication storage areas to ensure all proper labeling and storage procedures are in place daily on scheduled days of work for 4 weeks; 3 times a week for 4 weeks then weekly until compliance is maintained for 6 consecutive months. The findings will be reviewed during the facility's Quality Assurance 		

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	<p>Drug Kit (EDK) and that the vial of vancomycin should have been destroyed because more than 24 hours had passed from the time the vial was initially opened.</p> <p>Review of the facility ' s policy and procedure for the Emergency Drug Kit (EDK) provided by the DON did not include any instruction on how to label medication removed from the EDK.</p> <p>During an interview with the DON on 5/14/13 at 2:00 P.M., the DON indicated that the vial of vancomycin had been obtained from the EDK kit on the South hall when the nurse received the order from the physician. The DON indicated that the procedure for labeling a multi-dose vial from the EDK kit was to call the pharmacy and request a label for the medication as soon as the medication was removed from the kit.</p> <p>3.1-25(o)</p>		<p>meetings and the plan of action revised accordingly, if indicated.</p> <p>5. Date of Completion: June 13, 2013</p>				

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to</p>	F000441	F 441	06/13/2013			

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	<p>ensure infection control policies and procedures for isolation were maintained for 4 of 5 residents reviewed for isolation who resided on 3 of 5 units in the facility.</p> <p>Resident #111, Resident #106, Resident #113, Resident # 34, Resident #108</p> <p>B. Based on observation, interview and record review, staff failed to follow the facility 's policy and procedure for proper hand washing and sanitizing for 1 of 3 nurses observed during medication administration. The facility failed to distribute ice water to residents in a clean and sanitary manner when moving from one resident's room to another on 1 of 2 units observed for water pass.</p> <p>Resident #47, Resident #8, Resident #12</p> <p>Findings include:</p> <p>A. During initial tour of the facility on 5/6/13 at 10:45 A.M., the Rehabilitation unit was observed with the following noted: Resident #111 was observed in her room with the door open and a sign on both sides of the door frame which indicated to</p>		<p>The facility has policy and procedures to ensure infection control for isolation are maintained. The facility will ensure this requirement is met through the following corrective measures.</p> <p>1. Resident #111: Infection Control policies and procedures were maintained. Resident #106: Signs were placed on the door. The bedside cabinet was identified by room number for identification. Resident #113: Signs were placed on the door. The bedside cabinet was identified by room number for identification. Resident #34: Signs were placed on the door. The bedside cabinet was identified by room number for identification.</p> <p>Residents #47, #8 and #12 were not directly affected by practice observed during survey, however, staff were reinserviced on 05/23/13 regarding proper infection control practices during medication administration, distribution of ice water and water pass.</p> <p>2. All residents have the potential to be affected. The DON or her designee will observe all residents in isolation via Isolation Audit to ensure isolation precautions are in place. The DON or her designee will observe ice pass on one hall and 2</p>				

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	<p>"see the nurse." Resident #113 was observed in her room with a bedside cabinet in the hall to the left of her door. No sign was observed on the door and/or the cabinet and/or around it. Resident #106 was also observed in his room. There was a bedside cabinet across the hall with no identification on it. Resident #106's room was also without a sign on or around the door.</p> <p>On 5/6/13 at 11:20 A.M., the North units 1 and 2 were toured. RN #12 indicated Resident #108, who resided on North Unit 2, was in contact isolation for MRSA (methicillin resistant staphylococcus auerus) of a wound contained by a dressing. At that time, the resident's room was observed with a bedside cabinet, across the hall from the Resident's room, but there was no sign on the door or cabinet.</p> <p>On 5/9/13 at 9:30 A.M., the North Unit 1 was observed. Resident#34's room to her door was opened. There was no sign on her door and/or door frame and/or the bedside cabinet sitting outside her door. The door to the room was opened. Sitting on the cabinet beside her door in the hall, was a closed box of masks, with the package insert that said "face masks"</p>		<p>employees perform hand washing to ensure infection control is maintained during ice pass and proper technique is exhibited during hand washing. Any noncompliance noted will be immediately corrected and/or employee discipline as appropriate.</p> <p>3. An inservice was held for staff on 05/23/2013 that included policy and procedures for Water and Ice Passing and Fundamentals of Standard and Transmission Based Precautions. Instruction included placement of signage, identification of bedside cabinets and proper policy of hand washing during medication administration, ice and water passing.</p> <p>4. The Don or her designee will observe ice pass on one hall and 2 employees perform hand washing to ensure infection control is maintained during the ice pass and proper technique is exhibited during hand washing daily on scheduled days of work for 4 weeks; two times a week for four weeks; then monthly until compliance is maintained for 6 consecutive months. Additionally, administrative nursing shall be responsible to review new orders on scheduled days of work. Should isolation precautions be ordered, the resident shall be added to the administrative audit</p>				

