

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155689	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2015
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NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
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F 0000  Bldg. 00	<p>This visit was for the a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00176811.</p> <p>Complaint #IN00176811 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 19, 20, 21, 24, 25 and 26, 2015</p> <p>Facility number: 000091 Provider number: 155689 Aim number: 100290080</p> <p>Census bed type: SNF: 14 SNF/NF: 156 Total: 170</p> <p>Census payor type: Medicare: 19 Medicaid: 114 Other: 37 Total: 170</p> <p>Sample: 12</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>Please accept this Plan of Correction as our facility's Credible Allegation of compliance for our Recertification and State Licensure Survey concluded on August 26, 2015. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law.</p> <p>Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised or implemented as part of this plan of correction.</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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F 0156 SS=C Bldg. 00	<p>16.2-3.1.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under</p>				

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	<p>Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the</p>			

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	<p>facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>A. Based on record review and interview, the facility failed to ensure 3 of 3 residents reviewed for discharge from Medicare services received notification in a timely manner. (Resident #140, #66, and #63)</p> <p>B. Based on interview, record review and observation, the facility failed to ensure the location of the survey book, ombudsman information, and complaint hotline information was accurate and displayed in a prominent location for residents and visitors. This deficiency had the potential to impact 170 of 170 residents and visitors.</p> <p>Findings include:</p> <p>A. On 8/24/15 at 3:22 p.m., the Social Service Director provided the "Notice of Medicare Non-Coverage" (ABN) forms for Resident #140, #66 and #63. These forms indicated the following:</p> <ol style="list-style-type: none"> <li>1. Resident #140's form was not signed or dated. The resident's therapy services ended on 6/29/15.</li> <li>2. Resident #66's form was signed and dated on 7/31/15. The resident's therapy</li> </ol>	F 0156	<p><b>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</b></p> <p>The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will provide the resident with the notice of the State developed under 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the residents stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility will inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged and the amount of charges for those services; and inform each resident when changes are made to the items</p>	09/25/2015

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	<p>services ended on 7/31/15.</p> <p>3. Resident #63's form was signed and dated on 6/8/15. The resident's therapy services ended on 6/8/15.</p> <p>During an interview, on 08/25/2015 at 2:44 P.M., the Social Service Director indicated he received the therapy notices on Wednesday of each week. A Medicare meeting was held every Thursday and if the resident was discharging, the "Notice of Medicare Non-Coverage" (ABN) letter was generated. The notice was signed by the resident. He indicated he was not aware the notices were to be signed at least 48 hours prior to the end of services.</p> <p>On 8/26/15 at 2:20 P.M., the Social Services Director indicated the facility did not have a policy on Advanced Beneficiary Notice (ABN).</p> <p>B. On 8/19/15 at 10:06 A.M., during an initial tour, a framed information board was observed in the hallway to the Dogwood unit, just outside the therapy room. To locate the framed information board, one had to enter the front entrance, pass a separate men and women's bathroom, the Executive Director's office, a hallway leading to 4 offices (Director of Nursing, Staff Development, and 2 Social Service's</p>		<p>and services specified in paragraphs 95)(i)(A0 and (B) of this section. The facility will inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility will furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924 (c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the</p>				

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	<p>Offices) and then, pass the Director of Social Service office. This hallway led to the Dogwood unit and was observed not to be readily visible to resident's and family members visiting the Cedar or Birch nursing units, which were located down the left and right hallways immediately after entering the facility's front entrance. This framed information board contained a sign indicating the survey results were located in the front lobby in a white binder. An unlabeled brown/maroon colored binder was observed in the front lobby with the past survey results.</p> <p>On 8/24/15 at 9:00 A.M., during the Resident Counsel Interview, Resident #56 indicated she was unaware of where the information was for the survey book, the ombudsman and the complaint number. Resident resided on Dogwood hall. The resident's quarterly MDS (Minimum Data Set) assessment, dated 6/2/15, was reviewed at this time. The assessment indicated Resident #56 had a Brief Interview for Mental Status (BIMS) score of 15 with a score of 8 to 15 as interviewable.</p> <p>On 8/24/15 at 10:26 A.M., during a family interview Resident #61's spouse indicated she was unaware of where the information was for the survey book, the</p>		<p>protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility and non-compliance with the advance directive requirements. The facility will inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility will prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p><b>Corrective Actions:</b> A. Resident #140, #66 and #63 received notification of discharge from Medicare services. A new policy and procedure was developed to assure residents requiring Notice of Medicare Non-Coverage (ABN) notices are signed at least 48 hours prior to the end of services. B. Resident #56, Resident #61 spouse, Resident #203 son, Resident #169 husband, and Resident #72 were notified of the location of the survey book, ombudsman information, and complaint hotline information. The location of the</p>	

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	<p>ombudsman and the complaint number. Resident #61 resided on the Birch hall.</p> <p>On 8/24/15 at 10:29 A.M., during a family interview Resident #203's son indicated he was unaware of where the information was for the survey book, the ombudsman and the complaint number. Resident # 203 resided on the Birch hall.</p> <p>On 8/24/15 at 10:44 A.M., during a family interview Resident #169's husband indicated he was unaware of where the information was for the survey book, the ombudsman and the complaint number. Resident #169 resided on the Cedar hall.</p> <p>During an interview, on 08/25/2015 2:59 P.M., the Executive Director indicated he did not know how the family would know and suggested the Internet to look for the information. He also indicated he felt the information was prominently displayed.</p> <p>During an interview, on 08/25/15 at 4:24 P.M., the Receptionist indicated the survey book was located on the table in the front lobby and the information for the ombudsman and complaint hotline could be obtained from a nurses desk or Social Services.</p> <p>During an interview, on 8/26/15 at 2:21</p>		<p>survey book, ombudsman information, and complaint hotline information is accurately displayed in a prominent location for residents and visitors in the hallway leading to Dogwood. Additional prominent displays for the ombudsman information and complaint hotline information and where to locate the survey binder were added at the Birch, Dogwood, and front entrances. The survey book remains in a prominent location in the front lobby for residents and visitors. <b>How others identified:</b> A. All residents receiving Medicare benefits and requiring ABN notices have the potential to be affected. B. All residents and visitors have the potential to be affected by this alleged deficiency. <b>Preventative Measures:</b> A. To prevent this from reoccurring staff involved in the processing of ABN notices were educated on the new policy and procedure to assure residents receive timely notification. B. Residents and/or family members were notified on where to find the survey book, ombudsman information, and complaint hotline. Staff were educated on where to find the survey book, ombudsman information, and complaint hotline. In addition this information will be reviewed monthly during resident council meetings. It will be reviewed quarterly with residents and/or</p>				

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	<p>P.M., Resident #72 indicated she was unaware of where the survey book was located to review past survey reports. Resident #72 resided on the Birch hall. The resident's quarterly MDS assessment, dated 6/8/15, was reviewed at this time. The assessment indicated Resident #72 had a Brief Interview Mental Status (BIMS) score of 11 and was alert and oriented.</p> <p>During an interview, on 8/26/15 at 2:31 P.M., Resident #9 indicated she was unaware of where the ombudsman and complaint number were located. Resident #9 resided on the Cedar hall. The resident's quarterly MDS, dated 6/18/15, was reviewed at this time. The assessment indicated Resident #9 had a BIMS score of 9 and was alert and oriented.</p> <p>During an interview, on 8/26/15 at 2:35 P.M., the Admission Coordinator indicated the admission information packet did not include the location of the survey book, the complaint number or ombudsman information.</p> <p>During an interview, on 08/26/2015 at 3:30 P.M., the Maintenance Supervisor indicated the framed information board was 65 to 70 feet from the main entrance.</p>		<p>families during care conferences. <b>Monitoring:</b> A. The Director of Social Services/Designee will monitor ABN notices using an audit 5x weekly for 1 month, then 3x weekly for 2 months, then 2x weekly for 3 months. Results will be presented to QAPI for further need for monitoring. B. The Administrator/Designee will conduct an audit to survey residents and/or families and staff on where to find the survey book, ombudsman information and complaint hotline. This will be conducted 3x per week for 1 month, then 2x per week for 3 months, then 1x per week for 1 month. The results of these audits will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>				

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F 0160 SS=D Bldg. 00	<p>On 08/26/2015 at 3:55 P.M., the Director of Nursing (DON) indicated the survey sign in the framed information board was to be found in a white binder. In the lobby she indicated the survey reports were in a brown/maroon colored binder. She indicated she felt the information board was prominently displayed since the resident's received the information upon admission with numbers for ombudsman and state complaint line.</p> <p>On 8/25/14 at 3:00 P.M., a review of an admission packet indicated no written information was given to residents regarding ombudsman, complaint hotline number, or how to view past survey results.</p> <p>3.1-4(f)(3) 3.1-4(j)(3)(A) 3.1-4(j)(3)(B)</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on record review and interview,</p>	F 0160	<b>F 160 PERSONAL FUNDS</b> Within 30 days of death of a	09/25/2015

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F 0161 SS=E Bldg. 00	<p>the facility failed to ensure a resident's fund were conveyed timely upon death for 2 of 3 resident's fund accounts. (Resident #207 and #237). Finding includes: On 08/25/15 at 1:55 P.M., person funds accounts were reviewed with the Business Office Manager (BOM). The BOM indicated Resident #207's had a balance of \$30.00 remained in the resident's personal funds account. The resident had passed away on 4/14/15. The BOM indicated Resident #237's balance was \$833.00 in the resident's personal funds account. He had passed away on 4/20/15. During an interview, on 08/25/15 at 2:33 P.M., the BOM indicated she was new to the position and was unaware the money should be closed within 30 days. 3.1-6(h)</p> <p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Based on record review and interview,</p>			F 0161	<p>resident with a personal fund deposited with the facility, the facility will convey said and an accounting of those funds to the individual or probate jurisdiction administering the resident's estate. <b>Corrective Measures:</b> An audit was completed on all resident funds. Those that were for expired residents were conveyed to the appropriate parties. <b>How Others Identified:</b> All residents with funds held at the facility have the potential to be affected by this alleged deficient practice. <b>Preventive Measures:</b> The Executive Director/Designee will audit the account weekly to make sure that amounts are refunded within the 30 day timeline. <b>Monitoring:</b> The Executive Director/Designee will audit the account weekly for the next 6 months to make sure that amounts have been conveyed timely. Copies of those audits will be submitted to the QAPI for review. <b>Date of completion:</b> September 25, 2015.</p> <p><b>F 161 PERSONAL FUNDS</b> The facility will purchase a surety</p>		09/25/2015

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	<p>the facility failed to ensure the surety bond amount was sufficient to cover the daily balances of the resident's trust fund for 3 of 3 months reviewed. This deficient practice had the potential to impact 30 of 30 residents utilizing the resident's trust fund accounts. (May, June, and July 2015)</p> <p>Finding includes:</p> <p>On 08/25/15 at 3:33 P.M., a Surety Bond in the amount of \$50,000 was received from The Activities Assistant.</p> <p>On 08/25/15 at 4:03 P.M., the daily account balances for May, June, and July 2015, were received from the Business Office Manager. The Daily balances exceeding the \$50,000 were as follows:</p> <ol style="list-style-type: none"> <li>1. 05/01/15 daily balance of \$75,348.83</li> <li>2. 05/04/15 daily balance of \$75,148.83</li> <li>3. 06/03/15 daily balance of \$73, 645.82</li> <li>4. 07/02/15 daily balance of \$73,424.57</li> <li>5. 07/07/15 daily balance of \$73,397.12</li> <li>6. 07/08/15 daily balance of \$73,122.15</li> <li>7. 07/27/15 daily balance of \$71,887.28</li> <li>8. 07/30/15 daily balance of \$70,418.11</li> <li>9. 07/31/15 daily balance of \$73,639.44</li> </ol> <p>On 08/25/2015 at 4:27 P.M., the Business Office Manager (BOM) indicated the Surety bond was not enough to cover the</p>				<p>bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of resident deposited with the facility.</p> <p><b>Corrective Action:</b> We will increase the surety bond to cover \$100,000. <b>How Others Identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> We increased the surety bond to cover \$100,000. <b>Monitoring:</b> The Executive Director/Designee will audit the account twice monthly for the next six months to make sure the amount in the resident trust is not close to the threshold. Copies of those audits will be submitted to the QAPI for review. <b>Date of completion:</b> September 25, 2015.</p>		

