

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WEST MATADOR ST PERU, IN 46970
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, 12, 15 and 16, 2014</p> <p>Facility number: 003130 Provider number: 155702 AIM number: 200386750</p> <p>Survey team: Julie Wagoner, RN, TC Lora Swanson, RN Deb Kammeyer, RN (9/8, 9/9, 9/10, 9/15 and 9/16/2014)</p> <p>Census bed type: SNF: 3 SNF/NF: 59 Total: 62</p> <p>Census payor type: Medicare: 7 Medicaid: 48 Other: 7 Total: 62</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on September</p>	F000000	<p>The facility requests paper compliance for these citations. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</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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F000225 SS=D	<p>25, 2014, by Brenda Meredith, R.N.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>				

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interviews, the facility failed to ensure an allegation of abuse was immediately reported to the administrator for 1 of 4 allegations of abuse investigations reviewed. (Resident # 25)</p> <p>Finding includes:</p> <p>On 9/15/14 at 9:45 A.M., an investigation of alleged abuse was reviewed. The investigation indicated discharged Resident #25 had informed a facility licensed nurse, LPN #2, on 04/25/14, that a Hospice nurse, RN #3 was "mean" to him. LPN #2 did not report the allegation to the Administrator until 04/26/14.</p> <p>During an interview on 9/16/14 at 10:30 A.M., the Administrator indicated Resident #25 alleged the Hospice nurse was "mean" to him and told him "just do what we say and don't make any problems." The Administrator indicated the Hospice agency was immediately informed of the allegation. In addition, Hospice nurse, RN #3 was not allowed to</p>	F000225	<p>F225</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Resident #25 no longer resides in facility.</p> <p>2) How the facility identified other residents: All residents in the facility have the potential to be affected by this practice.</p> <p>1. Measures put into place/ System changes: All staff were in-serviced on the abuse policy.</p> <p>Each case of alleged abuse will be</p>	10/06/2014			

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	<p>care for any residents in the facility. Finally, LPN #2 was terminated for not following the facility abuse policy and procedure. There were no other Hospice contracted patients in contact with RN #3 so no other resident's could be interviewed regarding RN #3.</p> <p>Review of the facility policy and procedure, titled "Abuse, Neglect, and Misappropriation of Resident Property, dated 01/2012, indicated the following:</p> <p>"This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated [sic] and federal regulations. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.....8.</p> <p>The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with state law</p>		<p>audited by the Executive Director to ensure it was reported immediately.</p> <p>1. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>ED/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>		

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F000226 SS=D	<p>through established procedures...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility staff failed to implement the facility policy and procedure for abuse when an allegation of abuse was not timely reported to the administrator for 1 of 4 allegations of abuse investigations reviewed. (Residents # 25)</p> <p>Finding includes:</p> <p>On 9/15/14 at 9:45 A.M., an investigation of alleged abuse was reviewed. The investigation indicated discharged Resident #25 had informed a facility licensed nurse, LPN #2, on 04/25/14 that a Hospice nurse, RN #3 was "mean" to him. LPN #2 did not report the allegation to the Administrator until 04/26/14.</p> <p>During an interview on 9/16/14 at 10:30</p>	F000226	<p>F226</p> <p>The facility requestspaper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiencyexists. This plan of correction isprovided as evidence of the facility's desire to comply with the regulationsand to continue to provide quality care.</p> <p>1.Immediate actions taken for those residentsidentified: Resident #25 no longer resides infacility.</p> <p>2) How the facility identified other residents: All residents in the facility have the potential to beaffected</p>	10/06/2014	

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	<p>A.M., the Administrator indicated Resident #25 alleged the Hospice nurse was "mean" to him and told him "just do what we say and don't make any problems." The Administrator indicated the Hospice agency was immediately informed of the allegation. In addition, Hospice nurse, RN #3 was not allowed to care for any residents in the facility. Finally, LPN #2 was terminated for not following the facility abuse policy and procedure. There were no other Hospice contracted patients in contact with RN #3 so no other resident's could be interviewed regarding RN #3.</p> <p>Review of the facility policy and procedure, titled "Abuse, Neglect, and Misappropriation of Resident Property, dated 01/2012, indicated the following:</p> <p>"This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated [sic] and federal regulations. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals....</p>		<p>by this practice.</p> <p>1.Measures put into place/ System changes: All staffwere in-serviced on the Abuse policy.</p> <p>Eachcase of alleged abuse will be audited by the Executive Director to ensure itwas reported immediately.</p> <p>1.How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality AssuranceMeeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>ED/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>				

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F000242 SS=D	<p>...8. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with state law through established procedures...."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interviews, the facility failed to ensure bathing preferences were honored for 1 of 3 residents who met the criteria for choices. (Resident #3)</p> <p>Finding includes:</p> <p>During an interview with Resident #3, conducted on 09/09/14 at 2:00 P.M., she indicated she preferred a tub bath but her preference was not always honored. She indicated an administrative nursing staff member had informed her staff did not</p>	F000242	<p>F242</p> <p>The facility requestspaper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiencyexists. This plan of correction isprovided as evidence of the facility's desire to comply with the regulationsand to continue to provide quality care.</p> <p>1.Immediate actions taken for</p>	10/06/2014			