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	<p>sitting on the top of the cabinet beside the box. A package of gloves was also observed on top of the cabinet.</p> <p>On 5/9/13 at 9:35 A.M. LPN #35 was interviewed. She indicated she was the nurse working on North Unit 1 today. LPN #35 indicated Resident #34 was on droplet and contact isolation for MRSA and c diff (clostridium difficile). LPN #35 indicated the resident came back day before yesterday from (name of hospital). LPN #35 reviewed the clinical record at that time and indicated the resident "may just be on contact isolation for c diff." At that time, she found an order dated 5/9/13, which indicated "contact isolation for c diff." LPN #35 indicated at that time, the night shift nurse had passed on to her the resident had MRSA but didn't give any more specifics. LPN #35 indicated she had seen the respiratory masks on the cabinet outside of Resident #34's room. At that time, CNA #42 was standing at the desk. At that time, CNA #42 indicated she thought the resident was on droplet precautions due to seeing the masks on the cabinet outside the room.</p> <p>On 5/9/13 at 10:05 A.M., RN #15, on North Unit 2, was interviewed. She</p>		<p>to confirm all necessary signage, etc., is in place and remains in place for the duration of the isolation. The findings of the above audits will be reviewed during the facility's Quality Assurance meetings and the plan of action revised accordingly, if warranted. Corrective action will be taken against employees that fail to comply with the above practices.</p> <p>5. Date of Completion: June 13, 2013</p>		

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	<p>indicated the only resident in her hall on isolation was Resident #108. She indicated this resident is on contact precautions. RN #15 was interviewed, she indicated the reason the cabinet with the isolation supplies was located across the hall from the Resident #108's room and not beside it was that the facility has to keep one side of the hall cleared for fire hazards.</p> <p>On 5/9/13 at 10:20 A.M., the CNA (certified nursing assistant) sheets were received from the LPN #25, CNA #43 and CNA #42 for the Rehab unit and North Unit 1 and 2. Documentation was lacking of Resident #113 currently being on isolation. Resident #106 was identified on the sheet as "isolation for C diff." Resident #111 was lacking documentation of being in droplet precautions. Documentation was lacking on the sheet of Resident #108 being in contact precautions and Resident #34 being in contact precautions.</p> <p>On 5/9/13 at 10:25 A.M., CNA #43 was interviewed. She was working on the Rehab unit at that time. She indicated she works the day shift and is made aware of which residents are in isolation from the night shift. She</p>			

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	<p>indicated if a resident starts isolation on the day shift, the nurse will tell her who is on isolation and what type of isolation. At that time, two of the three isolation residents on the hall did not have a sign by their doors, directing those entering the room to see the nurse. CNA #43 was knowledgeable as to what type of isolation each resident was on and which residents were on isolation.</p> <p>On 5/9/13 at 10:50 A.M. Housekeeper #20 was interviewed. She indicated she is made aware of residents that were on isolation by her the nurses telling her boss and her boss tells her. She doesn't know what type of isolation the residents on the Rehab unit are on but she is aware for Resident #106 and #113 to clean their rooms with bleach. She was also aware of what types of PPE (personal protective equipment) to wear for the various types of isolation.</p> <p>On 5/9/13 at 11:40 A.M., the Infection Control (IC) Nurse was interviewed. She indicated at that time, she is also the ADON (Assistant Director of Nursing). At that time, she indicated the following: Resident #111 was admitted to the facility on 4/23/13. She indicated that resident had a positive nasal swab at the hospital,</p>			