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F 0241 SS=E Bldg. 00	<p>resident funds everyday. On 08/25/2015 at 4:49 P.M., the Executive Administrator indicated he was just made aware of the exceeding daily balances. He also indicated the BOM was responsible for the monitoring of the Surety Bond coverage. 3.1-6(i)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to maintain the dignity of the residents during dining observation by identifying their preference for wearing a cloth protector during 2 of 2 dining observations. (Resident #214, #29, #105, #61)</p> <p>Findings include:  During dining observation, on 8/19/2015 at 12:21 P.M., LPN #1 was observed to assist Resident #214 into the dining room and then, placed a clothing protector on without asking.</p>	F 0241	<p><b>F 241 DIGNITY AND RESPECT OF INDIVIDUALITY</b> The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <b>Corrective Action:</b> Resident #214, #29, #105, and #61 are asked if they want a clothing protector before assisting with donning. A new procedure was developed in relation to clothing protectors to optimize resident dignity during meals. <b>How</b> <b>Others Identified:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Preventative Measures:</b> Facility</p>	09/25/2015

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	<p>During dining observation, on 8/21/15 at 7:00 A.M., CNA (Certified Nursing Assistant) #2 was observed to place a clothing protector on Resident #29 without asking.</p> <p>During dining observation, on 8/21/15 at 7:40 A.M., CNA #3 was observed to place a clothing protector on Resident #105 without asking.</p> <p>During an interview, on 8/21/15 at 7:40 A.M., CNA #3 indicated they usually just place clothing protectors on and if residents do not want them, they will say something.</p> <p>During an interview, on 8/21/15 at 7:53 A.M., CNA #4 indicated they usually automatically place them on the residents.</p> <p>During an interview on 8/21/15 at 7:56 A.M., Resident #61 indicated before meals staff would place a clothing protector on him without asking first.</p> <p>During an interview, on 8/26/15 4:35 P.M., the Director of Nursing indicated she did not have a policy for dignity/placing clothing protectors.</p> <p>3.1-3(t)</p>		<p>staff wereeducated on the new procedure.</p> <p><b>Monitoring:</b> Residents will be observed during meals to assure this practice isfollowed. The D.O.N./Designee will be responsible for an audit conducted 5x weekly for the first month, 3 x weekly for 3 months, and 2x weekly for 2 months. Results of this audit will be presented to QAPI for need for further monitoring. <b>Date of Completion:</b> September 25, 2015.</p>	

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F 0272 SS=D Bldg. 00	<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 accurately and thoroughly assess bladder</p>	F 0272	<b>F 272 COMPREHENSIVE ASSESSMENTS</b> The facility will conduct initially and periodically a comprehensive, accurate,	09/25/2015

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	<p>incontinence for 1 of 3 residents reviewed for incontinence. (Resident #65)</p> <p>Finding includes:</p> <p>The clinical record for Resident #65 was reviewed on 08/24/2015 at 10:24 A.M. Resident #65 was admitted to the facility, on 06/22/15, with diagnoses, including but not limited to: persistent mental disorder, chronic kidney disease stage 3, hyperlipidemia, anxiety state, depressive disorder, shortness of breath, hypothyroidism, hypertension, chronic airway obstruction, generalized pain and Alzheimer's disease.</p> <p>A bowel and bladder assessment, completed on 06/23/15, indicated the resident always voided appropriately without incontinence and was always aware of the need to toilet. The assessment indicated the resident was independent but slow with her ability to get to the bathroom.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 07/01/15 indicated the resident scored a 6 out of 15 on the BIMS (Brief Interview for Mental Status), was moderately cognitively impaired, required limited assistance of staff for transfers, extensive staff</p>		<p>standardized reproducible assessment of each resident's functional capacity.</p> <p><b>Corrective Action:</b> Resident #62 received a comprehensive bladder assessment and subsequently her care plan was updated and reflects the current level of care she requires for toileting. Her current MDS reflects this information as well.</p> <p><b>How Others Identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents reviewed for comprehensive assessments related to bladder assessments and care plans updated as needed. Staff education completed on comprehensive assessments.</p> <p><b>Monitoring:</b> The D.O.N./Designee will conduct random audits on comprehensive assessments 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>assistance for wheelchair locomotion and extensive staff assistance for toilet use. The resident was documented as always continent of her bowels and bladder.</p> <p>A significant change MDS assessment, completed on 07/17/15, indicated the resident had declined and was occasionally incontinent of her bowels and bladder (more than twice weekly but not daily). A new bowel and bladder incontinence assessment was not completed.</p> <p>The resident was discharged from the facility on 08/09/15, and sent to the hospital due to pneumonia and a urinary tract infection. The resident was readmitted to the facility on 08/12/15.</p> <p>A Bowel and Bladder Assessment, completed on 08/13/15, indicated the resident always voided appropriately without incontinence, was always aware of the need for her bladder to void, was still independent but slowly for bathroom use.</p> <p>A significant change MDS assessment, completed on 08/26/15, indicated the resident had declined and was now frequently incontinent of her bladder (at least daily).</p>			

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	<p>The health care plans for Resident #65, related to ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Activity Intolerance indicated the resident required staff assistance for toileting. There was no other care plan related to incontinence or toileting needs for Resident #65.</p> <p>During an interview, on 08/24/15 at 10:20 A.M., the ADON (Assistant Director of Nursing) indicated indicated the resident required extensive staff assistance and was incontinent. The resident was to either be checked and changed or assisted to toilet before and after meals. The ADON then indicated the resident was able to put her call light on for toileting assistance.</p> <p>During an interview, on 08/25/2015 at 10:05 A.M., MDS Coordinator- RN #43 indicated she utilized the 6 day look back voiding documentation for her MDS assessments. She indicated she was not sure why the bowel and bladder assessments were completed on 08/13/15 or done the day after resident's were admitted or readmitted. She indicated she was not sure why the assessments, completed on 08/13/15, did not match the MDS assessments. She indicated the unit managers and nurses on the nursing unit were responsible for completing the</p>			

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F 0279 SS=D Bldg. 00	<p>bowel and bladder assessments and care plans. She indicated the 6 day look back documentation for Resident #65, completed by the CNAs (Certified Nursing Assistant), indicated Resident #65 had been incontinent at least daily but not always.</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>			
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	<p>Based on observations, record review and interviews, the facility failed to develop a comprehensive care plan with interventions to address bladder retraining for 1 of 3 resident's reviewed for incontinence. (Resident #44)</p> <p>Finding includes:</p> <p>On 8/24/15 at 8:41 AM, a review of the clinical record for Resident #44 was conducted. The record indicated the resident was admitted on 3/26/15. The resident's diagnoses included, but were not limited to; senile psychotic condition, difficulty walking, convulsions, diabetes, hypertrophy prostate without urinary obstruction, urinary incontinence and schizophrenia.</p> <p>A Bowel and Bladder Assessment, dated 3/27/15, indicated the resident was a "Good Candidate for retraining" his bladder incontinence. The assessment further indicated the resident was usually aware of his need to void.</p> <p>The Nursing Admission Assessment, dated 3/26/15, indicated the resident was continent.</p> <p>A care plan, dated 3/30/15 and revised on 5/14/15, indicated the resident had bladder incontinence related to prostate</p>	F 0279	<p><b>F 279 DEVELOP COMPREHENSIVE CARE PLANS</b> This facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. This facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any service that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10 including the right to refuse treatment under 483.10.</p> <p><b>Corrective Action:</b> Resident #44 has a comprehensive care plan with interventions that addresses bladder retraining.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Preventative Measures:</b> Residents reviewed for comprehensive care plans related to bladder retraining programs. Staff education completed on plan of care for bladder retraining programs.</p> <p><b>Monitoring:</b> The</p>	09/25/2015

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	<p>enlargement. The interventions included, but were not limited to: Brief use-encourage resident to allow staff to change brief when he dribbles, change brief as needed, observe/document signs &amp; symptoms of a urinary tract infection and report findings to physician.</p> <p>The Admission Minimum Data Set (MDS), dated 4/2/15, indicated the resident needed extensive assistance of one person with toileting and the resident was occasionally incontinent. A MDS Significant Change Assessment, dated 5/20/15, indicated the resident was occasionally incontinent (less than 7 episodes).</p> <p>On 8/24/15 at 9:00 A.M., Resident #44 was observed lying in bed, on his right side. The resident's wet pajama bottoms were located on the floor, at the end of the resident's bed. The room had a smell like urine to it. The restroom in the resident's room had toilet water which was yellow and the trash can had a heavy, wet, soiled brief in it. The restroom smelled like urine.</p> <p>During an interview on 8/24/15 at 10:05 A.M., CNA (Certified Nursing Assistant) #53 indicated the resident required assistance with dressing and toileting. However, the resident could get himself</p>		<p>D.O.N./Designee will conduct random audits on comprehensive care plans 5x per week for 1 month, 3x per week for 3 months, and 2 x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>				

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	<p>out of bed. If staff were not in his room when he got up the resident would go ahead and take himself to the restroom and dress himself.</p> <p>During an interview on 8/24/15 at 10:15 A.M., RN #52 indicated the resident had taken himself to the restroom as the bathroom floor was wet. She further indicated she had placed the paper towels on the floor to absorb the urine. She indicated the room smelled of urine and the staff had done everything to eliminate the odor. She further indicated the resident would urinate on the floor, in his bed, in his brief and where ever he wanted. RN #52 indicated when he urinated it was usually a large amount, soaking the floor and his clothes.</p> <p>On 8/24/15 at 2:45 P.M., Resident #44 was observed in the hallway with a large wet area on the back of his pants, the CNA #54 approached the resident and escorted him to his room. The CNA indicated the resident voided large amounts and often leaked through his brief.</p> <p>On 8/25/15 at 1:15 P.M., the Look Back Report, dated 5/14/15 thru 5/20/15 indicated on the first day the resident had 10 incontinent episodes, 1 continent episode and 1 episode he did not void.</p>			

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	<p>On day 2 the resident had 2 incontinent episodes and 7 continent episodes. On day 3 the resident had 6 episodes of incontinence, 4 continent episodes and 1 episode he did not void.</p> <p>During an interview, on 8/25/15 at 2:00 P.M., the MDS Coordinator indicated the first 3 days of the 7 day look back period was the 3 day voiding pattern assessment. The MDS Coordinator indicated the 3 day voiding pattern, the Admission Assessment and Bowel and Bladder Assessment would determine if the resident needed to have a bladder training program. She further indicated the bladder training would be implemented under the incontinence care plan. She did not have an explanation as to why the resident's care plan did not address his incontinence issues or have documentation as to why the resident was not part of a bladder retraining program or had failed a bladder training program.</p> <p>On 8/25/15 at 2:50 P.M., an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON indicated the facility was trying a new approach to incontinence/bladder training but had not gotten Resident #44 into the program. The ADON indicated there were no interventions to address bladder</p>			