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	<p>always have the time to stay in the shower room with her while she took a bath. She indicated the staff member insinuated the resident liked to soak in the tub for "an hour." Resident #3 indicated she had timed her bath and it usually only took her a half of an hour to take a bath.</p> <p>During an interview on 09/11/14 at 9:00 A.M., LPN #5 indicated there was a whirlpool tub in the shower room and she knew Resident #3 did prefer a tub bath.</p> <p>The clinical record for Resident #3 was reviewed on 09/15/14 at 1:45 P.M. Resident #3 was admitted to the facility on 08/01/2006 with diagnosis, including but not limited to, history of neoplasm of the breast, lumbago, hyperlipidemia, generalized osteoarthritis, rheumatoid arthritis, chronic pain and osteoporosis.</p> <p>The annual MDS (Minimum Data Set) assessment for Resident #3, completed on 08/01/14, indicated it was very important for the resident to choose between a tub bath, shower, or bed bath.</p> <p>The current health care plans for Resident #3 indicated there was no plan to indicate the resident's preference for tub baths. There was a plan regarding the resident's refusal of scheduled showers due to her</p>		<p>those residents identified: Resident #3's care plan was updated to reflect her preference of a bath. Resident #3's CNA assignmentsheet was updated to reflect her desire for a bath.</p> <p>2) How the facility identified other residents: All residents have the potential to be affected by this practice. Residents will be interviewed regarding their bathing preferences. Their care plan and Kardex will be updated to reflect their preferences.</p> <p>1. Measures put into place/ System changes: An in-service was held to educate staff on honoring resident bathing choices. An audit will be done on 5 residents per week to ensure staff is honoring their bathing choices and results will be reviewed in clinical morning meeting.</p> <p>1. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p>		

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	<p>demanding alternate times and her behaviors regarding showering issues.</p> <p>During an interview on 09/15/14 at 9:25 A.M., CNA #6 indicated she knew Resident #3 preferred a tub bath but the resident also accepted a shower. She indicated she tried to take the time to give Resident #3 a tub bath, because she knew it was her preference, but she admitted she did not always have time to give Resident #3 a bath.</p> <p>During an interview on 09/15/14 at 9:35 A.M., the MDS coordinator, LPN #7. indicated information regarding resident preferences would be brought to an IDT (interdisciplinary team) meeting and those preferences care planned. She indicated although the Activity Director completed the pretences section of the MDS assessments, ultimately it was nursing's responsibility to initiate a care plan regarding bathing preferences. She confirmed she was aware of Resident #3's preference for tub baths. There was no explanation as to why the bathing preference for Resident #3 was not care planned or her preference consistently honored.</p> <p>3.1-3(u)(3)</p>		<p>DON/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>	

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the bladder function of 3 of 3 residents with a decline in bladder continency were accurately and/or thoroughly assessed.</p>	F000272	<p>F272</p> <p>The facility requests paper compliance for this citation.</p> <p>Preparation and/or execution of this</p>	10/06/2014

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	<p>(Resident #10, 11, and 33)</p> <p>Findings include:</p> <p>1. Resident #11 was observed, on 09/11/14 at 9:50 A.M., lying in her bed awake, reading on an electronic book device. Interview with the resident indicated she preferred to stay in bed most of the time. She indicated the staff had to use a Hoyer lift (mechanical lift) to transfer her out of bed but she "hates Hoyers." She indicated at another facility her leg was wounded by a Hoyer lift. She indicated when she needed to use the restroom, staff brought her a bed pan. She indicated they were very good about routinely bringing a bedpan when she needed one.</p> <p>The clinical record for Resident #11 was reviewed on 09/11/14 at 2:40 P.M. Resident #11 was admitted to the facility on 05/12/14 with diagnosis, including but not limited to, obstructive sleep apnea, chronic airway obstruction, depressive disorder, atrial fibrillation, morbid obesity, gout, anemia, hypertension, and cardiomegaly.</p> <p>The Admission Minimum Date Set (MDS), completed on 05/19/14, indicated the resident was alert and oriented with a BIMS score of 15/15 indicating</p>		<p>plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1.Immediate actions taken for those residents identified:</p> <p>Res #10 no longer resides in facility.</p> <p>Res #33 had a new bowel and bladder assessment.</p> <p>Res #11 had a new bowel and bladder assessment.</p> <p>1.How the facility identified other residents:</p> <p>All residents have the potential to be affected by this practice.</p> <p>2.Measures put into place/ System changes:</p> <p>MDS Coordinator will be responsible for the completion of bowel and bladder assessments.</p> <p>The bowel and bladder assessment format has been updated.</p>		