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	<p>was currently asymptomatic and was receiving treatment. The IC nurse indicated by physician order, the resident was going to be discontinued from the droplet isolation after completion of the antibiotic therapy and when she was afebrile for 2 days after completion of the antibiotic. The antibiotic was to be completed on 5/9/13.</p> <p>At that time, the IC nurse indicated both Resident #106 and Resident #113 were in contact isolation for C Diff. Those 3 residents resided on the Rehab unit.</p> <p>On the North Unit 2, the IC nurse indicated Resident #108 was currently on contact precautions for MRSA to a wound which was contained by a wound vac system.</p> <p>At that time, the Infection Control nurse indicated the following for Resident #34: the resident returned to the facility on 5/7/13 and was on contact precautions and droplet precautions. She indicated the physician indicated the resident had had nasal swab done at the hospital and these were positive for MRSA. The Infection Control Nurse indicated after speaking with the resident's physician today, the droplet</p>			

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	<p>precautions were discontinued but the resident did remain in contact precautions. She indicated staff was made aware of which residents were in isolation by the signs posted on or by the doors.</p> <p>At that time, the IC Nurse was made aware of the residents who were currently in isolation and did not have signs on their doors to alert staff and visitors of the isolation. She indicated they should have had signs on their doors and they would be put up immediately.</p> <p>On 5/14/13 at 1:30 P.M. the current, undated policy and procedure for "Fundamentals of standard (minimum) and transmission based precautions" was received from the ADON. This included but was not limited to the following: For contact and droplet precautions: "...Place instructions on the CNA assignment sheet; post notification sign as per facility policy..."</p> <p>B.1. During an observation of medication administration on the north 1 hall on 5/10/13 at 1:00 P.M., LPN #12 was observed preparing Resident #8's medication. LPN #12 took the medication to Resident #8's room, but Resident #8 was in physical</p>			

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	<p>therapy. LPN #12 proceeded to find Resident # 8 in the hallway located in the front of the building. LPN #12 noticed a resident was trying to exit the building in his wheelchair. LPN #12 took the handles of the resident's wheel chair and pulled him back into the lobby where she alerted a CNA that the resident wanted to leave. LPN #12 returned to the medication cart on north 1 hall and prepared medication for Resident #12 by placing the pills in a medication cup. LPN #12 then poured water into a small plastic cup. Without sanitizing or washing her hands, LPN #12 grasped the cup around the rim and took the medication and water to Resident #12.</p> <p>After returning from administering Resident #12's medications, LPN #12 prepared Resident #47's medication and water. As LPN #12 was walking down the hall to Resident #47's room, LPN #12 stopped and leaned down to talk with a resident sitting in a wheelchair in the hall. As LPN #12 was talking with the resident, LPN #12 grasped the resident's right arm with her right hand and continued the conversation. LPN #12 then proceeded to Resident #47's room and administered medication to Resident #47. After grasping the water cup around the rim, LPN #12</p>			

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	<p>gave the water to Resident #47 to drink.</p> <p>The facility's policy and procedure for medication administration was reviewed on 5/12/13 at 3:00 P.M. The policy and procedure stated that "...hands will be washed following administration..."</p> <p>During an interview with LPN #12 on 5/10/13 at 1:30 P.M., LPN #12 indicated that the facility's policy and procedure for proper medication administration would be to sanitize one's hands after administering each resident's medication. LPN #12 indicated that she did not sanitize her hands a few times between various residents' medication administration or after she had touched other residents' objects.</p> <p>B.2. On 5/6/13 at 11:45 A.M., QMA #1 was observed on the North unit. She entered the soiled utility room with the biohazard label on the door. There was a hamper of soiled linen standing next to, and touching an ice chest atop a push cart. There was an open plastic tub without a lid on the cart. It had 3 to 4 inches of water in the bottom and an ice scoop lying in the water with the handle partially</p>						

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	<p>submerged. The QMA used the ice scoop to get ice from the chest and fill a pitcher which she then put on the medication cart for med pass. The pitcher had a red lid. The handle had a groove which followed the length of the handle. At the top of the groove there was loose black soil. At the bottom of the groove there was loose black soil.</p> <p>On 5/08/13 at 10:44 A.M., on the North unit RN #1 was noted to be at the medication cart using the same pitcher with the loose black dirt in the handle that was noted on 5/6/13.</p> <p>On 5/09/13 at 9:46 A.M., on the North Unit the same soiled pitcher was on the medication cart and RN #1 indicated it was used for morning medication pass. She indicated there was a system of changing it out wherein nurses took the old one to the kitchen and got a new clean one from storage daily and as needed.</p> <p>On 5/09/13 at 9:50 A.M., CNA#5 was observed passing ice water on the North unit hall. The CNA went from one room to another with the same activity in the same way stopping only once mid hall near room 12 to use hand sanitizer.</p> <p>As the CNA went from room to room</p>			