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F 0280 SS=D Bldg. 00	<p>training for the resident.</p> <p>The current policy, titled "Care Plans-Comprehensive", with a revised date of 2006, was received from the DON on 8/26/15 at 12:10 P.M. The policy indicated "...An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident..." The policy further indicated the Care Plan was designed to: "...a. Incorporate identified problem...f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels...."</p> <p>3.1-35(a)</p> <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</p>			

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	<p>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 record review and interviews, the facility failed to ensure a care plan related to pressure ulcer development was revised timely for 1 of 2 residents reviewed for pressure ulcers. (Resident #201)</p> <p>Finding includes:</p> <p>The clinical record for Resident #201 was reviewed on 08/25/15 at 2:30 P.M. Resident #201 was admitted to the facility, on 03/13/15, with diagnoses, including but not limited to: closed fracture of the femur, hypertension (HTN), arteriosclerosis, right bundle branch block, cataracts, protein-calorie malnutrition, difficulty walking, muscular wasting disuse atrophy and debility.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 03/20/15, indicated the resident was at risk for pressure ulcers but had no pressure ulcers.</p>	F 0280	<p><b>F 280 RIGHT TOPARTICIPATE PLANNING CARE-REVISE CP</b></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. A comprehensive care plan will 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><b>Corrective Action:</b> Resident #201 no longer resides at this facility.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient</p>	09/25/2015

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	<p>A skin assessment, completed on 03/28/15, indicated other than the surgical hip wound there were no other skin issues.</p> <p>A skin assessment, completed on 04/01/15, indicated both of the resident's heels were "very red" and there was a "black spot" on both big toes.</p> <p>A nursing progress note, dated 04/02/15, indicated the physician and POA (Power of Attorney) was notified of the last skin assessment, heels red bilaterally with soft blister to right outer heel 2 cm (centimeters) by 2 cm and 0.5 cm purple ringed blisters to bilateral large toes.</p> <p>On 04/07/15 there was an order for skin prep (skin protectant) to bilateral great toes and right outer heel blisters twice a day.</p> <p>On 04/08/15 there was an order for prevalon boots (pressure relieving heel protection) to bilateral feet while in bed.</p> <p>The care plan related to a potential for altered nutritional status due to limited appetite, HTN, constipation, history of weight loss, and protein- caloric malnutrition was intimated on 03/17/15. The care plan was not revised until 04/14/15 to add the treatment orders for</p>		<p>practice.</p> <p><b>Preventative Measures:</b> Residents care plans were reviewed for comprehensiveness related to assessments. Staff education completed on the timely development of a comprehensive plan of care based upon assessments.</p> <p><b>Monitoring:</b> The D.O.N./Designee will conduct random audits on comprehensive care plans and timeliness 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25,2015.</p>	

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F 0282 SS=D Bldg. 00	<p>the resident's pressure ulcers, 13 days after the resident's pressure ulcer developed.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interviews, the facility failed to follow the care plan and provide toileting assistance for 1 of 3 residents reviewed for incontinence. (Resident #65)</p> <p>Finding includes:</p> <p>The clinical record for Resident #65 was reviewed on 08/24/2015 at 10:24 A.M. Resident #65 was admitted to the facility, on 06/22/15, with diagnoses, including but not limited to: persistent mental disorder, chronic kidney disease stage 3, hyperlipidemia, anxiety state, depressive disorder, shortness of breath, hypothyroidism, hypertension, chronic airway obstruction, generalized pain and Alzheimer's disease.</p> <p>The admission MDS (Minimum Data</p>	F 0282	<p><b>F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p><b>Corrective Action:</b> Resident #65's MDS, Bladder Assessment, Care Plans, and C.N.A. Assignment/ADL Sheets have been updated to reflect the resident's accurate and current toileting needs. Staff have been trained on her needs.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents reviewed for needed services by qualified persons and care plans were updated as needed. Staff education</p>	09/25/2015

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	<p>Set) assessment, completed on 07/01/15, indicated the resident scored a 6 out of 15 on the BIMS (Brief Interview for Mental Status), required limited assistance of staff for transfers, extensive staff assistance for wheelchair locomotion and extensive staff assistance for toilet use. The resident was documented as always being continent of her bowels and bladder.</p> <p>A significant change MDS assessment, completed on 07/17/15, indicated the resident had declined and was occasionally incontinent of her bowels and bladder (more than twice weekly but not daily).</p> <p>The resident was discharged from the facility, on 08/09/15, and sent to the hospital due to pneumonia and a urinary tract infection. The resident was readmitted to the facility on 08/12/15.</p> <p>A Bowel and Bladder Assessment completed on 08/13/15 indicated the resident always voided appropriately without incontinence, was always aware of the need for her bladder to void, was still independent but slowly for bathroom use.</p> <p>A significant change MDS assessment, completed on 08/26/15, indicated the</p>		<p>completed on identifying services needed by qualified persons and capturing these services in the plan of care.</p> <p><b>Monitoring:</b> The D.O.N./Designee will conduct audits on services needed and reflected in the plan of care 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>resident had declined and was now frequently incontinent of her bladder (at least daily).</p> <p>The health care plans for Resident #65, related to ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Activity Intolerance indicated the resident required staff assistance for toileting. There was no other care plan related to incontinence or toileting needs for Resident #65.</p> <p>During an interview, on 08/24/15 at 10:20 A.M., the ADON (Assistant Director of Nursing) indicated the resident required extensive staff assistance and was incontinent. The resident was to either be checked and changed or assisted to toilet before and after meals. The ADON then indicated the resident was able to put her light on for toileting assistance.</p> <p>On 08/24/15 at 10:22 A.M., Resident #65 was seated in a recliner in her room watching television. She was dressed, dry and had a cloth incontinence pad on her recliner seat. She was noted to propel her wheelchair down the hallway at 10:55 A.M. and then proceeded off of the nursing unit to the main dining room.</p> <p>CNA (Certified Nursing Assistant) #40</p>			

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	<p>was interviewed on 08/24/15 at 10:55 A.M. She indicated Resident #65 had transferred herself from her recliner to her wheelchair and had not been assisted to the bathroom.</p> <p>On 08/24/15 at 11:15 A.M., Resident #65 was in her wheelchair in the dining room, seated at a dining table.</p> <p>On 08/24/15 at 1:48 P.M., CNA #40 indicated Resident #65 was usually independent for toileting needs. She indicated the resident did occasionally put her call light on if she needed a new brief. She indicated the resident's brief was wet at times but the resident changed them herself and she sometimes put the light on if she ran out of briefs or needed something brought to her in the bathroom, or her trash needed emptied.</p> <p>During an interview, on 08/24/2015 at 3:02 P.M., CNA #41 indicated Resident #65 was independent for toileting needs, wore briefs but pretty much changed them herself. She indicated if the resident was having "behaviors" she might say she needed help but generally it was not for toileting needs. She indicated she would empty the soiled briefs from the trash can but she was not sure if it was Resident #65's brief or her roommates as they both toileted</p>			

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	<p>themselves and changed their own briefs and put them into the trash can.</p> <p>On 08/25/2015 at 9:23 A.M., Resident #65 was walking from her television to her recliner in her room, unassisted. She remained in her room seated in her recliner until she was informed it was time for lunch and she was pushed to the dining room by staff. She was not observed to be asked and/or assisted to the bathroom.</p> <p>On 08/25/2015 at 9:35 A.M., CNA #42 indicated Resident #65 required just stand by assist for transfers and dressing but was independent to transfer herself to the bathroom and toileted herself independently. She indicated the resident did not wear a brief and was continent of her bladder.</p> <p>On 08/26/2015 at 9:13 A.M., Resident #65 was in room ambulating near the end of her bed. She indicated she did not feel good. She sat on the edge of her bed and was moving her call light cord.</p> <p>On 08/26/2015 at 9:33 A.M., CNA #44 indicated Resident #65 required limited to extensive assistance for ADL's. She indicated she had just checked on the resident and the resident had already toileted herself. She indicated the</p>			

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F 0309 SS=D Bldg. 00	<p>resident does sometimes toilet herself but not always and is incontinent at times. She indicated the resident did usually pull the call light if she needed help with incontinence issues after she had put herself on the toilet. CNA #44 indicated there was no toileting plan or schedule for Resident #44.</p> <p>During an interview, on 08/25/2015 at 10:05 A.M., MDS Coordinator - RN #43 indicated she did not know what toileting plan was to be utilized Resident #65.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to ensure post dialysis assessments were accurately documented for 1 of 1 residents reviewed for dialysis. (Resident #66)</p> <p>Finding includes:</p>	F 0309	<p><b>F 309</b> <b>PROVIDECARE/SERVICES FOR HIGHEST WELL BEING</b> Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in</p>	09/25/2015

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	<p>Resident #66 was observed, on 08/24/2015 at 9:03 A.M., lying in his bed awake, covered partially with a sheet. He was noted to have a left leg below the knee amputation, and bruising on his left arm. He indicated he was to go to dialysis later this morning. He indicated his dialysis was performed from a port in his chest. (He pointed to his right subclavin area.) He indicated they had not been able to perform his dialysis treatments in his left upper arm for some time.</p> <p>The clinical record for Resident #66 was reviewed on 08/25/15 at 10:30 A.M. Resident #66 was admitted to the facility, on 06/11/15, with diagnoses, including but not limited to: difficulty walking, muscle weakness, peripheral vascular disease, below the knee amputation, hypertension, carcinoma of the prostate, end stage renal disease, hyperlipidema, chronic airway obstruction, depressive disorder, atrial fibrillation, anemia, dyspnea and altered mental status.</p> <p>A Post Dialysis Assessment form, dated 06/12/2015, indicated the resident had dialysis scheduled weekly for Monday, Wednesday and Friday at a local dialysis provider.</p> <p>The Dialysis Communication binder, for</p>		<p>accordance with the comprehensive assessment and plan of care. <b>Corrective Action:</b> Resident #66 receives accurate post dialysis assessments. The use of his port was only temporary as the physician order indicated and nursing staff understand which site is being utilized for dialysis at this time. <b>How others identified:</b> All residents receiving dialysis services have the potential to be affected by this alleged deficient practice. <b>Preventative Measures:</b> Residents receiving Dialysis services were reviewed for comprehensive assessments and plan of care. Staff education completed regarding providing services to maintain a resident's highest practicable physical, mental, and psychosocial well-being. <b>Monitoring:</b> The D.O.N./Designee will conduct audits on post dialysis services assessments 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>Resident #66, indicated the daily forms had vital signs and occasionally had comments written on the forms but there was no indication on the forms which site was utilized. There was a form, located in the side pocket of the binder, titled "Fistula/Graft Study Discharge Instructions," dated 08/05/15, which indicated "Do Not use AVF (arterio/venous fistula) for 2 weeks."</p> <p>During an interview on 08/24/2015 at 2:57 P.M., RN #46 and #47, the day and evening shift nurse responsible for the care of Resident #66, indicated Resident #66 had both a fistula in the left arm and a port in his subclavin. Neither nurse was certain which site was being utilized for his dialysis treatments. RN #47 indicated there was a dialysis communication book currently at the dialysis center with the resident. She thought perhaps which access site was utilized would have been documented on the forms in the communication book.</p> <p>The post dialysis assessment forms, completed on 08/05/15, 08/07/15, 08/10/15, 08/12/15 and 08/24/15, after the resident returned from dialysis, indicated the resident's AV shunt in the left upper arm was assessed. The bruit was audible and the thrill was present and a dressing was present on some of the</p>			