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	<p>cognitively intact, required extensive staff assistance for transfers, bed mobility, toileting dressing, and personal hygiene needs, and was always continent of her bladder.</p> <p>The most recent full MDS, completed on 07/09/14 due to a significant change in condition, indicated the resident the resident was alert and oriented and scored 15/15 on a Brief Interview Mental Status (BIMS), required extensive staff assistance for bed mobility, transfers, toilet use, and dressing and hygiene needs, and was occasionally incontinent of her bladder.</p> <p>The bowel and bladder evaluation and plan form, completed on 05/19/14, indicated the resident was totally dependent on staff for toileting assistance and was continent of urine.</p> <p>A review all of the assessments since 05/19/14, an indicated there were no other bladder evaluation assessments completed for Resident #11.</p> <p>During an interview on 09/11/14 at 9:30 A.M., CNA #8 indicated Resident #11 was very alert and oriented and was totally continent of her urine. She indicated a bed pan was utilized for Resident #11 at her request when she</p>		<p>Nursing staff will be in-serviced on their responsibility related to the bowel and bladder assessments.</p> <p>The Director of Nursing/Designee will audit the completed bowel and bladder assessments for accuracy.</p> <p>3. How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1</p> <p>The DON /designee will audit at least 3 bowel and bladder assessments per week to ensure accuracy."</p> <p>5) Date of compliance: 10/6/14</p>				

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	<p>needed to urinate or defecate. She indicated she had not noticed any incontinence for Resident #11 on her shift. RN #9, who was listening to CNA #8 confirmed Resident #11 was continent of her bladder.</p> <p>During an interview on 9/12/14 at 2:00 P.M., LPN #7, the MDS (minimum data set) nurse, indicated she only utilized the voiding diaries and/or the continence documentation completed by the certified nursing assistants when completing the MDS assessments. She indicated the staff nurses completed the bladder incontinence assessments. She indicated she did not know why there was a discrepancy between the bladder incontinence assessments and the bladder section of the MDS assessments. She indicated she thought the documented "occasional incontinence" was accurate for Resident #11 because the CNA documentation indicated some occasional incontinence.</p> <p>2. Resident #33 was observed, on 09/10/14 at 1:15 P.M., lying in her bed awake, working a cross word puzzle. Resident #33 indicated she did not get out of bed much at all. She indicated she was not toileted and did not use a bed pan. She indicated she just "used a towel" when she needed to use the</p>						

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	<p>bathroom.</p> <p>The clinical record for Resident #33 was reviewed on 09/10/14 at 1:20 P.M. Resident #33 was admitted to the facility on 05/30/14 with diagnosis, including but not limited to, recent acute respiratory failure, cardiomyopathy, dyspnea, morbid obesity, diabetes, history of arthritis, hypercholesterolemia, hypertension, hypothyroidism, atrial fibrillation, and cellulitis</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 06/06/14, indicated the resident was alert and oriented with a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitively intact, did not exhibit any behavior issues, required extensive staff assistance for bed mobility, was dependent upon staff for transfers, required extensive staff assistance for dressing, toilet use, and personal hygiene needs, and was occasionally incontinent of her bladder.</p> <p>An MDS assessment, completed on 07/24/14 due to a significant change, indicated the resident's condition had not changed except she had not been transferred out of bed and her bladder continency had declined and she was now frequently incontinent of her bladder.</p>						

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	<p>The initial bowel and bladder evaluation and plan of care assessment, completed on 06/07/14, indicated the resident was able to identify the need to void, had diabetes, received diuretic medications, had no mobility or environmental limitations, required total staff assistance for toileting needs, and was continent of urine and had urge bladder incontinence. There was no toileting plan recommended on the assessment form.</p> <p>A bowel and bladder evaluation and plan of care, completed on 07/23/14, indicated the resident was able to identify the need to void, had diabetes, received diuretic medications, had no mobility or environmental limitation, required assistance to transfer, required total staff assistance to toilet, was continent of her urine, and demonstrated urge bladder incontinence. The bladder elimination plan indicated the resident had cognitive impairment, was functionally disabled and needed an elimination plan to retrain the resident to their previous pattern/retraining.</p> <p>The initial care plan related to incontinence, initiated on 06/18/14, indicated the resident had occasional bladder incontinence, impaired mobility, and obesity. The goal was for the</p>			

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	<p>resident to be content at all times. The plan was for the resident to encourage fluids during the day to promote prompted voiding responses, the resident preferred to use a towel for toileting as this was her normal at home, and to monitor any signs and/or symptoms of a urinary tract infection. The care plan was not updated after 06/18/14.</p> <p>During an interview on 9/11/14 at 9:30 A.M., CNA #8 and RN #9 indicated Resident #33 was not able to be toileted on the toilet, on a bedside commode, or a bedpan because when her head was elevated or she was rolled to her back or other side, she passed out. CNA #8 indicated the resident was totally alert and oriented and aware of her need to void. CNA#8 indicated a towel was placed by staff and the resident would then urinate on the towel and was then cleaned up. She indicated occasionally the resident's bladder might be so full the towel would not hold all the urine but she was unaware the resident was incontinent of her urine. She indicated there had been no change in continency that she had noticed on her shift.</p> <p>During an interview on 9/12/14 at 11:00 A.M., MDS nurse, LPN #7, indicated it was unclear as to whether Resident #33 had an increase in incontinence or it was</p>				