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	<p>to pass ice water she also collected soiled glasses from rooms, handling them as she stacked then in long line. Each time she added a glass she contacted multiple soiled glass rims with her hands and relayed the stack horizontally on the cart next to the ice chest. Then she scooped ice holding the handle of the scoop which she stored atop the ice in the chest with the handle contacting the ice and prepared each pitcher as she went from resident to resident. The CNA was interviewed afterward and indicated she may have been taught not to put the scoop handle in the ice but was not aware she had combined a clean task and a dirty task. She indicated she thought using the sanitizer once would be adequate and she planned to do pass ice to the resident in isolation last and then bleach the handle of the scoop.</p> <p>3.1-18(b)(1)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to provide safe and/or sanitary showers, bathrooms, and nurses stations on 2 of 3 units. This involved 10 of 10 resident bathrooms, 2 of 3 shower rooms and 2 of 4 nurse ' s stations. Resident #91, Resident #49, Resident #53, Resident #102, Resident #81, Resident #67, Resident #80, Resident #8, Resident #3, Resident #62</p> <p>Findings include:</p> <p>South Unit: Observations occurred on 5/14/13 between 10:15 A.M. and 10:25 A.M.</p> <p>1. The main central shower room had heavy soil accumulation and loose debris on the floor. There was ceiling damage around a vent which was laden with dust and dust shreds were clinging to and hanging down from the ceiling. There was gouged, scarred and chipped wall finish damage and multiple prior screw and fixture holes on walls. The toilet had an ill fitting tank cover. There was no</p>	F000465	<p>F 465</p> <p>The facility has policy and procedures to provide safe and/or sanitary showers, bathrooms and nurses stations. The facility will ensure this requirement is met through the following corrective measures.</p> <p>1. -The floor of the Main Central Shower was cleaned and sanitized. -The ceiling damage was repaired and cleaned. -The walls were cleaned, resurfaced and repainted. -The toilet tank cover has been replaced to fit. -The toilet paper holder has been placed. -The room entry light switch has been cleaned. -The wall behind the liquid soap dispenser has been cleaned. -The door has been repainted. -The hand wash sink has been cleaned and sanitized. -The 2 black combs on the sink have been removed and discarded. -The counter top of the nurses station has been cleaned and sanitized. -The white cube refrigerator beneath the nurses station has</p>	06/13/2013			

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	<p>toilet paper holder. The room entry light switch had heavy hand soil. There was liquid hand soap drip lines accumulated on the wall beneath the dispenser. Door paint was scarred, marred and chipped. The hand wash sink bowl had accumulated soap scum and soil dried in the bottom such that a thumb nail scrapes thru it revealed white porcelain beneath. There were 2 black combs on the sink, behind the faucets. Each was laden with hair at least 2 different colors, dandruff scales and oil.</p> <p>2. The nurses ' station counter tops had chipped cracked veneer with missing pieces. The counter top was soiled with dried spatters, soil and loose debris.</p> <p>There was a white cube refrigerator on the floor beneath the nurses desk with a handle grip on top which had accumulated food and debris collected in its groove.</p> <p>The chart rack holder unit had soil, crumbs and debris accumulated beneath all the charts. Chart bindings were all visibly discolored with brownish gray hand soil creating a tacky, oily hand.</p> <p>There were 2 ceiling fans mounted above the desk area. The blades of both white fan blades were laden with sooty charcoal colored dust and dirt</p>		<p>been cleaned and sanitized.</p> <p>-The chart rack and chart bindings have been cleaned and sanitized and placed on a routine cleaning schedule by Medical Records.</p> <p>-The 2 ceiling fans mounted above the desk area were cleaned and added to the housekeeping cleaning schedule.</p> <p>-The nurses chairs at the desk have been replaced.</p> <p>-The alcove has been cleaned and sanitized. The wall has been resurfaced.</p> <p>-Resident #91: walls have been resurfaced/repared/painted</p> <p>-Resident #49: The window blind has been repaired. The mirror behind the sink has been cleaned.</p> <p>-Resident #53: The toilet caulking has been repaired, cleaned and sanitized. The toilet bowl has been cleaned and sanitized.</p> <p>-Resident #102: The wall damage has been repaired around the light switch. The light switch has been cleaned. The caulk around the toilet has been repaired and cleaned. The loose soil and debris has been cleaned. The floor tiles have been cleaned. The wall has been resurfaced and painted.</p> <p>-Resident #81: The wall has been resurfaced and painted behind the recliner. The bedside chair, 2 bedside cabinets have been replaced.</p> <p>The knobs on the white closet</p>		