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F 0311 SS=D Bldg. 00	<p>assessments on the left upper arm. The section of the form to assess a central line was not marked as assessed.</p> <p>During an interview on 08/26/15 at 11:15 A.M., the Director of Nursing indicated she had called the Dialysis center and the resident had received his dialysis treatments from the subclavian port from 08/05/15 through 08/25/15.</p> <p>3.1-37(a)</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.</p> <p>Based on observations, interviews and record review the facility failed to provide Activities of Daily Living (ADL's) assistance in regards to toileting, transfers and dressing for 1 of 3 residents reviewed for ADL's. (Resident #44).</p> <p>Finding includes:</p> <p>On 8/24/15 at 8:41 AM, a review of the clinical record for Resident #44 was conducted. The record indicated the resident was admitted on 3/26/15. The</p>	F 0311	<p><b>F311 TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</b> A resident is given the appropriate treatment and services to maintain or improve his or her abilities. <b>Corrective Action:</b> Resident #44 received a bladder assessment, toileting program, and his plan of care was updated to reflect his current ADL care. He was screened for therapy services related to his incontinence. Staff are aware of the plan of care to assist resident #44 with ADL care including toileting and</p>	09/25/2015

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	<p>resident's diagnoses included, but were not limited to; senile psychotic condition, difficulty walking, hypertension, convulsions, diabetes, hypertrophy prostate without urinary obstruction, urinary incontinence and schizophrenia.</p> <p>A care plan, dated 3/30/15 and revised on 5//14/15, indicated the resident had a Activities of Daily Living (ADL) self care performance deficit related to dementia and limited mobility. The interventions included but were not limited to: "...Toilet Use: resident requires staff participation to use toilet... Personal Hygiene/Oral Care: the resident requires staff participation with personal hygiene and oral care...Dressing: the resident requires staff participation to dress...."</p> <p>The Admission Minimum Data Set (MDS) Assessment, dated 4/2/15, indicated the resident's Brief Interview Mental Status (BIMS) score was 3. A score of 3 indicated the resident had severe cognitive impairment. The functional status indicated the resident needed extensive assistance of one person with toileting and personal hygiene and limited assistance of one person with dressing. The Significant Change MDS Assessment, dated 5/20/15, indicated no changes from the admission</p>		<p>incontinence care.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents were reviewed for current ADL needs to maintain or improve their abilities by completing comprehensive assessments related to ADL care. ADL care plans reflecting their needs were updated as needed. C.N.A. care guides were updated to reflect the level of care they require including information on toileting programs. Staff education was completed on providing these treatments and services to maintain or improve resident abilities.</p> <p><b>Monitoring:</b> The D.O.N./Designee will audit for resident ADL care to maintain or improve his other abilities. This will be done 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>assessment regarding functional status. However, the BIMS score had increased to an 8, indicating moderately impaired cognition.</p> <p>The Certified Nursing Assistant (CNA) worksheet, dated 7/27/15, indicated the resident required extensive assistance.</p> <p>On 8/24/15 at 9:00 A.M., Resident #44 was lying in bed, on his right side. The resident's wet pajama bottoms were located on the floor, at the end of the resident's bed. The room smelled like urine to it. The restroom in the resident's room had toilet water which was yellow and the trash can had a heavy, wet, soiled brief in it. The restroom smelled like urine.</p> <p>On 8/24/15 at 9:45 A.M., Activity Assistant #51 was observed entering the resident's room and asking the resident if he wanted to go on the bus trip.</p> <p>On 8/24/15 at 9:50 A.M., resident was standing in his room naked, in the corner, near his closet.</p> <p>On 8/24/15 at 9:56 A.M., Activity Assistant #51 was observed entering the resident's room with RN #52, and the resident was standing in his room naked by his closet. The nurse stayed in the</p>			

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	<p>room and was observed assisting the resident with dressing.</p> <p>On 8/24/15 at 10:01 A.M., the resident was leaving his room with the Activity Assistant #51 and going on a bus trip.</p> <p>During an interview on 8/24/15 at 10:05 A.M., CNA #53 indicated the resident required assistance with dressing and toileting.</p> <p>During an interview on 8/24/15 at 10:15 A.M., RN #52 indicated the resident had taken himself to the restroom as the bathroom floor was wet. She further indicated she had placed paper towels on the floor to absorb the urine. She indicated the room smelled of urine and the staff had done everything to eliminate the odor. She further indicated the resident would urinate on the floor, in his bed, and where ever he wanted and when he urinated it was usually a large amount, soaking the floor and his clothes.</p> <p>On 8/24/15 at 2:45 P.M. resident was in the hallway with a large wet area on the back of his pants, the CNA #54 approached the resident and escorted him to his room. The CNA indicated the resident voided large amounts and often leaked through his brief.</p>			

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	<p>On 8/26/15 at 9:35 A.M., the resident was in bed on his left side with a shirt no and a sagging brief. At 9:46 A.M., the resident was observed getting himself up out of bed and walked toward the restroom. As he was walking towards the restroom CNA #57 walked by and went into the room. The resident was observed walking into the restroom. CNA #57 was observed walking out of resident's room and said "he is so hard and doesn't want to do anything." The resident went back to bed.</p> <p>On 8/26/15 at 10:04 A.M., the resident was walking, wearing with a T-shirt and brief towards the restroom. A staff member walked by, looked at the resident and shut the door.</p> <p>On 8/26/15 at 10:06 A.M., the resident was standing by his bed taking his brief off and throwing it in the trash can beside his bed. He put on another brief and a pair of draw-string pants on. At 10:10 A.M. the resident exited the room with nonskid socks and walked down the hallway. The resident was walking by himself to the main entrance area, and laid down on the couch.</p> <p>On 8/26/15 at 11:05 A.M., the resident was getting off the couch and walking by himself to the dining room and taking a</p>			

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F 0314 SS=D Bldg. 00	<p>seat.</p> <p>On 8/26/15 at 2:05 P.M., the resident was walking in the main hallway near the Social Service Offices, thru main lobby and down to Cedar Unit. The resident's pants were sagging as if the brief was full.. The resident stopped at the nurses station and talked to nurses and turned around and sat down on a couch across from the nurses station.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(2)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure interventions were implemented to prevent pressure ulcer development on heels and failed to ensure interventions to address pressure ulcers were implemented timely for 1 of</p>	F 0314	<p><b>F314</b> <b>TREATMENT/SERVICESTO PREVENT HEAL PRESSURE SORES</b> Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores</p>	09/25/2015			

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	<p>3 residents reviewed for pressure ulcers. (Resident #65)</p> <p>Finding includes:</p> <p>The clinical record for Resident #201 was reviewed on 08/25/15 at 2:30 P.M. Resident #201 was admitted to the facility, on 03/13/15, with diagnoses, including but not limited to: closed fracture of the femur, hypertension, arteriosclerosis, right bundle branch block, cataracts, protein-calorie malnutrition, difficulty walking, muscular wasting, disuse atrophy and debility.</p> <p>The admission nursing assessment, completed on 03/13/15, indicated the resident had a surgical incision on her right trochanter, a hard callous on her left toe, and both ankles were a red "muddy" color. There were no pressure ulcers noted.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 03/20/15, indicated the resident was at risk for pressure ulcers but had no pressure ulcers.</p> <p>A care plan to address the resident's potential for impaired skin was implemented, on 03/20/15, with</p>		<p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p><b>Corrective Action:</b> Resident #201 no longer resides at this facility.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents received skin assessments to ensure there were no further pressure sore development. Residents at risk for the development of pressure areas have the necessary services and interventions to prevent the development of pressure sores. Staff education completed on pressure sore prevention.</p> <p><b>Monitoring:</b> The D.O.N./Designee will conduct random resident skin assessments 3x per week for 1 month, 2x per week for 3 months, and 1x per week for 2 months. In addition, an audit will be conducted to ensure residents with pressure sores are receiving appropriate treatments and services to promote healing. This audit will be done 5x per week for 1month, 3x per week for 3 months, and 2x per week for 2</p>		

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	<p>interventions as follows:</p> <ul style="list-style-type: none"> <li>*Avoid scratching and keep hands and body parts from excessive moisture.</li> <li>*Keep fingernails short</li> <li>*Dressing change per MD orders (for surgical hip incision)</li> <li>*Encourage good nutrition and hydration in order to promote healthier skin</li> <li>*Keep skin clean and dry.</li> <li>*Use lotion on dry skin, do not apply on site of injury</li> <li>*Pressure redistribution mattress</li> <li>*Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard object.</li> </ul> <p>A skin assessment, completed on 03/28/15, indicated other than the surgical hip wound there were no other skin issues.</p> <p>A skin assessment, completed on 04/01/15, indicated both of the resident's heels were "very red" and there was a "black spot" on both big toes.</p> <p>A nursing progress note, dated 04/02/15, indicated the physician and POA (power of Attorney) was notified of the last skin assessment, heels red bilaterally with soft blister to right outer heel 2 cm (centimeters) by 2 cm and 0.5 cm purple ringed blisters to bilateral large toes.</p>		<p>months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25,2015.</p>		

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	<p>On 04/07/15, there was a physician order for skin prep (skin protectant) to bilateral great toes and right outer heel blisters bid (twice a day). On 04/08/15, there was a physician order for prevalon boots (pressure relieving heel protector) to bilateral feet while in bed.</p> <p>A wound assessment, completed on 04/10/15 by the facility wound nurse, RN #45 indicated there were 3 pressure ulcers noted, a 0.8 cm x 0.8 cm pressure area to the right great toe, a 0.9 cm x 1.9 cm pressure area to the left great toe, and a 1.0 x 2.5 cm pressure ulcer to the right lateral heel. The wounds were described as intact, attached, and deep maroon - not open with erythema (redness) around the wounds.</p> <p>The care plan regarding the use of Prevalon boots was not updated until 04/10/15.</p> <p>Review of the clinical record, on 08/26/15 at 11:30 A.M. with the Director of Nursing (DON) indicated she could only locate the physician's orders on 04/07/15 regarding the skin prep treatment and the 04/08/15 Prevalon boots as the treatments for the resident's wounds. She indicated the wound nurse only assessed resident's on Fridays in the</p>			

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F 0315 SS=D Bldg. 00	<p>facility.</p> <p>Review of TAR (Treatment Administration Record) on April 2015 indicated both the skin prep and the Prevalon boots were not initiated and administered until 04/08/15.</p> <p>During an interview, on 08/26/2015 at 11:23 A. M, the DON indicated on a CNA (Certified Nursing Assistant) assignment sheet there were instructions to assist Resident #201 with turning and repositioning. She also indicated an air mattress was offered and declined by the resident after her pressure ulcers had developed, but there was no documentation regarding the mattress. The DON indicated the 5 day lag in treatment was because there was a wait for the wound nurse and the wound physician, both of whom, only visited on Fridays to decide what treatment was going to be used.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p>				