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	<p>charted as incontinence due to her method of voiding. The MDS nurse, LPN #7, indicated the floor nurses were responsible for completing the bowel and bladder assessments. She did not know why they were completed with inaccuracies such as no mobility impairment, had sections related to incontinence history left blank, and did contradicted itself regarding the resident's continence status. She indicated a voiding pattern was done on all residents on admission and with significant change MDS but she could not access the 3 day patterning due to company change.</p> <p>A care plan to cover both incontinence with a toileting schedule and her preferred method of voiding were initiated because she wanted to cover both possibilities. It was unclear which care plan the CNAs were to follow. The MDS nurse, LPN #7 was not aware CNAs were not following the resident's care plan regarding timed voiding. She indicated she would have to check with the nurses who completed the assessment regarding the documentation. She indicated she utilized the 3 day patterning and the Kiosk plan of care documentation to complete her care plan but did not utilize the bladder incontinence assessments. Another care plan, initiated on 08/19/14 indicated a plan to toilet the</p>			

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	<p>resident 5 times a day with a bedpan before and after meals, upon rising, and at bedtime.</p> <p>3. On 9/16/14 at 11:40 A.M., a review of the clinical record for Resident #10 was conducted. The resident was admitted to the facility on 3/31/14 and deceased on 7/16/14. Diagnoses included, but were not limited to: congestive heart failure, muscle weakness, diabetes mellitus type II, hypertrophy prostate and depressive disorder.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 4/8/14, indicated urinary continence: always continent. The quarterly MDS assessment, dated 7/8/14, indicated urinary continence: occasionally incontinent.</p> <p>A bowel and bladder evaluation and plan form, completed on 4/12/14, indicated the resident was independent for toileting and was continent of urine.</p> <p>A bowel and bladder quarterly evaluation form, completed on 7/5/14, indicated the resident continues to be continent of bladder and bowel.</p> <p>During an interview on 9/16/14 at 12:30 P.M., the Director of Nursing (DON) indicated, the bowel and bladder assessment should match the MDS</p>						

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F000311 SS=D	<p>assessment. The DON further indicated a care plan should be initiated when a resident has a decline in urine continence and a care plan was not completed for this resident.</p> <p>On 9/16/14 at 12:45 P.M., review of the current policy titled "Bowel and Bladder: Incontinence Management" received from the Director of Nursing indicated "...Purpose: 2. To ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible...Protocol: 2. residents will have a bowel and bladder evaluation completed within 7 days of admission, annually, and with a significant change in bowel and bladder function..."</p> <p>3.1-31(c)(3)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, record review and interviews, the facility failed to ensure 1 of 2 residents reviewed for oral care needs in a sample of 17 were provided assistance to brush their teeth. (Resident</p>	F000311	<p>F311</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan</p>	10/06/2014	

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	<p>#8)</p> <p>Finding includes:</p> <p>During an interview with Resident #8, conducted on 09/09/14 at 11:22 A.M., the resident indicated she could brush her own teeth if she had supplies but she had not seen a toothbrush in months.</p> <p>Resident #8 was observed, on 09/11/14 at 8:53 A.M., lying in her bed, awake, reading a book. Interview with Resident #8, indicated she had not been offered a toothbrush yet this morning. She indicated she figured she had one (a toothbrush) "around here somewhere." She indicated she had been up in the dining room for breakfast but was having some edema in her legs and so she laid back down for awhile to help. No toothbrush or toothpaste were observed in her room or her bathroom.</p> <p>Resident #8 was noted in her room, dressed in her wheelchair on 09/12/14 at 10:00 A.M. The resident indicated she had just been given a shower by CNA #21 but she was not offered a tooth brush or toothpaste to brush her teeth. Resident #8's room searched for a toothbrush and/or toothpaste. The dresser drawers, closet, and bathroom were searched and there was no toothbrush and/or toothpaste</p>		<p>of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Resident #8 no longer resides in facility.</p> <p>2) How the facility identified other residents: All residents have the potential to be affected by this practice.</p> <p>1. Measures put into place/ System changes: Observation audit will be done on at least 5 random residents per week on varied shifts to ensure oral care is completed per policy.</p> <p>Nursing staff will be in-serviced regarding policy for oral care."</p> <p>1. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p>				