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	<p>which was propelled in small clumps when fans were first turned on. The same character of dirt was clinging to the ceiling around the fans. Both chairs at the desk had dirty, torn and worn upholstery and the legs had accumulated dust and soil.</p> <p>3. The resident gathering area in front of the nurse ' s station had an alcove with a counter and coffee pot. The corner of the counter was torn away exposing raw wood. The cabinet was heavily soiled with accumulated dry food and loose dirt especially on doors and false drawer edges. The wall paper in the area was discolored, torn and had gaping edges exposing the wall beneath.</p> <p>4. Resident #91 had extensive wall damage from screw holes and mountings which had not been repaired. Large areas of the wall had jagged joint compound dried but unsmoothed which had soil accumulating atop the old unpainted repairs.</p> <p>5. Resident #49 had a room window blind which was falling off the wall on the right side. The mirror behind the sink was heavily soiled with spatters which had made clean vertical lines in the dust as they dripped down and</p>		<p>doors were cleaned and sanitized. Main Central Shower/North -The wall behind the body wash/shampoo was cleaned and sanitized. -The ceiling light was cleaned and sanitized. -The toilet bowl was cleaned and sanitized. -The floor was cleaned and sanitized. -The Nurse's Station was cleaned and resurfaced. -The chairs were replaced. -The caddy atop the desk was cleaned. -The gate style door was repaired. -Resident #67: The exhaust fan was repaired. The toilet caulking was repaired and cleaned. The metal closet doors were repaired. -Resident #80: The toilet caulking was repaired, cleaned and sanitized. -Resident #8: The tile was cleaned and sanitized. -Resident #3: The light switch was cleaned and sanitized. The walls and door frame were repaired. The toilet caulk was repaired, cleaned and sanitized. The bathroom floor was cleaned and sanitized. The toilet paper roll was repaired. -Resident #62: The area around the toilet has been cleaned and sanitized. The caulk has been repaired.</p> <p>2. All residents have the</p>		

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	<p>dried on the surface.</p> <p>6. Resident #53 had toilet caulking in the bathroom which was jagged and failed to seal the crevice. In the unsmooth surface the caulk had dried dark brownish/ yellow accumulation of soil which extended onto the floor surrounding the toilet. The toilet bowl had black stained scarring and marring which discolored the porcelain.</p> <p>7. Resident #102 had wall damage around the light switch on entry to the room. The damage extended down to the floor level. The light switch plate grooves were filled with hand soil. Toilet had been white caulk applied in clumping fashion which was dark brownish yellow where soil had adhered and dried. This soil had accumulated and was dry around the whole base of the toilet. There was loose soil and debris all around room edges especially behind the toilet. There were separated floor tiles around the toilet in which the same character of soil had accumulated. There was chipped and worn wall paint exposing prior paint colors.</p> <p>8. Resident #81 had gouges and scrapes where there was exposed plaster behind a recliner. The</p>		<p>potential to be affected. Thus, housewide rounds were completed to identify other similar concerns in need of repairs. The housekeeping supervisor will monitor areas of the resident rooms and shower room during daily routine rounds. Any areas of concern will be immediately corrected. Maintenance areas of concern will be corrected via Maintenance Request form for needed repairs.</p> <p>3. All housekeeping/laundry staff were inserviced 05/14/2013 regarding The 5-Step Patient Room Cleaning Procedure for proper cleaning method to sanitize a patient's room and other areas of the facility and The 7-Step Daily Washroom Cleaning for proper cleaning method to sanitize a washroom or bathroom.</p> <p>4. The Quality Assurance program will include a random Quality Inspection report with employee duties, involving random resident room inspections and monitoring/inspections of shower rooms and common areas conducted by the Housekeeping Supervisor daily on scheduled days of work for 4 weeks; two times a week for four weeks; then monthly until compliance is maintained for 6 consecutive months. The findings of the above audits will be reviewed during the facility's Quality</p>		