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	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interviews, the facility failed to accurately and thoroughly assess bladder incontinence, develop and implement an individualized plan to assist 2 of 3 incontinent residents maintain as much continency as possible. (Residents #44 and #65)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #65 was reviewed on 8/24/2015 at 10:24 A.M. Resident #65 was admitted to the facility, on 6/22/15, with diagnoses, including but not limited to: persistent mental disorder, chronic kidney disease stage 3, hyperlipidemia, anxiety state, depressive disorder, shortness of breath, hypothyroidism, hypertension, chronic airway obstruction, generalized pain and Alzheimer's disease.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 7/01/15,</p>	F 0315	<p><b>F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p><b>Corrective Action:</b> Resident #65 and #44 received a bladder assessment, toileting program, and their plan of care was updated to reflect their current ADL care including bladder incontinence. They remain free from infection of the urinary tract. They were screened for therapy services for urinary incontinence. Staff are aware of the plan of care to assist resident #65 and #44.</p> <p><b>How others identified:</b> All</p>	09/25/2015

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	<p>indicated the resident scored a 6 out of 15 on the BIMS (Brief Interview for Mental Status), required limited assistance of staff for transfers, extensive staff assistance for wheelchair locomotion and extensive staff assistance for toilet use. The resident was documented as always continent of her bowels and bladder.</p> <p>A bowel and bladder assessment, completed on 6/23/15, indicated the resident always voided appropriately without incontinence and was always aware of the need to toilet. The assessment indicated the resident was independent but slowly with her ability to get to the bathroom.</p> <p>A significant change MDS assessment, completed on 7/17/15, indicated the resident had declined and was occasionally incontinent of her bowels and bladder (more than twice weekly but not daily).</p> <p>The resident was discharged from the facility, on 8/09/15, and sent to the hospital due to pneumonia and a urinary tract infection. The resident was readmitted to the facility on 08/12/15.</p> <p>A Bowel and Bladder Assessment, completed on 8/13/15, indicated the resident always voided appropriately</p>		<p>residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents who are incontinent of bladder were reviewed for appropriate treatment and services. Their plan of care was updated as needed. Staff received education on this facility's Urinary Incontinence program and its benefits of reducing incontinence episodes and preventing UTIs.</p> <p><b>Monitoring:</b> The D.O.N./Designee will audit for resident ADL care specific to bladder incontinence to ensure appropriate services are rendered. This will be done 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>without incontinence, was always aware of the need for her bladder to void, was still independent but slowly for bathroom use.</p> <p>A significant change MDS assessment, completed on 8/26/15, indicated the resident had declined and was now frequently incontinent of her bladder (at least daily).</p> <p>The health care plans for Resident #65, related to ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Activity Intolerance indicated the resident required staff assistance for toileting. There was no other care plan related to incontinence or toileting needs for Resident #65.</p> <p>During an interview, on 8/24/15 at 10:20 A.M., the ADON (Assistant Director of Nursing) indicated the resident required extensive staff assistance and was incontinent. The resident was to either be checked and changed or assisted to the toilet before and after meals. The ADON then indicated the resident was able to put her light on for toileting assistance.</p> <p>On 08/24/15 at 10:22 A.M., Resident #65 was seated in a recliner in her room watching television. She was dressed, dry and had a cloth incontinence pad on her</p>			

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	<p>recliner seat. She was noted to propel her wheelchair down the hallway at 10:55 A.M. and then proceeded off of the nursing unit to the main dining room.</p> <p>During an interview on 08/24/15 at 10:55 A.M., CNA (Certified Nursing Assistant) #40 indicated Resident #65 had transferred herself from her recliner to her wheelchair and had not been assisted to the bathroom.</p> <p>On 08/24/15 at 11:15 A.M., Resident #65 was in her wheelchair in the dining room, seated at a dining table.</p> <p>During an interview, on 8/24/2015 at 1:48 P.M., CNA #40 indicated Resident #65 was usually independent for toileting needs. She indicated the resident did occasionally put her light on if she needed a new brief. She indicated the resident's brief was wet at times but the resident changed them herself and she sometimes put the light on if she ran out of briefs or needed something brought to her in the bathroom, or her trash needed emptied.</p> <p>During an interview, on 8/24/2015 at 3:02 P.M., CNA #41 indicated Resident #65 was independent for toileting needs, wore briefs but pretty much changed them herself. She indicated if the</p>			

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	<p>resident was having "behaviors" she might say she needed help but generally it was not for toileting needs. She indicated she would empty the soiled briefs from the trash can but she was not sure if it was Resident #65's brief or her roommates as they both toileted themselves and changed their own briefs and put them into the trash can.</p> <p>On 8/25/15 at 9:23 A.M., Resident #65 walked from her television to her recliner in her room, unassisted. She remained in her room seated in her recliner until she was informed it was time for lunch and she was pushed to the dining room by staff. She was not observed to be asked and/or assisted to the bathroom.</p> <p>During an interview, on 8/25/2015 at 9:35 A.M., CNA #42 indicated Resident #65 required just stand by assist for transfers and dressing but was independent to transfer herself to the bathroom and toileted herself independently. She indicated the resident did not wear a brief and was continent of her bladder.</p> <p>During an interview, on 8/25/2015 at 10:05 A.M., the MDS Coordinator, RN #43 indicated she utilized the 6 day look back voiding documentation for her MDS assessments. She indicated she was not</p>			

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	<p>sure why the bowel and bladder assessments were completed on 08/13/15, or done the day after resident's were admitted or readmitted. She indicated she was not sure why the assessments, completed on 08/13/15 did not match the MDS assessments. She indicated the unit managers and nurses on the nursing unit were responsible for completing the bowel and bladder assessments and care plans. She indicated the 6 day look back documentation for Resident #65, completed by the CNAs, indicated Resident #65 had been incontinent at least daily but not always.</p> <p>2. On 8/24/15 at 8:41 AM, a review of the clinical record for Resident #44 was conducted. The record indicated the resident was admitted on 3/26/15. The resident's diagnoses included, but were not limited to; senile psychotic condition, difficulty walking, convulsions, diabetes, hypertrophy prostate without urinary obstruction, urinary incontinence and schizophrenia.</p> <p>A Bowel and Bladder Assessment, dated 3/27/15, indicated the resident was a "Good Candidate for retracing." The assessment further indicated the resident was usually aware of his need to void.</p> <p>The Admission Assessment, dated</p>			

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	<p>3/26/15, indicated the resident was continent.</p> <p>A care plan, dated 3/30/15 and revised on 5/14/15, indicated the resident had bladder incontinence related to prostate enlargement. The interventions included, but were not limited to: Brief use-encourage resident to allow staff to change brief when he dribbles, change brief as needed, observe/document signs &amp; symptoms of a urinary tract infection and report findings to physician.</p> <p>The Admission Minimum Data Set (MDS), dated 4/2/15, indicated the resident needed extensive assistance of one person with toileting and the resident was occasionally incontinent. A MDS Significant Change Assessment, dated 5/20/15 indicated the resident was occasionally incontinent (less than 7 episodes).</p> <p>On 8/24/15 at 9:00 A.M., Resident #44 was lying in bed, on his right side. The resident's wet pajama bottoms were located on the floor, at the end of the resident's bed. The room had a smell like urine to it. The restroom in the resident's room had yellow water in the toilet and the trash can had a heavy, wet, soiled brief in it. The restroom smelled like urine.</p>			

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	<p>On 8/24/15 at 9:45 A.M., Activity Assistant #51 was observed entering the resident's room and asking the resident if he wanted to go on the bus trip.</p> <p>On 8/24/15 at 9:50 A.M., Resident #44 was standing in his room naked, in the corner, near his closet.</p> <p>On 8/24/15 at 9:56 A.M., Activity Assistant #51 was observed entering the resident's room with RN #52, and the resident was standing in his room naked by his closet. The nurse stayed in the room and was observed assisting the resident with dressing.</p> <p>On 8/24/15 at 10:01 A.M., Resident #44 was leaving his room with the Activity Assistant #51 and going on a bus trip.</p> <p>During an interview on 8/24/15 at 10:05 A.M., CNA #53 indicated the resident required assistance with dressing and toileting, however the resident could get himself out of bed and if you're not in his room when he gets up the resident would go ahead and take himself to the restroom and dress himself.</p> <p>During an interview on 8/24/15 at 10:15 A.M., RN #52 indicated the resident had taken himself to the restroom as the</p>			

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	<p>bathroom floor was wet. She further indicated she had placed the paper towels on the floor to absorb the urine. She indicated the room smelled of urine and the staff had done everything to eliminate the odor. She further indicated the resident would urinate on the floor, in his bed, in his brief and where ever he wanted. RN #52 indicated when he urinated it was usually a large amount, soaking the floor and his clothes.</p> <p>On 8/24/15 at 2:45 P.M., Resident #44 was in the hallway with a large wet area on the back of his pants, CNA #54 approached the resident and escorted him to his room. CNA #54 indicated the resident voided large amounts and often leaked through his brief.</p> <p>On 8/25/15 at 1:155 P.M., the Look Back Report, dated 5/14/15 thru 5/20/15 indicated on the first day the resident had 10 incontinent episodes, 1 continent episode and 1 episode he did not void. On day 2 the resident had 2 incontinent and 7 continent episodes. On day 3 the resident had 6 episodes of incontinence, 4 continent episodes and 1 episode he did not void.</p> <p>During an interview, on 8/25/15 at 2:00 P.M., the MDS Coordinator indicated the the first 3 days of the 7 day look back</p>			
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	<p>period was the 3 day voiding pattern assessment. The MDS Coordinator indicated the 3 day voiding pattern, the Admission Assessment and Bowel and Bladder Assessment would determine if the resident needed to have a bladder training program. She further indicated the bladder training would be implemented under the incontinence care plan. She did not have an explanation as to why the resident's care plan did not address his incontinence issues or have documentation as to why the resident wasn't part of a bladder retraining program or had failed a bladder training program.</p> <p>On 8/25/15 at 2:50 P.M., an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON indicated the facility was trying a new approach to incontinence/bladder training but had not gotten Resident #44 into the program. The ADON indicated there were no interventions to address bladder training for the resident.</p> <p>On 8/25/15 at 3:15 P.M., the DON provided a policy titled "Urinary Incontinence-Clinical Protocol", dated 2005, and indicated the policy was the one currently used by the facility. The policy indicated Treatment Management:</p>			

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F 0323 SS=D Bldg. 00	<p>"...6. As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status...Monitoring:1. The staff and physician will review the progress of individuals with impaired continence until continence is restored or improved as much as possible, or it is identified that further improvement is unlikely... a. This should include documentation of a resident's responses to attempted interventions such as scheduled toileting, prompted voiding, or medications used to treat incontinence...."</p> <p>3.1-41(a)(2)</p> <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 and interview, the facility failed to ensure hazardous chemicals were not accessible and failed to ensure safe usage of powerstrips in one double occupancy room in 1 of 38 rooms observed.</p>	F 0323	<p><b>F323 FREE OFACCIDENT HAZARDS/SUPERVISION/DEVICES</b> This facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision</p>	09/25/2015