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	<p>noted.</p> <p>During an interview on 09/12/14 at 10:05 A.M., CNA #21 indicated she had given Resident #8 a shower this morning. She indicated the resident had brushed her teeth. When CNA #21 was asked to show the location of Resident #21's toothbrush and toothpaste, CNA #21 proceeded to look through the resident's dresser drawers and closet. CNA #21 could not locate a toothbrush or any toothpaste. CNA #21 then indicated perhaps the items had been left in the shower room. After searching the shower room, CNA #21 confirmed she could not locate either item for Resident #8.</p> <p>During an interview on 09/12/14 at 10:15 A.M., CNA #21 indicated she had just remembered she had "thrown" Resident #8's toothbrush away. She indicated she had located Resident #8's tube of toothpaste in her uniform pocket and had placed the toothpaste and a new toothbrush in Resident #8's room.</p> <p>Observation of Resident #8's room, on 09/12/14 at 10:20 A.M., indicated there was now a new toothbrush, still in plastic bag, in a plastic tub in the closet on the shelf. There was also a small tube of toothpaste in the tub. Resident #8, who was in the room, indicated CNA #21</p>		<p>DON/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>	

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F000312 SS=D	<p>had just placed the items in the plastic tub. Resident #8 indicated she had not been offered a toothbrush or toothpaste.</p> <p>The most recent MDS (Minimum Data Set) assessment, completed on 06/10/14, indicated Resident #8 required the extensive assistance of one staff for personal hygiene needs, which included brushing her teeth.</p> <p>The care plan for Resident #8 included a plan, initiated on 09/02/14, related to an ADL (activities of daily living) self care deficit related to impaired mobility. The goal of the plan was for the resident to maintain her current level of function in bed mobility, transfers, eating ,dressing, toileting, and personal hygiene needs. The interventions included encouraging the resident to participate to the fullest extent possible with each interaction.</p> <p>There were no instructions regarding oral care needs for hygiene needs for Resident #8 on the CNA assignment sheet.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the</p>				

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	<p>necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interviews, the facility failed to ensure oral care was provided for 1 of 2 resident's reviewed for activities of daily living (ADL's) who required staff assistance to complete oral care needs. (Resident #32)</p> <p>Finding includes:</p> <p>On 9/11/14 at 9:30 A.M., a review of Resident #32's record was conducted. Resident #32 was admitted to the facility on 2/5/13, with diagnoses, including but not limited to, diabetes mellitus type II, personality disorder, mood disorder, edema, anemia, depressive disorder, renal failure, insomnia and abnormal posture.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 6/24/14, indicated the resident required extensive assistance for personal hygiene and indicated the resident was alert and oriented and scored 15/15 on a BIMS (Brief Interview for Mental Status) indicating cognitively intact.</p> <p>During an interview on 9/11/14 at 9:30 A.M., Resident #32 indicated he does not wear dentures and he prefers not to have</p>	F000312	<p>F312 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Resident #32 was assessed for dental care with no negative findings. Resident #32 is dentureless. Oral swabs and mouthwash were provided to the resident and oral care was provided.</p> <p>2) How the facility identified other residents: All residents who require staff assistance have the potential to be affected by this practice.</p> <p>1. Measures put into place/ System changes: Observation audit will be done on at least 5 random residents per week on varied shifts to ensure oral care is completed per policy. Nursing staff will be in-serviced regarding policy for oral care.</p> <p>1. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly</p>	10/06/2014			

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	<p>them. He further indicated he can not perform his own oral care and would need the help of staff, but that staff do not offer him mouth swabs or mouthwash to rinse his mouth. The resident denied having a toothbrush, mouth swabs or mouthwash in his room.</p> <p>During an interview on 9/11/14 at 10:15 A.M., CNA #11 indicated the resident requires total assist with his ADL care. The CNA further indicated that she performs oral care for the resident twice a day on her shift using mouth swabs, and that all of the resident's personal care supplies are kept in his bedside cabinets. The CNA further indicated she had just performed ADL care for the resident.</p> <p>On 9/11/14 at 10:20 A.M., an observation was made of the resident's room including the bedside cabinets with CNA #11 present, no mouth care supplies were observed in any of the drawers. After observation of the bedside cabinets the CNA indicated that she obtains the mouth swabs from the supply closet every time she needs supplies for the resident.</p> <p>On 9/11/14 at 10:30 A.M., Resident #32 was observed sitting in his wheelchair in the dining room. The resident indicated the CNA did not offer to clean his mouth</p>		<p>x1 for a total of 6 months. DON/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>				

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	<p>or have him use mouthwash to rinse his mouth during his morning care.</p> <p>On 9/16/14 at 9:15 A.M., the resident was observed resting in bed. The resident indicated he had just finished eating his breakfast and staff had not assisted him with any oral care. No oral supplies were observed in the residents bedside cabinets or in the bathroom.</p> <p>The initial care plan, dated 10/15/12 with a revision date of 9/1/14, indicated the resident states his dentures do not fit properly and states that he has chewing/eating problems in regards to this but refuses to be seen by dentistry for denture concerns. The interventions include: will have adequate meal intake thru next review date, notify doctor as needed, resident will receive routine oral care. A care plan, dated 10/15/12 with a revision date of 11/14/12, indicated the resident has an ADL self care performance deficit related to limited mobility. The interventions included but were not limited to:" resident will maintain current level of function in (bed mobility, transfers, eating, dressing, toilet use and personal hygiene) through the next review date. Resident requires limited to extensive assistance with all aspects of ADL's."</p>				