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	<p>bedside chair and 2 bedside cabinets had chipped, scarred and gouged surfaces exposing unstained wood. The white closet doors were medium gray with hand soil around knobs.</p> <p>North Unit: Observations occurred on 5/14/13 between 10:50 A. M. and 11:10 A.M. as follows:</p> <p>9. The main central shower room had accumulated streaks of dried body wash/ shampoo the length of the wall beneath the dispenser. The ceiling light fixture was deeply yellowed and had a thick coating of dead bugs in the bottom. The toilet bowl had black streaks following the pattern of water refill lines. The floor, throughout, was scattered with debris including shredded toilet paper and hand towels, paper clips, dust ball, hair, plastic bottle caps, pins and paper clips.</p> <p>10. The larger nurse's station had a wood veneer panels facing the hall and dining room. They were streaked with extensive horizontal scraping which exposed raw wood and soiled with dried spills and food matter which had accumulated during meal service. Inside the station the desk and countertop veneer was ripped and chipped exposing wood. The</p>		<p>Assurance meetings and the plan of action revised accordingly, as warranted. Corrective action will be taken against employees that fail to comply with the above practices.</p> <p>5. Date of Completion: June 13, 2013</p>		

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	<p>desk surfaces were uneven with gaps and level variances where they had been pieced together. In the seams there was accumulated dirt and debris and small office supplies. Both chairs were soiled with torn upholstery and wobbly legs. A two drawer plastic caddy atop the desk had accumulated dust and dirt on top. In the dirt there was hair, food crumbs, and one unwrapped sticky piece of hard candy. The gate style wooden door did not fit properly, was not functional. It could not swing freely with its uneven hinges. The lock mechanism had worn deep gouges and grooves in the side of a cabinet.</p> <p>11. Resident #67 bathroom had a marked rattling sound when the exhaust fan was turned on. The toilet caulking was jagged and was heavily soiled brownish/ yellow as was the floor surrounding the toilet. The metal closet doors were off their track and the doors were not functioning. There was a missing knob and the knob that was present had been bent out of alignment.</p> <p>12. Resident #80 had a dark yellow/brown soiled bathroom floor around the base of the toilet and lodged in the caulking. The floor was discolored gray in spots and was</p>			

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	<p>overall soiled especially in corners.</p> <p>13. Resident #8 had separated bathroom tiles around the toilet with brown matter in them and a musty odor was present.</p> <p>14. Resident #3 had a heavily hand soiled light switch. The walls and door and door frame were scarred and marred with exposed wood. The toilet caulk was heavily soiled and had a urine odor. The bathroom floor was sticky with drying pooled urine trapped between tiles. The toilet paper roll dispenser was broken.</p> <p>15. Resident #62 had a bathroom floor of 1 inch white tiles. Around the base of the toilet there was dark brown matter filling in grout lines. The matter was remaining after a dried pool of feces had been inadequately cleaned up. The 8 x 10 inch pool of dried feces had been observed on the floor and in the jagged caulk around the base of the toilet on 5/6, 5/ 8, 5/9, and 5/10/13 between 10:30 A.M. and 11:15 A.M. On 5/8/13 at 1:22 P.M. Housekeeper #1 was interviewed regarding cleaning bathrooms. He indicated there was not enough time to get all the floors in the bathrooms on North unit and so made sure to get the</p>			

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	<p>toilets and sinks at least. Review of worksheets on which he was keeping track of tasks he had finished documented the areas and floors as cleaned.</p> <p>On 5/10/13 at 1:20 P.M. the Housekeeping/Laundry supervisor was informed of the the feces on the bathroom floor of Resident 62. He indicated there was adequate staffing to clean the unit and provide daily thorough bathroom cleaning.</p> <p>On 5/14/13 at 12:15 P.M., the Administrator indicated there was a plan to paint rooms and hallways during the summer. There were no bids or contracts or invoices since the work was to be done by in house staff. After touring to see and/or see the above concerns the Administrator indicated those problems were known to her and was planning resolution this summer.</p> <p>3.1-19(f)</p>			

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