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	<p>Findings include:</p> <p>On 08/20/2015 at 10:30 A.M., a bottle of mouth wash was observed on a bedside table. The labeled on the bottle indicated "keep out of reach of children."</p> <p>On 08/25/2015 at 9:48 A.M., the following was observed in room 114: one alcohol hand sanitizer on the right bedside table sitting next to the lift chair, one alcohol hand sanitizer sitting on the bedside table to the left of the lift chair. There were two lotions located on the bedside stand next to the bed. All bottles were labeled, "Keep out of reach of children."</p> <p>During an interview, on 08/25/2015 at 2:22 P.M., Employee #21 indicated there were four bottles of chemicals in the room.</p> <p>On 08/25/2015 at 9:38 A.M., observation of room 114 indicated a powerstrip located on the floor behind a Residents lift chair. The powerstrip had an oxygen tank, lift chair, and several other items plugged into it.</p> <p>During an interview, on 08/25/2015 at 10:15 A.M., LPN #24 indicated there was a nebulizer and an oxygen machine</p>		<p>and assistance devices to prevent accidents.</p> <p><b>Corrective Action:</b> The facility removed the indicated mouthwash, hand sanitizer and lotions that were noted during the survey. In addition, the power strips were removed from room #114.</p> <p><b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Staff completed a facility wide search for resident hazards such as mouth wash, hand sanitizer, lotion and powerstrips. ADL items that indicate, "Keep out of reach of children," will be stored in the resident's medicine cabinet in their bathroom where staff can assist them with these items.</p> <p>Staff education was completed on accidents and hazards and specifically what items constitute hazardous such as those items labeled, "keep out of reach from children."</p> <p><b>Monitoring:</b> The D.O.N./Designee will do an environmental search for hazards 5 x per week for 1 month, 3x per week for 3 months, and 2 x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September25, 2015.</p>		

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F 0329 SS=D Bldg. 00	<p>plugged into a powerstrip located on the floor behind the lift chair in room 114.</p> <p>During an interview, on 08/25/2015 at 1:30 P.M., the Maintenance Director indicated neither lift chair, oxygen machine, or nebulizer should not be plugged into the powerstrip at any time.</p> <p>3.1-45(a)(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</p>			

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	<p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure there were adequate indications to support the use of an antipsychotic and antianxiety medication for 2 of 5 residents reviewed for unnecessary medication use. (Resident #126 and Resident #136)</p> <p>Findings include:</p> <p>1. On 8/25/15 at 11:12 A.M., record review indicated, Resident #126 was admitted to the facility on 6/19/15, with diagnoses included, but were not limited to, "...vascular dementia, depressive disorder, hypertension and diabetes mellitus type II...."</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 6/26/15, indicated Resident #126 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 3.</p> <p>The Physician admission orders, dated 6/19/15, indicated the resident was on Donepezil (given for dementia) 10 mg (milligrams) once daily at bedtime and Sertraline (given for depression) 25 mg once daily.</p>	F 0329	<p><b>F329 DRUG REGIMENIS FREE FROM UNNECESSARY DRUGS</b></p> <p>The facility will continue to ensure that 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 combination of the reasons above.</p> <p><b>Corrective Action:</b> The medication regimens of residents #126 and #136 were reviewed for unnecessary drugs by their physicians. Their psychosocial care plans were updated with non-pharmacological interventions for behaviors and signs and symptoms of anxiety.</p> <p><b>How others identified:</b> All residents receiving medications have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> Residents receiving medications were reviewed for unnecessary drugs and physician orders were processed when indicated. The IDT developed a systematic approach to preventing the use of unnecessary drugs and outlined</p>	09/25/2015

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	<p>A Resident Behavior Management Log, indicated the following:</p> <p>*On 6/21/15 at 0115 (1:15 A.M.), Resident was yelling at CNA's (Certified Nursing Assistant's) and was resisting getting changed after being soiled. Telling staff members to get out of her room. Intervention: Tried to calm resident down. Interventions successful.</p> <p>*On 6/22/15 at 4:00 P.M., 5:00 P.M. and 6:00 P.M. refused medication.</p> <p>*On 6/25/15 at 0930 (9:30 A.M.), physically abusive to staff, interventions unsuccessful.</p> <p>*On 6/26/15 at 0005 (12:05 A.M.), physically abusive to staff, interventions unsuccessful.</p> <p>*On 6/29/15 at 1530 (3:30 P.M.), bit a CNA, interventions successful.</p> <p>*On 7/4/15 at 0645 (6:45 A.M.), hitting others, interventions unsuccessful.</p> <p>*On 7/12/15 at 0110 (1:10 A.M.), hitting staff and verbally abusive, interventions unsuccessful.</p> <p>*On 7/13/15 at 0100 (1:00 A.M.), hitting, yelling and scratching, interventions unsuccessful.</p> <p>A nurse note, dated 6/29/15, indicated "...CNA reports that during transfer after shower resident leaned in and bit her. Resident was angry and became combative during shower. Staff spoke softly to her and attempted to redirect</p>		<p>this approach in a policy and procedure. The staff was educated on this new policy and procedure. <b>Monitoring:</b> The IDT will review behavior logs daily in morning meeting to review the effectiveness of non-pharmacological interventions and analyze root cause of behaviors so that new interventions can be implemented. Weekly the IDT will meet to review resident's plan of care and medication regimen for appropriateness. The Executive Director/Designee will monitor this process 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.</p> <p><b>Date of Completion:</b> September 25, 2015.</p>				

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	<p>without success. Staff attempted to change caregiver without success. Resident was dressed and left safely alone. No further behaviors noted...."</p> <p>A Social Service note, dated 6/30/15, indicated "...IDT [Interdisciplinary Team]discussed behaviors from 6/29/15. Resident was combative during a shower and bit a staff member. Redirection, changing caregivers unsuccessful. Resident was left safely alone after being dressed. Message left for son to return call. Will speak with him about psych services...."</p> <p>A nurse note, dated 7/7/15, indicated "...Spoke with [nurse practitioner] from [behavioral health]. New order to d/c [discontinue] Namenda (given for dementia) due to increased behaviors and delusions. Start Risperidone (an antipsychotic) 0.25 mg po (oral) daily for delusions...."</p> <p>A physician order, dated 7/7/15, indicated Risperidone 0.25 mg oral once daily for vascular dementia.</p> <p>A Social Service Note, dated 7/13/15, indicated "...[Resident] continues to strike out during caregiving. Staff attempts to alternate caregivers and reassurance without success. Resident</p>			

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	<p>triggers appear to be mostly in the room with personal care. Resident is very hard of hearing and IDT believes communication failure may be part of the behavior triggers. New intervention will be to try a white board for communication prior to caregiving...."</p> <p>A Physician Progress Note, dated 7/14/15, indicated "...Pt [patient] was seen this pm [evening] due to increased confusion and behaviors. Pt denies dysuria [painful urination]. Febrile temperature 100.0 degrees today. Will get UA [urinalysis] with C&amp;S [culture and sensitivity]...."</p> <p>A Physician Progress Note, dated 7/16/15, indicated "...follow up on UTI [urinary tract infection]. Not able to collect urine after several attempts per nursing reports, ABX [antibiotic] started for emperical tx [treatment] for UTI. Pt was seen this pm much improved affect, no behaviors...Son here and states that mother not as confused and more pleasant...."</p> <p>A Psychiatric Progress Note, dated 7/30/14, indicated "...[Resident] has depression, anxiety, and dementia with behavioral disturbances. She had been having increased behaviors and delusions about staff and roommate and Namenda</p>			

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	<p>was stopped and Risperdal was started. She states that she is having some depression and blaming son for being here...."</p> <p>A Psychiatric Progress Note, dated 8/21/15, indicated "...She states that she hasn't been sleeping well, does sleep with a radio on and falls asleep then when she wakes up "I hear them talking about my family on the radio" and states she is worried about her decision to file for bankruptcy and what people think of her...."</p> <p>On 8/25/15 at 11:00 A.M., review of a care plan, initiated on 6/22/15 and revised on 7/6/15, indicated the focus: Resident has demonstrated behavioral symptoms including: yelling at staff, refused to take meds, she is also hitting and biting staff. She is also going through closet looking for glasses. Interventions included but were not limited to "...will ask for the ok that resident is seen by psych services. Approach in a calm manner. Assess for pain. ...Explain desired task prior to start...Labs as ordered. Staff to use white board for communication prior to ADL[Activity of Daily Living] caregiving tasks...."</p> <p>During an interview, on 8/25/15 at 11:30 A.M., the Assistant Director of Nursing</p>			

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	<p>indicated the resident was being very resistant to care she was combative and verbally abusive. Then we discovered that she is very hard of hearing and did an intervention of communicating with a white erase board before we do care and she has very few behaviors since.</p> <p>During an interview, on 8/25/15 at 1:53 P.M., the Employee #30 indicated the resident has documented behaviors as far as refusal of care and being combative but no documented behaviors of delusions.</p> <p>2. On 8/26/15 at 2:07 P.M., record review indicated, Resident #136 was admitted to the facility on 1/22/13, with diagnoses included, but were not limited to, "...dementia with behavioral disturbance, anemia, mood disorder, depressive disorder and congestive heart failure...."</p> <p>The quarterly MDS assessment, completed on 8/10/15, indicated Resident #136 was mildly cognitively impaired with a BIMS score of 12.</p> <p>A physician order, dated 4/17/15, indicated Clonazepam (given for anxiety) 1 mg po BID (twice a day).</p> <p>A Physician order, dated 4/22/15, indicated Clonazepam 0.5 mg po every</p>			

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	<p>12 hours for anxiety.</p> <p>A Worksheet for Measuring the Behavior, indicated the following:</p> <p>*On 4/8/15 at 2:15 P.M., refused staff care in emptying colostomy bag, interventions unsuccessful.</p> <p>*On 4/13/15 at 1:30 P.M., refused to empty colostomy bag, interventions unsuccessful.</p> <p>*On 7/5/15 at 8:00 P.M., refused nurse to change colostomy, interventions unsuccessful.</p> <p>*On 7/19/15 at 9:00 P.M., refused to have colostomy changed, interventions unsuccessful.</p> <p>A review of the nurses notes, from 4/4/15 to 5/1/15, indicated there was no documentation of any anxious behaviors.</p> <p>On 8/26/15 at 3:05 P.M., review of a care plan, initiated on 8/15/14, indicated the focus: resident has demonstrated behavioral symptoms including: resistant with care. Interventions included but were not limited to "...Call resident by preferred name. Encourage verbal expression of feelings. Encourage/assist with wearing functional hearing aid. Encourage/assist with wearing glasses. Explain desired task prior to start. Have another caregiver attempt tasks. Prefers male care givers for personal care if</p>			

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	<p>unable to do it himself...."</p> <p>On 8/26/15 at 3:10 P.M., review of a care plan, initiated on 5/20/15, indicated the focus: [resident name] has diagnosis of anxiety and takes anti anxiety depressants. Interventions included but were not limited to "...Administer medications as ordered. Monitor/document for side effects and effectiveness. Behavioral health consults as needed. [Resident name] needs encouragement/assistance/support to maintain as much independence and control as possible...."</p> <p>During an interview, on 8/26/15 at 3:15 P.M. the Assistant Director of Nursing indicated the resident was started on Clonazepam for anxiety because he has anxiety during his care, he likes certain staff to assist him and prefers males to care for him if that doesn't happen he gets really anxious, unfortunately staff are not documenting his anxious behaviors. She further indicated there are only a few behaviors documented from April to July of 2015 and all of them are refusal of care.</p> <p>On 8/26/15 at 3:30 P.M., the Social Service Director was asked about a policy regarding the use of anti-psychotic/anti-anxiety medications,</p>			

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F 0356 SS=C Bldg. 00	<p>he indicated there was not currently a policy regarding this.</p> <p>3.1-48(a)(4)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p>			