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F000329 SS=D	<p>On 9/16/14 at 10:10 A.M., review of the current policy titled "Personal Hygiene" received from the Director of Nursing indicated "To ensure residents receive necessary care and assistance for personal hygiene tasks...1. Personal hygiene will be performed 2 times daily in the morning and before bed...4. Personal hygiene may include, but is not limited to: a. oral care...."</p> <p>3.1-38(a)(3)(C) 3.1-38(b)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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</p>						

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	<p>these drugs.</p> <p>Based on observation, record review and interviews, the facility failed to ensure there was adequate monitoring of medical symptoms for which antipsychotic medications were given for 1 of 5 residents reviewed for unnecessary medications. (Resident #102)</p> <p>Finding includes:</p> <p>Resident #102 observed, on 09/11/14 at 9:30 A.M., lying in his bed, low bed, in his room awake. The resident was polite and initiated a conversation.</p> <p>The clinical record for Resident #102 was reviewed on 09/11/14 at 10:30 A.M. Resident #102 was admitted to the facility on 08/19/14 with diagnosis, including but not limited to, urinary tract infections, atrial fibrillation, psoriasis, hepatitis, clostridium difficile, dementia with behavioral disturbances, history of bladder cancer, debility, hypertension, diarrhea, hypothyroidism, history of schizophrenia, vitamin D deficiency, and congestive heart failure.</p> <p>The current medication orders for Resident #102 included the antipsychotic medications, Ziprasidone (Geodon) 20 mgs (milligrams) two capsules twice a day for "antipsychotic" and Abilify 15 mg</p>	F000329	<p>F329</p> <p>The facility request paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Resident #102's care plan and Kardex were updated to reflect targeted behavior symptoms and interventions.</p> <p>2) How the facility identified other residents: Care plan and Kardex for all residents receiving antipsychotic medications will be reviewed and updated to include targeted behavior symptoms and interventions.</p> <p>1. Measures put into place/ System changes: Nursing staff will be in-serviced regarding Behavior Management Program, monitoring, reporting and</p>	10/06/2014	

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	<p>two tablets at bedtime for "behavior disorders." The resident also received the antidepressant medication, Remeron 15 mg once a day at bedtime for "behaviors."</p> <p>During an interview on 9/15/14 at 1:35 P.M., the Administrator indicated behaviors were discussed at the morning meetings and at the pharmacy review meetings.</p> <p>During an interview on 09/11/14 at 10:00 A.M., the SSD (Social Service Director), Employee #22, provided copies of the Interdisciplinary Psychopharmacological Review form for Resident #102, dated 09/09/14, which indicated the resident was receiving Abilify and Remeron for "schizophrenia - yelling, screaming, agitation, hallucinations, and delusions." The SSD, employee #22, also indicated the nursing assistants documented behaviors in the KIOSK electronic documentation system and were to report any behaviors to the licensed nurse. The licensed nurse was then to document the behaviors in the electronic charting system.</p> <p>The care plans, dated 8/20/14, regarding behavior monitoring for Resident #102 included the following plans: "[Resident's first name] has diagnosis of</p>		<p>documenting behaviors, and location of resident specific behavior symptoms and interventions on the careplan and kardex.</p> <p>Audit of behavior documentation will be completed on at least 5 residents receiving antipsychotic medication per week to ensure compliance.</p> <p>SS Director/Designee will be responsible for oversight of these audits</p> <p>1. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>Social Service Designee/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>				

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	behavior disorders and is a new admit to facility. He may exhibit adjustment issues to admission. [Resident's first name] has delusions that staff is trying to kill him or playing with his genitals. He is very verbally abusive towards staff including cursing, name calling, aggressively resistant to care, and at times has outburst [sic] in public settings." Interventions to the plan included: "[Resident's first name] needs the opportunity to communicate feelings regarding NH [nursing home] placement, encourage him to participate in conversation with staff, other residents daily, encourage ongoing family involvement. Invite [Resident's first name]'s family to attend special events, activities, meals, resident requested that his bed be placed next to wall so he could look out window, medications as ordered, psych services as necessary, explain care to resident, cease interaction as necessary and enter room in pairs when providing him with ADL [Activity of Daily Living] care, medications as ordered." There was also a plan addressing the resident's need for an antidepressant medication. The interventions to the plan included: "give antidepressant medications ordered by physician, monitor/document side effects and effectiveness, monitor/document/report to MD [Medical Doctor] prn [as needed]				

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	<p>ongoing s/sx [signs and/or symptoms] of depression unaltered by antidepressant meds such as[listed general potential signs and symptoms of depression]."</p> <p>During an interview on 09/16/14 at 10:30 A.M., CNA #8 indicated she was to monitor Resident #102 for Cussing and Hitting/Violent behaviors. She indicated there were no other behaviors she was to monitor Resident #102 for. CNA #8 indicated when the resident is cussing she would request that he calm down and she asked him what is bothering him, redirected him, and reported the behavior to the nurse. CNA #8 indicated in the KIOSK system she could look up on a "Kardex" information and instructions regarding behavior and mood issues for Resident #102. CNA #8 then pulled up Resident #102's instructions on the KIOSK system, which was available to the direct care nursing staff and there were no instructions on the Kardex for Resident #102. The Kardex only indicated "behaviors" and "mood" on the Kardex. The portion to document behaviors listed multiple general behavior issues resident's might exhibit but there was no specific instructions to monitor Resident #102 for delusional or hallucinatory behaviors. CNA #8 indicated she was not aware of the need to monitor Resident #8 for any delusional</p>			

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	<p>behaviors.</p> <p>During an interview on 09/16/14 at 10:35 A.M., QMA #23, indicated she had just met Resident#102 and she did not know his target behaviors and only had access to the Medication Administration Record so she could administer medications to Resident #102.</p> <p>During an interview on 09/15/14 at 1:29 P.M., LPN #24 indicated she did not know Resident #102's targeted behaviors. She indicated she knew from what she had heard that he exhibited intermittent confusion and would refuse care at times. LPN #24 then looked up Resident #102's electronic charting and indicated if the resident was refusing care or yelling at staff, they should explain care, leave the resident alone and reapproach, and get a nurse or another "new face" to reapproach. She indicated the only issue she had experienced with Resident #102 was when he was first admitted and she was working on the night shift he would often want to get up out of bed and when she informed him on the time using military time, he was able to be easily reoriented.</p> <p>During an interview on 09/15/14 at 1:55 P.M., RN #9 indicated she did not know what targeted behaviors she was to</p>				

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	<p>monitor for Resident #102. She indicated daily he was easily agitated and would curse at staff. She indicated he was verbally abusive and "cantankerous." She indicated it usually centered around care staff were attempting to complete when the resident desired to be left alone. The nurse indicated she would have to look in the electronic care plan to see what interventions staff should utilize if Resident #102 exhibited behaviors.</p> <p>During an interview on 09/15/14 at 1:40 P.M., the SSD indicated the Geodon medication did not "pull up" as a antipsychotic medication on the facility Interdisciplinary Psychopharmacological Review forms. She indicated she depended on nursing to "catch it." A pharmacy review for Resident #102, completed on 09/08/14 indicated diagnosis were requested for the use of both the Geodon and the Abilify medications. The SSD, employee #22 also indicated there was a behavior book on each nurse's station with care plans and behavior management plans. In addition, the psychiatric nurse practitioner reviewed Resident #102, on 09/08/14, and recommended a full psychiatric review, from the psychiatrist, to obtain records from any previous psych provider, and to continue to redirect behaviors as needed</p>						

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	<p>and document.</p> <p>LPN #25, on the South Unit, was interviewed on 9/15/14 at 2:15 P.M., and LPN #26 on the north unit, was interviewed on 09/15/14 at 2:20 P.M. Neither nurse indicated they were aware of a Behavior Management binder or book on either unit. After searching each unit, there were 3 ring binders labeled behaviors. The books contained copies of all of the care plans for specific residents. The North unit behavior binder did contain copies of all of the care plans for Resident #102. There was also a page of general instruction for behavior documentation, missing items forms, and complaint/grievance forms in the binder.</p> <p>During the interview on 09/15/14 at 2:20 P.M., LPN #26 indicated she was not aware of a behavior book and was not sure what targeted behaviors for which Resident #102 was to be monitored. She indicated, after looking up the care plans in the computer ,he had verbally abusive behaviors and physically abusive behaviors to staff. She did not indicate any monitoring awareness of delusional behaviors. She indicated the resident was to be redirected when he was verbally or physically abusive. She did not indicate any other individualized interventions.</p>						

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F000364 SS=E	<p>During an interview on 09/15/14 at 2:00 P.M., the SSD indicated the Kardex for the CNAs had been wiped out and she needed to go back in and add the interventions for behaviors for Resident #102. She also indicated there was no where on the electronic Kiosk system for the CNAs to add the targeted behaviors, just the behavioral interventions. There was no facility system to ensure direct care staff and licensed nursing staff were aware of the targeted medical symptoms to ensure adequate monitoring for the use of the antipsychotic medication received by Resident #102.</p> <p>3.1-48(a)(3)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to serve food at the proper temperature at point of service. This had the potential to affect 23 of 23 residents who received meals in the West dining room out of the total census of 62.</p>	F000364	<p>F364</p> <p>The facility request paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of</p>	10/06/2014