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	<p>Based on observation and interview, the facility failed to ensure timely posting of the daily nursing staff information and knowledge for retaining the posting records for 3 of 6 days observed during the survey. This deficient practice had the potential to impact 170 of 170 residents and visitors. (8/19/15, 8/21/15, and 8/25/15)</p> <p>Finding includes:</p> <p>On 8/19/15 at 10:06 A.M., during initial tour nurse staffing information was not posted for 08/19/15.</p> <p>On 08/21/2015 at 5:06 A.M., 6:58 A.M. and 7:59 A.M., nurse staffing information was not posted for 08/21/15.</p> <p>On 08/25/15 at 8:10 A.M., nurse staffing information was not posted for 08/25/15.</p> <p>On 8/26/15 at 1:30 P.M., during an interview with the Staff Scheduling Coordinator, she indicated she would check the census after she arrived for work between 7:30 A.M. and 8:00 A.M. before posting the information. She indicated the day shift started at 6:00 A.M. and the staffing should be posted by 6:00 a.m.. She also indicated she was unaware of how long staff posting records needed to be kept.</p>	F 0356	<p><b>F 356 POSTED NURSE STAFFING INFORMATION</b> The facility will post the following information on a daily basis; Facility name, current date, total number and the actual hours worked by the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift; Registered nurses, Licensed practical nurses, certified nurse aides and resident census. It will be in a prominent place readily available to residents and visitors. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. <b>Corrective Action:</b> The facility posts accurate staffing information daily. The staff scheduling coordinator received education on timely postings and the timeframe for which staffing records must be kept.</p> <p><b>How others identified:</b> All residents and visitors have the potential to be affected by this alleged deficient practice.</p> <p><b>Preventative Measures:</b> A procedure was developed for timely posting of nurse staffing information. Staff was educated on this procedure.</p> <p><b>Monitoring:</b> The D.O.N/Designee will monitor for timely postings 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be</p>	09/25/2015			

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F 0371 SS=F Bldg. 00	<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</p> <p>A. Based on observation, record review, and interview, the facility failed to ensure food was stored, served and prepared in a sanitary manner in 1 of 1 kitchen and 2 of 3 nourishment refrigerators. This related to the cleanliness and storage of equipment/utensils, maintenance of refrigerator and freezer temperatures, handwashing and glove use.</p> <p>B. Based on observation, record review and interview, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing in 1 of 2 dining rooms. This had the potential to affect 122 of 166 residents that receive meals in the main dining room.</p> <p>Findings include:</p> <p>A.1. On 8/19/15 from 10:15 A.M.-11:00 A.M. the initial kitchen tour was conducted with the Dietary Manager and</p>	F 0371	<p>presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p> <p><b>F 371 FOOD PROCURE,STORE/PREPARE/SERVE- SANITARY</b> The facility will establish and maintain safe and sanitary food service distribution and service under proper sanitary conditions in regards to cleanliness and storage of equipment/utensils, maintenance of refrigerator and freezer temperatures, hand washing, and glove use. <b>Corrective Action:</b> Utensils/equipment identified as dirty during the survey were removed from service immediately and cleaned. The thermometer in the Birch refrigerator/freezer was replaced and the refrigerator/freezer was cleaned.. <b>How others identified:</b> All residents have the potential to be effected by these alleged deficiencies. <b>Preventative Measures:</b> Dietary Staff education and review of proper handling, washing, and storage of dishes and utensils. Logs and monitoring of</p>	09/25/2015			

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	<p>the following was observed:</p> <p>A large stand up mixer was covered with plastic. The Dietary Manager removed the plastic covering and indicated the mixer was clean and had not been used for a while. A dried white substance was observed on the back of the mixer. In addition, one paring knife and 2 rubber spatulas located inside a metal drawer were put away as clean but had dried food substances on them.</p> <p>On 8/19/15 from 11:35 A.M.-12:35 P.M., the following was observed in the kitchen during the noon meal service:</p> <p>At 11:35 A.M. Cook #25 was observed to wash her hands and donn clean gloves She then coughed into her shirt sleeve and wiped her nose on her shirt sleeve then began to temp the food on the steam line.</p> <p>At 11:43 A.M., Cook #25 had donned clean gloves and opened the oven door with her gloved hands and placed a metal pan inside. After opening the oven door with her gloved hands, she returned to the steam table and placed a thermometer into the pureed peas, the thermometer sank down into the puree and with her contaminated gloves, she reached down into the puree mixture to retrieve the</p>		<p>equipment use/cleaning put into place. Change of practice/procedure: Glove use no longer permitted during meal service, and during food prep without direct food contact. Review with additional education of Proper hand washing/glove use, with instruction of CDC handwashing guidelines. Education of proper handling of dinnerware with additional changes and expectations added to General Employee Orientation by CDM. Nursing staff were educated on responsibility to maintain refrigerator logs routinely and handwashing as well. <b>Monitoring:</b> The CDM/Designee will conduct random handwashing observations, 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. New logs placed for equipment/utensils-daily checks to be completed per shift by scheduled staff, with random monitoring by CDM/Designee 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. The Director of Nursing/Designee will do systematic audits of refrigerators on units 5x per week for 1 month, 3x per week for 3 months and 2x per week for 2 months. Results of these audits will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>				

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	<p>thermometer.</p> <p>At 11:55 A.M., Employee #26 was observed donning gloves on both hands, handled paper menus, opened a can of soup and placed the bowl of soup in the microwave, obtained a bowl of fruit by placing her contaminated gloved hand over the top of the bowl, placed it on a tray to be served to a resident.</p> <p>From 12:00 P.M.-12:33 P.M. Cook #25 had donned clean gloves at the start of the meal service, she opened and the reached in the cooler doors several times with her gloves on and retrieve food items, she handled the paper menus, opened drawers, obtained plates from the plate warmer and continued to serve food without changing her gloves. She was also observed holding the plates with her thumb on the inside rim, touching the food. Employee #27 was observed serving food from the steam line and was handling paper menus, opening drawers to retrieve utensils, and pressed the metal handicap button on the side of the wall to open the dietary door two times during the food service. Employee #27 was observed serving food by holding the plate with her thumb on the inside rim touching the food. She was not observed to wash her hands or use gloves during the meal service.</p>			

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	<p>At 12:35 P.M. Employee #28 was observed mixing cookie dough in a large metal bowl. Employee #28 donned a pair of gloves, walked over to the mixer on the counter and placed pieces of cookies in the mixer. While the cookies were mixing, she opened a drawer to obtain a spatula, walked over to the large trash barrel and lifted the lid with her gloved hand to throw away trash, then returned to the mixer and emptied the cookie pieces into the batter in the metal bowl. With her contaminated gloved hands, she smoothed the cookie pieces over the batter.</p> <p>On 8/24/15, from 9:10 A.M.-9:20 A.M., an observation of the nourishment refrigerators on the nursing units was conducted with the Dietary Manager and the following was observed:</p> <p>At 9:10 A.M., on the Birch, the unit the freezer had no thermometer in it. A red sticky substance was splattered on all of the metal racks and the two plastic drawers on the bottom of the refrigerator. Review of the refrigerator temperature sheet indicated no freezer temperatures were documented for the month of August. An interview at that time with the Dietary Manager indicated the cleaning and temperatures of the</p>						

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	<p>nourishment refrigerators on the nursing units were the responsibility of the nurses not the Dietary department.</p> <p>At 9:20 A.M. on the Dogwood unit, an observation of the monthly refrigerator temp log indicated no temperatures were documented for the refrigerator or freezer on August 16, 17, 18 and 19th 2015. An interview, at that time, with LPN #29 indicated it is the responsibility of the night shift on each unit to clean and record the temperatures every night for the nourishment refrigerators.</p> <p>On 8/24/15 at 9:00 A.M., a second kitchen tour was conducted with the Dietary Manager and the following was observed:</p> <p>A large standing mixer had a dried white substance splattered on the back of the mixer. An interview at that time with the Dietary Manager indicated the mixer should not have been put away like that. Three plastic spatulas and one metal cake server were put away as clean in a metal drawer and each utensil had a dried brown substance on it.</p> <p>On 8/24/15 from 11:25 A.M.-11:45 A.M., a second food service observation was made the following was observed:</p>			

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	<p>At 11:25 A.M., Cook #25 was preparing pureed chicken in the robo coupe mixer. She donned gloves and placed the chicken breasts in the blender, her cellular phone rang, she picked up the phone with her gloved hands to turn the phone off, then she walked across the kitchen into the dry pantry room obtained a container of chicken base, she removed the lid and with her gloved hands walked to the large trash barrel and lifted the lid, to throw the trash away, then returned to the robo coupe mixer and continued to prepare the pureed chicken. Cook #25 was not observed to change her gloves until the pureed chicken was completely prepared.</p> <p>At 11:42 A.M., Cook #25 was observed to remove 3 ladles from a metal drawer to use during food service on the steam table. One ladle had a dried brown substance on the inside of it.</p> <p>During an interview, on 8/24/15 at 4:16 P.M., the Dietary Manager indicated all dishes and utensils should not be put away until they were inspected. She further indicated her expectation of staff, during food service, gloves were changed between tasks and their hands should be washed frequently. She indicated if staff served without gloves they should not touch the food and wash their hands</p>			

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	<p>frequently.</p> <p>On 8/24/15 at 4:30 P.M., review of the current policy titled "Refrigerator and Freezers," with a revised date of 2006, received from the Assistant Director of Nursing, indicated "...2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 3. Monthly tracking sheets will include time, temperature, initials, and "action taken."...4. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily...10. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary...."</p> <p>On 8/25/15 at 1:15 P.M., review of the undated current policy titled "Dish Washing/Ware Washing Procedures" received from the Dietary Manager indicated "...All dishes and cookware will be washed and sanitized after each use...2. d. Each rack will be inspected for items that may not have come completely clean after completing the washing cycle. Dirty items will be run through again until they are completely clean...."</p> <p>On 8/25/15 at 1:30 P.M., review of the current policy titled "Personnel</p>			

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	<p>Adherence to Sanitary Procedures," with a revised date of 2006, received from the Dietary Manager indicated "...1. c. Staff must wash their hands after each trip to the restroom, after leaving storage rooms, washrooms, etc., after touching the hair, mouth, or nose, and at any other time when contamination could occur...3. If gloves are used in food preparation, Food Services and Dietary Personnel will wash hands before donning gloves. If a task is interrupted, gloves will be removed and clean gloves donned when the task is resumed...."</p> <p>2. During the dining observation, on 8/19/15 at 11:50 A.M., Activity Assistant #5 was observed to wash her hands for 15 seconds then she served Resident #235 her meal. She was observed to wash her hands for 15 seconds two more times between serving Resident #234 and Resident # 106 their meal trays. At 11:59 A.M., CNA (Certified Nursing Assistant) #6 was observed to wash her hands, turned off the faucet with the paper towel, then proceeded to use the same paper towel to dry her hands. After drying her hands she was observed serving Resident #236 her meal tray.</p> <p>During the dining observation, on 8/21/15 at 7:13 A.M., Employee #8 was observed to wash her hands for 10 seconds and then served Resident # 149</p>			

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F 0431 SS=D Bldg. 00	<p>his meal tray. At 7:20 A.M., CNA #6 was observed to wash her hands, turned off the faucet with the paper towel, then proceeded to use the same paper towel to dry her hands. She, then was observed assisting Resident #171 to her table.</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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</p>			

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	<p>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 ensure expired medications were disposed of in a timely manner, failed to ensure appropriate labeling of medication and failed to ensure medications were stored in a proper manner on 2 out of 9 medication carts in the facility.</p> <p>Findings include:</p> <p>1. On 08/25/2015 at 10:44 A.M., one out of four insulin vials observed on the Cedar Unit medication cart was labeled to belong to Resident #84. The vial for Resident #84 had no dated indicating when the vial had been opened.</p> <p>During an interview, on 08/25/2015 at 10:44 A.M., QMA (Qualified Medication Assistant) #1 indicated the Lantus insulin vial for Resident #84 had been opened and was not labeled with an open date.</p> <p>2. On 08/25/2015 4:31 P.M., Novolog insulin was observed with an expiration date of 08/22/2015 labeled on the vial. The vial belong to Resident #91, and was</p>	F 0431	<p><b>F431 DRUG RECORDS,LABEL/STORE DRUGS &amp; BIOLOGICALS.</b> The facility will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable <b>Corrective Action:</b> Resident #84 and #91 expired insulin was discarded and new insulin vials were obtained from the pharmacy. The medications located in the Birch medication refrigerator were discarded and the refrigerator unit was replaced with a new one (Surveyors misquoted this refrigerator as the Dogwood refrigerator). Medication carts were cleaned and loose pills were discarded. <b>How others</b></p>	09/25/2015

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	<p>located in the medication cart in Dogwood Hall.</p> <p>During an interview, on 08/25/2015 at 4:32 P.M., LPN #15 confirmed the Novolog insulin labeled for Resident #91, expired on 08/22/2015.</p> <p>During a record review on 08/26/2015 at 4:51 P.M., medication administration record for Resident #91 indicated resident had received doses of Novolog insulin after the labeled expiration date.</p> <p>3. On 08/25/2015 at 10:44 A.M., four pills and one capsule were observed loose behind packets of medication in the medication cart drawer in Cedar Hall. During an interview at this time QMA #11 confirmed there were five loose pills in the medication cart and dirt located in the resident cup area of the medication cart in Cedar Hall.</p> <p>4. On 08/25/2015 at 4:38 P.M., a refrigerator in the medication room in Dogwood Unit was observed to have a thick ice built up in freezer section of the refrigerator. The ice built up prevented freezer door from moving. There was thirty medication bottles were observed to be sitting in two boxes in the refrigerator. The two boxes had standing water in them. The labels on the</p>		<p><b>identified:</b> All residents receiving medications have the potential to be affected by this alleged practice. <b>Preventative Measures:</b> A daily schedule was developed for cart audits to review for dated medications, expired medications and this will include an inspection of the medication room and refrigerator. Staff education completed on drug labeling and storing. <b>Monitoring:</b> The D.O.N/Designee will complete a random audit for drug storage and labeling 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>medication bottles were partially blurred.</p> <p>During an interview, on 08/25/2015 at 4:39 P.M., RN #16 confirmed the medication bottles were sitting in standing water located in two boxes inside refrigerator located in the medication room in Dogwood unit.</p> <p>On 08/26/2015 at 4:51 P.M., the DON (Director of Nursing) provided a policy titled, "Preparation and General Guidelines," dated December 2009, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedures B. The date and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose)..." and "... F. Medication in multidose vials may be used (until the manufacturer's expiration date/for the length of time allowed by state law/according to facility policy/for thirty days) if inspection reveals no problems during that time...."</p> <p>On 08/26/2015 at 4:51 PM, the DON provided a policy titled, "Medication Storage in the Facility," dated December 2009, and indicated the policy was the one currently used by the facility. The policy indicated "...M. Outdated, contaminated, or deteriorated</p>			

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F 0441 SS=E	<p>medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (see Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (see IC3: ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS FROM THE DISPENSING PHARMACY), if a current order exists....". and "...N. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures...."</p> <p>On 08/26/2015 at 4:51 PM, the DON provided the manufacturers guidelines for the refrigerator in the medication room on Dogwood unit. The manufacturers guidelines indicated "...For maximum energy efficiency, defrost freezer section whenever frost accumulates to a thickness of 1/4" or more on freezer walls. Note that frost tends to accumulate more during the summer months...."</p> <p>3.1-25(m) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT</p>			

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Bldg. 00	<p><b>SPREAD, LINENS</b></p> <p>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 and interview the facility failed to ensure timely disposal of sharps containers on 2 of 9 medication</p>	F 0441	<b>F 441 INFECTIONCONTROL, PREVENT SPREAD, LINENS</b> The facility will establish and maintain an Infection Control	09/25/2015

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	<p>carts. The facility also failed to properly transport residents clothing throughout facility. In addition, the facility failed to ensure staff washed their hands in a manner to prevent the spread of infection on 2 of 3 units.</p> <p>Findings include:</p> <p>1. During an observation, on 8/19/2015 at 10:17 A.M., a sharps container on the Birch unit medication cart had syringes sticking out, over the the full line.</p> <p>On 08/24/2015 at 3:18 P.M., a sharps container was observed to be over the full line in Birch medication cart.</p> <p>During an interview, on 08/24/2015 at 3:19 P.M., LPN #16 indicated the sharps container was over the full line on Birch medication cart and indicated she would be "changing it".</p> <p>On 08/26/2015 at 12:00 PM, the DON (Director of Nursing) provided a policy titled, "Sharps Disposal," dated September 2005, and indicated the policy was the one currently used by the facility. The policy indicated "...c. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when</p>		<p>Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Personnel will handle, store, process and transport linens so as to prevent the spread of infection. <b>Corrective Action.</b> Sharps containers on the Birch Unit were changed out for new ones. <b>How others identified:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Preventative Measures:</b> Correct handwashing procedures were reviewed and staff were checked off by return demonstration. Covers were purchased to cover laundry carts to ensure linens are not exposed during delivery. Staff were also educated on linen handling/transporting and when to replace sharps containers. <b>Monitoring:</b> The D.O.N/Designee will conduct random staff handwashing observations for 5x per week for 1 month, 3x per week for 3 months, and 2x perweek for 2 months. Results of this audit will be presented to QAPI for further need for monitoring. The Housekeeping/Laundry Supervisor/Designee will monitor for appropriate linen handling and transporting 5x per week for 1 month, 3x per week for 3 months,and 2x per week for 2 months. Results of this audit will be presented to QAPI for further</p>		

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	<p>attempting to push sharps into the container...."</p> <p>2. During an observation on 08/21/2015 at 04:55 A.M., CNA (Certified Nursing Assistant) #56 failed to wash her hands while caring for a resident in their room and she proceeded to come out of the room with a trash bag in her hand; without stopping, with trash bag still in hand she stopped at a resident in the hallway to adjust his oxygen tubing around his ears.</p> <p>On 08/25/2015 at 4:31 P.M., LPN #15 was observed to wash her hands for a total of 12 seconds and proceeded to her medcart to prepare medications.</p> <p>On 08/26/2015 at 12:30 P.M., the DON provided a policy titled, "Handwashing/Hand Hygiene," dated August 2007, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents;...."</p> <p>"When &amp; How to Wash Hands / Handwashing" (last updated July 22, 2015) was retrieved on 8/26/15, from the</p>		<p>need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>				

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	<p>Center of Disease Control (CDC) website. The CDC guidelines indicated "...Scrub your hands for at least 20 seconds..."</p> <p>3. On 8/19/15 at 10:06 A.M., during initial tour, a striped blanket was observed on the floor in a linen closet on the Dogwood Unit.</p> <p>On 8/19/2015 at 12:33 P.M., Employee #9 was observed transporting uncovered personal clothing on a hanging laundry cart through the hallways.</p> <p>On 8/21/2015 at 6:47 A.M., Employee #9 was observed transporting uncovered personal clothing on a hanging laundry cart through the hallway.</p> <p>On 08/21/2015 at 7:43 A.M., a clean laundry cart with resident clothing with resident clo thing hanging on it was observed to be sitting in hallway uncovered.</p> <p>On 8/21/2015 at 2:33 P.M., Employee #9 was observed transporting uncovered sheets in a push cart down the hallway.</p> <p>On 08/24/2015 at 12:04 P.M., a clean laundry cart with resident clothing hanging on it was observed to be sitting in front lobby unattended and uncovered.</p>			

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F 0465 SS=E Bldg. 00	<p>On 8/25/2015 at 1:25 P.M., during the environmental tour on the Cedar Unit, linen was observed on the floor, in a linen closet.</p> <p>During an interview, on 8/21/2015 at 2:34 P.M., Employee #9, indicated she was not instructed to cover the laundry during delivery.</p> <p>3.1-18(l) 3.1-18(b)(6) 3.1-19(g)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to ensure walls, doors, and carpets in seven residents rooms were in good repair and failed to ensure resident rooms and facility halls were free from urine odor for two of three nursing units. (Birch and Cedar Units)</p> <p>Findings include:</p> <p>On 08/20/2015 from 09:16 A.M. to 10:55 A.M., an environmental observation was</p>	F 0465	<p><b>F 465</b> <b>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</b> The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. <b>Corrective Action:</b> Room 202, 220, 114, 230 and 132 were deep cleaned to remove odors. Walls were painted to correct scrapes and scuffs. <b>How Others Identified:</b> All residents, staff and visitors have the potential to be affected by this alleged</p>	09/25/2015	

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	<p>conducted, during which the following was observed:</p> <p>The resident restroom in Room 202 was observed to have a strong odor. There were several quarter size areas areas of yellow/clear liquid on the floor surrounding the toilet. A dark gray area the size of a school ruler observed on the bathroom floor in the doorway in resident room.</p> <p>On 08/25/2015 from 09:18 A.M. thru 10:40 A.M., a second environmental observation was conducted, during which the following was observed:</p> <p>Several dark brown areas ranging from the size of a quarter to the size of a basketball observed on the carpet in Room 220. There was peeling paint on bathroom door the size of a football observed in Room 221.</p> <p>There was a brown raised substance observed to be on the carpet by the head of the bed and a smear of brown raised substance observed on the carpet and wheel of a bedside table located in Room 114-2.</p> <p>On 08/25/2015 at 9:27 A.M., observation of Room 220 indicated the carpet to have several stains ranging from the size of a</p>		<p>deficient practice.</p> <p><b>Preventative Measures:</b> Environmental rounds were done to identify other rooms with odors, scrapes, scuffs and subsequent problems were corrected. Staff education completed on how to report environmental concerns to Maintenance/Housekeeping supervisors. <b>Monitoring:</b> The Executive Director/Designee will complete weekly facility rounds to monitor for odors and other environmental corrections. Results of this audit will be presented to QAPI for further need for monitoring. <b>Date of Completion:</b> September 25, 2015.</p>		

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	<p>basketball down to the size of a baseball.</p> <p>On 08/25/2015 at 9:52 A.M., several scrapes and scuffs on door and doorway frame observed in Room 230.</p> <p>On 08/25/2015 at 9:54 A.M., two scuff marks the size of school rulers observed to be on the wall of the bathroom in Room 132.</p> <p>Interviews were conducted on 08/25/2015 at 1:15 P.M. related to environmental issues. Employee #22 indicated when a room has too much odor and there is nothing else he can do to help it, the carpet is taken up. He further indicated the staff clean up the "urine" smell every day. Employee #23 indicated Room 202 was cleaned with urozyme, "digestive stuff," and an air purifier 3 times a week. Employee #21 indicated there was a gray area on the floor in the bathroom of Room 202. Employee #21 indicated the scuffs in Room 132 were from a residents wheelchair. Employee #22 indicated Room 220 had several dark colored areas on the carpet. She further indicated the resident had spilled his urinal on the floor at times in the past. Employee #21 indicated that it had been a challenge with the paint on the bathroom doors. Employee #21 indicated there was a hole</p>			

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	<p>in the drywall and the painter would have to fix it in Room 102. Employee #21 indicated if the room will not come clean after multiple cleanings, the carpets are taken up. Employee #22 indicated the housekeeping department treats the "urine" smell everyday.</p> <p>3.1-19(f)</p>				