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	<p>Findings include:</p> <p>On 9/9/14 at 10:45 A.M., an interview with Resident #32 indicated sometimes his food was cold. He further indicated he ate his breakfast meal in his room and his lunch and dinner meal in the West dining room.</p> <p>On 9/9/14 at 10:50 A.M., an interview with Resident #64 indicated she ate her meals in the West dining room and a lot of the time, her meals were cold. She further indicated a couple of days ago the food was very cold but she was hungry so she ate it anyway.</p> <p>On 9/11/14 at 11:30 A.M., an observation of the cook obtaining food temperatures from the main steam table in the kitchen indicated the following temperatures: Swiss steak 170 degrees, carrots 166 degrees and browned potatoes 150 degrees. The food for the West hall dining room was then loaded into an insulated cart and taken to the hallway. The food service was scheduled to start at 11:30 A.M. in the West dining room. The Dietary Aide, serving the food from the steam table, was not observed to assess the food temperatures prior to meal service. At 11:55 A.M., the food was served to Resident #64. The temperature of the Swiss steak was 110 degrees</p>		<p>correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Food provided to the residents on west hall was replaced with food at proper temperature or was reheated to bring food to the proper temperature.</p> <p>2) How the facility identified other residents: All the residents on the West Hall had the potential to be affected by this practice.</p> <p>1. Measures put into place/ System changes: Dietary staff will be in-serviced to ensure food is at the proper serving temperature on the West Hall Dining Room.</p> <p>An audit on meal trays will be done on 3 random trays 5 times per week at varied times and results will be reviewed at the weekly nutritional at risk meeting.</p> <p>Food not meeting the required temperature will be replaced for the resident.</p>				

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	<p>Fahrenheit (F), the carrots were 110 degrees and the browned potatoes were 100 degrees (F).</p> <p>On 9/11/14 at 12:00 P.M., an interview with Resident #64 indicated the carrots and potatoes were cold.</p> <p>On 9/11/14 at 12:05 P.M. an interview with Employee #10 indicated the food was prepared in the main kitchen and placed into metal pans. The food was then loaded into an insulated cart and taken to the West hall dining room. When the food arrived, the metal pans were then placed into a steam table. The individual portions were then served from the steam table.</p> <p>On 9/11/14 at 2:00 P.M., review of the current policy titled "Tray Service for Rooms or Remote Dining Rooms" received from the Dietary Manager indicated "...Trays will be assembled in the central kitchen and transported to unit dining rooms or halls...2. Temperatures are taken of all foods prior to the start of meal service...c. The cook portions hot food items onto a warm plate or insulated bowl. Hot pellets or other heat-holding devices shall be placed under the plate...."</p> <p>3.1-21(a)(2)</p>		<p>1.How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>Dietary Manager/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and</p>	F000441	F441	10/06/2014			

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	<p>interview, the facility failed to ensure the urine catheter bag for urine collection for 1 of 2 residents was off the floor. (Resident #102)</p> <p>Finding includes:</p> <p>On 9/8/14 at 2:54 P.M., Resident #102 was observed in bed. The bed was in the low position. The resident's urinary catheter bag was lying on the floor.</p> <p>On 09/11/14 at 9:30 A.M., Resident #102 was observed lying in his bed. The bed was in a low position and the bottom of the catheter collection bag was touching the floor.</p> <p>On 9/16/14 at 10:03 A.M., Resident #102 was observed in his bed with his indwelling urinary catheter bag lying on the floor.</p> <p>On 9/16/14 at 10:30 A.M., a review of the clinical record for Resident #102 was conducted. The record indicated the resident was admitted to the facility on 08/19/14. The resident's diagnoses included, but were not limited to: urinary tract infections, atrial fibrillation, hepatitis, clostridium difficile, history recent surgery for bladder cancer, diarrhea, and congestive heart failure.</p>		<p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1. Immediate actions taken for those residents identified: Resident #102 had his catheter bag placed in an external privacy bag.</p> <p>2) How the facility identified other residents: All residents with catheters have the potential to be affected by this practice.</p> <p>1. Measures put into place/ System changes: Nursing staff will be in-serviced on the need to have the catheter bag remain off the floor.</p> <p>An audit will be done on residents with catheters 3 times a week at varied times and results will be reviewed in clinical morning meeting.</p> <p>1. How the corrective</p>				

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	<p>During an interview on 9/16/14 at 10:55 A.M., RN #1 indicated Resident #102's urinary catheter collection bag should not be lying on the floor and folded over. The RN was observed trying to get the resident's urinary catheter bag off of the floor but indicated she could not get it off the floor due to the bed being in a low position. RN #1 was observed raising the bed slightly to unfold the urinary catheter bag, however she did not get the entire bag off of the floor.</p> <p>During an interview on 9/16/14 at 11:29 A.M., the Director of Nursing indicated she was unable to locate a policy regarding urinary catheter tubing and/or bag positioning to prevent infection and or contamination.</p> <p>3.1-18(b)(2)</p>		<p>actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>DON/Designee will be responsible for oversight of these audits.</p> <p>5) Date of compliance: 10/6/2014</p>		